



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

**Building Service 32BJ Health Fund
Tri-State Plan**

The following is an address change which has occurred since the printing of the Building Service 32BJ Health Fund Summary Plan Description (SPD) for the Tri-State Plan dated July 1, 2008. 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 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 10: 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.

Extension of FMLA Leave Types to inactive service members Page 10: 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.

Change in the Definition of Lawful Spouse Page 11: The definition of your lawful spouse will exclude the words "opposite gender".

Addition of Special Enrollment Right Page 15: 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-planned Home Birth as a Covered Service Page 30: 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 the Requirement to participate in Medco's prescription drug management program – Annual Maximum on Prescription Drug Benefit Page 35: Delete the following sentences: **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.**

Replacement of Pathmark Pharmacy Pages 36 and 37: Effective March 1, 2009, Rite Aid will replace Pathmark as the retail pharmacy vendor. 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.

Elimination of EAP The section titled Employee Assistance Program on Pages 38—45 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 Pages 39 - 40, the first paragraph under the subheading Outpatient is replaced with the following:

Outpatient. You are covered for up to 20 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 9-20 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 20 visits per year.

Replacement of EAP and HMC References: All references though out 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.

Addition of the Dental Center Pages 45-47: Effective November 1, 2009, the 32BJ Dental Center will be available as an option of where to receive dental care. The 32BJ Dental Center is equipped to provide a broad range of dental services, except those that require general anesthesia. Care received at the 32BJ Dental Center does not require predeterminations or pre-treatment estimates and is free of charge.

Relocation of Misplaced Text related to Short-Term Disability Page 62: The subsection titled *When Benefits End* on page 62 relates to Short-Term Disability and is moved in its entirety to page 59.

Change in Short-Term Disability Administrator Page 62: The Short-Term Disability Benefit is administered by Insurance Programmers Inc. (IPI), 60 North Main Street, Wallingford, CT 06492-7617.

Change in Mailing Address for Life Insurance and Accidental Death & Dismemberment Claims and Appeals

Pages 63 and 68: 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

Clarification in Coordination of Benefits Language The following language is added after the first paragraph on

Page 71: 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.

Addition of 2 New Leave Types **Page 78:** 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 service member 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.

Enactment of COBRA Subsidy **Pages 80-84:** 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 100: 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.

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.