

Building Service 32BJ

HEALTH FUND

101 Avenue of the Americas, New York, NY 10013-1991

Telephone 1-212-388-3500

or 1-800-551-3225

The Building Service 32BJ Health Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

UNION TRUSTEES

Michael P. Fishman
President
SEIU Local 32BJ
101 Avenue of the Americas
New York, NY 10013-1991

Kevin J. Doyle
Executive Vice President
SEIU Local 32BJ
101 Avenue of the Americas
New York, NY 10013-1991

Hector J. Figueroa
Secretary – Treasurer
SEIU Local 32BJ
101 Avenue of the Americas
New York, NY 10013-1991

Brian Lambert
Vice President
SEIU Local 32BJ
101 Avenue of the Americas
New York, NY 10013-1991

EMPLOYER TRUSTEES

James F. Berg
President
Realty Advisory Board on Labor Relations, Inc.
292 Madison Avenue
New York, NY 10017-6307

Charles C. Dorego
General Counsel
Glenwood Management
1200 Union Turnpike
New Hyde Park, NY 11040-1708

John Santora
Chief Operating Officer
Executive Vice President, Asset Services
Cushman & Wakefield, Inc.
51 West 52nd Street
New York, NY 10019-6178

Fred Ward
Senior Vice President, Labor Relations
One Source
321 West 44th Street, 7th Floor
New York, NY 10036-5454

EXECUTIVE DIRECTOR, BUILDING SERVICE 32BJ BENEFIT FUNDS

Susan Cowell

DIRECTOR, BUILDING SERVICE 32BJ HEALTH FUND

Angelo Dascoli

ACCOUNTANTS

John R. Mani, CPA
Salibello & Broder, LLP

LEGAL COUNSEL

Bredhoff & Kaiser P.L.L.C.
Proskauer Rose LLP
Raab, Sturm & Goldman LLP

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SECTION I

IMPORTANT NOTICE

This booklet is Section I of the Summary Plan Description (“SPD”) of the plan of benefits (“the Plan”) of the Building Service 32BJ Health Fund (“the Fund”) with regard to the Basic Health Plan. Your rights to benefits can only be determined by this SPD (including Section II), as interpreted by official action of the Board of Trustees (“the Board”). You should refer to this booklet when you need information about your Plan benefits. In addition, the Board reserves the right, in its sole and absolute discretion, to amend the Plan at any time.

- Save this booklet – put it in a safe place. If you lose a copy, you can ask Member Services for another or obtain it from www.seiu32bj.org
- If you change your name or address – notify Member Services immediately so your records are up-to-date.
- Words that appear in **boldface** print are defined in the Glossary.
- Throughout this booklet, the words “you” and “your” refer to participants whose employment makes them eligible for Plan benefits. The word “dependent” refers to a family member of a participant who is eligible for Plan benefits. In the sections describing the benefits payable to participants and dependents, the words “you” and “your” may also be used to refer to the patient.
- This booklet describes the provisions of the Plan in effect as of October 1, 2007, unless specified otherwise.
- In the event there is any conflict between the terms and conditions for Plan benefits as set forth in this booklet and any oral advice you receive from a Building Service 32BJ Benefit Funds employee or union representative, the terms and conditions set forth in this booklet shall control.

The level of contributions provided for in your collective bargaining agreement or participation agreement determines the Plan for which you are eligible. In general, the Basic Health Plan covers security officers who work *inside New York City*. While the Fund provides other plans, they are not described in this booklet. If you are unsure about which plan applies to you, contact Member Services for information.

ELIGIBILITY AND PARTICIPATION

When You Are Eligible

Eligibility for benefits from the Plan depends upon the particular agreement that covers your work. Unless specified otherwise in your collective bargaining agreement or participation agreement, eligibility is as follows.

Your employer will be required to begin making contributions to the Plan on your behalf when you have completed 120 consecutive days of **covered employment** with the same employer working more than 27.5 hours a week, unless specified otherwise in your collective bargaining agreement or participation agreement. For this purpose, **covered employment** includes certain leaves of absence. Days of illness, pregnancy or injury count toward the 120-day waiting period. When you have completed that 120-day period working for your employer, you and your eligible dependents become eligible for the benefits described in this booklet on your 121st day of **covered employment**.

When You Are No Longer Eligible

Your eligibility for the Plan ends:

- at the end of the 30th day after you no longer regularly work full-time in **covered employment**, subject to COBRA rights (See Section II for more information.)
- on the date when your employer terminates its participation in the Plan, or
- on the date the Plan is terminated.

In addition, the Board reserves the right in its sole discretion to terminate eligibility if your employer becomes seriously delinquent in its contributions to the Fund.

If You Come Back to Work

If your employment ends after your eligibility commenced and you return to **covered employment** (with the same **contributing employer**, or a different **contributing employer**):

- *within 90 days*, your Plan participation starts again on your first day back at work, or

- *more than 90 days later*, you would have to complete 120 consecutive days of **covered employment** with the same employer before being able to resume participation.

As long as you are eligible, your dependents are eligible, provided they meet the definition of “dependent” under the Plan (see “Dependent Eligibility” on pages 8–10).

Extension of Health Benefits

Health coverage may be continued while you are not working in the following circumstances:

COBRA

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. “Health coverage” includes the Plan’s hospital, medical, and prescription drug coverage. (See Section II for more information about COBRA.)

FMLA

You may be entitled to take up to a 12-week leave of absence from your job under the Family and Medical Leave Act (FMLA). You may be able to continue Plan coverage during an FMLA leave. (See Section II for more information.)

Military Leave

If you are on active military duty, you have certain rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provided you enroll for coverage. (See Section II for more information.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

Dependent Eligibility

If your collective bargaining agreement or participation agreement provides for dependent coverage, eligible dependents under the Plan are described below:

Dependency	Age Limitation	Requirements
Lawful spouse	None	The person of the opposite gender to whom you are legally married under the laws of the place where you live (if you are legally separated or divorced, your spouse is not covered).
Domestic partner		<p>You and your same-gender domestic partner:</p> <ul style="list-style-type: none"> • Have a marriage certificate from a state in the U.S. or province in Canada where same-gender marriages are valid, or • Have a civil union certificate from a state in the U.S. or province in Canada where same-gender civil unions are valid, or • Are two individuals 18 years or older of the same gender who: <ul style="list-style-type: none"> • have been living together for at least 12 months; and • are not married to anyone else, and are not related by blood in a manner that would bar marriage under the law; and • are financially interdependent, and can show proof of such; and • have a close and committed personal relationship and have not been registered as members of another domestic partnership within the last 12 months. <p>In order to establish eligibility for these benefits, you and your domestic partner will need to provide:</p> <ul style="list-style-type: none"> • A marriage certificate from a state in the U.S. or a province in Canada where same-gender marriages are valid, or • A civil union certificate from a state in the U.S. or province in Canada where same-gender civil unions are valid, or • If neither marriage nor civil union is available, affidavits attesting to your relationship, plus a domestic-partner registration under state or local law (if permitted where you live), and proof of financial interdependence. <p>You are required to provide the highest level of certificate available in the jurisdiction where you reside.</p> <p>Contact Member Services for an application or general information.</p> <p>There may be significant tax consequences for covering your domestic partner. Contact a tax advisor for tax advice.</p> <p>If you lose coverage due to a qualifying event, you and your domestic partner may elect to continue coverage on a self-pay basis through COBRA. Domestic partners will not have an independent right to COBRA continuation coverage unless the qualifying event is the participant's death.</p>

Dependency	Age Limitation	Requirements
<i>Children (except disabled children)</i>	Until end of calendar year in which dependent child reaches age 19 (or age 23, if a full-time student in an accredited college, university or trade school)	<p>The child:</p> <ul style="list-style-type: none"> • is not married • has the same principal address as the participant* or as required under the terms of a "QMCSO" (See Section II) and • is dependent on the participant for over one-half of his or her annual support and is claimed as a dependent on your tax return* <p>AND</p> <p>is one of the following:</p> <ul style="list-style-type: none"> • your biological child • your adopted** child or one placed with you in anticipation of adoption • your stepchild: this includes your spouse's biological or adopted child • your domestic partner's biological or adopted child • a foster child ONLY if you have adopted** the child or applied for adoption • your grandchild, niece or nephew ONLY if you are the legal guardian and the child is dependent on you and only you for all support and maintenance; if application for legal guardianship is pending, you must provide documentation that papers are filed and provide proof when legal process is complete.
<i>Children (disabled)</i>	None	<p>The child:</p> <ul style="list-style-type: none"> • is totally and permanently disabled • became disabled while an eligible dependent, and • meets all of the requirements listed above for a dependent child except age. <p>You must apply for a disabled child's dependent coverage extension and provide proof of the child's total and permanent disability no later than 60 days after the date the child would have otherwise lost eligibility, and you must remain covered under the Plan. You will be notified by the Fund if your adult disabled child is found eligible for continuing coverage. You must enroll your adult disabled child within 60 days of receiving confirmation of your adult child's eligibility. Failure to enroll at this time means your disabled adult child loses his or her special eligibility. If your child becomes eligible for extended coverage as a result of disability, you will be required to pay a monthly premium to cover part of the coverage cost. Contact Member Services for details.</p>

A child is not considered a dependent under the Plan if he or she:

- is not a United States citizen and lives outside the United States, Canada or Mexico, or
 - is in the military or similar forces of any country.
- * If you are legally separated or divorced, then your child may live with and/or be the tax dependent of the legally separated or divorced spouse.
- ** Your adopted dependent child will be covered from the date that child is adopted or “placed for adoption” with you, whichever is earlier (but not before you become eligible), if you enroll the child within 30 days after the earlier of placement or adoption (See “Your Notification Responsibility” on page 11). A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. However, if a child is placed for adoption with you, but the adoption does not become final, that child’s coverage will end as of the date you no longer have a legal obligation to support that child. If you adopt a newborn child, the child is covered from birth as long as you take custody immediately after the child is released from the hospital and you file an adoption petition with the appropriate state authorities within 30 days after the infant’s birth. However, adopted newborns will not be covered from birth if one of the child’s biological parents covers the newborn’s initial hospital stay, a notice revoking the adoption has been filed or a biological parent revokes consent to the adoption.

When Your Dependents Are No Longer Eligible

Your dependents remain eligible for as long as you remain eligible, except for the following:

- Your *spouse’s* eligibility ends 30 days after legal separation or divorce. Your domestic partner’s eligibility ends 30 days after the requirements for domestic partnership on page 8 are no longer satisfied.
- Your *child’s* eligibility ends when your child marries or no longer satisfies the rules regarding residence or financial dependency that are described on pages 9–10, or
 - *if not in school*, at the end of the calendar year in which the child reaches age 19, or
 - *if in school*,
 - 30 days after the child’s graduation from school, or, if earlier,
 - 30 days after the date the child leaves school, or, if earlier,
 - at the end of the calendar year in which the child reaches age 23.
- Eligibility of a spouse, a domestic partner, and dependent children ends 30 days after your death.

How to Enroll

Coverage under the Plan is not automatic. In order for your coverage to begin, you must enroll in the Plan by completing the Building Service 32BJ Health Fund Enrollment Form (Enrollment Form) and submitting it to the Fund for processing. In most cases, your coverage will begin on the date you were first eligible, not the date you completed and returned the Enrollment Form. However, a delay in completing and returning the Enrollment Form will delay any claims payment(s) to you. You may contact Member Services for information or a copy of the Enrollment Form.

Enroll your dependents as soon as they become eligible. Please see “Dependent Eligibility” on pages 8–10 to determine when your dependents are eligible. If at the time you enroll in the Plan, your dependents are eligible for benefits, you must complete the “Dependent Information” section of the Enrollment Form. You will be required to submit documents proving dependent status including a marriage certificate (for your spouse), birth certificates and, if applicable, proof of full-time student status (for your children). In most cases, your dependent’s coverage will begin on the date he or she was first eligible. However, if you do not enroll your dependents that are eligible when you first complete the Enrollment Form, your dependent’s coverage will not begin until the date you notify the Fund. No benefits will be paid until you provide the Fund with your eligible dependent’s information and supporting documentation. After your coverage under the Plan begins, if you have a change in family status (e.g., get married, adopt a child) or wish to change existing dependent coverage for any reason, you must complete the appropriate form. Special rules apply regarding the effective date of your new dependent’s coverage. Please see “Your Notification Responsibility” below for further details.

Claims for eligible expenses will be paid only after the Fund has received your completed Enrollment Form, supporting documentation and proof of hiring from your **contributing employer**. If your forms are not completely or accurately filled out, or if the Fund is missing requested documentation, any benefits payable will be delayed. The Fund may periodically require proof of continued eligibility for you or a dependent. Failure to provide such information could result in a loss of coverage.

Your Notification Responsibility

If, after your coverage under the Plan becomes effective, there is any change in your family status (e.g., marriage, legal separation, divorce, birth or adoption of a child), it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 30 days of marriage or birth or adoption of a child, coverage for your new spouse or child will begin as of the date of marriage or date of birth or adoption. If you do not notify the Fund within 30 days,

coverage for your new spouse or child will begin as of the date you notify the Fund. No benefits will be paid until you provide the Fund with the necessary supporting documentation. Also, be sure to notify the Fund if your child is between age 19 and 23 and graduates or otherwise leaves school, or if your child marries or no longer satisfies the rules regarding residence or financial dependency that are described on pages 9 – 10.

Failure to notify the Fund of a change in family status could lead to a delay or denial in the payment of health benefits or the loss of a right to elect health continuation under COBRA. In addition, knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution.

WHAT BENEFITS ARE PROVIDED

The Fund provides a comprehensive program of benefits, including hospital and medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment and pensioner death benefits (only to pensioners from the Building Service 32BJ Pension Fund). Each of these benefits is described in the sections that follow.

HOSPITAL AND MEDICAL BENEFITS

Overview of Eligible Expenses

Provision	In-Network
How you can receive treatment	Go to any network provider. Except for emergencies, there are no out-of-network benefits.
Basis for reimbursement	All in-network reimbursements are based on the allowed amount for medically necessary eligible expenses and subject to pre-certification and co-payments where required; network providers have agreed to accept the allowed amount as payment in full. There is no reimbursement for out-of-network services.
Annual deductible	None
Co-payments (where applicable)	\$20 for each visit to a primary care provider and for certain therapies: \$40 for each visit to a specialist \$250 for a hospital admission \$100 for a maternity admission \$100 for an emergency room visit Plan pays 100% after the co-payment
Annual maximum benefit	\$200,000
Lifetime maximum benefit	\$2,500,000

About the MagnaCare Networks

The Plan provides hospital and medical benefits through MagnaCare. This **network** includes over 59,000 **participating provider** locations and 240 hospitals in the metropolitan area.

MagnaCare ID Card. This card gives you access to thousands of **doctors**, surgeons, hospitals and other health care facilities in the **network**. It also gives you 24-hour phone access to a registered nurse who can help you with your health care decisions.

Nurse's Helpline. For immediate medical advice, call the Nurse's Helpline. This is free round-the-clock information. When you call, you can either speak to a registered nurse or select from over 1,100 audiotaped messages in English or Spanish on a wide variety of topics. To reach the tape library, press #1, then enter pin #1032. You may find it helpful to speak to a registered nurse when you need help assessing symptoms, deciding whether a trip to the **emergency** room is necessary or understanding a medical condition, procedure, prescription or diagnosis. You can reach the Nurse's Helpline at 1-866-443-0116.

In-Network Benefits

You must use **network** providers. If you do so, there are no **deductibles** to pay, and no claims to file or track.

In-network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a **network** provider. The **network** provider will assess your medical needs and advise you on appropriate care, as well as take care of any necessary tests, pre-certifications or hospital admissions. When you use a **doctor**, hospital or other provider **in-network**, the Plan generally pays 100% for most charges, including hospitalization. You will not have to satisfy a **deductible** — you will pay a **co-payment** for most services.

When You Go Out-of-Network

Your Plan does not cover any out-of-**network** expenses.

Coverage When You Are Away from Home

When you are outside of the area covered by the MagnaCare **network**, **emergency** treatment will be considered **in-network**; all other services will not be covered.

Benefit Maximums

There is an *annual* limit of \$200,000, and a *lifetime* limit of \$2,500,000 on hospital and medical benefits payable for each covered person. There are also limits on how much (and how often) the Plan will pay for certain

expenses, even when they are covered. If there are limits on a particular expense, those limits will be indicated under “**Covered Services.**” (See pages 16–19.)

Conditions for Hospital and Medical Expense Reimbursement

- Charges must be for **medically necessary** care. The Plan will pay benefits only for services, supplies and equipment that the Plan considers to be **medically necessary**.
- Charges must be less than or equal to the **allowed amount**. The Plan will pay benefits only up to the **allowed amount**.
- Charges must be incurred while the patient is covered. The Plan will not reimburse any expenses incurred by a person while the person is not covered under the Plan.

Pre-Certification

Your **network** provider will do the pre-certification for you. However, it is your responsibility to verify that the provider has obtained the required pre-certification.

Pre-Certification for Medical/Hospital

The following services must be pre-certified

Call 1-877-624-6219

24 hours a day, seven days a week.

Type of Care	When You Must Call
<u>Outpatient:</u> <ul style="list-style-type: none">• Cardiac rehabilitation• Endoscopy• Colonoscopy• Cosmetic reconstruction• Dental surgery due to accidental injury to teeth• Home health care and home infusion therapy• Speech, occupational and vision therapy• MRI or MRA or PET exams• Physical therapy• Prosthetics/orthotics or durable medical equipment (rental or purchase over \$2,500)	As soon as possible before you receive care
<u>Inpatient:</u> <ul style="list-style-type: none">• Scheduled hospital admissions• Admissions to skilled nursing or rehabilitation facilities	Two weeks before you receive care or as soon as care is scheduled
<ul style="list-style-type: none">• Maternity admissions• Emergency admissions	Within 48 hours after delivery or admission
<ul style="list-style-type: none">• Maternity admissions lasting longer than two days (or four days for cesarean delivery)• Ongoing hospitalization	As soon as you know care is lasting longer than originally planned
<ul style="list-style-type: none">• Admissions to hospice facilities	As soon as possible after receiving care or being admitted

How pre-certification works. MagnaCare Medical Management professionals will review the proposed care to certify the length of stay or number of visits (as applicable) and will approve or deny coverage for the procedure based on medical necessity. They will then send you a written statement of approval or denial within three business days after they have received all necessary information. In urgent care situations, they will make a decision within 72 hours after they have received all necessary information (for more information, see Section II).

If you do not pre-certify the care listed on page 15 within the required time frames, benefit payments will be reduced by 20%, up to a maximum \$500 reduction for each admission, treatment or procedure. If the Plan determines that the admission or procedure was not **medically necessary**, no benefits are payable.

Covered Services

The following tables show different types of health care expenses and how they are covered.

In the Hospital¹ and Outpatient Treatment Centers*

Benefit	What you pay	Then the Plan pays
Semi-private room and board (for obstetrical care, hospital stays are covered for at least 48 hours following normal delivery, or at least 96 hours following cesarean section)	\$250 for an admission or \$100 for a maternity admission	100%
In-hospital services of licensed doctors and surgeons	\$0	100%
Outpatient ² surgery and care related to surgery (including operating and recovery rooms)	\$100	100%
Anesthesia and oxygen	\$0	100%
Blood and blood transfusions	\$0	100%
Cardiac Care Unit (CCU) and Intensive Care Unit (ICU)	\$0 (if \$250 co-pay paid for admission already satisfied)	100%
Chemotherapy and radiation therapy	\$0	100%
Kidney dialysis ³	\$0	100%
Pre-surgical testing	\$0	100%
Special diet and nutritional services while in the hospital	\$0	100%
Skilled Nursing Care Facility⁴*	\$0	100%
Benefits are payable for up to 10 days for sub-acute care		
Hospice Care⁵ Facility*	\$0	100%
Benefits are payable for up to 180 days per lifetime		

* Pre-certification required.
See footnotes 1 – 5 on pages 44 – 45.

Benefit	What you pay	Then the Plan pays
Home Health Care⁶		
Home health care visits*	\$0	
Benefits are payable for up to 40 year for IV infusion and some wound care or to allow early discharge from a facility		
Home infusion therapy ^{7*}	\$0	100%
Emergency Care		
Emergency room⁸ (no benefit if condition is not emergency)	Plan pays 100% after \$100 co-payment (\$100 co-payment waived if admitted from emergency room).	
Office visits	\$20 for primary care \$40 for specialist care	100%
Ambulance Services ⁹	\$30	100%

Care in the Doctor's Office

Benefit	What you pay	Then the Plan pays
Office visits	\$20 for primary care	100%
Specialist visits	\$40	100%
Chiropractic visits 10 visit maximum per year	\$40	100%
Allergy care: Testing only; \$1,000 annual benefit maximum	\$40	100%
Dermatology care: \$1,000 annual benefit maximum	\$40	100%
Diagnostic procedures: • X-rays and other imaging • MRIs/MRAs/PETs* • All lab tests	\$0 for free-standing facility; \$100 for MRI, MRA, CAT if at outpatient hospital	100%
Chemotherapy and radiation therapy	\$0	100%
Podiatric care for up to 12 visits per year for diabetic patients or other medically necessary diagnoses; podiatric surgery to \$5,000 once every three years*	\$20	100%

* Pre-certification required.
See footnotes 6 – 9 on page 46.

Preventive Medical Care

Benefit	What you pay	Then the Plan pays
Annual physical exam ¹⁰ including the necessary diagnostic screening tests based on the patient's age, sex and health risk factors.	\$20	100%
Well-woman care	\$0	100%
<ul style="list-style-type: none"> • Mammogram for women age 35–39, one baseline test is covered <li style="padding-left: 20px;">for women age 40 and older, test covered once per year • PAP Smear once a year • Bone density test age 50 or older, every other year 		
Well-child care ¹¹ (including immunizations, up to age 19)	\$0	100%

Pregnancy and Maternity Care

Benefit	What you pay	Then the Plan pays
Office visits for prenatal and postnatal care from a licensed doctor or certified midwife ¹² , including diagnostic procedures	\$20 for 1 st visit, then \$0	100%
Newborn in-hospital nursery care	\$0	100%
Obstetrical care* (in hospital or birthing center)	\$100 for an admission	100%.
Circumcision of newborn males	\$0	100%

* Pre-certification required.

See footnotes 10, 11 and 12 on page 46.

Physical, Occupational, Speech or Vision Therapy (including rehabilitation)¹³

Benefit	What you pay	Then the Plan pays
Inpatient Services* Covered only with prior hospital admission, not covered without admission	\$0	100%
Office/home* Benefits are payable for up to 20 visits a year (not covered for outpatient hospital)	\$20	100%

Durable Medical Equipment and Supplies¹⁴

Benefit	What you pay	Then the Plan pays
Durable medical equipment* (pre-certification required for DME over \$2,500 such as wheelchairs and hospital beds)	\$30	100%
Prosthetics*	\$30	100%

* Pre-certification required.
See footnotes 13 and 14 on pages 46 – 47.

Excluded Hospital and Medical Expenses

The following expenses are not covered under the hospital or medical coverage. However, some of these expenses are covered under your prescription drug or vision coverage. Check the other sections of this booklet to see if an expense not paid under hospital/medical is covered elsewhere under the Plan.

- expenses incurred before the patient's coverage began or after the patient's coverage ended
- treatment that is not **medically necessary**
- out-of-network services
- cosmetic treatment¹⁵
- technology, treatments, procedures, drugs, biological products or medical devices that in Magnacare's judgment are experimental, investigative, obsolete or ineffective¹⁶ – also excluded is any hospitalization in connection with experimental or investigational treatments
- expenses for the diagnosis or treatment of infertility
- assisted reproductive technologies including, but not limited to, in-vitro fertilization, artificial insemination, gamete and zygote intrafallopian tube transfer and intracytoplasmic sperm injection
- surgery and/or non-surgical treatment for gender change
- reversal of sterilization
- travel expenses, except as specified
- psychological testing for educational purposes for children or adults
- common first-aid supplies such as adhesive tape, gauze, antiseptics, ace bandages, and surgical appliances that are stock items, such as braces, elastic supports, semi-rigid cervical collars or surgical shoes
- expenses for acupressure, prayer, religious healing including services, and naturopathic, naprapathic, or homeopathic services or supplies
- expenses for memberships in or visits to health clubs, exercise programs, gymnasiums or other physical fitness facilities
- operating room fees for surgery, surgical trays and sterile packs done in a non-state-licensed facility including the **doctor's** office. *However, a flat fee for surgical trays will be covered when a colonoscopy, andoscopy, or endoscopy is performed in the **doctor's** office instead of a hospital.*

See footnotes 15 and 16 on pages 47–48.

- orthotics for foot care (including dispensing of surgical shoe(s) and pre- and post-operative X-rays)
- hearing exams
- the following specific preventive care services:
 - screening tests done at your place of work at no cost to you
 - free screening services offered by a government health department
 - tests done by a mobile screening unit, unless a **doctor** not affiliated with the mobile unit prescribes the tests
- the following specific **emergency** services:
 - use of the **emergency** room to treat routine ailments because you have no regular **doctor** or because it is late at night (and the need for treatment does not meet the Plan's definition of **emergency** – see page 42)
 - use of the emergency room for follow-up visits
 - ambulette
- the following specific maternity care services:
 - days in hospital that are not **medically necessary** (beyond the 48-hour/96-hour stays the Fund is required by law to cover)
 - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The additional cost does not count toward your **co-payment**.)
 - private-duty nursing
 - expenses for pre-planned home delivery of a child
- the following specific inpatient hospital care expenses:
 - private-duty nursing
 - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The difference does not count towards your **co-payment**.)
 - diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
 - any part of a hospital stay that is primarily custodial

- elective cosmetic surgery¹⁵ or any related hospital expenses or treatment of any related complications
- hospital services received in clinic settings that do not meet MagnaCare's definition of a hospital or other covered facility
- the following specific outpatient hospital care expenses:
 - certain same-day surgeries not pre-certified as **medically necessary** by the Health Services Program
 - routine medical care, including (but not limited to) inoculation, vaccination, drug administration or injection, excluding chemotherapy
 - collection or storage of your own blood, blood products, semen or bone marrow
 - physical medicine or rehabilitation services
- the following specific equipment:
 - air conditioners or purifiers
 - humidifiers or de-humidifiers
 - exercise equipment
 - swimming pools
- skilled nursing facility care that primarily:
 - gives assistance with daily living activities
 - is for rest or for the aged
 - is convalescent care
 - is sanitarium-type care, or
 - is a rest cure
- the following specific home health care services:
 - custodial services, including bathing, feeding, changing or other services that do not require skilled care
 - out-of-network home infusion therapy
- the following specific physical, occupational, speech or vision therapy services:
 - therapy to maintain or prevent deterioration of the patient's current physical abilities
 - treatment for developmental delay, including speech therapy

See footnote 15 on page 47.

- the following specific vision care services:
 - expenses for surgical correction of refractive error or refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK), photo-refractive keratotomy (PRK) and laser in situ keratomileusis 21 (LASIK) and its variants
 - eyeglasses, contact lenses and the examination for their fitting except following cataract surgery (However, see “Vision Care Benefits,” pages 35–36, to find out how vision care services may be covered.)
 - routine vision care (See “Vision Care Services”, pages 35–36, for coverage information.)
- the following services that may be covered elsewhere under the Plan:
 - all prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, vitamin therapy, appetite suppressants, or any other type of medication, unless specifically indicated (However, see “Prescription Drug Benefits,” pages 25–28, to find out how prescription drug expenses may be covered.)
 - services of a nutritionist and nutritional therapy or counseling
 - contraceptive devices (See “Prescription Drug Benefits,” page 27, to find out how oral contraceptives may be covered under the prescription drug program.)
- the following miscellaneous health care services and expenses:
 - services performed in nursing or convalescent homes, institutions primarily for rest or for the aged, rehabilitation facilities (except for physical therapy), spas, sanitariums, or infirmaries at schools, colleges or camps
 - injury or sickness that arises out of any occupation or employment for wage or profit for which there is Workers’ Compensation or occupational disease law coverage (for information about subrogation of benefits, see Section II)
 - injury or sickness that arises out of any act of war (declared or undeclared) or military service for any country
 - injury or sickness that arises out of a criminal act by the covered person, or an intentionally self-inflicted injury that is not the result of mental illness
 - expenses for services or supplies for which a covered person receives payment or reimbursement from casualty insurance or as a result of legal action, or expenses for which the covered person has already been reimbursed by another party who was responsible

because of negligence or other tort or wrongful act of that party (for information about subrogation of benefits, see Section II)

- expenses reimbursable under the “no-fault” provisions of a state law
- services covered under government programs, except under Medicare, Medicaid or where otherwise noted
- any hospital care received outside of the U.S. that is not **emergency** care
- government hospital services, except specific services covered under a special agreement between MagnaCare and a government hospital or services in United States Veterans’ Administration or Department of Defense hospitals for conditions not related to military service
- treatment or care for temporomandibular disorder or temporomandibular joint disorder (TMJ) syndrome
- services such as laboratory, X-ray and imaging, and pharmacy services from a facility in which the referring **doctor** or his or her immediate family member has a financial interest or relationship
- services given by an unlicensed provider or performed outside the scope of the provider’s license
- charges for services a relative provides
- charges that exceed the maximum allowed amount for that service or supply
- services performed at home, except for those services specifically noted in this booklet as covered either at home or in an **emergency**
- services usually given without charge, even if charges are billed
- services performed by hospital or institutional staff that are billed separately from other hospital or institutional services, except as otherwise specified in this booklet.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are administered by Medco Health Solutions, Inc. (“Medco”). The list of prescription drugs that are covered by your Plan is known as a “formulary.” Your Plan’s formulary includes a wide selection of generic and brand-name medications.

There are two ways to get your prescriptions filled:

At the Pharmacy

To have your prescription filled at a retail pharmacy, go to a participating Medco pharmacy with your prescription and your Medco prescription drug ID card. All prescriptions filled at a participating pharmacy provide you with up to a 30-day supply and one refill of up to a 30-day supply. You pay:

- \$7 if the prescription or refill is filled with a generic drug, or
- \$22 if it is filled with a brand-name drug.

If your **doctor** prescribes a formulary brand-name drug and initials the Dispense As Written (“DAW”) box when an “A”-rated generic equivalent drug is available, you will have a \$22 **co-payment** and you will have to pay the difference in cost between the brand-name drug and the generic drug. Brand-name drugs can be very costly so always ask your **doctor** to prescribe generic drugs when possible.

Note: you can have your prescription filled at a non-participating pharmacy, but you will have to pay the full cost and then file a claim with Medco to be reimbursed up to the amount Medco would have paid (minus your **co-payment**). Contact Medco over the phone or on-line to obtain the necessary claim form if you have your prescription filled at a non-participating pharmacy.

Through Mail Order

The mail order program is mandatory for those who take maintenance drugs (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma). Every calendar year, you and your eligible dependents each have a \$2,000 maximum drug benefit available through Medco Mail. Once the Plan has paid \$2,000 in any calendar year for your mail order drugs (excluding insulin), you are required to participate in Medco’s maintenance drug program in order to be covered for any additional mail order prescriptions beyond the \$2,000 limit. This \$2,000 limit does not apply to any acute medications received at the pharmacy or insulin prescriptions received by mail.

When you order drugs through the mail order program, you pay:

- \$14 for up to a three-month supply per *generic* prescription or refill, or
- \$44 for up to a three-month supply per *brand name* prescription or refill.

If your **doctor** prescribes a brand-name formulary drug and initials the “DAW” box when an “A”-rated generic equivalent drug is available, you will have to make a \$44 **co-payment** and you will have to pay the difference in cost between the brand-name drug and the generic drug.

If you have a chronic condition and you need to take the same medication for more than 30 days, use the Medco mail order service by following these steps.

- When your **doctor** prescribes a maintenance drug, ask your **doctor** to write two prescriptions—one for a 30-day supply for you to fill right away at your local retail pharmacy, and a second (for 90 days) to send to the mail order pharmacy for a long-term supply.
- For your first mail service order, fill in the patient profile sections of the Mail Order Pharmacy Order Form, which you can get from Member Services or by calling Medco at 1-800-318-7451. Be sure to complete as much of the information requested as possible. You must provide your unique Medco identification number, name of the person or persons for whom you are sending prescriptions, and the address to whom the medication should be sent. Provide any allergy or history information so that the pharmacist will be aware of any potential drug conflict.
- Complete the Mail Order Pharmacy Order Form for each new prescription.
- Enclose your maintenance drug prescription, the Mail Order Pharmacy Order Form and your payment in the pre-addressed mail service envelope. You must make the necessary **co-payment** for your mail order or your prescription may not be filled. Your medications are delivered to you at home postage-paid by United Parcel Service or by U.S. mail. Allow 10 to 14 days after the prescription is filled for delivery of your medicine.
- A new order form and envelope will be sent to you with each delivery. These forms are also available from Member Services.

You can order refills by phone (call Medco customer service toll-free at 1-800-318-7451) or from their website (www.medco.com). Have your prescription number and credit card ready when you call or log on.

Please note that certain prescription drugs are not covered or require prior authorization. Your pharmacist can tell you if the prescription drug order you need to have filled is covered by the Plan or requires

prior authorization. Contact Medco at 1-800-318-7451 before having the prescription filled to ensure that you will receive regular reimbursement for the prescription that you have been given. If you have a prescription filled for a drug that is on the list of those requiring prior authorization, and you fail to contact Medco before having the prescription filled, you may be fully responsible for the cost of the prescription drug.

Refills are not shipped automatically. If you have remaining refills on your original prescription, request your Medco refill three weeks before you need it to avoid running out of medication. You should receive your refill within a week.

Prescriptions for medicines not available through the mail (such as narcotics) will be returned to you. These prescriptions can be filled at the pharmacy for up to a 30-day supply.

Eligible Drugs

The following are covered under the Plan:

- Federal legend prescription drugs
- drugs requiring a prescription under the applicable state law
- insulin, insulin syringes and needles
- diabetic test strips
- oral contraceptives (for participant or spouse; dependents when **medically necessary**)
- prescription vitamins for infants to 12 months

Excluded Drugs

The following are not covered under the Plan:

- cough and cold preparations
- non-sedating antihistamines
- gastrointestinal drugs, including H2 blockers and proton pump inhibitors (PPIs)
- dermatological agents like retinoids, keratolytics, rosacea, emollients and hypopigmentation agents
- drugs for erectile dysfunction
- injectable drugs (except insulin)
- over-the-counter drugs and vitamins

- prescription drugs that require prior authorization and for which you have not received prior authorization
- drugs used in clinical trials or experimental studies
- drugs used for infertility treatment
- birth control devices
- drugs prescribed for cosmetic purposes (See footnote 15 on page 47 for more information.)
- drugs used for weight loss unless you meet the Plan's medical criteria
- non-formulary drugs, unless your **doctor** can prove (i.e., clinical documentation; patient's drug therapy history) to Medco's satisfaction that the non-formulary drug is necessary (non-formulary drugs are drugs that are not on the Plan's list of approved drugs and medicines)
- therapeutic devices or appliances, support garments and other non-medical substances
- drugs intended for use in a **doctor's** office or another setting other than home use
- prescriptions that an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state or Federal program

DENTAL BENEFITS

How the Plan Works

The Plan provides coverage for necessary dental care received through the 32BJ Dental Center at 101 Avenue of the Americas, New York, NY 10013.

Necessary dental care is a service or supply that is required to identify or treat a dental condition, disease or injury. The fact that a dentist prescribes or approves a service or supply or a court orders a service or supply to be rendered does not make it dentally necessary. The service or supply must be all of the following:

- provided by a dentist, or solely in the case of cleaning or scaling of teeth, performed by a licensed, registered dental hygienist under the supervision and direction of a dentist
- consistent with the symptoms, diagnosis or treatment of the condition, disease or injury
- consistent with standards of good dental practice

- not solely for the patient’s or the dentist’s convenience, and
- the most appropriate supply or level of service that can safely be provided to the patient.

Covered services are listed in the “Schedule of Covered Dental Services” (see pages 30–32), subject to frequency limitations that are stated in that schedule. The Plan does not cover procedures that are not on the schedule, but may provide an alternate benefit if approved by the Fund.

The 32BJ Dental Center

The 32BJ Dental Center is equipped to provide a broad range of dental services. If you receive your dental care from the 32BJ Dental Center, you will not have to pay for any of that care. Call 1-212-388-2099 to make an appointment at the 32BJ Dental Center.

Participating Dental Providers

The Fund has a **network** of participating dental providers (PDPs). You have the privilege of accessing this **network** of PDPs at a discounted rate. Should you choose to secure dental services from a **network** PDP you will pay to the PDP the same rate that the Fund pays for these services based on its contract with the PDP. You will pay the PDP directly for services received from the **network** PDP.

What Dental Services Are Covered

The Plan covers a wide range of dental services, including:

- preventive and diagnostic services such as routine oral exams, cleanings, X-rays, topical fluoride applications and sealants
- basic therapeutic services such as extractions and oral surgery, intravenous conscious sedation when for oral surgery, gum treatment, fillings and root canal therapy, and
- major services such as fixed bridgework, crowns, dentures, and gum surgery.

See the Schedule of Covered Dental Services on pages 30–32 for details.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services on pages 30–32.

Schedule of Covered Dental Services at the 32BJ Dental Center

Procedure	Limits
DIAGNOSTIC	
Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused)	Once every six months
X-rays:	
• full mouth, complete series, including bitewings or panoramic film	Once in any 36 consecutive months
• bitewings, back teeth	Four films every six months
• periapicals, single tooth	As necessary
• occlusal film	As necessary
• cephalometric film (orthodontic coverage only)	Once in a lifetime
PREVENTIVE	
Dental prophylaxis (cleaning, scaling and polishing)	Once every six months
Topical fluoride treatment	Once in any calendar year for patients under age 16
Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)	Once per tooth in any 24 consecutive months for patients under age 16
Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)	Once per tooth for patients under age 16
SIMPLE RESTORATIVE	
Amalgam (metal) fillings	Once per tooth surface in any 24 consecutive months
Resin (composite, tooth-colored) fillings	Once per tooth surface in any 24 consecutive months
MAJOR RESTORATIVE	
Recementation of crown	Once per tooth in any calendar year
Prefabricated stainless steel/resin crown (deciduous teeth only)	Once per tooth in any 60 consecutive months
Crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture	Once per tooth in any 60 consecutive months

Procedure	Limits
ENDODONTICS	
Root canal therapy	Once per tooth in a lifetime
Retreatment of root canal	Once per tooth in a lifetime
Apicoectomy (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment)	Once per tooth in a lifetime
Pulpotomy	Once per tooth in a lifetime
PERIODONTICS	
Gingivectomy or gingivoplasty	Once per quadrant in a lifetime
Osseous surgery	Once per quadrant in a lifetime
Periodontal scaling and root planing	As necessary (not to exceed once in every 12 months)
Periodontal maintenance (covered only if the Plan also covered periodontal surgery and the maintenance procedure is performed by a periodontist)	Twice in any calendar year
REMOVABLE PROSTHODONTICS	
Complete or immediate (full) upper and lower dentures or partial dentures, including 6 months of routine post-delivery care	One denture per arch in any 60 consecutive months
Denture rebase or reline procedures, including 6 months of routine post-delivery care	Once per appliance in any 36 consecutive months
Interim maxillary and mandibular partial denture (anterior teeth only); no other temporary or transitional denture is covered by the Dental Plan	Once per appliance in any 60 consecutive months
FIXED PROSTHODONTICS	
Fixed partial dentures and individual crowns	Once per tooth in any 60 consecutive months
Prefabricated post and core procedures related to fixed partial denture (X-ray showing completed endodontic procedure is required)	Once per tooth in any 60 consecutive months

Procedure	Limits
SIMPLE EXTRACTIONS	
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Once per tooth
ORAL AND MAXILLOFACIAL SURGERY	
Removal of impacted tooth	Once per tooth in a lifetime
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)	Once per quadrant in a lifetime
Frenulectomy	Once per arch in a lifetime
Removal of exostosis (removal of overgrowth of bone)	Once per site in a lifetime
EMERGENCY TREATMENT	
Palliative treatment to alleviate immediate discomfort (minor procedure only)	Twice in any calendar year
REPAIRS	
Temporary crown (fractured tooth)	Once per tooth in a lifetime
Crown repair	Once per tooth in any 36 consecutive months
Overcrown	Once per tooth in any 60 consecutive months
Repairs to complete or partial dentures	Once per appliance in any calendar year
Recent fixed or partial dentures	Once per appliance in any calendar year
Additions to partial dentures	As necessary
MISCELLANEOUS	
Occlusal guard	One appliance in any 60 consecutive months

Alternate Benefit

There is often more than one way to treat a given dental problem. For example, a tooth could be repaired with an amalgam filling, a resin composite or a crown. If this is the case, the Plan will generally limit benefits to the least expensive method of treatment that is appropriate and that meets acceptable dental standards.

Access to Discounted Services from Network Dentists

The Plan has over 1000 dentists who are participating dental providers (PDPs) located throughout the metropolitan New York area. If you choose to get dental services from one of these PDPs instead of the Dental Center you will need to pay the PDP directly for dental services. You will pay the PDP the Plan's contracted fee which is a significant discount off the PDP's regular charges.

To find a PDP simply call Member Services at the Fund and we will mail you a Dental Directory that lists all PDPs. Or you can stop in at the Walk-In-Center and pick up a Directory. If you need help selecting a dentist call our Provider Selection Service department at 1-212-388-2174.

You can also obtain the fee schedule for each dental procedure from our Member Services department. This schedule will clearly identify the specific fee that a PDP will charge you for each dental service. This way you will know exactly what your dental care will cost you if you use a PDP.

What Is Not Covered

The Plan's dental coverage excludes the following:

- any service performed outside the 32BJ Dental Center
- any services performed before a patient becomes eligible for benefits or after a patient's eligibility terminates, even if a treatment plan has been approved
- any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services
- orthodontic services
- treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accident
- services or supplies that the Plan determines are experimental or investigative in nature
- services or treatments that the Plan determines do not have a reasonably favorable prognosis
- any treatment performed principally for cosmetic reasons, including, but not limited to, laminate, veneers and tooth bleaching

- special techniques, including precision dentures, overdenture, characterization or personalization of crowns, dentures, fillings or any other service (This includes, but is not limited to, precision attachments and stress-breakers. Full or partial dentures that require special techniques and time due to special problems, such as loss of supporting bone structure, are also excluded.)
- any procedures, appliances or restorations that alter the “bite,” or the way the teeth meet (also referred to as occlusion and vertical dimension) and/or restore or maintain the bite, except as provided under orthodontic benefits (Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition, and restoration for misalignment of teeth.)
- any procedures involving full-mouth reconstruction, or any services related to dental implants, including any surgical implant with a prosthetic device attached to it
- diagnosis and/or treatment of jaw joint problems, including temporomandibular joint disorder (TMJ) syndrome, craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull or the complex of muscles, nerves, and other tissue related to that joint
- multiple abutments
- treatment for self-inflicted injury or illness
- treatment to correct harmful habits, including, but not limited to, smoking and myofunctional therapy
- habit-breaking appliances
- services for plaque-control programs, oral hygiene instruction, and dietary counseling
- services related to the replacement or repair of appliances or devices, including:
 - duplicate dentures, appliances or devices
 - the replacement of lost, missing or stolen dentures and appliances less than five years from the date of insertion
 - replacement of existing dentures, bridges or appliances that can be made useable according to dental standards
 - adjustments to a prosthetic device within the first six months of its placement that were not included in the device’s original price
- drugs or medications (Any prescriptions that are required may be covered by the Plan’s prescription drug benefits – see pages 25–28.)

- services for which a participant has contractual rights to recover cost, whether a claim is asserted or not, under Workers' Compensation, or automobile, medical, personal injury protection, homeowners or other no-fault insurance
- treatment of conditions caused by war or any act of war, whether declared or undeclared, or a condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries
- any portion of the charges for which benefits are payable under any other part of the Plan
- if a participant transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for the same procedure, the Plan will not pay benefits greater than what it would have paid if the service had been rendered by one dentist
- transportation to or from treatment
- fees for completing reports or for providing records, or
- any procedures not listed under the Schedule of Covered Dental Services.

VISION CARE BENEFITS

If you need an eye exam, corrective lenses (including contact lenses) or frames, you can go to a **participating provider** or a non-participating provider. By using a **participating provider**, you can get an exam and glasses with no out-of-pocket cost, but your choice of frames will be limited. If you want frames and/or lenses that cost more than the Plan's limit, you will pay the difference.

If you use a non-participating provider, you can get up to \$30 for eye exams, \$60 for lenses and \$60 for frames. You will be responsible for paying the charges in full and will be reimbursed up to the **allowed amounts**.

If you secure contact lenses instead of frames and lenses, from either a participating or non-participating provider, the maximum reimbursement is \$120. You will be responsible for paying any charges in excess of this maximum reimbursement.

These maximum benefits are payable within any 24-month period, starting with the date you first incur a vision care expense (typically an eye exam). For example, if you get an eye exam on September 1, 2007, you have up to September 1, 2009 (assuming you remain eligible for Fund benefits) to receive the benefits cited above for the lenses and frames or

contacts. Any unused vision care benefits cannot be carried over and used in a subsequent 24-month period.

You can access your Vision Plan benefits by:

- Provide the Vision Plan **participating provider** with your (the union member's) Social Security number (The Plan has four **participating providers**: Comprehensive Professional Systems, Davis Vision, General Vision Services ("GVS") and Vision Screening.) or
- visiting a non-participating provider and later submitting a Vision Plan claim form to the Fund for reimbursement.

Each **participating provider** has many office locations throughout the metropolitan New York/New Jersey area. Some providers also have office locations outside New York and New Jersey. You can select the **participating provider** that is most convenient to you. You *cannot* switch back and forth between **participating providers** within a 24-month period. For example, if you use Davis Vision for your exam and you receive a prescription for glasses or contacts, you must also use Davis to receive your frames and lenses within the 24-month period. (You could use different providers within Davis for the exam and the glasses, as long as both providers are part of Davis.) Also, each member of your family can use a different **participating provider** if they wish.

You can switch back and forth between non-participating providers.

To find a **participating provider**, call 1-212-388-2174.

Eligible Expenses

The Plan covers the following vision care expenses:

- eye examinations performed by a legally qualified and licensed ophthalmologist or optometrist
- prescribed corrective lenses you receive from a legally qualified and licensed optician, ophthalmologist or optometrist.

Excluded Expenses

The Plan's vision care coverage will not reimburse or make payments for expenses incurred for, caused by, or resulting from:

- ophthalmic treatment or services payable under the provisions of any other benefit of the Plan (see your hospital/medical plan for eligible ophthalmic treatment)
- non-prescription eyeglasses
- adornment expenses.

LIFE INSURANCE BENEFITS

Benefit Amount

Your life insurance coverage, which is administered by MetLife, is \$10,000 for Basic Plan participants. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

Naming a Beneficiary

Your beneficiary will be the person or persons you name in writing on a form that is kept on file at MetLife. Your beneficiary can be anyone you choose, and you can change your beneficiary designation at any time by completing and submitting a new form to MetLife. You can also change your beneficiary designation on the MetLife website which you can access through www.seiu32bj.org.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your life insurance benefit will be payable in the following order:

- (1) your wife or husband, if living
- (2) your living children, equally
- (3) your living parents, equally, and
- (4) if none of the above, to your estate.

The Plan does not pay life insurance benefits to a designated beneficiary who is involved in any way in the purposeful death of the participant.

Life Insurance Disability Extension

If you are disabled and receiving statutory short-term disability or Workers' Compensation benefits, your life insurance will continue for six months from the date of disability, or until your disability ends, whichever happens first. If you are eligible for a Disability Pension under the Building Service 32BJ Pension Fund, your life insurance will continue until your disability ends or you reach age 65, whichever happens first. For as long as this extended coverage lasts, your benefit level will be frozen at the level in effect at the time you became disabled.

You must submit proof of your disability within nine months of the date you became disabled. If you first apply for benefits after this nine-month period, it will be presumed that your disability did not commence while you were working in **covered employment**, unless you can provide the Fund with clear and convincing evidence otherwise. If you die before you submit proof of your disability, your beneficiary must submit proof of death and total disability within 90 days after your death.

Notice of approval or denial of benefits will be sent to your designated beneficiary in writing (see page 40 for information on appealing a denied claim).

While your extended life insurance coverage is in effect, the Fund may require you to be examined periodically by one or more Fund-selected **doctors** to confirm your continued disability. The Board or its designee has the sole and absolute discretion to make all determinations of disability.

When Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, except as provided above. See Section II for information about converting your group life insurance to an individual life insurance policy.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

Accidental Death & Dismemberment (AD&D) insurance, which is administered by MetLife, applies to accidents on or off the job, at home or away from home. This is unlike Workers' Compensation insurance, which covers you only on the job. You are eligible while in **covered employment** and for 30 days after your **covered employment** ends. Your AD&D benefit is in addition to your life insurance and is payable if you die or become dismembered as the result of an accident within 90 days after an accident.

How AD&D Benefits Work

Your AD&D insurance coverage is shown in the following chart. Benefits are payable to your beneficiary if you die, or to you if you have an accident and suffer one of the specific injuries listed in the chart below. Benefits will not be paid if your death or injury was caused by anything excluded under "What Is Not Covered" on page 39. Your beneficiary will be the same as your life insurance beneficiary on file with MetLife, unless you choose otherwise.

Loss	Benefit Payable
Life	\$10,000
Both hands at or above the wrist; or both feet at or above the ankle; or sight in both eyes; or any combination of hand, foot and sight in one eye	\$10,000
One hand at or above the wrist; or one foot at or above the ankle; or sight in one eye	\$5,000

“Loss” of a hand or foot means the actual and complete severance through or above the wrist or ankle joint. Loss of sight means the irrevocable and complete loss of sight.

For all covered losses caused by all injuries that you sustain in one accident, not more than the full amount will be paid.

Contact MetLife to claim AD&D benefits.

What Is Not Covered

AD&D insurance benefits will not be paid for injuries that result from any of the following causes:

- physical or mental illness, or diagnosis of or treatment for the illness
- an infection, unless it is caused by an external wound that can be seen and that was sustained in an accident
- suicide or attempted suicide
- injuring oneself on purpose
- the use of any drug or medicine
- a war, or a warlike action in time of peace
- committing or trying to commit a felony or other serious crime or an assault
- the injured party was intoxicated at the time of the incident and was operating a vehicle or other device involved in the incident. “Intoxicated” means that the injured person’s blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Coverage Ends

AD&D insurance coverage ends 30 days after you terminate employment.

DEATH BENEFIT FOR PENSIONERS

If you are a pensioner collecting a pension from the Building Service 32BJ Pension Fund, you are entitled to a death benefit of \$1,000. However, if you are eligible to receive life insurance coverage from this Plan, this \$1,000 death benefit is not payable.

Your beneficiary for the death benefit will be the person or persons you name in writing on a claim form that is kept on file in the Retirement Services Department. Your beneficiary can be anyone you choose, and you

can change your beneficiary at any time by completing and submitting a new form to Member Services.

If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your pensioner’s death benefit will be payable in the following order:

- (1) your wife or husband, if living
- (2) your living children, equally
- (3) your living parents, equally, and
- (4) if none of the above, to your estate

The Plan does not pay this benefit to anyone who is involved in any way in the purposeful death of the participant.

CLAIMS AND APPEALS PROCEDURES

See attached Section II for a detailed description of the procedures for filing claims for Plan benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal that decision. The Table below shows where to send claims for each of your benefits.

Claims Reviewers

Benefit	Filing Address
Medical/Hospital No claims forms are necessary	MagnaCare 825 East Gate Boulevard Garden City, NY 11530
Pharmacy (non-participating providers only; no claim forms are necessary for participating providers)	Medco Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512-4711
Dental (no claim forms are necessary)	Building Service 32BJ Dental Center 101 Avenue of the Americas New York, NY 10013-1991
Vision (non-participating providers only; no claim forms are necessary for participating providers)	Building Service 32BJ Health Fund Health Benefits Processing Group 101 Avenue of the Americas New York, NY 10013-1991
Life insurance Accidental Death & Dismemberment	MetLife Recordkeeping P.O. Box 6169 Utica, NY 13504-6169 1-866 492-6983

Appeals Reviewers

Benefit	Write to:	Or Call
Medical and Hospital	MagnaCare 825 East Gate Boulevard Garden City, NY 11530	1-877-624-6219
Pharmacy	Medco Health Solutions, Inc. Attention: Coverage Appeals 8111 Royal Ridge Parkway Irving, TX 75063-2820	1-800-318-7451
Dental	Building Service 32BJ Health Fund* Board of Trustees Appeals Committee 101 Avenue of the Americas New York, NY 10013-1991	Appeals are only accepted in writing**
Vision	Building Service 32BJ Health Fund* Board of Trustees Appeals Committee 101 Avenue of the Americas New York, NY 10013-1991	Appeals are only accepted in writing
Life insurance Accidental Death & Dismemberment	MetLife P.O. Box 3016 Utica, NY 13504-6169	Appeals are only accepted in writing

Subrogation Vendor:

Meridian Resource Company
P.O. Box 2025
Milwaukee, WI 53201-2025

* You may appear in person at the Appeals Committee meeting with the Fund, but you do not have to be there. If you do not attend, the Appeals Committee will decide your appeal based on all of the materials you have submitted.

** An appeal of an urgent care dental claim may be filed orally by calling 1-212-388-2099.

GLOSSARY

Allowed amount means the maximum the Fund will pay for a covered service. The allowed amount is based on an agreement with the provider.

Contributing employer (or “employer”) is a person, company or other employing entity that has signed a collective bargaining agreement or participation agreement with the union or trust, and the agreement requires contributions to the Health Fund for work in **covered employment**.

Co-payment means the flat-dollar fee you pay for office visits and certain **covered services**. The Plan then pays 100% of remaining covered expenses.

Covered employment means work in a classification for which your employer is required to make contributions to the Fund.

Covered services are the services for which the Fund provides benefits under the terms of the Plan.

Deductible means the dollar amount you must pay each calendar year before benefits become payable for covered **out-of-network** services.

Doctor means a licensed and qualified provider (M.D., D.O., D.C., or D.P.M.) who is authorized to practice medicine, perform surgery and/or prescribe drugs under the laws of the state or jurisdiction where the services are rendered, acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Emergency means a condition whose symptoms are so serious that someone who is not a **doctor**—but who has average knowledge of health and medicine—could reasonably expect that, without immediate medical attention, the following would happen:

- the patient’s health would be placed in serious jeopardy
- there would be serious problems with the patient’s body functions, organs or parts
- there would be serious disfigurement, or
- the patient or those around him or her would be placed in serious jeopardy, in the event of a behavioral health **emergency**.

Severe chest pains, extensive bleeding and seizures are examples of **emergency** conditions.

In-network benefits are benefits for **covered services** delivered by providers and suppliers who have contracted with the Fund, MagnaCare or Medco or with any other administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services provided must fall within the scope of their individual professional licenses. There are no out-of-network hospital or medical benefits.

Medically necessary, as determined by the applicable insurance carrier or the Fund, means services, supplies or equipment that satisfy all of the following criteria:

- are provided by a **doctor**, hospital or other provider of health services
- are consistent with the symptoms or diagnosis and treatment of an illness or injury; or are preventive in nature, such as annual physical examinations, well-woman care, well-child care and immunizations, and are specified by the Plan as covered
- are not experimental, except as specified otherwise in this booklet
- meet the standards of good medical practice
- meet the medical and surgical appropriateness requirements established under MagnaCare medical policy guidelines
- provide the most appropriate level and type of service that can be safely provided to the patient
- are not solely for the convenience of the patient, the family or the provider, and
- are not primarily custodial.

The fact that a **network** provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it **medically necessary**.

Network means the same as **in-network**.

Participating provider means a provider that has agreed to provide services, treatment and supplies at a pre-negotiated rate under the medical and prescription drug plans.

FOOTNOTES

1 *Hospital/facility* is a fully licensed acute-care general facility that has all of the following on its own premises:

- a broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
- 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
- a fully staffed operating room suitable for major surgery, together with anesthesia service and equipment (the hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care)
- assigned **emergency** personnel and a “crash cart” to treat cardiac arrest and other medical emergencies
- diagnostic radiology facilities
- a pathology laboratory, and
- an organized medical staff of licensed **doctors**.

For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with MagnaCare.

For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility approved by MagnaCare.

For kidney dialysis treatment, a facility in New York State qualifies for **in-network** benefits if the facility has an operating certificate issued by the New York State Department of Health and participates with MagnaCare.

For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with MagnaCare.

MagnaCare does not recognize as hospitals: nursing or convalescent homes and institutions; rehabilitation facilities (except as noted above), institutions primarily for rest or for the aged, spas, sanitariums, infirmaries at schools, colleges or camps; and any institution primarily for the treatment of drug addiction, alcoholism or behavioral care.

2 *Outpatient surgery* includes hospital surgical facilities, surgeons and surgical assistants; chemotherapy and radiation therapy, including medications, in a hospital outpatient department, **doctor’s** office or facility (medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy). Same-day, ambulatory or outpatient surgery (including invasive diagnostic procedures) means surgery that does not require an overnight stay in a hospital and:

- is performed in a same-day or hospital outpatient surgical facility

- requires the use of both surgical operating and postoperative recovery rooms
 - does not require an inpatient hospital admission, and
 - would justify an inpatient hospital admission in the absence of a same-day surgery program.
- 3** *Kidney dialysis treatment* (including hemodialysis and peritoneal dialysis) is covered in the following settings until Medicare becomes primary for end-stage renal disease dialysis (which occurs after 30 months):
- at home, when provided, supervised and arranged by a **doctor** and the patient has registered with an approved kidney disease treatment center (not covered: professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment), or
 - in a hospital-based or free-standing facility.
- 4** *Skilled nursing facility* means a licensed institution (or a distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services. Skilled nursing facilities are useful when you do not need the level of care a hospital provides, but you are not well enough to recover at home. The Plan covers inpatient care in a skilled nursing facility, for up to 10 days of inpatient care for IV antibiotics or for sub-acute rehabilitation from surgery or for wound care.
- 5** *Hospice care* is for patients who are diagnosed as terminally ill (that is, they have a life expectancy of six months or less). Up to 180 days of hospice care are covered in full **in-network** only. The Plan covers hospice services when the patient’s **doctor** certifies that the patient is terminally ill and the hospice care is provided by a hospice organization certified by the state in which the hospice organization is located. Hospice care services include:
- up to 12 hours a day of intermittent nursing care by an RN or LPN
 - medical care by the hospice **doctor**
 - drugs and medications prescribed by the patient’s **doctor** that are not experimental and are approved for use by the most recent “Physicians’ Desk Reference”
 - approved drugs and medications
 - physical, occupational, speech and respiratory therapy when required
 - lab tests, X-rays, chemotherapy and radiation therapy
 - social and counseling services for the patient’s family, including bereavement counseling visits for up to one year following the patient’s death (if eligible)
 - **medically necessary** transportation between home and hospital or hospice
 - medical supplies and rental of durable medical equipment, and
 - up to 14 hours of respite care a week.

- 6 *Home health care* means services and supplies including nursing care by a registered nurse (RN) or licensed practical nurse (LPN) and home health aid services. The Plan covers up to 40 home health care visits for IV infusion, wound care or to allow earlier discharge from a hospital.
- 7 *Home infusion therapy*, a service sometimes provided during home health care visits.
- 8 *Emergency room treatment benefits* are limited to the initial visit for **emergency** care. An **in-network** provider (not an **emergency** room of a participating hospital) must provide all follow-up care for you to receive maximum benefits. Also remember to contact MagnaCare Medical Management Program within 48 hours after an **emergency** hospital admission, as described on page 15, to pre-certify any continued stay in the hospital. If it is a non-participating hospital, you will need to file a claim in order to be reimbursed for your eligible expenses.
- 9 *Ambulance services* (land or air) are covered in an **emergency** and in other situations when it is medically appropriate (such as taking a patient home when the patient has a major fracture or needs oxygen during the trip home). Air ambulance service, which requires pre-certification, is covered only as a last resort (such as when you need to go to a distant hospital because the nearest hospital you can get to in a land ambulance cannot help you, or using land transportation would pose an immediate threat to your health).
- 10 *Preventive care* under the Plan includes routine physicals, subject to limits shown on page 18. Eligible expenses include X-rays, laboratory or other tests given in connection with the exam and materials for immunizations for infectious diseases. *Adults are covered for immunizations if **medically necessary**.*
- 11 *Well-child care* covers visits to a pediatrician, family practice **doctor**, nurse or licensed nurse practitioner. Regular checkups may include a physical examination, medical history review, developmental assessment, guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory and must be within five days of the **doctor's** office visit. The number of well-child visits covered per year depends on your child's age. Covered immunizations include: Diphtheria, tetanus and pertussis (DtaP), Hepatitis B, Haemophilus influenza Type B (Hib), Pneumococcus (Pcv), Polio (IPV), Measles, mumps and rubella (MMR), Varicella (chicken pox), Tetanus-diphtheria (Td), Hepatitis A and influenza for certain patients, other immunizations as determined by the American Academy of Pediatrics, Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.
- 12 Services of a certified nurse-*midwife* are covered if she or he is affiliated with or practicing in conjunction with a licensed facility and the services are provided under qualified medical direction.
- 13 *Physical therapy* is covered for inpatient physical therapy if it immediately follows a regular hospital admission. Physical therapy, physical medicine and rehabilitation services—or any combination of these—are covered as long as the treatment is prescribed by your **doctor** and designed to improve or restore

physical functioning within a reasonable period of time. If you receive therapy on an inpatient basis, it must be short-term. Occupational, Speech and Vision therapy are covered if prescribed by your **doctor** and provided by a licensed therapist (occupational, speech or vision, as applicable) in your home, in a therapist's office or in an approved outpatient facility.

Up to 20 outpatient visits are covered per year for physical and other therapy. You must receive any such services through a **network** provider in the home or office. Physical therapy provided in an outpatient department of a hospital is not covered. For outpatient physical therapy, you must pre-certify from the first visit.

14 *Durable medical equipment and supplies* means buying, renting and/or repairing prosthetics (such as artificial limbs), and other durable medical equipment and supplies—but you generally must go **in-network** for them. In addition to the items listed above, the Plan covers:

- prosthetics and durable medical equipment from **in-network** suppliers, when prescribed by a **doctor** and approved by the MagnaCare Medical Management Program including:
 - artificial arms, legs, eyes, ears, nose, larynx and external breast prostheses
 - supportive devices essential to the use of an artificial limb
 - corrective braces
 - wheelchairs, hospital-type beds, oxygen equipment, sleep apnea monitors
 - replacement of covered medical equipment because of wear, damage, growth or change in patient's need, when ordered by a **doctor**
 - reasonable cost of repairs and maintenance for covered medical equipment.

You must pre-certify for the rental or purchase of durable medical equipment costing \$2,500 or more. In addition, the Plan will cover the cost of buying equipment when the purchase price is expected to be less costly than long-term rental, or when the item is not available on a rental basis.

15 *Cosmetic Surgery* will be considered not **medically necessary** unless it is necessitated by injury, is for breast reconstruction after cancer surgery, or is necessary to lessen a disfiguring disease or a deformity arising from or directly related to a congenital abnormality. *Cosmetic treatment* includes any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease and requires pre-certification.

16 *Experimental or "investigative"* means treatment that, for the particular diagnosis or treatment of the enrolled person's condition, is not of proven benefit and not generally recognized by the medical community (as reflected in published literature). Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of an enrolled person's condition. A claims administrator may require that any or all of the following criteria be met to

determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- there is final market approval by the U.S. Food and Drug Administration (FDA) for the patient's particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer; once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met
- published peer-reviewed medical literature must conclude that the technology has a definite positive effect on health outcomes
- published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects)
- published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.
- improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

Contact Information

What do you need?	Who to contact	How
<ul style="list-style-type: none"> General information about your benefits and eligibility 	Member Services	Call 1-212-388-3500 or 1-800-551-3225 8:30 am – 5:00 pm Monday – Friday or Visit the walk-in center at 101 Avenue of the Americas 8:00 am – 5:30 pm Monday – Friday
<ul style="list-style-type: none"> Information on your hospital/medical benefits and claims To find a primary care physician To find participating providers To pre-certify a hospital or medical service 	MagnaCare	Call 1-877-624-6219 or visit www.magnacare.com
<ul style="list-style-type: none"> Information about your prescription drug benefits, formulary listing, participating pharmacy 	Medco	Call 1-800-318-7451 or Visit www.medco.com
<ul style="list-style-type: none"> Immediate medical advice 	Nurse's Helpline	Call 1-877-624-6219. To access health information library press #1 then enter pin #1032, 24 hours day/7 days a week
<ul style="list-style-type: none"> Information about your life insurance plan 	MetLife	Call 1-866-492-6983
<ul style="list-style-type: none"> To find a participating vision provider or a participating dental provider 	Health Fund	Call 1-212-388-2174
<ul style="list-style-type: none"> To make an appointment at the 32BJ Dental Center 	Dental Center	Call 1-212-388-2099



Building Service 32BJ Health Fund

101 Avenue of the Americas
New York, NY 10013-1991

www.seiu32bj.org

212-388-3500 Benefits Information
212-388-2000 General Information

Summary of Material Modifications

Building Service 32BJ Health Fund Basic Plan

The following is a list of changes and clarifications which have occurred since the printing of the Building Service 32BJ Health Fund Summary Plan Description (SPD) for the Basic Plan dated October 1, 2007. This Summary of Material Modifications (SMM) supplements or modifies the information presented in your SPD with respect to the Plan. **Please keep this document with your copy of the SPD for future reference.**

Clarification of Definition of Legal Guardian Page 9: The term legal guardian is interpreted by the Trustees to include legal custodian.

Change in Definition of Dependent Page 10: The definition of a dependent is revised to state that a dependent must live in the United States, Canada or Mexico unless he or she is a United States Citizen. In addition, if a member was never married to the other parent of the member's child, that child will be considered the member's dependent regardless of where the child resides, as long as the child is the tax dependent of the member.

Coverage of Bariatric Surgery only at Accredited Facilities Page 16: Effective January 1, 2009, bariatric surgery will only be covered at accredited facilities. There is no out-of-network coverage.

Elimination of Contraceptive Device Exclusion Page 23: Effective February 1, 2008, the medical coverage exclusion for contraceptive devices is eliminated. The Plan's medical coverage will now include contraceptive devices.

Clarification of Exclusion Page 23: the following exclusion under hospital and medical expenses is clarified by adding the parenthetical:

-injury or sickness that arises out of a criminal act (other than domestic violence) by the covered person, or an intentionally self-inflicted injury that is not the result of mental illness.

Addition of Annual Maximum on Prescription Drug Benefit Page 25: Effective January 1, 2009, the prescription drug benefit has an annual maximum of \$5,000. Every calendar year you and your eligible dependents each have a \$5,000 maximum drug benefit. Once the Plan has paid \$2,000 in any calendar year for you or one of your dependents, you are required to participate in Medco's prescription drug management program in order to be covered for any additional prescription drugs, up to the \$5,000 annual maximum.

Addition of Pathmark Retail Pharmacy as a Way to Get Maintenance Drugs through the Mail Pages 25-27: Effective June 1, 2008, if you work or live in an area that has a Pathmark Retail Pharmacy, you can fill your mail order prescription at a Pathmark Retail Pharmacy instead of mailing it to Medco By Mail. Simply drop off your 90-day prescription at a Pathmark pharmacy. Make sure you have your Medco prescription drug

ID card with you when you visit the Pathmark pharmacy. The Pathmark pharmacist will send this prescription to Medco By Mail for filling. As soon as your prescription is ready (usually within 8 to 10 days), you can return to that Pathmark pharmacy to get your prescription. When you pick up your prescription at Pathmark, you pay the pharmacist the appropriate co-payment--\$14 for a 90-day supply of a generic prescription drug or \$44 for a 90-day supply of a brand name prescription drug.

Addition of Omeprazole to Formulary Page 27: Effective May 1, 2008, the Fund excludes only brand name gastrointestinal drugs.

If you have any questions about this notice or want further information about the changes please contact Member Services at 1-212-355-3500 between the hours of 8:30 AM and 5:00 PM Monday through Friday.

11/1/08