SCHOOL CAFETERIA EMPLOYEES

UNITE/HERE LOCAL NO. 634

HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION

January 2013

Dear Participants,

We are pleased to present you with this booklet describing your benefits as a participant in the School Cafeteria Employees UNITE/HERE Local No. 634 Health & Welfare Fund (the “Fund”).

The Fund was established as a result of collective bargaining between the School Cafeteria Employees UNITE/HERE Local No. 634 (the “Union”) and the School District of Philadelphia. The Trustees have been appointed by the Union and the School District of Philadelphia. The Trustees serve without compensation and their authority is established by a Trust Agreement.

We urge you to familiarize yourself with the Fund and to keep this booklet for future reference. Should you ever have any questions or desire more information about your benefits, you should contact Valley Forge Benefit Administrators, Inc., the firm that the Trustees have hired to perform the day-to-day administration of the Fund at:

Valley Forge Benefit Administrators, Inc.
Davis Road & Oakwood Lane
P.O. Box 740
Valley Forge, PA 19482
(215) 483-6000

The Fund provides benefits through providers selected by the Trustees after careful consideration of the providers’ qualifications. If the Trustees select a new provider, you will receive the information you need to access the services through the new provider. Of course, if a new provider is selected, the information you receive regarding the new provider will supersede the information contained in this booklet. The Trustees have entered into contracts with the providers of your benefits. These contracts are incorporated into this document by reference. If there is a conflict between the contract and this document, the terms of the contract will govern.

The benefits provided by the Fund are available only to eligible employees and with respect to certain benefits, to their eligible dependents. When this booklet refers to an “employee” or “dependent” receiving benefits, it refers only to employees or dependents actually eligible to receive the benefits. Please read the “Eligibility” section below for a full description of the eligibility requirements.

The Trustees are proud of the programs that the Fund offers. The Trustees, however, may determine that some or all benefits shall be increased, decreased or even eliminated, without advance notice to participants and dependents. Please call the Fund office for any questions about your coverage. The Trustees have final authority to make all determinations regarding the Fund’s provisions and any rules or policies developed by the Trustees. The Trustees have full authority and discretion to make factual findings regarding any claim or any request for review and to interpret the

terms of the Fund as they apply to the claim or request for review. The Trustees will provide only those benefits to which you or a dependent are entitled under the terms of the Fund.

The great majority of our participants and dependents use only the benefits to which they are entitled. A few participants and dependents, however, attempt to receive benefits to which they are not entitled. If any individual receives benefits to which he/she is not entitled, or provides false or incorrect information regarding the eligibility of a spouse, child or other party to receive benefits, the Fund can terminate benefits to all family members, subtract the cost of these benefits against other benefits payable to any family member or, in the discretion of the Trustees, initiate legal action to recover the cost of the benefits. The Trustees regret having to take these actions, but they must safeguard the Fund for all deserving participants and their dependents.

Sincerely,

THE BOARD OF TRUSTEES

**IMPORTANT INFORMATION ABOUT
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

Grandfathered Status

The Trustees believe the Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund office at (215)483-6000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Benefit Dollar Limits

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage for certain benefits in a year, that limit must be at least $750,000.

The Fund does not meet the minimum standards required by the Affordable Care Act as described above. Your prescription benefit coverage has an annual limit of $3,000 for single coverage and $3,750 for family coverage. This means that your health coverage might not pay for all of the health care expenses you incur.

The Fund has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least $750,000 this year. The Fund has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for the Fund through at least December 31, 2013.

If you are concerned about the Fund's lower dollar limits on key benefits, you and

your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.

ARTICLE I
FUND OPERATIONS

The following information is provided to help you better understand how the Fund operates.

1. **Fund Administration.** The Trustees are responsible for the administration of the Fund.

2. **Third Party Administrator.** Valley Forge Benefit Administrators, Inc. is responsible for the day-to-day administration of the Fund.

3. **Type of Plan.** The Fund is a welfare plan designed to provide vision, dental, prescription, medical and other benefits.

4. **Identification Number.** The employer identification number assigned to the Fund by the Internal Revenue Service is 23-2788903.

5. **Agent for Service of Legal Process**. The Trustees are the Fund's agent for service of legal process. The Trustees' address is: School Cafeteria Employees UNITE/HERE Local No. 634 Health & Welfare Fund, c/o Valley Forge Benefit Administrators, Inc., Davis Road & Oakwood Lane, P.O. Box 740, Valley Forge, PA 19482.

6. **Union Trustees.**

Cheryl Brandon, Chairperson
School Cafeteria Employees
Local No. 634, UNITE HERE
421 North 7th Street
Suite 611
Philadelphia, PA 19123
19123
(215) 440-0245
(215) 440-0376 fax

Shirley Robinson
School Cafeteria Employees
Local No. 634, UNITE HERE
421 North 7th Street
Suite 611
Philadelphia, PA

(215) 440-0245
(215) 440-0376 fax

Nicole Hunt
School Cafeteria Employees
Local No. 634, UNITE HERE
421 North 7th Street
Suite 611
Philadelphia, PA 19123
(215) 440-0245
(215) 440-0376 fax

7. **School District of Philadelphia Trustees.**

Mr. Wayne T. Grasela
Sr. Vice President - Food Services
School District of Philadelphia
440 North Broad Street, 3rd Floor
G10
Philadelphia, PA 19130
(215) 400-5534
(215) 400-4361 fax

Ms. Susan Gilbert
Employee Support Operations
School District of Philadelphia
440 North Broad Street, Suite
Philadelphia, PA 19130
(215) 400-6328
(215) 400-4631 fax

8. **Benefit Providers**

Prescription Drug Benefit Provider
Envisions RX Options
1301 E. Broward Boulevard, Suite 300
Fort Lauderdale, FL 33301
(800) 361-4542
(330) 405-8081 fax
customerservice@envisionrx.com

Dental Benefit Provider
Louis P. Mattucci & Associates
1037 Mill Creek Drive, Suite B
Feasterville, PA 19053
(215) 364-6500

Vision Benefit Provider
Vision Benefits of America (VBA)
300 Weyman Plaza
Pittsburgh, PA 15236-1588
(800) 432-4966
(412) 881-6040 fax

Orthotics Provider
Dr. Elliot Diamond
123 South 2nd Street
Philadelphia, PA 19106
(215) 923-2455
(215) 923-4535

Health Benefit Assistance
Health Advocates, Inc.
3043 Walton Road, Suite 150
Plymouth Meeting, PA 19462
(610) 397-6964

Medical Benefits Provider
City Health Centers
500 South Broad Street, 3rd Floor
Philadelphia, PA 19146
(215) 685-6790

9. **Plan Year.** The records of the Fund are kept on a fiscal year basis September 1 to August 31. The Fund measures the Benefit Year from July 1 to June 30, unless otherwise provided.

10. **Financing the Fund.** The School District of Philadelphia makes regular contributions to the Fund pursuant to the collective bargaining agreement between the Union and the School District of Philadelphia.

11. **Procedure of Obtaining Fund Documents.** If you wish to inspect or receive copies of additional documents relating to the Fund, contact the Fund office. If the Trustees determine that the documents should be provided, the Fund office will

make copies and you may be charged a reasonable fee to cover the cost of any materials you request.

12. **Amendment of the Fund and Benefits.** The benefits and services provided under the Fund may be amended, added to, subtracted from, changed or terminated by the Trustees at any time subject to the provisions of the Trust Agreement.

This booklet describes the Fund in general terms. In the event of any inconsistency between this booklet and the Fund documents, Trust Agreement, collective bargaining agreement or other Fund rules or policies or contracts between the Fund and a provider, the Fund documents and Trust Agreement, collective bargaining agreement, contracts and Fund rules and policies will control. All of these documents are incorporated by reference into this booklet.

The School District of Philadelphia and the Union representatives are not authorized to interpret the Fund's provisions or eligibility requirements. Only the Trustees can make such interpretations. If you would like a specific benefit provision clarified, contact the Fund office at the address below:

School Cafeteria Employees UNITE/HERE Local No. 634
Health & Welfare Fund
c/o Valley Forge Benefit Administrators, Inc.
Davis Road & Oakwood Lane
P.O. Box 740
Valley Forge, PA 19482
(215) 483-6000

ARTICLE II
SCHEDULE OF BENEFITS

COVERAGE	BENEFIT
Dental	
Employee and Dependents	$1,500 per family per year $1,000 per individual per year
Orthodontic	
Employee and Dependents	$1,500 per individual lifetime maximum
Prescription	
Employee and Dependents	$5,000 per family per year $4,000 per individual per year
Vision	
Employee and Dependents	One eye exam per year One pair of lenses per year, and One pair of frames per year.
Medical	
Employee Only	Outpatient Medical Services at Philadelphia City Health Centers
Orthotic	
Employee Only	One (1) orthotic (custom-fit shoe insert) per year Five (5) office visits with a $10 co-pay per visit
Wig	
Employee Only	$200 for purchase of first wig and supplies $125 maximum thereafter per year
Health Benefit Assistance	
Employee and Dependents	Assistance with health care and prescription choices and problems
Death Benefit	
Noon Time Aides Only	$2,000.00

ARTICLE III
ELIGIBILITY AND COVERAGE

WHEN ELIGIBILITY BEGINS

All Members will be covered by the Fund consistent with the rules set forth in the collective bargaining agreement between the Union and the School District of Philadelphia. Under these rules,

- Cafeteria Workers are eligible for benefits on the first day of the month following completion of six (6) months of employment from the first day worked. For example:
    - If you begin working on January 1st and continued to work in covered employment, you will become covered by the Fund on July 1st.
    - If you began working on January 10th and continued to work in covered employment, you will become covered by the Fund on August 1st.

- Noon Time Aides are eligible for benefits on the first day of the month following the completion of ninety (90) working days from the first day worked.

When you become eligible for coverage under the Fund, you will continue to be covered on a month-by-month basis provided that the School District of Philadelphia makes a contribution on your behalf. If you are laid off from the School District of Philadelphia, your coverage will continue for 12 months from the date of your lay-off. If you terminate employment with the School District of Philadelphia for a reason other than layoff or if you no longer work in a position covered under the collective bargaining agreement between the Union and the School District of Philadelphia, your coverage will end on the last day of the month of your termination or change in position.

ELIGIBLE DEPENDENTS

Your dependents include:

- Your lawful spouse; including a common law spouse (limited to common law marriages entered into prior to January 2, 2005) and your domestic partner.

- Children up to age 26, provided the child does not have coverage available to him/her through employment.

- Children over the age of 26, provided the child is incapable of self-sustaining employment solely because of physical or mental handicap; became so

incapable prior to attainment of age 26; written evidence of such incapacity is sent to the Fund within 31 days after attainment of such age; and proof that he continues to be so incapable is sent to the Fund from time to time as requested, but not more frequently than once a year after two years from the date the child attained the age 26.

Spouse and Domestic Partner. The Fund will not recognize any common law marriage first entered into after January 1, 2005. If you wish to enroll your common law spouse as a dependent, you must provide the Fund with an affidavit affirming that your marriage began before January 2, 2005, that you understand that you cannot terminate this marriage without a lawful divorce, and that you are submitting four of the six documents listed below to the Fund. (You may obtain the required affidavit from the Fund office.) Similarly, if you wish to enroll your domestic partner for benefits, you must provide the Fund with an affidavit regarding your domestic partnership as well as four of the applicable documents listed below. (You may obtain the required affidavit from the Fund office.)

- Lease or mortgage naming both parties;
- With respect to common law marriages, tax returns for the year 2004 or earlier listing the parties as filing "Married" (regardless of whether filed jointly or separate);
- Bank account documents listing both parties as holders of the account;
- Life insurance policies in which the parties name one another as the beneficiary;
- Credit card bills showing that the card is listed in the names of both parties;
- Birth certificates of children showing the parties as the parents of the children.

Children. As used in this Fund, "child" means your natural child. In addition, the term child shall also include:

- An adopted child, from the date the child is placed for adoption in your home;
- A stepchild if such child is a member of your household.

If a dependent is also eligible for benefits as an employee under this Fund, he/she will not be considered an eligible dependent.

Effective Date of Dependent Coverage

A dependent shall become eligible for benefits on the date your coverage starts or on the date you acquire an eligible dependent, only if you have fully completed an enrollment card and submitted the completed form to the Fund office along with all required documentation. **If you do not submit all information required by the Fund, your dependent will not be eligible for coverage under the Fund until the required information is submitted.** Your dependent's coverage will begin on the first day of the month following the Fund's receipt of a fully completed enrollment form and all required documents.

In addition to filling out and submitting a properly completed enrollment card, you must also provide the Fund with certain documents before dependents can be added.

- If you wish to add a natural child as a dependent, you must present a valid copy of the child's birth certificate showing that you are the natural parent.

- If you wish to add an adopted child as a dependent, you must show documents demonstrating either that the child has been placed with you for adoption or that you have adopted the child and a valid copy of the child's birth certificate.

- If you wish to add a stepchild as a dependent, you must present documents demonstrating that his/her parent has primary custody and a valid copy of the child's birth certificate.

- If you wish to cover your spouse, you must submit a marriage license. If you wish to add a common law spouse or a domestic partner, you must provide the Fund office with the documents described above.

Termination of Dependent Coverage

Unless otherwise stated, your dependent's coverage under this Fund will terminate upon the earliest of:

- The date your coverage terminates;

- The date the plan of benefits is amended to terminate coverage for your dependent;

- The date your dependent is no longer a dependent, as defined under the Fund;

- The date your dependent enters into full-time, active duty with the Armed Forces of any country.

ARTICLE IV
DENTAL AND ORTHODONTIC BENEFITS

The Fund provides dental benefits to you and your dependents under a dental "preferred provider organization," Louis P. Mattucci & Associates ("LPMA"). LPMA is a network of dentists who will provide services to you and your dependents at a discounted rate.

The Fund provides a benefit maximum of $1,000 for single employees and $1,500 for family coverage (you and your dependents) per Benefit Year. The Fund measures the Benefit Year for dental benefits from July 1 to June 30.

Orthodontic Benefit. The Fund provides an orthodontic benefit maximum of $1,500 per individual for orthodontia, provided the individual uses a network orthodontist ("LPMA Orthodontist"). The Fund office will send you a list of the LPMA Orthodontists, upon request. In addition, you can call the Fund office to receive an updated provider list.

Using a LPMA Dentist

You can make the most of your dental benefits by using a network dentist (an "LPMA Dentist"). If you use a LPMA Dentist, the LPMA Dentist will accept the Fund's rate as payment in full for the services provided. If you or your dependents receive services from an LPMA Dentist after exhausting your annual maximum, the LPMA Dentist will bill you directly for the services at the Fund's negotiated rate.

There are more than 100 dentists, including specialists, in the LPMA network. The Fund office will send you a list of the LPMA Dentists, upon request. In addition, you can call the Fund office to receive an updated provider list.

If you use a LPMA Dentist, your bill will be submitted directly by the LPMA Dentist to the Fund office. The Fund office will review the bill to determine whether your remaining available annual benefit amount is sufficient to cover the cost of the services. If the Fund determines that there is a sufficient amount of your annual benefit remaining, the Fund office will pay the LPMA Dentist directly. If the bill is greater than the amount of your remaining annual benefit, the Fund office will pay the LPMA Dentist your remaining annual benefit maximum and send you a statement regarding the amount you must pay directly to the LPMA dentist.

Using an Out-Of-Network Dentist

If you use a dentist outside of the LMPA network, the Fund will only pay the Fund's negotiated rate for the services you receive, even if your dentist charges more for such services. The out-of-network dentist may bill you for the difference between the dentist's rate and the Fund's rate for the services.

If you use an out-of-network dentist, the dentist will probably require payment of the bill in full at the time of your visit. If you pay the bill in full at the time of the visit, you should obtain an itemized bill from the dentist and submit the bill to the Fund office. If the services you received are covered by the Fund and you have not used your entire annual benefit amount, you will be reimbursed directly from the Fund at the Fund's negotiated rate for the services you received. If the out-of-network dentist submits the bill directly to the Fund office, the Fund will make payment directly to the out-of-network dentist at the Fund's negotiated rates, provided you have a sufficient amount of your annual benefit amount remaining to cover the services. The out-of-network dentist may then bill you for the difference between his/her rate and the Fund's negotiated rate for the services.

Alternate Treatments

Many dental conditions can be properly treated in more than one way. As a result, the Fund does not pay for treatment that is more expensive than necessary for good dental care. Therefore, if you are being treated for a condition for which there is more than one suitable treatment, the Fund will cover the treatment that provides the best and most economical treatment.

Exclusions

The Fund does **not** cover the following dental expenses:

- Services not provided by a dentist, except x-rays ordered by a dentist and services by a licensed dental hygienist under the dentist's supervision;
- Services not necessarily or customarily provided for dental care;
- Services furnished by or for the U.S. Government or any other government unless payment is legally required;
- Services that are for cosmetic treatment, including teeth bleaching;
- Charges for more than two routine cleanings, two routine exams, two fluoride treatments, two sets of bite-wing x-rays and one full mouth type x-ray once per thirty six (36) months;
- Charges related to treatment of temporomandibular joint (TMJ) conditions;
- Services provided under any governmental program or law under which the individual is, or could be, covered;

- Services due to an injury arising out of, or in the course of, employment for wage or profit, or disease covered by any Worker's Compensation law or any other occupational disease law or similar legislation;

- Charges for sealants for any dependent over age 15 or fluoride treatments for any dependent over age 19;

- A charge incurred while the patient's coverage is not in effect;

- Any portion of a charge for a service in excess of the Fund's scheduled allowance;

- Charges for medical procedures (including those that could be performed by an oral surgeon);

- Charges related to dental implants;

- Replacement or modification of a partial or full removable denture or fixed bridgework, or for the addition of teeth thereto, or for a crown or gold restoration, if the denture, bridgework, crown, or gold restoration was initially installed in the preceding five years.

- A service furnished after you terminate your employment. However, benefits will be paid for the following services if they begin while you are covered by the Fund and are provided within 30 days after your coverage ends.

    - Dentures, full and partial, if the impression was made while you were covered by the Fund.

    - A bridge or crown, if a tooth was prepared for it while you were covered by the Fund.

ARTICLE V
PRESCRIPTION BENEFITS

The Fund provides prescription benefits to you and your dependents under the Fund's "mandatory generic" prescription plan. Under the "mandatory generic" prescription plan, the Fund will only pay benefits for a generic prescription drug, and not for a brand name drug, unless there is no generic equivalent prescription drug available to you. In addition, if you receive a brand name drug for which there is a generic equivalent, you will be required to pay a co-payment plus the difference between the cost of the generic drug and the cost of the brand name drug.

The Fund provides a benefit maximum of $4,000 for single employees and $5,000 for family coverage (you and your dependents, not $5,000 per person) per Benefit Year. The Fund measures the Benefit Year for prescription benefits from January 1 to December 31.

The Fund purchases prescription drugs through Envisions Rx Options ("Envisions") at a significant discount. Even after you have exhausted your annual benefit for prescription drugs, you will be able to purchase drugs at this same discounted rate, even though you will have to pay the full discounted cost of the drug.

Retail Claims

You will receive a prescription card from Envisions when you become eligible for benefits. You can obtain a prescription at any pharmacy by paying the required co-payment, presenting a valid prescription, and your prescription card.

The Fund's retail prescription benefit allows you to fill a prescription (up to a 30-day supply) at a pharmacy. However, any refills on maintenance drug prescriptions (medications that are taken regularly – for example, blood pressure, cholesterol and allergies medications) must be filled through the Fund's mail order program.

The co-payment is $5.00. The Trustees may change this copayment. You will be informed if the co-payment is changed.

Mail Order Claims

With respect to maintenance drug prescriptions (medications that are taken regularly – for example, blood pressure, cholesterol and allergies medications), the Fund requires that you use the mail order program. You may also use the mail order program for any other prescription that you receive.

The mail order program will save you time and money, especially with medication you will be taking for more than thirty (30) days. You may receive up to a ninety (90) day supply of your medication through the mail order program. You will only be required to make one (1) co-payment for each prescription. **You can request information from the Fund office about how to obtain prescriptions through mail order program. If you have questions about how to obtain prescriptions through mail order, call the Fund office at (215) 483-6000.**

Exclusions and Limitations

The Trustees have adopted the exclusions and limitations on prescription drugs recommended by Envisions. If you would like to see a list of these exclusions, please call the Fund office at 215-483-6000. The Trustees may, on a case by case basis, consider providing benefits for a brand name drug even if a generic drug is available, if

your physician presents detailed information establishing the medical necessity of the brand name drug and a favorable cost/benefit analysis showing the benefits of providing a brand name drug.

NOTE: This prescription program covers only prescription medications. For example, it does not include bandages, supports, or non-prescription vitamins. Other Fund exclusions may also apply.

ARTICLE VI
VISION BENEFITS

The Fund provides you and your dependents with benefits for eye examinations, glasses (lenses and frames) and contact lenses. The Fund's vision plan is administered through Vision Benefits of America ("VBA").

In order to obtain vision benefits, you must contact VBA for a paper vision benefits voucher. VBA will mail the voucher to your home. VBA will also provide you with a list of VBA participating providers in your area. You can also find a provider by calling **1-800-432-4966** or visiting the VBA website at **www.visionbenefits.com**. The voucher will be valid for thirty (30) days from the date that the voucher is issued. If you obtain services from a VBA provider, you will receive the benefits listed below at no charge to you. The cost of any additional or specialty items not listed below will be the patient's responsibility. A VBA participating provider will submit all billing directly to VBA.

Frequency of Services

Adults (over 19):

- Examination: Once per twelve (12) month period;
- Lenses: Once per twelve (12) month period;
- Frames: Once per twelve (12) month period.

Children (up to 19):

- Examination: Once per twelve (12) month period;
- Lenses: Once per twelve (12) month period;
- Frames: Once per twelve (12) month period.

Benefits Available

- If a VBA participating provider is used:
  - Examination: Fully covered.

- Lenses: Fully covered (glass, plastic, regular, oversized, 1 year scratch protection, polycarbonate lens or solid or gradient lens tint).
  - Single Vision
  - Bifocals
  - Blended "No-Line" Bifocal
  - Trifocals
  - Progressive
  - Lenticular
  - Transitional
  - Anti-Reflective Coating
- Frame Allowance: $60.00
- Elective Contact Lens Allowance: $175.00 annually (including vision exam allowance)

- If a non-VBA provider is used:

  - Examination: $35.00;
  - Lenses
    - Single Vision: $30.00
    - Bifocal: $40.00
    - Blended "No-Line" Bifocal: $40.00
    - Trifocal: $60.00
    - Progresive: $60.00
    - Lenticular: $80.00
    - Polycarbonate Lens Material: $40.00
  - Frame Allowance: $40.00
  - Elective Contact Lens Allowance: $175.00 annually (including vision exam allowance)

- Medically required contact lens allowance:

  - If a VBA participating provider is used: The usual, customary and reasonable rate is covered;
  - If a non-VBA provider is used: $300.00.

If you use a non-VBA provider, you should submit your claims to VBA for reimbursement at:

Vision Benefits of America
300 Weyman Plaza
Pittsburgh, PA 15236
1-800-432-4966

Your paid receipt itemizing the services you received must be submitted to VBA no later than one year after you receive the service.

Exclusions and Limitations

Extra Cost

The vision benefit is designed to cover visual needs rather than cosmetic materials. When an individual selects any of the following extras, the Fund will only pay for the items and services covered by the Fund. The individual is solely responsible for the additional costs for the extras selected or requested.

- Contact Lenses (except as noted elsewhere in this booklet or Fund updates);
- Coating of Lenses, except anti-reflective coating;
- Laminating of Lenses; and
- A Frame that costs more than the Plan Allowance.

Not Covered

The Fund does not provide any benefits related to professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano (non-prescription) lenses; glasses secured when there is not a prescription change; or two (2) pair of glasses in lieu of bifocals;

- The replacement or repair of lenses and frames furnished under the Fund, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Any eye examination, or any corrective eye wear, required by an employer as a condition of employment; and

- Services or materials compensated under Workmen's Compensation laws or by any first party benefits paid under the patient's automobile insurance or by any catastrophic loss benefits paid by the catastrophic loss trust fund.

VBA may at its discretion waive any of the plan limitations, if in the opinion of its optometric consultants it is necessary for the visual welfare of the patient.

ARTICLE VII
MEDICAL BENEFITS

If you do not have medical insurance, you are eligible to receive basic primary and specialty health care benefits at any of the Philadelphia City Health Centers, without having to pay a co-payment. Note: Dependents are not eligible for medical benefits from the Fund.

Some of the benefits that the City Health Centers may provide are:

- Physician Office Visits
  - Primary Care
  - Cardiology
  - Endocrinology
  - Podiatry
  - Gynecology (annual visit)

- Diagnostic Screenings
  - Chest x-rays
  - Annual flu shot
  - Basic laboratory services
  - Annual pap smear

You can visit any of the eight (8) City Health Center locations. All you need to do is show your prescription identification card.

- 1720 S. Broad Street
Philadelphia, PA 19145
215-685-1803
- 555 S. 43rd Street
Philadelphia, PA 19104
215-685-7504
- 4400 Haverford Avenue
Philadelphia, PA 19104
215-685-7601
- 1900 N 20th Street
Philadelphia, PA 19121
215-685-2933
- 321 W. Girard Avenue
Philadelphia, PA 19123
215-685-3800
- 131 E. Chelten Avenue
Philadelphia, PA 19144
215-685-5701
- 2230 Cottman Avenue
Philadelphia, PA 19149
215-685-0639
- 2840 Dauphin Street
Philadelphia, PA 19132
215-685-2400

You may also use any of the City Health Centers' Pharmacies to fill your prescription without having to pay a co-payment. Even if you meet the Fund's annual maximum limit for prescriptions, you can continue to use the City Health Centers'

Pharmacies without having to pay a co-payment.

The City Health Centers offer translation and interpretation services for patients and their families.

You may walk-in and will be seen that day; however, there could be a long wait. You can call 215-685-6790 to check on the wait time for an appointment at each clinic.

For additional information, contact the City Health Center website – www.phila.gov/health/.

ARTICLE VIII
ORTHOTIC BENEFIT

The Fund provides you with benefits for orthotics and podiatry office visits. The Fund's orthotics benefit is administered through Dr. Elliot Diamond. Dr. Diamond is a podiatrist who is engaged in the business of podiatric rehabilitation and acupuncture, including the measuring and fitting of orthotics.

To schedule an appointment with Dr. Diamond call his office at 215-923-2455. Dr. Diamond's office is located at 123 South Second Street, Suite 201, Philadelphia, Pennsylvania 19106.

Benefits Available

Orthotics. You may obtain one (1) pair of custom designed orthotics every Benefit Year. At your office visit, you will be charged a $10 co-payment. This co-payment covers your orthotic, the Gait Scan system and casting.

Office Visits. Every Benefit Year you are entitled to five (5) office visits with a $10 co-payment per office visit. You will be responsible for the cost of any additional office visits in a Benefit Year.

Refurbishment of Orthotics. You may elect to use one (1) of your covered office visits per Benefit Year for the refurbishment of your orthotics. Therefore, during such Benefit Year, you would be entitled to four (4) office visits with a $10 co-payment per office visit and the refurbishment of your orthotics with a $10 co-payment.

Benefit Year. With respect to the orthotic benefit, Benefit Year means July 1 through June 30.

ARTICLE IX
WIG BENEFIT

The Fund provides you with benefits for the purchase of a Wig and Related Supplies.

Benefit. You may receive up to $200 for the purchase of your first Wig and Related Supplies. Thereafter, the maximum annual benefit is $125 per Benefit Year.

Prescription Required. Your Wig must be prescribed by a doctor for hair loss due to (1) the effects of chemotherapy, radiation or other treatments for cancer; or (2) alopecia or other disease causing hair loss.

Definitions. For purposes of this benefit, "Wig" shall mean an artificial covering of hair for all or most of the head, either synthetic or natural hair. "Related supplies" shall include wig stand and adhesives (tape).

Benefit Year. With respect to the wig benefit, Benefit Year means July 1 through June 30.

ARTICLE X
HEALTH BENEFIT ASSISTANCE

The Fund provides you and your dependents with access to a health advocate to assist you in navigating the increasingly complex medical environment. The provider of this benefit is Health Advocate, Inc. ("Health Advocate").

Some of the services Health Advocate offers under the Fund are:

- **Personal Health Advocate**
  - 24/7 help
  - Care coordination
  - Claims assistance
  - Fee negotiation
  - Grievance advice
  - Prescription advice

- **Physician Locator**

- **Health Advocate CareQuest**
  - Senior care assistance
  - Appeals representation
  - Case stewardship
  - Home care assistance

- Complementary and alternative medicine
- Wellness advantage
- Healthy wheels

To contact Health Advocate call 1-866-695-8622.

ARTICLE XI
DEATH BENEFITS

Each Noon Time Aide who has worked as a Noon Time Aide for at least two years at the time of death is eligible for a $2,000.00 death benefit in the event of his/her “accidental” death. An accidental death is one caused by an event which is external, sudden, violent, by chance and unexpected.

You will be eligible for death benefits if you worked as a Noon Time Aide for at least two years at the time of your death. In determining whether you worked for two years, the Fund will consider all time that you worked as a Noon Time Aide (whether as a permanent or temporary employee), provided that (a) you are eligible for benefits from the Fund at the time of your death and that (b) the time you worked as a Noon Time Aide is greater than any breaks in service between your hire date and the date of your death. Note: If a Noon Time Aide otherwise eligible for death benefits except for the required length of service also worked as a Per Diem Employee in the capacity of a Noon Time Aide for an average of twelve (12) hours per week, the Trustees will consider the time worked as a Per Diem Employee when determining eligibility for the death benefit.

You should designate a beneficiary for your death benefits. To designate a beneficiary, you must complete a beneficiary designation form. You can get a beneficiary designation form from the Fund office. You may name any individual to be the beneficiary of your death benefit. If you do not name a beneficiary prior to your death, the Fund will pay your death benefit to the first of your surviving relatives in the following order:

- widow or widower;
- surviving children in equal shares;
- surviving parents in equal shares;
- surviving brothers and sisters in equal shares; and
- executors or administrators in the event an estate is raised.

ARTICLE XII
IMPORTANT FEDERAL LAWS

Continuing Coverage under COBRA

COBRA continuation coverage is a temporary extension of health care coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you and to your dependents who are covered under the Fund when you would otherwise lose your group health care coverage. Each individual covered by the Fund has the right to make his/her own decision about COBRA continuation coverage. Both you and your spouse or domestic partner should read this section.

Qualified Beneficiaries and Qualifying Events

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, employees, spouses or domestic partners of employees, and dependent children of employees may be qualified beneficiaries.

You will become a qualified beneficiary if you will lose your coverage under the Fund because either of the following qualifying events occur:

- Your employment is terminated for any reason except gross misconduct.
- Your work hours are reduced and that results in the loss of benefits.

Your spouse or domestic partner will become a qualified beneficiary if your spouse or domestic partner loses coverage under the Fund because any of the following qualifying events occur:

- Your employment is terminated for any reason except gross misconduct.
- Your work hours are reduced and that results in the loss of benefits.
- You die.
- You become covered by Medicare and that results in the loss of benefits.
- You and your spouse become divorced.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Fund because any of the following qualifying events occur:

- Your employment is terminated for any reason other than gross misconduct.
- Your work hours are reduced and that results in the loss of benefits.
- You die.
- You and your spouse become divorced.
- Your child ceases to be a "dependent" under the terms of the Fund.

Type of Coverage

Generally, you can elect to receive the same type of group health care coverage you had immediately prior to the qualifying event. However, your benefits will change if the Fund's benefits change.

Notification Requirements

You must notify the Fund office, within 60 days of the qualifying event, if any of the following qualifying events occur:

- You get divorced.
- Your child ceases to qualify as a dependent under the Fund.

If you do not notify the Fund office about these events in a timely manner, the Fund may not offer COBRA coverage to the qualified beneficiary.

The Fund office will notify you and your spouse or domestic partner, within 14 days of the later of (i) the qualifying event or (ii) the date the Fund office is notified of the qualifying event, if any of the following qualifying events occur:

- Your employment is terminated.
- Your work hours are reduced and that results in the loss of benefits.
- Your enrollment in Medicare.
- Your death.

Maximum Coverage Period

Once the Fund office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage under the Fund would otherwise have been lost. The maximum COBRA continuation coverage period will be:

- Up to 18 months from the date coverage is lost when the qualifying event is your termination of employment or reduction in work hours.

- Up to 29 months from the date coverage is lost when you, your spouse or domestic partner, or your dependent is found by the Social Security Administration (SSA) to have been disabled at any time during the first 60 days of COBRA continuation coverage, but only if the disabled person (or a family member) notifies the Fund office of the SSA's determination within 60 days after he/she receives the notice of the decision and before the end of the 18 month coverage period. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Fund office of that fact within 30 days of SSA's determination.

- Up to 36 months from the date coverage is lost in all other cases.

<u>Second Qualifying Event</u>. If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse or domestic partner and dependent children may elect additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse or domestic partner and dependents if you die or get divorced. The extension is also available to your dependents when they stop being eligible under the Fund as a dependent. In all these cases, you must notify the Fund office of the second qualifying event within 60 days of the second qualifying event.

Cost of COBRA Continuation Coverage

You must pay for COBRA continuation coverage. The charge for the coverage is equal to the Fund's cost of providing group coverage plus two percent. The two percent charge covers a portion of the Fund's cost to provide you this coverage. If there is an increase or decrease in the Fund's cost, your future premiums will be adjusted accordingly.

When and How Payment for COBRA Continuation Coverage Must Be Made

Certain grace periods apply for the first payment for COBRA continuation coverage and subsequent periodic payments for COBRA continuation coverage.

First Payment for COBRA Continuation Coverage. If you elect COBRA continuation coverage, you do not have to send any payment for COBRA continuation coverage with the election form. However, you must make your first payment for COBRA continuation coverage within a 45-day grace period after the date of your election. (This is the date the election form is post-marked, if mailed.) This first payment must cover the cost of COBRA continuation coverage from the time your coverage under the Fund otherwise would have ended up to the time you make your first payment.

If you do not make your first payment for COBRA continuation coverage in full within those 45 days, you will lose all COBRA continuation coverage rights under the Fund. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund office to confirm the correct amount of your first payment.

Monthly Payments for COBRA Continuation Coverage. After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. Under the Fund, these payments for COBRA continuation coverage are due on the first day of each month. If you make a monthly payment on or before its due date, your coverage under the Fund will continue for that month without any break. The Fund office will send monthly notices of when payments are due.

Grace Period for Monthly Payments. Although monthly payments are due on the first day of each month, you will be given a grace period of 30 days to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the 30-day grace period for that payment.

If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Fund. Your first payment and all monthly payments for COBRA continuation coverage should be made to:

School Cafeteria Employees UNITE/HERE Local No. 634
Health & Welfare Fund
Davis Road & Oakwood Lane
P.O. Box 740
Valley Forge, PA 19482

Election of COBRA Continuation Coverage

You will have at least 60 days to elect COBRA continuation coverage. This election period will end on the later of (1) 60 days from the date you would otherwise lose coverage or (2) 60 days from the date the Fund mails your notice of COBRA

continuation coverage and provides you with an election form.

If you incur covered expenses during the election period before you have made an election, your claims will not be processed until the Fund receives your election form and the payment of your first premium.

Termination of COBRA Continuation Coverage

Your COBRA continuation coverage will terminate before the end of the maximum coverage period if any of the following occurs:

- You fail to pay the premium for your COBRA continuation coverage when it is due (including any grace period).
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not impose any pre-existing conditions exclusion for a pre-existing condition of the qualified beneficiary.
- A qualified beneficiary first becomes entitled to Medicare after already becoming eligible for COBRA.
- The Fund ceases to provide any group coverage under the Fund to any of its members.

Mastectomies and Reconstructive Surgery

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgeries effective January 1, 1999. However, since the Fund only provides prescription benefits, the prescription benefits provided by the Fund will cover prescriptions related to mastectomies, subject to the same limits applicable to all medical conditions. If you have any questions about your prescription benefits related to mastectomies and reconstructive surgery, please contact the Fund office.

Continuation Coverage if You Temporarily Serve in the Armed Services

The Fund will provide continuation coverage pursuant to the terms of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), 38 U.S.C. § 4301 et seq., for all qualified leaves while you are serving in the uniformed services beginning on or after October 13, 1994. The Fund will provide continuation coverage for a period of thirty-six (36) months. This coverage will be funded by the School District of Philadelphia for the duration of your military leave.

Upon reemployment, you will be entitled to the same benefits to which you would be entitled had the service in the uniformed services not occurred. The coverage will end if you fail to return to covered employment during the time period prescribed by USERRA. If you have a question about your rights under USERRA, please call the Fund office.

ARTICLE XIII
CLAIM PROCEDURES

Claim Filing Deadline

In order for a claim to be considered for payment, the claim must be submitted within a certain time frame. Read the following information carefully to determine the specific claim filing deadline for each benefit. If you file a claim after the deadline, it will not be paid by the Fund. This "Claims Procedures" section describes the time period within which the claim must be approved or denied by the Fund and the procedures that you must follow to appeal any denial of the claim.

- Dental Benefits – Claims must be filed no later than 1 year from the date of service.

- Prescription Drug Benefits – Claims must be filed no later than 30 business days after the prescription was dispensed.

- Vision Benefits – Claims must be filed no later than 1 year from the date of service.

- Medical Benefits – Claims must be filed no later than 1 year from the date of service.

- Orthotic Benefits - Claims must be filed no later than 1 year from the date of service.

- Wig Benefits – Claims must be filed no later than 1 year from the date of service.

If your claim is denied by any provider, you may file an appeal in writing with the Fund office. You should attach any information that you believe is relevant to your claim. Your claim will be considered by the Trustees at the next regularly scheduled meeting. If you believe that your appeal should be considered on an emergency basis, you should request that the Fund administrator bring the appeal to the Trustees' attention on an expedited basis. The Trustees have delegated to the Fund administrator discretion to determine whether an appeal is an emergency.

ARTICLE XIV
HIPAA NOTICE OF PRIVACY POLICIES AND PRACTICES

The Fund is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your protected health information and to provide you with this notice of the Fund's privacy policies and, as permitted by law, the Fund reserves the right to amend or modify its privacy policies and practices. Such amendments or modifications may be required by changes in federal and state laws and regulations. Regardless of the reason for the revision, the Fund will provide you with revised notice of the Fund's privacy policies and practices within 60 days of such changes.

Under HIPAA, how can the Fund use my health information? The Fund can use your health information to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Fund use my health information with respect to payment for my treatment? The Fund may use your health information for the broad range of actions needed to make sure that the Fund makes payment for the services you and your family receive. The Fund may use your health information when making payment to providers for services or treatment you received, when making arrangements for payment through one of the networks of providers through which the Fund provides benefits to you, as well as for coordinating payment to providers through other health plans under the Fund's coordination of benefit rules.

Does HIPAA permit the Fund to use my health information for other purposes? HIPAA provides that the Fund may use the health information of the individuals the Fund covers for "health care operations." This includes the broad range of actions required to assess the quality of the Fund's plan of benefits and its administration and operations. They include, but are not limited to, ensuring that participants or their beneficiaries are eligible for certain benefits prior to payment or taking corrective action to recoup overpayments, assessment of health plan performance; review of the Fund's plan of benefits and determining whether a reduction in costs is possible; case management and coordination of care; actuarial studies relating to the cost of benefits; management studies relating to the operation and administration of the Fund; resolution of internal grievances; and medical review, legal services, and auditing functions. For example, the Fund may use health information to determine the most cost-effective manner to provide vision benefits to its participants and beneficiaries.

May the Fund use my health information for purposes besides payment and health care operations? Yes. HIPAA permits the Fund to use your health information for a number of other purposes, including treatment alternatives or other health-related benefits that may be of interest to you.

Does HIPAA permit the Fund to disclose my health information to my employer? Under HIPAA, the Fund generally cannot disclose your personal health information to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Fund to disclose your health information without your authorization to workers' compensation insurers, State administrators, or others involved in the workers' compensation systems to the extent the disclosure is required by state or other law.

May the Fund release my personal health information to the Fund's plan sponsor? HIPAA does permit the Fund to disclose information to the "plan sponsor" for administrative functions. Here, the "plan sponsor" is the Fund's Trustees. The Fund may also provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the Fund.

May the Fund release my personal health information to law enforcement or other governmental entities? Your health information may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. Note, however, that the Fund may not disclose your health information if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public benefits. In addition, the Fund may disclose your personal health information in the course of a judicial or administrative proceeding if the Fund receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Fund will make reasonable efforts either to notify you or to obtain an order protecting your health information.

Would the Fund release my personal health information if my health or safety or public health or safety would be jeopardized if it did not? If the Fund has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Fund will do so, after consideration of appropriate legal and ethical standards.

My wife often assists me by calling to find out the status of my health claims and to get other information about me or my benefits. Can the Fund release information to her? Unless you tell the Fund otherwise, the Fund will treat your spouse as your personal representative **without** requiring that you fill out and submit a form designating your spouse as your personal representative. As your personal representative, your spouse steps into your shoes and, therefore, will have access to your protected health information. **If you do not wish the Fund to treat your spouse as your personal representative, you must tell the Fund in writing that you do not wish your spouse to be treated as your personal representative.**

Must the Fund have an authorization to release my health information? Disclosure of your health information or its use for any purpose other than those

described above requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Fund office. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Fund of your decision to revoke the authorization.

Do I have rights under the federal privacy standards? Your rights to information under HIPAA include:

- The right to request restrictions on the use and disclosure of your protected health information. The Fund will carefully consider, although is not required to honor, your request for restrictions;

- The right to receive confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, for example, that you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your health information remains confidential). The Fund will attempt to honor reasonable requests;

- The right to inspect and copy your protected health information. The Fund may charge a reasonable fee for copying, assembling and postage;

- The right to amend or submit corrections to your protected health information. If you believe that the information in your records are inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason you wish to correct your records or if the records were not created by the Fund;

- The right to receive an accounting of how and to whom your protected health information has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Fund and should state the period of time for which you are requesting an accounting;

- The right to file a complaint that your privacy rights have been violated with the Fund and the Secretary of the U.S. Department of Health & Human Services. **Note:** You will **not** be penalized or otherwise retaliated against for filing a complaint ;

- The right to receive a printed copy of this notice.

Complaints? Comments? Requests? If you wish to request information to which you have a right to or to file a complaint with the Fund or if you have any questions regarding this notice, you should address them to Privacy Officer, School Cafeteria Employees UNITE/HERE Local No. 634 Health & Welfare Fund, Davis Road & Oakwood Lane, P.O. Box 740, Valley Forge, PA 19482. Please note that the Fund can assess reasonable charges for copying and assembling documents you request as well as for postage.

ARTICLE XV
MEDICARE PART D PRESCRIPTION DRUG COVERAGE

This Article contains information about your current prescription drug coverage with the Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Plan Administrator has determined that the prescription drug coverage offered by the Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Fund coverage may be affected. The Fund provides a prescription drug benefit up to$3,000 annually for single employees and up to $3,750 annually for the employee and family. There is a $5.00 co-payment for all prescription drugs.

If you do decide to join a Medicare drug plan and drop your current Fund coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with the Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Your Current Prescription Drug Coverage. For further information, call the Fund Office at (215) 483-6000.

For More Information About Your Options Under Medicare Prescription Drug Coverage. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

ARTICLE XVI
MISCELLANEOUS

Plan Continuation

The Fund is intended to provide only the plans of benefits described in this booklet. It does not provide any form of deferred compensation, nor does it create any vested rights.

The Fund sponsors and the Trustees expect to continue this Fund indefinitely. However, the Trustees, the School District of Philadelphia and the Union reserve the right to amend, change, modify, suspend or terminate the Fund or any plan of benefits provided thereunder, in whole or in part at any time, or to amend, change, implement, modify, suspend or terminate any contribution requirement by participants (including retirees) for benefits under the Fund at any time.

Assignment of Benefits

You cannot assign, sell or pledge your benefits to another person, or use them as security for a loan. We will not pay benefits to anyone other than you or your covered dependents.

Several exceptions, however, may apply. For some benefits, it is customary for your doctor or other service provider to accept an assignment of benefit payment. In that case, payments will be made on your behalf directly to that doctor or other service provider.

Also, a court order (such as a QMCSO) may require benefits to be paid directly to someone other than a covered person or his/her beneficiary. The Fund must honor those court orders.

When appropriate, the Fund may also withhold taxes from benefit payments. The Fund may also honor tax liens or garnishes against your payments. Finally, the Fund may make deductions from benefit payments to recover previous overpayments or to coordinate benefits with other plans.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Fund office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund office.