
Plan Information and Rights

This section includes information about general provisions that apply to the Benefit Plans, explains how the Plans are administered, and describes your rights under two laws:

- ◆ *ERISA (the Employee Retirement Income Security Act of 1974) ensures that benefit Plans are administered responsibly and gives you certain rights.*
- ◆ *COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) entitles you to continue Medical and/or Dental coverage (at your expense) for a limited time after your coverage or coverage for a dependent ends.*

Taken together, the Summary Plan Description for each Plan and this Plan Information and Rights section are considered to be your total Summary Plan Description as required (for most of the Plans) by the Employee Retirement Income Security Act (ERISA) of 1974.

Plan Information and Rights

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Plan Information and Rights



About This Section

This section describes your rights to:

- ◆ continue health care coverage in the event that you are no longer covered under the Benefit Fund for Hospital and Health Care Employees Plan;
- ◆ portability of your coverage should you become covered under another employer's or union's benefit plan;
- ◆ privacy in the disclosure of your personal health information; and
- ◆ enforce your rights under Federal law.

If there is any conflict or inconsistency between the benefits described in this book and the contracts and agreements that are the official plan documents, the legal documents constituting the official plan documents will control.

Benefit Fund participants and beneficiaries should not rely on any oral description of the plans because the written terms of the plans will always govern.

Continued Health Care Coverage through COBRA

A Federal law—the Consolidated Omnibus Budget Reconciliation Act—(commonly known as “COBRA”) requires organizations who sponsor health care plans to offer a temporary coverage extension in certain situations. This section provides a detailed description of COBRA coverage.

Who May Be Eligible

COBRA coverage may be provided to “qualified beneficiaries” who include:

- ◆ an active working member of the Benefit Fund covered under the Fund on the date of a qualifying event,

- ◆ the spouse or dependent of a member covered under the Fund on the date of the qualifying event or
- ◆ if a member is on COBRA, a newborn or adopted child who becomes the member's insured dependent while COBRA coverage is in effect, provided the member adds the child within 30 days of the birth or adoption and pays the required premium.

The chart on the next page shows the Qualifying Events that may entitle you (or your dependent) to COBRA coverage. The chart also shows the length of time coverage may continue.

This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continued coverage provisions of the law. You and your spouse should take time to read this section carefully.

Remember: *The maximum continuation coverage period is measured from the date of the event that eventually leads to the loss of coverage, not from the date on which coverage is actually lost. For example, if you are eligible for 26 weeks of extended coverage due to disability, the continuation coverage period will run concurrently with the extended coverage period.*

Qualifying Event	Who May Continue and for How Long
Your hours are reduced so that you are no longer eligible for benefits, your employment ends for any reason other than gross misconduct, or you retire.	<p>You and your dependents may continue coverage for 18 months (29 months if any family member who is a qualified beneficiary is disabled at time of the event or within 60 days of beginning COBRA benefits).</p> <p>If you become entitled to Medicare benefits and during the subsequent 18-month period lose coverage due to a termination of employment or a reduction in hours, your family members (but not you) will be entitled to a maximum of 36 months of coverage from the date of your Medicare entitlement.</p> <p>If you are on duty in the uniformed services for more than 31 days, you, your spouse and dependents may continue coverage for 18 months from the date of your absence.</p>
Divorce/legal separation and you stop coverage for your spouse or children.	Your ex-spouse or legally separated spouse and/or your dependent children may continue coverage for up to 36 months from date of divorce/legal separation.
Dependent child no longer eligible.	Dependent children who no longer qualify for coverage may continue coverage for up to 36 months.
You become entitled to Medicare and drop the Benefit Fund Plan (this means you have applied for coverage and been notified that your coverage is in effect).	Dependent spouse/children may continue coverage for up to 36 months.
You die.	Dependent spouse/children may elect coverage for up to 36 months.

Notification of COBRA Eligibility

The Benefit Fund, your employer, or the person entitled to COBRA coverage may be required to provide information about COBRA eligibility, as follows:

- ◆ **Benefit Fund**—When a member becomes covered under the Fund, the Benefit Fund must send a written notice about COBRA rights to the member and to his or her spouse, if applicable. The Benefit Fund will send a written notice about COBRA rights to any individual for whom it receives notice, as described below.
- ◆ **Your Employer**—Your employer must send the Benefit Fund written notice within 30 days of the event if your employment ends (except for gross misconduct), your hours are reduced so you are not eligible for benefits, you become entitled to Medicare, or you die.
- ◆ **You, Your Spouse, or Your Dependent**—If you and your spouse divorce, you and your spouse legally separate and you drop coverage, or if your dependent child is no longer eligible for coverage, **you, your spouse, or your dependent must notify the Benefit Fund in writing within 60 days of the event.**

Electing COBRA Coverage

When the Benefit Fund is notified (or on notice) that a COBRA qualifying event has occurred, they will notify each qualified beneficiary (you, your spouse, or your eligible dependents) about his or her right to choose continued coverage.

Under the law, you (the qualified beneficiary) have **60 days** to inform the Benefit Fund that you want to continue coverage. This 60-day period is counted from the date the Fund notifies you of the right to elect coverage, or the date you lose coverage, if later. **If you do not return a signed election form within this 60-day period, you will lose your right to elect COBRA coverage.**

COBRA Coverage Options

Assuming the Qualified Beneficiary was covered immediately before the COBRA qualifying event, his or her COBRA coverage options are as follows:

- ◆ **Wage Class I Members**—For most COBRA events, each Qualified Beneficiary may elect to continue medical, prescription drug and dental coverage OR elect medical and prescription drug only (but not dental). However, if you lose coverage because your Wage Class changes, you may elect the coverage needed to keep the same level of coverage you had before the change. Therefore:
 - **If you move to Wage Class II**, you and/or your dependents may elect prescription drug and dental coverage (or you may elect prescription drug coverage only with no dental).
 - If you move to Wage Class III, you may elect prescription drug and dental coverage (or just prescription coverage), while eligible dependents may elect medical, prescription, and dental coverage (or just medical and prescription).
- ◆ **Wage Class II Members**—Each Qualified Beneficiary may continue the medical benefits that covered the person immediately before the COBRA qualifying event. If your Wage Class changes to Wage Class III, your dependents may continue medical coverage provided they were covered immediately before your change in Wage Class.
- ◆ **Wage Class III Members**—You (the 1199C member) may continue the medical coverage in effect immediately before the COBRA qualifying event.

Individual Election

If the member does not elect to continue all existing coverage, then each Qualified Beneficiary has the right to make a separate election of COBRA coverage. However, if a dependent is under 21, the member or the spouse may make the election.

The Cost of COBRA Coverage

Any qualified beneficiary who elects to continue coverage must pay the full premium cost plus 2% for administrative expenses. A disabled qualified beneficiary (and any dependents whose eligibility continues because of a disabled qualified beneficiary) who extends coverage for more than 18 months will be required to pay 150% of the premium for months 19 through 29 (or through the 36th month if applicable).

The first premium payment is due 45 days after the date you elect COBRA coverage. Subsequent payments for continued coverage must be made no later than the first day of coverage in each month, subject to a 30-day grace period.

How Long Coverage May Last

In the event of termination of employment or reduction of hours, coverage may be continued for 18 months; the continuation period for other qualifying events is 29 or 36 months (see the chart earlier in this section).

However, if you or any family member is disabled under the Social Security laws at the time of the reduction in hours or termination of employment, or becomes disabled within 60 days of the commencement of COBRA benefits, you and family members who are also entitled to COBRA coverage may extend the continued coverage period to 29 months.

To obtain an extension to 29 months, you must notify the Benefit Fund within 60 days of a determination by the Social Security Administration that you or a family member are disabled under the Social Security laws and before the end of the first 18 months of COBRA coverage. If Social Security determines that the person is no longer disabled, the Benefit Fund must be notified within 30 days of the final determination by Social Security.

If, during the 18- or 29-month period, a second event that would require continued coverage occurs, coverage for your spouse or dependents (as applicable) may be extended—**but not beyond a total period of 36 months**. The Benefit Fund must be informed in writing if a second event is divorce/legal separation or if a child is no longer eligible for coverage.

In addition, if you become entitled to Medicare benefits and during the subsequent 18-month period lose coverage due to a termination of employment or a reduction in hours, your family members (but not you) will be entitled to a maximum of 36 months of coverage from the date of your Medicare entitlement.

Continued Coverage May End Before the Maximum Period

The law also provides that continued coverage for an individual may be cut short for any of the following reasons:

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- ◆ the premium for the individual's continued coverage is not received on time (this means 45 days after COBRA is elected or 30 days after the due date of every subsequent premium),
 - ◆ an individual who has elected COBRA coverage becomes covered under another health care plan as an employee or dependent—unless the other plan contains a pre-existing condition exclusion or limitation that applies to the individual or the new plan does not cover the particular service needed. Continued coverage will not terminate until the individual is no longer affected by a pre-existing condition exclusion or limitation under the other group health plan,
 - ◆ the individual becomes entitled to Medicare benefits after electing COBRA coverage,
 - ◆ in the case of an individual whose coverage is being continued because of the special extended coverage period for disabled individuals, it is determined that the individual is no longer disabled under the Social Security laws,
 - ◆ a member who is on duty in the uniformed services fails to apply for, or return to, active employment with the employer or
 - ◆ the Benefit Fund no longer provides group health coverage to any of its members.

COBRA coverage may also be cut short if your contributing employer stops contributing to the Benefit Fund and later makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of that employer's employees formerly covered under the Benefit Fund. In that case, the plan maintained by the employer (or the other multiemployer plan), from that date forward, generally has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving coverage under the Benefit Fund on the day before the cessation of contributions.

Conversion Coverage

If your period of COBRA continuation coverage expires, the plan administrator must provide you the option of enrolling yourself, at your own cost, under a conversion health plan otherwise generally available under the plan within 6 months of the expiration of your COBRA coverage.

For More Information

If you experience a Qualifying Event, additional information will be provided (assuming you notify the Benefit Fund when you are required to do so).

If you have any questions, please write or call the Benefit Fund. Also notify the Benefit Fund if your marital status changes or if there are any address changes.

General Exclusions

The Benefit Fund will not pay any benefits for:

- ◆ accidental death, injury, or sickness covered by Workers' Compensation Law or Act or similar legislation, except as otherwise provided in the plan,
- ◆ benefits, services, equipment, or supplies provided by or eligible for payment by or through Medicare, to the extent allowed under Federal law, or through a government or instrumentality of a nation, state, province, or other subdivision of government,
- ◆ disability payments and/or charges for services and supplies with respect to a deceased member if the dependent or authorized person fails (or refuses) to give the Fund an executed assignment of their interests (to the extent of benefits provided by the Fund) in a claim or proceeding to recover from some other source,
- ◆ charges for drugs, devices, medical treatments, or procedures that are experimental or investigative as defined in the plan document or insurance contract,
- ◆ charges for injury or sickness resulting from:
 - war, declared or undeclared, or any act of war,
 - committing or attempting to commit a felony or
 - use of drugs, except as prescribed by a physician or dentist or from use of legally obtained over-the-counter drugs,
- ◆ charges for injury or sickness resulting from a member's or an eligible dependent's suicide or attempt to commit suicide, whether sane or insane,
- ◆ charges that would not have been made if no coverage existed or charges that neither the member nor eligible dependent is personally liable to pay,
- ◆ charges for services or supplies that are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government,
- ◆ the first \$5,000 of medical expenses that arise from an automobile accident if the member (or eligible dependent) owns an automobile but does not have auto insurance,
- ◆ expenses for which a third party is liable and for which the member or eligible dependent has not signed a subrogation/reimbursement agreement (except as otherwise provided under New Jersey law relative to disability benefits) or
- ◆ services or supplies that are excluded by any vendor providing services to the Fund under an agreement with the Fund.

About Appealing Denied Claims

The procedures described in this section apply to all claims for benefits other than medical or dental benefits. See the medical and/or dental section that applies to you for claims and appeal information applicable to medical and/or dental claims.

To receive benefits, you or any other plan participant must file claims according to the procedures of each type of benefit. (Plan participants include the member, eligible dependents, pensioners, qualified retirees or their beneficiary or their duly-authorized representative.) The Fund has the right to request reasonable proof and documentation of claims, including, but not limited to:

- ◆ completed claim forms listing all services and supplies and certified by an appropriate provider (physician, dentist or dental specialist, optician, optometrist, or ophthalmologist),
- ◆ completed prescription forms submitted by the participating pharmacy or a valid, paid, itemized receipt and claim form submitted by the plan participant,
- ◆ a completed claim form certified by a physician and other documents as required by the Fund for disability benefits or
- ◆ a certified copy of the death certificate for death benefits.

Notification of Decision

You will be notified of the claim decision within 90 days after you file your claim, unless special circumstances require more time. In that case, you will receive written notice of this extension within the 90-day period. This extension will not exceed 180 days from the date the claim is filed.

If the claim is denied in whole or in part, you will receive a written notice that outlines the specific reasons for this denial. This notice also will refer to the plan provisions on which the denial is based and will describe any additional information or material needed to honor the claim, along with an explanation of why this information is needed.

Filing an Appeal

Under the Employee Retirement Income Security Act of 1974 as amended (ERISA), you have the right to appeal a denied claim. You must file a written appeal within 60 days of receiving the written claim denial. Your letter should include a copy of the denial letter and any additional claim information such as appropriate issues, comments and reasons why you believe the claim should not have been denied.

To appeal a denied claim, follow these procedures:

- ◆ **Medical**—To appeal a claim denial for hospital or medical benefits, submit your appeal directly to Keystone Health Plan East for the Point of Service Plan or to Blue Cross/Blue Shield for the Out-of-Area Medical Plan. If supplemental medical benefits paid by the Benefit Fund (such as hospital copayments for using 1199C facilities) are denied, submit your appeal to the Benefit Fund.
- ◆ **All Other Benefits**—To appeal a denied claim for supplemental medical, out-of-area dental, disability, prescription, vision (if applicable), death and accidental death and

dismemberment, or scholarship benefits, submit your initial appeal to the Director of the Benefit Fund, following the process outlined in “Appeals Submitted to the Benefit Fund” below.

- ◆ **Managed Dental Care Plan Complaint**—If you wish to file a complaint, submit a Dental Complaint Information Form to the Fund Office (the form is available from the Fund Office). The complaint will be reviewed by the Fund, a representative of the Managed Dental Care Plan and/or the Benefit Fund Dental Consultant and Patient Care Committee. You will be notified of the findings. If the complaint is not resolved to your satisfaction, you may appeal to the Fund’s Board of Trustees as explained below.

Appeals Submitted to the Benefit Fund

You must file a written appeal within 60 days of receiving the written claim denial. If you (or any other plan participant) send the Benefit Fund a written request for an appeal, the Director, or a designee, will review the claim and make a decision within 30 days of receiving the request.

If the claim is denied, you have the right to request (in writing) that the Trustees conduct a full and fair review of the claim denial. You may review pertinent documents and submit issues and comments in writing to the Trustees within 30 days from the notice of the Director’s denial.

If your first request for review by the Trustees is received more than 30 days before the next regularly scheduled Trustees’ meeting, a decision will be made by the date of that meeting. If the Trustees receive your request less than 30 days before the next Trustees’ meeting, a decision will be made by the date of the second Trustees’ meeting after your request is received. The decision will include specific reasons for the denial and specific references to the plan.

If special circumstances warrant an extension of time for reviewing the claim (such as the need to hold a hearing), the Trustees will notify you in writing prior to the extension. In this case, a decision will be made no later than the third meeting after the initial receipt of the request for review by the Trustees.

The Trustees’ decision on the appealed claim will be conclusive and binding upon all members, dependents, pensioners, qualified retirees, and/or beneficiaries.

If you challenge the decision, a review by a court of law will be limited to the facts, evidence, and issues presented during the claims procedure set forth above. Facts and evidence that become known to you after exhausting the appeals procedures may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the initial appeal will be deemed waived.

Plan Operation

This section gives you information about how the benefit plans are administered.

Plan Administration

The Benefit Fund for Hospital and Health Care Employees, Philadelphia and Vicinity is administered by a Board of Trustees. The Board includes ten members, five appointed by District 1199C, National Union of Hospital and Health Care Employees, AFSCME, AFL-CIO, and five appointed by the contributing employers.

In general, the Board's responsibilities include, but are not limited to:

- ◆ developing and amending the Health and Welfare Plan and
- ◆ providing for the payment of benefits in accordance with the provisions of the Health and Welfare Plan.

The Board is also the "Plan Administrator" of the Benefit Fund. The Plan Administrator has the right in their sole and exclusive discretion to decide all questions arising from or respecting interpretation, application, or administration of the plan, including determining:

- ◆ eligibility for benefits or services furnished by the plan,
- ◆ rules for participation in the plan,
- ◆ resolution of factual disputes in benefits or beneficiary issues,
- ◆ whether a particular medical or surgical procedure is medically necessary and
- ◆ whether a particular condition is physical or mental in nature.

These decisions by the Plan Administrator are conclusive and binding upon all members, dependents, and/or beneficiaries.

In accordance with the Trust Agreement, the Board may delegate authority to a subcommittee of Trustees or to another fiduciary to perform specific functions with respect to administration of the Fund.

The Board performs day-to-day administrative functions through the Director of the Benefit Fund. You may write to the Director of the Benefit Fund at this address:

Plan Administrator/Executive Director of the Benefit Fund
Benefit Fund for Hospital and Health Care
Employees, Philadelphia and Vicinity
1319 Locust Street, Philadelphia, PA 19107
215-735-5720

Names and Addresses of the Trustees

Employer Trustees

James J. Mohan
Assistant Vice President,
Personnel Services
Temple University
University Services Building
Broad and Oxford Street
Philadelphia, PA 19122

Mario Porro
Chief Financial Officer
Inglis Foundation
2600 Belmont Avenue
Philadelphia, PA 19131

Stephanie Sloggett O'Dell
Vice President,
Labor Relations & Chief Negotiator
Tenet Health Care
13737 Noel Road
Suite 100 Dallas, TX 75240

Brian Bowie
Associate Vice President,
Human Resources
Thomas Jefferson University
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Philadelphia, PA 19107

William Kreider
Assistant Vice President,
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One Medical Center Boulevard
Upland, PA 19013

Union Trustees

Henry Nicholas
President
District 1199C, National Union of Hospital &
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1319 Locust Street
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1319 Locust Street
Philadelphia, PA 19107

Marguerite Morrison
Secretary-Treasurer
District 1199C, National Union of Hospital &
Health Care Employees
1319 Locust Street
Philadelphia, PA 19107

Agent for Service of Legal Process

If it becomes necessary to take legal action because of a dispute relating to the plan, legal process may be served on the Trustees or the Benefit Fund Director at the Benefit Fund Office (1319 Locust Street, Philadelphia, PA 19107).

Plan Name and Plan Year

The official plan name is the Benefit Fund for Hospital and Health Care Employees—Philadelphia and Vicinity. The Plan Year begins on January 1 and ends on December 31 of each year.

Plan Number

The Employer Identification Number (EIN) assigned to the Board of Trustees is 23-2627429. The Plan Number for the benefit plan is 501.

Plan Type

This plan is a multiemployer health and welfare plan designed to provide medical, dental, vision, prescription drug, disability, death, and accidental death and dismemberment benefits. This plan is intended to comply in all respects with the requirements of Title I of the Employee Retirement Income Security Act (ERISA).

Plan Assets and Funding

The assets of the plan are held in a trust fund under the trust agreement. The Board may, in its discretion, delegate management of certain fund assets to an investment manager(s).

The plan is maintained and contribution amounts are determined according to the provisions of the collective bargaining agreement between the union and the employers. Copies of the collective bargaining agreements are available in the Fund Office.

Portions of the plan are self-insured. This means the Trust's assets are used by the Fund and designated Claim Administrators to pay current benefit claims only. Although the Claims Administrator (if applicable) pays claims under the plan on behalf of the Fund, the Claims Administrator does not insure or guarantee that the claim will be paid. Rather, the Administrator relies on the Fund to provide it with enough money to pay the claims. The Administrator cannot pay the claims if the Fund does not provide the money to the Administrator.

For the portions of the plan that are insured, the insurance company is responsible for investing the premiums and paying benefit claims. The insurance company guarantees the payment of claims incurred before the group insurance contract terminates.

Contributing Employers

The plan is supported by contributions made by employers. Member contributions are neither required nor permitted. A list of contributing employers is available at the Fund Office. You may also request, in writing, information about whether a specific employer or employee organization is a sponsor of the plan, and if so, that organization's address.

Summary of Administrative Information

The following chart summarizes the specific plan numbers, as well as funding and administrative information, for each Plan.

<i>Type of Benefit</i>	<i>Administrative Information</i>
<p>Point of Service Medical Plan Group Numbers: 811093 418984 90020</p>	<p>The Plan is insured by:*</p> <p>Keystone Health Plan East** 1901 Market Street, Philadelphia, PA 19103</p> <p>AmeriHealth PA (available only to NJ residents) 1901 Market Street, Philadelphia, PA 19103</p> <p>AmeriHealth (available only to Delaware residents) 1901 Market Street, Philadelphia, PA 19103</p>
<p>Out-of-Area Medical Plan Group Number: 5543174</p>	<p>The Plan is insured by: *</p> <p>Personal Choice ** 1901 Market Street, Philadelphia, PA 19103</p>
<p>* Note: The Fund reimburses certain copayments from Fund assets as described in the <i>Point of Service Medical Plan</i> and <i>Personal Choice PPO Plan</i> sections.</p> <p>** Independent licensee of the Blue Cross and Blue Shield Association</p>	
<p>Managed Dental Care Plan</p>	<p>Benefits are self-insured and provided through a pre-paid agreement with: Dominion Dental Services, Inc. 115 S. Union St., Suite 300 Alexandria, VA 22314</p>
<p>Out-of-Area Dental Plan</p>	<p>Benefits are self-insured and administered by: O'Neill Consulting Corporation 1560 Old York Rd. Abington, PA 19001</p>
<p>Prescription Drug Plan Sponsor Number: 0417</p>	<p>Benefits are self-insured and administered by: Medco Health Solutions, Inc. 100 Parsons Pond Drive Franklin Lakes, NJ 07417</p>
<p>Disability Benefits</p>	<p>Benefits are self-insured and administered by: O'Neill Consulting Corporation 1560 Old York Rd. Abington, PA 19001</p>
<p>Death and Accidental Death & Dismemberment Benefits</p>	<p>The Plan is self-insured and administered by: O'Neill Consulting Corporation 1560 Old York Rd. Abington, PA 19001</p>
<p>Camp and Scholarship Benefits</p>	<p>Benefits are self-insured and administered by: Benefit Fund for Hospital and Health Care Employees, Philadelphia and Vicinity 1319 Locust Street Philadelphia, PA 19107</p>

Role of Insurance Companies and Other Third Parties

The administrative services provided by insurance companies or other companies for the benefit plans may include:

- ◆ network establishment, maintenance and management,
- ◆ pre-certification and other utilization review determinations, as well as the review of all utilization review appeals,
- ◆ payment of benefit claims, including benefit determination, claims processing and the initial review of appeals and
- ◆ certain other customer services.

Qualified Medical Child Support Orders

If a qualified medical child support court order (QMCSO) issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- ◆ name and last known address of the parent who is covered under this plan;
 - ◆ name and last known address of each child to be covered under this plan;
 - ◆ type of coverage to be provided to each child; and
 - ◆ period of time the coverage is to be provided.
- ◆ QMCSOs should be sent to the Benefit Fund Office. Upon receipt, the Benefit Fund will notify you and describe the plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the plan. As a beneficiary covered under the plan, your child will be entitled to information that the plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Your Rights Under HIPAA

Changing Your Benefits—Special Enrollment Events

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you, your spouse, or your child(ren) may enroll in the medical or dental plan at any time during the year in the case of marriage, birth or placement for adoption of a child, or loss of other coverage, as long as you provide written notice to the Benefit Fund within 30 days of the event. Medical coverage will be made retroactive to the date of the event (i.e., marriage, birth). Dental coverage will become effective on the first of the month following the event. Under certain circumstances, retroactive payroll deductions may be taken on a post-tax basis.

- ◆ **After declining health coverage.** If you are declining enrollment for yourself or your dependents (including your spouse) because of other medical or dental coverage, and eligibility for that coverage is lost due to certain reasons (divorce, legal separation, death, termination of employment, reduction in hours, or exhaustion of COBRA coverage under another plan), you may be able to enroll yourself or your dependents in this medical and/or dental plan in the future, provided that you request enrollment within 30 days after your other coverage ends.

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- ◆ **New dependents.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Your Health Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Benefit Fund for Hospital and Health Care Employees (the "Plan").

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your Medical, Dental and Disability benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers. Please review this notice carefully.

Our Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- ◆ make sure that health information that identifies you is kept private;
- ◆ give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- ◆ follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

- ◆ **For Treatment.** The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

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- ◆ For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
 - ◆ **For Health Care Operations.** The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to the Benefit Fund in summary fashion so it can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the Benefit Fund so it may be used without the Fund learning who the specific participants are.
 - ◆ **To the Benefit Fund.** The Plan may disclose your PHI to designated Benefit Fund personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to members of the Benefit Fund Office. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information:
 - may not be disclosed by the Plan to any other employee or department; and
 - will not be used by the Benefit Fund for any employment-related actions and decisions or in connection with any other employee benefit Plan sponsored by the Fund.
 - ◆ **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.
 - ◆ **Treatment Alternatives.** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
 - ◆ **Health-Related Benefits and Services.** The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
 - ◆ **Individual Involved in Your Care or Payment of Your Care.** The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the Hospital), or death.
 - ◆ **As Required by Law.** The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

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- ◆ **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
 - ◆ **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime. Information will be released in accordance with Benefit Fund policy.
 - ◆ **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.
 - ◆ **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.
 - ◆ **To Avert Serious Threat to Health or Safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
 - ◆ **Public Health Risks.** The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury, or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
 - ◆ **Health Oversight Activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
 - ◆ **Research.** Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.
 - ◆ **National Security, Intelligence Activities, and Protective Services.** The Plan may release your PHI to authorized federal officials:
 - for intelligence, counterintelligence, and other national security activities authorized by law; and
 - to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
 - ◆ **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
 - ◆ **Coroners, Medical Examiners, and Funeral Directors.** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- ◆ **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your Plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

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- ◆ To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.
 - ◆ Right to Amend. If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.
 - ◆ To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete; not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.
 - ◆ Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.
 - ◆ To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.
 - ◆ Right to Request Restrictions. You have the right to request a restriction on the health information the Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.
 - ◆ To request restrictions, make your request in writing to the Plan Administrator. You must advise us:
 - what information you want to limit;
 - whether you want to limit the Plan’s use, disclosure, or both; and
 - to whom you want the limit(s) to apply.
- Note:** The Plan is not required to agree to your request.
- ◆ **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.
 - ◆ To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
 - ◆ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to This Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any

information the Plan receives in the future. The Plan will post a copy of the current notice in the Benefit Fund Office at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Benefit Fund at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact the Benefit Fund Director, who is the Privacy Official at the Benefit Fund Office, at this address:

Privacy Official/Director of the Benefit Fund
Benefit Fund for Hospital and Health Care
Employees, Philadelphia and Vicinity
1319 Locust Street, Philadelphia, PA 19107
215-735-5720

Your Rights Under ERISA

As a participant in the Benefit Fund plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following:

Receive Information About Your Plan and Benefits

You are entitled to:

- ◆ Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- ◆ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated

summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- ◆ Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to:

- ◆ Continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage (see "Continued Health Care Coverage through COBRA" earlier in this section). You may review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- ◆ Receive a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you are entitled to:

- ◆ know why this was done and
- ◆ obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you or any other plan participant has any questions about your plan, you should contact the Plan Administrator. If you have questions about this ERISA statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact an area office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S.

The address of the EBSA is:

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Washington, DC 20210

The Philadelphia office address and phone number is:

Employee Benefits Security Administration Philadelphia Regional Office
U.S. Department of Labor
Curtis Center
170 S. Independence Mall West
Suite 870 West
Philadelphia, PA 19106
Telephone: 215-861-5300

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Situations That May Result in Loss of Benefits

It is important to be aware that a loss of benefits may result from any of the following events:

- ◆ you lose your status as an eligible member;
- ◆ you (or your employer) stop making any required contributions;
- ◆ your benefits may be affected by absences or a change in hours (such as layoff, leave of absence, and in some cases, sickness, injury, or a reduction in hours that makes you ineligible for benefits);
- ◆ you or a family member reaches any applicable annual or lifetime benefit limit; or
- ◆ your employment ends.