



Building Service 32BJ Benefit Funds

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
Metropolitan and Suburban Plans**

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 Metropolitan and Suburban Plans dated December 31, 2005. 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.**

Change in Employer Trustee Page 1: Effective December 4, 2009, Howard Rothschild replaces James Berg as an Employer Trustee. The following replaces the information for James Berg:

**Howard I. Rothschild
President
Realty Advisory Board on Labor Relations, Inc.
292 Madison Avenue
New York, NY 10017-6307**

Change in Employer Trustee Page 1: Effective November 1, 2006, Charles Dorego replaces William Stuhlbarg as an Employer Trustee. The following replaces the information for William Stuhlbarg:

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

Change in Employer Trustee Address Page 1: The following Employer Trustee's address replaces the address in the SPD:

Fred Ward
Vice President
ABM
321 West 44th Street
New York, NY 10036-5454

Change in FMLA Maximum Leave Length Page 11: Effective January 28, 2008, you may be able to take up to a 26-week leave of absence from your job under the Family Medical Leave Act.

Change in the Definition of Lawful Spouse Page 12: The definition of your lawful spouse will exclude the words "opposite gender".

Change in definition of Domestic Partner Page 12: Effective, February 14, 2007, the requirements for domestic partner have been changed as follows:

You and your same-gender domestic partner:

- 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:
 - 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.

In order to establish eligibility for these benefits, you and your domestic partner will need to provide:

- A marriage certificate from a state in the U.S. or 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.

You are required to prove the highest level of certificate available in the jurisdiction where you reside.

Addition of Niece/Nephew as a Dependent Child Page 13: The definition of dependent child is modified to include your niece or nephew only if you are the legal guardian and the child is dependent upon you and only you for all support and maintenance; if an application for legal guardianship is pending, you must provide documentation that papers are filed and provide proof when legal process is complete.

Clarification of Definition of Legal Guardian Page 13: The term legal guardian is interpreted by the Trustees to include legal custodian.

Change in Definition of Dependent Page 14: 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.

Addition of Special Enrollment Right Page 16: If, after your coverage under the Plan becomes effective, your dependent(s) lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan, it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 60 days of the loss of Medicaid/CHIP or of your dependent's becoming eligible for the state subsidy, coverage for your dependent(s) will begin as of the date your dependent(s) lost eligibility for Medicaid/CHIP or the date they became eligible for the subsidy. If you do not notify the Fund within 60 days, coverage for your dependent(s) will begin as of the date you notify the Funds. Failure to notify the Funds of your dependents' loss of eligibility for Medicaid/CHIP or becoming eligible for the state subsidy 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.

Addition of Pre-certification Requirement for certain Outpatient and diagnostic Tests Pages 22 and 26: Effective January 1, 2009, the following Outpatient and Diagnostic Tests require Pre-certification: CAT and PET exams and nuclear imaging studies.

Elimination of Out-of Network Kidney Dialysis Page 24: Effective April 5, 2007, for those participants who have not already begun dialysis treatment, the Plan will no longer cover out-of-network kidney dialysis. If you choose to go to an out-of-network kidney dialysis provider, you will pay the entire cost.

Coverage of Bariatric Surgery only at Facilities Accredited by the American College of Surgeons Page 24: Effective January 1, 2009, bariatric surgery will only be covered at facilities accredited by the American College of Surgeons. There is no out-of-network coverage.

Change in Frequency of Well Child Visits to Conform to the American Academy of Pediatrics Guidelines Page 27: The following frequency limits apply to well child visits; birth to age 1, 7 visits; age 1 through age 4, 6 visits; age 5 through age 11, 7 visits; age 12 through age 17, 6 visits; and age 18 through age 23, 2 visits.

Addition of Pre-planned Home Birth as a Covered Service Page 31: Effective April 14, 2009, pre-planned home delivery of a child by a certified nurse-midwife is a covered service. The reimbursement rate for this service is at the contracted Empire BlueCross BlueShield Direct Point-of-Service (Direct POS) Obstetrician/Gynecologist global rate.

Elimination of Contraceptive Device Exclusion Page 34: 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 34: 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 Rite Aid Pharmacy as a Way to Get Maintenance Drugs through the Mail (for the period June 1, 2008 to February 28, 2009, the pharmacy offering this benefit was Pathmark Retail Pharmacy) Pages 36-38: Effective March 1, 2009, you can fill your mail order prescription at a Rite Aid Pharmacy in New York or New Jersey instead of mailing it to Medco By Mail. Simply drop off your 90-day prescription at a Rite Aid pharmacy. Make sure you have your Medco prescription drug ID card with you when you visit the Rite Aid pharmacy. The Rite Aid 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 Rite Aid pharmacy to get your prescription. When you pick up your prescription at Rite Aid, 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.

Elimination of EAP The section titled **Employee Assistance Program on Pages 39 - 40** is replaced with the following text:

Behavioral Health and Substance Abuse Benefit

Your Plan provides you and your eligible dependents with a behavioral health and substance abuse benefit which is administered by MHN. This benefit provides services for mental health or behavioral issues as well as assistance with substance abuse treatments. Services are available both in the hospital and on an outpatient basis. All behavioral health care and substance abuse services must be provided by an MHN participating hospital or provider. There is no coverage for services received from a non-participating MHN provider except in cases of an emergency.

Elimination of \$15 co-pay for first 8 Behavioral Health Visits Page 40, the first paragraph under the subheading Outpatient is replaced with the following:

Outpatient. You are covered for up to 40 visits per year when you see an MHN participating provider on an outpatient

basis. For outpatient treatment from a network provider your first eight (8) visits have a \$0 copayment. Then for visits 9-40 you must pay a \$15 copayment per visit. If you use an out-of-network therapist or do not pre-certify care, no benefits are payable. Outpatient treatment may include individual and group psychotherapy, couples and family treatment, psychiatric and medication evaluations, and ongoing medication management, depending on the patient's needs. Outpatient services are subject to a limit of 40 visits per year.

Replacement of EAP and HMC References: All references throughout the entire SPD to HMC are replaced by MHN; to EAP are replaced by behavioral health or behavioral health benefit; and to EAP network are replaced by MHN Behavioral network. In addition, the definition of EAP is stricken from the Glossary.

Change in Dental Pre-Approval Requirement Pages 48 and 49: Effective October 1, 2007, the Health Fund no longer requires pre-approval for treatment plans of \$300 or more but rather requires pre-approval for the following:

- Major Restorative procedures (page 50) for prefabricated stainless steel/resin crown (deciduous teeth only) and crowns.
- Periodontics (page 51) for osseous surgery
- Removable Prosthodontics (page 51)
- Fixed Prosthodontics (page 51)
- Oral and Maxillofacial Surgery (page 52) for removal of impacted tooth
- Orthodontics (page 52)
- All treatment plans that exceed \$1,500.

Effective October 1, 2008 Pre-approval must be requested from Administrative Services Only, Inc., Building Service 32BJ Health Fund Dedicated Unit, P.O. Box 9011, Lynbrook, NY 11563-9011.

Change in Orthodontic Benefit Pages 49 and 52: Effective October 1, 2007, the lifetime maximum on an orthodontic course of treatment for patients age 16 and older is raised from \$1,500 to \$2,500 and the course of treatment is increased from 24 to 30 months. For all orthodontic cases, initial diagnosis coverage of \$100 is added.

Change in Exam Frequency and Dental Prophylaxis Limits Page 50: Effective October 1, 2007, the frequency limit for the diagnostic procedure: oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused) and the preventive procedure; dental prophylaxis (cleaning, scaling and polishing) is changed from twice in any calendar year to once every 6 months.

Increased Co-Payment Page 51: Effective October 1, 2007, the co-payment for periodontic scaling and root planing, is increased from zero to 100% when performed outside the Dental Center. In addition, the \$80 maximum annual payment amount is eliminated.

Elimination of Limit on Denture Repairs Page 52: Effective October 1, 2007, the "two procedures in a calendar year limit" on the repair: additions to partial dentures, is eliminated.

Addition of an Exclusion under Accidental Death & Dismemberment (AD&D) Page 62: Under the heading **What Is Not Covered** the following bullet is added as cause for which AD&D insurance benefits will not be paid:

- 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."

Change in Dental Claims Out-of-Network Billing Pages 64 and 65: Effective June 1, 2007, the third bullet under Filing Dental Claims is replaced by the following bullet:

- When you are the patient, your original signature or signature on file are acceptable on all claims for payment. If the patient is a child, an original signature or signature on file of the child's parent or guardian are acceptable.

Additionally, the following new bullet is added as the seventh bullet under Filing Dental Claims:

- Effective June 1, 2007 the Fund no longer accepts assignment of payment to an out-of-network dentist. This means if you use an out-of-network dentist, the Fund will no longer make payment directly to that dentist. You will have to pay the dentist first, and you will be reimbursed according to the Plan's coverage limits.

Change in Disability Claims and Appeals Processes Pages 66 & 73: Effective January 1, 2010, MetLife will make the clinical determinations related to Long Term Disability and Disability Pension. Applications will continue to be mailed to Building Service 32BJ Health Fund, however these applications will be sent to the Department of Eligibility. The Department of Eligibility will make administrative determinations related to Long Term Disability and Disability Pension. MetLife will also handle appeals related to denials of benefits based on clinical reasons. Appeals to MetLife should be mailed to MetLife Disability, P.O. Box 14592, Lexington, KY 40511-4592. The Board of Trustees will handle appeals related to administrative denials of benefits. Appeals to the Board of Trustees should be mailed to: Building Service 32BJ Benefit Funds, Board of Trustees-Appeals Committee, 101 Avenue of the Americas, New York, NY 10013-1991.

Change in Dental Claims Reviewer Page 67: Effective October 1, 2008, dental claims must be filed with Administrative Services Only, Inc., Building Service 32BJ Health Fund Dedicated Unit, P.O. Box 9011, Lynbrook, NY 11563-9011.

Change in Mailing Address for Life Insurance and Accidental Death & Dismemberment Claims and Appeals Pages 67 and 73: Claims and appeals for life insurance or accidental death & dismemberment should be mailed or faxed to:

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

1-570-558-8645

Change in Dental Claim Appeals Process Pages 72-76: Effective October 1, 2008, an appeal of a denied dental claim must be filed with Administrative Services Only, Inc., Building Service 32BJ Health Fund Dedicated Unit, P.O. Box 9011, Lynbrook, NY 11563-9011. Once you have been notified of the outcome of your appeal, you have exhausted all required internal appeal options. If you disagree with the decision, you are free to file a civil action under Section 502(a) of ERISA. No lawsuit may be started more than three years after the date of the appeal denial letter. Alternatively, you may file a voluntary appeal with the Appeals Committee of the Board of Trustees. This voluntary appeal must be filed within 180 days of the appeal denial letter made by Administrative Services Only, Inc. If you chose to pursue a claim in court after completing the voluntary appeal, the timeframe within which the plan permits you to bring a civil action will be suspended during the voluntary appeals process.

Change in Life Insurance and Accidental Death & Dismemberment (AD&D) Appeals Process Pages 72-76
Effective September 1, 2007, an appeal of a denied life insurance or AD&D claim must be filed with Metlife, P.O. Box 3016 Utica NY, 13405 within 180 days of the date of the claim denial letter. Once you have been notified of the outcome of your appeal, you have exhausted all required internal appeal options. If you disagree with the decision, you are free to file a civil action under Section 502(a) of ERISA. No lawsuit may be started more than three years after the date of the appeal denial letter. Alternatively, you may file a voluntary appeal with the Appeals Committee of the Board of Trustees. This voluntary appeal must be filed within 180 days of Metlife's appeal denial letter. If you chose to pursue a claim in court after completing the voluntary appeal, the timeframe within which the plan permits you to bring a civil action will be suspended during the voluntary appeals process.

Clarification in Coordination of Benefits Language The following language is added after the first paragraph on Page 77: Your Plan uses the Non-Duplication of Benefits application of COB. This means that when this Plan is the secondary plan it determines how much it would have paid had it paid as the primary plan and then subtracts whatever the primary

plan paid as its benefit. Then your Plan, the secondary plan, pays that difference. If there is no difference then your Plan, as the secondary plan, pays nothing.

Clarification in Plan Coverage when Entitled to Medicare Page 78: Under the **Medicare** heading the following two bullets are substituted for the existing bullets:

- If you (or a dependent) become eligible for Medicare due to age or disability (according to the standards applied by Social Security) and you are in covered employment, you or your dependent(s) can keep or cancel (spouse can cancel when he or she reaches age 65) your coverage under this Plan. If you (or your dependent) decide to be covered by both this Plan and Medicare, this Plan will be primary and Medicare will be secondary as long as you remain in covered employment.
- If you are not in covered employment (for example, you are an early retiree or you are receiving LTD benefits) and you (or a dependent) are eligible for Medicare due to age or disability (according to the standards applied by Social Security), Medicare is primary and this Plan is secondary for each covered family member who is eligible for Medicare. Those covered family members who are not eligible for Medicare continue to receive primary coverage from this Plan.

Addition of 2 New Leave Types Page 83: The Family Medical Leave Act provides for two new leave types:

(1) Effective January 16, 2009, up to 12 weeks of leave for certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status, in support of a contingency operation, and

(2) Effective January 28, 2008 up to 26 weeks of leave in a single 12-month period to care for a covered servicemember recovering from a serious injury or illness incurred in the line of duty on active duty. Eligible employees are entitled to a combined total of up to 26 weeks of all types of FMLA leave during the single 12-month period.

Extension of FMLA Leave Types to inactive service members Page 83-84: Effective October 28, 2009, qualified exigency and military caregiver leaves have been extended to include exigencies, injuries and illnesses incurred by certain service members while not in the line of active duty.

Enactment of COBRA Subsidy Pages 85-89: Effective February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium for Assistance Eligible Individuals (AEIs). If you qualify for the premium reduction, you need only pay 35% of the COBRA premium otherwise due under the Plan.

This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA coverage. If you are receiving Fund paid COBRA due to short term disability, workers compensation, long term disability, Disability Pension, or Early Retirement at age 62, the amount of time that you are eligible for the premium reduction is reduced by the period of time the Fund pays your COBRA premium.

An AEI is a participant who experiences a qualifying event that is an involuntary termination of employment beginning September 1, 2008 and ending February 28, 2010 and who is not eligible for other group health coverage or Medicare. In order to establish eligibility for the premium reduction you must complete the "Application For Treatment As An Assistance Eligible Individual Form." If you incur a qualifying event, this form will be mailed to you with the COBRA notice and election form. It is also available from Member Services. The Fund will review your application and make a determination as to whether or not you will be treated as an AEI. If you are denied treatment as an AEI, you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the AARA premium reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

If, you are determined by the Fund to be an AEI, you will be eligible for reduced COBRA premiums for up to 15 months, assuming you elect COBRA continuation coverage.

If you are paying the reduced premium and you become eligible for other group health coverage or Medicare you must notify the Fund by completing and returning the "Premium Reduction Ineligibility Notice." This form is available in Member Services.

Elimination of Pre-certification for Air Ambulance in Emergency Situations Footnote 9, page 105 is replaced with the following text: Air ambulance is covered when the patient's medical condition is such that the time needed to transport by land poses a threat to the patient's survival or seriously endangers the patient's health or the patient's location is such that accessibility is only feasible by air transportation; and patient is transported to the nearest hospital with appropriate facilities for treatment; and there is a medical condition that is life threatening. Life threatening medical conditions include, but are not limited to, the following:

- Intracranial bleeding
- Cardiogenic shock
- Major burns requiring immediate treatment in a Burn Center
- Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit
- Multiple severe injuries
- Transplants
- Limb-threatening trauma
- High risk pregnancy
- Acute myocardial infarction; if this would enable the patient to receive a more timely medically necessary intervention (such as PTCA or fibrinolytic therapy)

Pre-certification of air ambulance is still required in non-emergency situations.

Clarification in Second Surgical Opinion Coverage Page 105: Footnote 10 is replaced with the following: Second surgical opinions are covered under the Plan. When you secure a second opinion from a participating provider you are responsible only for the appropriate co-payment. Should you secure a second opinion from a non-participating provider, you are responsible for any deductibles and coinsurances required under the Plan as well as charges that exceed the Plan's allowed amount.

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.