

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 & Ganchrow LLP

CONTENTS

	Page
Important Notice	7
Eligibility and Participation	8
When You Are Eligible.....	8
When You Are No Longer Eligible	8
If You Come Back to Work.....	9
Extension of Health Benefits	9
COBRA.....	9
Fund-paid COBRA	9
Disability	9
Arbitration	10
FMLA.....	10
Military Leave.....	10
Dependent Eligibility	11
When Your Dependents Are No Longer Eligible	13
How to Enroll	14
Your Notification Responsibility	15
What Benefits Are Provided	15
Hospital and Medical Benefits	16
Overview of Eligible Expenses.....	16
About the Empire Networks	17
When You Go In-Network.....	18
When You Go Out-of-Network.....	18
Coverage When You Are Away from Home.....	19
Benefit Maximums	20
Conditions for Hospital and Medical Expense Reimbursement	20
Pre-Certification	20
Covered Services.....	23
In the Hospital and Outpatient Treatment Centers.....	23
Skilled Nursing Facility.....	24
Hospice Care Facility.....	24
Home Health Care	24
Emergency Care.....	24
Care in the Doctor’s Office.....	25
Preventive Medical Care	26

Pregnancy and Maternity Care.....	27
Physical, Occupational, Speech or Vision Therapy (including rehabilitation).....	28
Durable Medical Equipment and Supplies.....	28
Excluded Hospital And Medical Expenses.....	29
Prescription Drug Benefits	34
At the Pharmacy.....	34
Through Mail Order.....	35
Eligible Drugs.....	37
Excluded Drugs.....	37
Employee Assistance Program (EAP)	38
Behavioral and Substance Abuse Treatment.....	39
Confidentiality.....	39
Pre-Certifying Behavioral or Substance Abuse Treatment.....	40
Eligible Providers.....	40
Conditions for Coverage.....	40
What Is Not Covered.....	41
Dental Benefits	45
How the Plan Works.....	45
The 32BJ Dental Center.....	45
Participating Dental Providers.....	46
Non-Participating Dentists.....	46
Prior Approval.....	46
What Dental Services Are Covered.....	47
Schedule of Covered Dental Services.....	48
Frequency Limitations.....	51
Alternate Benefit.....	51
What Is Not Covered.....	51
Coordination of Dental Benefits.....	53
Vision Care Benefits	54
Eligible Expenses.....	55
Excluded Expenses.....	55
Life Insurance Benefits	55
Benefit Amount.....	55
Naming a Beneficiary.....	55
Life Insurance Disability Extension.....	56
When Coverage Ends.....	56

Accidental Death & Dismemberment (AD&D) Benefits	57
How AD&D Benefits Work.....	57
What Is Not Covered.....	58
When Coverage Ends.....	58
Death Benefit for Pensioners	58
Claims and Appeals Procedures	59
Claims for Benefits.....	59
Filing Hospital and Medical Claims.....	59
Filing Dental Claims.....	60
Filing Pharmacy Claims.....	60
Filing EAP Claims.....	61
Filing Vision Claims.....	61
Filing for a Pensioner's Death Benefit.....	61
Filing Life Insurance and AD&D Claims.....	61
Where to Send Claim Forms.....	62
Approval and Denial of Claims.....	63
Health Service Claims (hospital/medical, pharmacy, EAP, dental and vision).....	63
Life and AD&D Claims.....	66
Pensioner's Death Benefit Claims.....	66
Notice of Decision.....	66
Appealing Denied Claims.....	66
Filing an Appeal.....	66
Where to File an Appeal.....	68
Time Frames for Decisions on Appeals.....	68
Expedited Appeals for Urgent Care Claims.....	68
Pre-Service or Concurrent Medical, Hospital, Pharmacy, Dental or EAP Claim Appeal.....	69
Post-Service Medical, Hospital, Pharmacy, Dental or EAP Claim Appeal.....	69
Voluntary Second Level Appeal of a Medical, Hospital, Pharmacy, Dental, Life Insurance, AD&D or EAP Claim.....	69
Vision and Pensioner's Death Benefit Claim Appeal.....	70
Appeal Decision Notice.....	70
Further Action.....	71

Incompetence	71
Mailing Address	71
Coordination of Benefits	71
Your Disclosures to The Fund	74
Subrogation and Reimbursement	75
Fraud	77
Overpayments	78
Continued Group Health Coverage	78
During a Family and Medical Leave	78
During Military Leave.....	79
Under COBRA.....	80
COBRA Continuation of Coverage	81
Other Health Plan Information You Should Know	84
Assignment of Plan Benefits	84
No Liability for Practice of Medicine	85
Privacy of Protected Health Information	85
Certificate of Creditable Coverage.....	86
Converting to Individual Coverage.....	86
General Information	87
Employer Contributions	87
How Benefits May Be Reduced, Delayed or Lost.....	87
Compliance with Federal Law	88
Plan Amendment or Termination	88
Plan Administration	88
Statement of Rights under the Employee Retirement Income Security Act of 1974 as Amended.....	89
Plan Facts	92
Glossary	94
Footnotes	97
Contact Information	104

IMPORTANT NOTICE

This booklet is 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 Tri-State Preferred Plan. Your rights to benefits can only be determined by this SPD, 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 February 1, 2008, 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 Tri-State Preferred Plan covers certain participants who work primarily in New Jersey and Long Island employment. 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 180 consecutive days of **covered employment** with the same employer working full-time (as defined by your collective bargaining agreement or participation agreement) more than 2 days 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 180-day waiting period. When you have completed that 180-day period working for your employer, you and your eligible dependents become eligible for the benefits described in this booklet on your 181st day of **covered employment**.

Additional eligibility requirements apply to the death benefits for pensioners; see page 58 for more information.

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 pages 80 – 84)
- 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 180 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 11 – 14).

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 and medical, prescription drug, **EAP**, dental and vision coverage. See pages 80 - 84 for more information about COBRA.

Fund-paid COBRA

If all eligibility requirements are met, the Fund will pay for COBRA coverage in the following situations: disability and arbitration. All periods of Fund-paid COBRA will count toward the period in which you are entitled to continuing coverage under COBRA.

To receive this extended coverage, you must complete the COBRA Continuation of Coverage Election Form you receive in the mail. If you fail to timely return the Election Form, you may lose eligibility for continuation coverage under Fund-paid COBRA. The completed Election Form along with all required documents (e.g., proof of disability) must be returned to:

Building Service 32BJ Health Fund
Attn: COBRA Payments
101 Avenue of the Americas
New York, NY 10013-1991

Disability

If provided in your collective bargaining agreement or participation agreement, you may continue to be eligible for up to thirty (30) months of health coverage, provided you enroll for coverage, are unable to work and are receiving (or are approved to receive) one of the following disability benefits:

- short-term disability
- Workers' Compensation, or
- Building Service 32BJ Pension Fund Disability Pension.

When any of the following events occurs, your extended coverage will end:

- if you work at any job
- if your Workers' Compensation or short-term disability benefit ends
- 30 months after you stopped working due to a disability
- when you receive the maximum benefits under short-term disability or Workers' Compensation, and are not eligible for a disability pension under the Building Service 32BJ Pension Fund, or
- when you become eligible for Medicare as your primary insurer.

If you die while receiving extended health coverage, your dependents' eligibility will end 30 days after the date of your death.

To receive this extended coverage, you must complete the COBRA Continuation of Coverage Election Form you receive in the mail as described above. The completed Election Form along with all required documents must be returned to the Fund no later than 60 days after the date coverage would have been lost (90 days after you stopped working due to a disability). The Plan reserves the right to require proof of your continued disability from time to time. Fund-paid COBRA will count toward the period in which you are entitled to continuing coverage under COBRA. See pages 80 - 84 for COBRA information.

Arbitration

If you are discharged and the Union takes your grievance to arbitration seeking reinstatement to your job, the Fund will pay for your COBRA coverage for up to six months or until your arbitration is decided, whichever occurs first. This Fund-paid COBRA will count toward the period in which you are entitled to continuing coverage under 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 pages 78 – 79 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 pages 79 – 80 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 a province in Canada where same-gender marriages are valid, or • have a civil union certificate from a state in the U.S. or a 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 prove 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	
Children (except disabled children)	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 pages 84 – 85, 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 the legal process is complete. 	<p>A child is not considered a dependent under the Plan if he or she:</p> <ul style="list-style-type: none"> • is not a United States citizen <u>and</u> lives outside the United States, Canada or Mexico, or • is in the military or similar forces of any country. <p>* 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.</p> <p>**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 15). 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.</p> <p>*** Legal guardian(ship) includes legal custodian(ship).</p>
Children (disabled)	None	<p>The child:</p> <ul style="list-style-type: none"> • is totally and permanently disabled • became disabled while or before becoming 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>	<p>When Your Dependents Are No Longer Eligible</p> <p>Your dependents remain eligible for as long as you remain eligible, except for the following:</p> <ul style="list-style-type: none"> • Your <i>spouse's</i> 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 11 are no longer satisfied. • Your <i>child's</i> eligibility ends when your child marries or no longer satisfies the rules regarding residence or financial dependency that are described on page 12, 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 11 – 14 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" on page 15 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 page 12.

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, **EAP**, dental, vision, life insurance, accidental death and dismemberment and pensioner death benefits (only to pensioners under 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	Out-of-Network
How you can receive treatment	Go to any network provider	Go to any licensed/certified provider unless out-of-network care is specifically excluded, see pages 23-28
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.	All out-of-network reimbursements are based on the allowed amount for medically necessary eligible expenses and subject to the annual deductible, co-insurance and pre-certification where required. Out-of-network providers may or may not accept Empire BlueCross BlueShield payment as payment in full (excluding deductibles and co-insurance); if they do not, you are responsible for paying any excess amount.
Annual deductible — individual — family	Not applicable Not applicable	\$500 \$1,000
Co-payments (where applicable)	\$15 per visit \$50/emergency room visit	Not applicable \$50/emergency room visit
Co-insurance (where applicable)	Plan pays 100% after the co-payment	Plan pays 50% of the allowed amount after the deductible
Annual co-insurance maximums (excluding deductibles) — individual — family	Not applicable Not applicable	\$1,250 \$2,500
Annual maximum benefit (combined for both in-network and out-of-network coverage)	\$250,000	\$250,000
Lifetime maximum benefit (combined for both in-network and out-of-network coverage)	\$2,500,000	\$2,500,000

About the Empire Networks

The Plan provides hospital and medical benefits through Empire BlueCross BlueShield (“Empire”). The Plan offers the Empire Direct Point-of-Service (“Direct POS”) **network**. This **network** includes over 65,000 **doctors** and other providers and 150 hospitals in the following two states:

- *New York*: 29 eastern counties -- Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.
- *New Jersey*: 8 northern counties -- Bergen, Essex, Hudson, Middlesex, Monmouth, Passaic, Sussex and Union.

*Participants who reside outside the New York and New Jersey counties identified above will receive their hospital and medical benefits through the Empire Preferred Provider Organization (“PPO”) **network**. The PPO allows participants and their dependents to access **in-network** benefits through providers who participate in the local BlueCross BlueShield plan where the participant resides on the same terms as **in-network** providers under the Direct POS. (All hospital and medical benefits described on the pages that follow are identical for the Direct POS and PPO **networks**.)*

When you use a **network** provider, you will have minimal or no cost for services.

You are also covered when seeing **out-of-network doctors**, but you will incur substantial charges since the Plan pays 50% of the **allowed amount**, which is generally less than the amount you are charged. So when you go **out-of-network**, you pay 50% plus the difference between what you are actually charged and what the Plan recognizes as the **allowed amount** for that particular service, treatment or supply.

Empire 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. Plus, your Empire ID card can get you discounts on certain non-covered services, such as laser vision correction, health club memberships and Weight Watchers programs.

Nurses Healthline. This is round-the-clock information free to Empire members. 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. If you do not speak English or Spanish, interpreters are available through the AT&T Language Line.

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 Nurses Healthline at 1-877-825-5276.

When You Go In-Network

When you use an **in-network** provider, your expenses are covered at the highest level. In addition, there are no **deductibles** or **co-insurance** 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 only a \$15 **co-payment** for **doctor** visits and certain other services and supplies, such as outpatient physical therapy or chiropractic care.

When You Go Out-of-Network

Care that is not provided by a **network** provider is considered **out-of-network** care and, as such, reimbursed at a lower level. If you use **out-of-network** providers, you must first satisfy the annual **deductible** before being reimbursed at 50% of the **allowed amount**. Amounts above the **allowed amount** are not eligible for reimbursement and are your responsibility to pay, in addition to any **deductibles** and required **co-insurance**. If you use an **out-of-network** provider, ask your provider if he or she will accept Empire's payment as payment in full (excluding your **deductible** or **co-insurance** requirements). While many providers will tell you that they take "32BJ" or "Empire" coverage, they may not accept Plan coverage as payment in full. Then they will bill you directly for charges that are over the Plan's **allowed amount**. In addition to the 50% you pay, you will then be responsible for the excess charges.

Annual deductible. \$500 individual or \$1,000 family, provided one covered individual in a family has met the individual **deductible**.

Common accident deductible. If two or more family members are injured in the same accident and require medical care, the family must meet only one individual **deductible**.

*Expenses that do not count toward the **deductible**.*

- **in-network co-payments**
- charges that exceed the **allowed amount** for eligible **out-of-network** expenses
- amounts that you pay because you failed to pre-certify a hospital stay or meet any other similar pre-certification requirements
- charges excluded or limited by the Plan (see pages 29 – 34).

Co-insurance. Once the annual **deductible** is met, the Plan pays 50% of the **allowed amount** for eligible **out-of-network** expenses. You pay the remaining 50%, which is your **co-insurance**. You also pay any amounts over the **allowed amount**.

Annual co-insurance maximum. The Plan limits the **co-insurance** each patient has to pay in a given calendar year to \$1,250. The family limit is \$2,500. Once one person in the family has paid \$1,250 in **co-insurance** and the rest of the covered family members combined have paid \$1,250 more in **co-insurance** (for a total of \$2,500), you have met the family **co-insurance** maximum for that year. Any eligible expenses submitted for reimbursement after the annual **co-insurance** maximum is reached are paid at 100% of the **allowed amount**. You still have to pay any charge above the **allowed amount**.

*Expenses that do not count toward the **co-insurance** maximum.* The following expenses are not applied toward the **out-of-network** annual **co-insurance** maximum:

- **in-network co-payments**
- **deductibles**
- charges that exceed the **allowed amount** for eligible **out-of-network** expenses
- amounts that you pay because you failed to pre-certify a hospital stay or meet any other similar pre-certification requirements
- charges excluded or limited by the Plan (see pages 29 – 34).

Coverage When You Are Away from Home

When you are outside of the area covered by Direct POS **network** (see page 17), **emergency** treatment will be considered **in-network**; all other services will be considered **out-of-network**.

Benefit Maximums

For **in-network** and **out-of-network** care combined, there is an *annual* limit of \$250,000 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 23 – 28.)

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

When you use a **network** provider, the provider will do the pre-certification for you.

When you use an **out-of-network** provider, it is your responsibility to have the required services pre-certified. This means that you have to contact the Fund’s Health Services Program as shown on page 21, or make sure that your provider has done so. Failure to pre-certify will result in a financial penalty, which you will be responsible for paying.

Pre-Certification for Medical/Hospital

The following services must be pre-certified

Call 1-866-230-3225

24 hours a day, seven days a week.

Type of Care	When You Must Call
Outpatient: <ul style="list-style-type: none">• Air ambulance• Cardiac rehabilitation• Home health care and home infusion therapy• Speech, occupational and vision therapy• MRI or MRA exams• Physical therapy• Prosthetics/orthotics or durable medical equipment (rental or purchase)	As soon as possible before you receive care
• Maternity	Within the first 3 months of pregnancy. Also within the first 3 months of pregnancy to qualify for prenatal vitamin coverage (see page 37)
• Surgical procedures	Two weeks before you receive surgery (inpatient and ambulatory) or as soon as care is scheduled
Inpatient: <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
• Maternity admissions	Within 48 hours after delivery or admission
• Emergency admissions	
• Maternity admissions lasting longer than two days (or four days for cesarean delivery)	As soon as you know care is lasting longer than originally planned
• Ongoing hospitalization	
• Admissions to hospice facilities	As soon as possible after receiving care or being admitted

How pre-certification works. The Health Services Program 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, the Health Services Program will make its decision within 72 hours after they have received all necessary information (for more information, see pages 64 – 65).

If you do not pre-certify the care (except for outpatient maternity) listed above within the required time frames, benefit payments will be reduced by 50%, up to a maximum \$250 reduction for each admission, treatment or procedure. If the Plan determines that the admission or procedure was not medically necessary, no benefits are payable.

To pre-certify behavioral or substance abuse treatment, you must go through our Employee Assistance Program (**EAP**). See pages 38-44 for more information.

The Health Services Program's Case Management staff can help you and your family explore your options and make the right treatment choices when you are facing a chronic or complicated illness or injury, such as cancer, heart disease, diabetes, or spinal cord and other traumatic injuries.

Covered Services

The following tables show different types of health care expenses and how they are covered **in-network** versus **out-of-network**.

In the Hospital¹ and Outpatient Treatment Centers*

Benefit	What You Pay	
	In-network	Out-of-network
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)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
In-hospital services of licensed doctors and surgeons	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Surgery (inpatient or outpatient ²) and care related to surgery (including operating and recovery rooms)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Anesthesia and oxygen	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Blood and blood transfusions	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Cardiac Care Unit (CCU) and Intensive Care Unit (ICU)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Chemotherapy and radiation therapy	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Kidney dialysis ³	Plan pays 100%	Not covered except for those participants in continuing dialysis care as of April 5, 2007
Pre-surgical testing	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Special diet and nutritional services while in the hospital	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible

* Pre-certification required.

See footnotes 1, 2 and 3: pages 97 – 98.

Benefit	What You Pay	
	In-network	Out-of-network
Skilled nursing care facility^{4*} Benefits are payable for up to 60 days per year	Plan pays 100%	Not Covered
Hospice care⁵ facility* Benefits are payable for up to 210 days per lifetime (includes up to 12 hours a day of intermittent nursing care by an RN or LPN)	Plan pays 100%	Not Covered
Home Health Care⁶		
Home health care visits* Benefits are payable for up to 200 visits per year	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Home infusion therapy ^{7*}	Plan pays 100%	Not Covered
Emergency Care		
Emergency room ⁸ (no benefit if condition is not emergency)	Plan pays 100% after \$50 co-payment (\$50 reimbursed if referred by Nurses Healthline -- call 1-877-825-5276); or, \$50 waived if admitted from emergency room to hospital within 24 hours	
Office visits	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Ambulance services ⁹	Plan pays 100%	Plan pays 50% of the allowed amount after deductible

* Pre-certification required.

See footnotes 4 - 9: pages 98 – 100.

Care in the Doctor's Office

Benefit	What You Pay	
	In-network	Out-of-network
Office visits (including surgery ² in the office)	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Specialist visits	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Chiropractic visits 10 visit maximum per year	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Second surgical opinion ¹⁰	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Diabetes education and management ¹¹	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Allergy care: • Testing • Treatment \$1,500 annual benefit maximum for testing/treatment combined	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Dermatology care: No maximum for the treatment of skin cancer; \$1,000 annual benefit maximum for other conditions	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Diagnostic procedures: • X-rays and other imaging • MRIs/MRAs* • All lab tests	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Chemotherapy and radiation therapy	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Hearing exams (only when medically necessary)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Podiatric care, including routine foot care (care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain, and treatment of symptomatic complaints of the feet), but excluding routine orthotics	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible

* Pre-certification required.

See footnotes 2, 10 and 11: pages 98 and 100.

Preventive Medical Care

Benefit	What You Pay	
	In-network	Out-of-network
Annual physical exam ¹² including the necessary diagnostic screening tests based on the patient's age, sex and health risk factors.	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
Well-woman care		
• Office visits	\$15 co-payment per visit	Plan pays 50% of the allowed amount after the deductible
– An annual gynecological exam, including Pap smear, may be performed by an obstetrician/gynecologist or the patient's Primary Care Physician.		
• Mammogram	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
– for women age 35–39, one baseline test is covered		
– for women age 40 and older, test covered once per year		
Well-child care ¹³ (including immunizations) subject to the following frequency limitations:	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
– newborns: 1 exam at birth		
– birth to age 1: 6 visits		
– age 1 through age 2: 3 visits		
– age 3 through age 6: 4 visits		
– age 7 through age 18: 6 visits		

See footnotes 12 and 13: page 101.

Pregnancy and Maternity Care

Benefit	What You Pay	
	In-network	Out-of-network
Office visits for prenatal and postnatal care from a licensed doctor or certified midwife ¹⁴ , including diagnostic procedures	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Newborn in-hospital nursery care	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Obstetrical care* (in hospital or birthing center)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible No coverage for a non-participating birthing center.
A home health care visit (if the mother leaves the hospital before the 48- or 96-hour period indicated under hospital benefits)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Circumcision of newborn males	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible

* Pre-certification required.

See footnote 14: page 101.

Remember to call the Health Services Program at 1-866-230-3225 within the first three months of pregnancy to be covered for prenatal vitamins through a special program established under the Plan's pharmacy program (see page 37 for information).

Physical, Occupational, Speech or Vision Therapy (including rehabilitation)¹⁵

Benefit	What You Pay	
	In-network	Out-of-network
Inpatient Services* Benefits are payable for up to 30 days a year	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Outpatient Services* Benefits are payable for up to 30 visits a year	\$15 co-payment per visit	Not Covered

Durable Medical Equipment and Supplies¹⁶

Benefit	What You Pay	
	In-network	Out-of-network
Durable medical equipment* (such as wheelchairs and hospital beds)	Plan pays 100%	Not Covered
Prosthetics/orthotics* (orthotics are covered only for non-routine foot orthotics – limited to one pair per year)	Plan pays 100%	Not Covered
Medical supplies (such as catheters and syringes)	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Nutritional supplements ¹⁷ that require a prescription (formulas and modified solid-food products) \$2,500 maximum benefit in any 12-consecutive month period	Plan pays 100%	Plan pays 50% of the allowed amount after the deductible
Hearing Aids – Benefits are payable for one hearing aid per ear per lifetime	Plan pays 100% up to \$550 per hearing aid	

* Pre-certification required.

See footnotes 15, 16 and 17: pages 101 – 102.

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 **EAP**, prescription drug, vision or dental coverages. 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**
- cosmetic treatment¹⁸
- technology, treatments, procedures, drugs, biological products or medical devices that in Empire's judgment are experimental, investigative, obsolete or ineffective¹⁹. 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
- orthotics for routine foot care (including dispensing of surgical shoe(s) and pre- and post-operative X-rays)
- routine hearing exams

See footnotes 18 and 19: pages 102 – 103.

- 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 95)
 - use of the emergency room for follow-up visits
 - **ambulette**, except for home health care services

- 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 **deductible** or **co-insurance**.)
 - **out-of-network** birthing center facilities
 - 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 additional cost does not count toward your **deductible** or **co-insurance**.)
 - 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 surgery¹⁸ or any related hospital expenses or treatment of any related complications
- hospital services received in clinic settings that do not meet Empire'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

- the following **out-of-network** services and/or expenses:
 - kidney dialysis
 - skilled nursing care facility
 - hospice care facility
 - home infusion therapy
 - birthing centers
 - outpatient physical therapy
 - outpatient occupational, speech and vision therapies
 - durable medical equipment
 - prosthetics/orthotics

- the following specific equipment:
 - air conditioners or purifiers
 - humidifiers or de-humidifiers
 - exercise equipment
 - swimming pools

See footnote 18: page 102.

- 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
- 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 54 -55, to find out how eyeglasses and contact lenses may be covered under the vision program
 - routine vision care (See "Vision Care Benefits," pages 54-55, 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 34 – 37, to find out how prescription drug expenses may be covered.
 - services of a nutritionist and nutritional therapy or counseling, except as provided on pages 23, 28 and 102
- 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 pages 75 –77)
 - injury or sickness that arises out of any act of war (declared or undeclared) or military service of any country
 - 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
 - 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 pages 75 – 77)
 - 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 Empire and a governmental 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:

- \$7.00 if the prescription or refill is filled with a generic drug, or
- \$22.00 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 \$22.00 **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). You pay:

- \$14.00 for up to a three-month supply per *generic* prescription or refill, or
- \$44.00 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 \$44.00 **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** first 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, you can fill your prescription through Medco By Mail in two different ways. You can mail your prescription to Medco By Mail, or beginning June 1, 2008 you can go to a Pathmark retail pharmacy to place and pick up your Medco mail order.
- If you choose to fill your prescription through the mail, 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.
- If you prefer to use a Pathmark pharmacy, simply drop off your 90-day prescription at a Pathmark pharmacy convenient to you. 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 filing. As soon as your prescription is ready (usually within 8-10 days), you can return to that Pathmark pharmacy to get your prescription. In fact, Medco will call you just before your prescription is shipped to Pathmark so you know it will be arriving in a couple of days.
- When you pick up your prescription at Pathmark, simply pay the pharmacist the appropriate **co-payment** (you can pay in cash) – \$14 for a 90-day supply of a generic medication or \$44 for a 90-day supply of a brand. If you have any questions about your medication, you can either ask the Pathmark pharmacist or call a Medco pharmacist when you get home. There are no forms to fill out. No need for a check or credit cards. And, your prescription is shipped to the same Pathmark location where you dropped it off, ready to be picked up by you.

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 require prior authorization. Your pharmacist can tell you if the prescription drug order you need to have filled 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
- pre-natal vitamins, with no **co-payment** required, provided the Health Services Program is notified within the first 3 months of pregnancy.

Excluded Drugs

The following are not covered under the Plan:

- over-the-counter drugs and vitamins (however, certain vitamins are covered for prenatal care – see above for information)
- 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 18 on page 102 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.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

“EAP” stands for the Employee Assistance Program. It provides you and your family with confidential, professional counseling, and benefits for behavioral and substance abuse treatment. The EAP’s staff of health professionals, counselors, psychologists, social workers and psychiatrists can help you deal with stress, depression, gambling, drinking or drug abuse, domestic violence, family or relationship issues and other personal problems.

This EAP is administered by Managed Health Network (MHN), an independent organization that manages a **network** of behavioral health specialists and also arranges consultations, assessments and referrals. This **network** is separate from and not part of the Empire Direct POS **network**.

These benefits for behavioral and substance abuse treatment are payable for **in-network** care only. You must use a participating MHN **network** provider to get benefits. If you use an **out-of-network** facility or provider, no benefits are payable.

All services, including counseling, behavioral and substance abuse treatment, both inpatient and outpatient, require referral from MHN (see below for how emergency treatment is handled). If you need services or want to discuss a problem, call MHN at 1-800-798-2150.

When you call MHN at their toll-free number, an MHN representative will assess your problem and refer you to a trained EAP counselor. The EAP counselor will discuss your problem with you, assess your individual needs and outline a plan of action for you to consider. You may talk to an EAP counselor by phone, through scheduled telephone appointments or be referred to see an EAP counselor in his or her office. For each problem you call about, you can get up to eight office-based sessions with a counselor. There is no limit on counseling by telephone.

For many people, talking to an EAP counselor, by telephone or in the office, is all the help they need. However, if you need more specialized or extensive behavioral or substance abuse treatment, the EAP counselor will refer you to a MHN specialist or inpatient facility. This benefit is described below.

If you know that you do not want to use the EAP services when you first call MHN, an MHN representative can provide you with a referral directly to an MHN participating specialist near where you work or live.

All these services, including counseling, behavioral and substance abuse must be **in-network** and must be arranged through MHN. **Call MHN toll-free at 1-800-798-2150 at any time of the day or night.**

Behavioral and Substance Abuse Treatment

Inpatient. As long as you go to an **in-network** facility and the stay has been pre-certified (see below), the Plan pays the **allowed amount** for up to 30 days per year, including partial hospitalization and day programs. If you use an **out-of-network** facility and/or do not pre-certify care, no benefits are payable unless it is an **emergency**. If there is an **emergency**, the patient should first go to the nearest emergency room, then call MHN (a provider or relative may make the call for the patient). As long as MHN is contacted within 48 hours of admission, the Plan will pay benefits for charges that are determined to be **emergency** care charges. If the facility is not an MHN **network** provider, the patient may be transferred to a **network** facility once the **emergency** has passed.

Benefits for inpatient substance abuse rehabilitation are payable only once in each person’s lifetime. This limit does not apply when the only care provided is for detoxification.

Outpatient. For outpatient treatment from a **network** provider, you pay \$15 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. This is subject to a limit of 40 visits per year.

Psychological testing is covered as long as it is clinically indicated and pre-certified. Psychological testing for educational purposes is not covered.

Electro-convulsive therapy (ECT) is covered on either an inpatient or outpatient basis, subject to the applicable limits and/or co-payments described above, as long as it is pre-certified and received from a **network** provider.

Confidentiality

MHN is committed to protecting your privacy, and all contact with them is strictly confidential as required by Federal and state laws. If anyone else requests information, MHN must first get your approval before they can release it. All services are kept confidential in accordance with Federal, state and local laws, and professional standards of confidentiality. Among the situations where the provider is required by law to notify authorities are instances of child abuse, elder abuse or a professional determination that the patient is a threat to personal safety.

Pre-Certifying Behavioral or Substance Abuse Treatment

To pre-certify care, call MHN toll-free at 1-800-798-2150. If you are unable to make the call yourself, your MHN **network** provider, **EAP** counselor, treatment facility or a family member can call instead. As part of the pre-certification process, your MHN case manager will determine eligibility and help make arrangements for required admissions, transportation to and from facilities, and ongoing case management during and after hospitalization.

Eligible Providers

For behavioral health care purposes, “providers” include psychiatrists, psychologists and certified social workers with six or more years of post-degree experience, who are certified by the New York State Board for Social Work or a comparable organization outside New York to provide psychiatric or psychological services within the scope of their practice, including the diagnosis and treatment of mental and behavioral disorders.

Conditions for Coverage

In order to be covered, any expenses you incur for behavioral and substance abuse treatment must be **in-network**, **medically necessary** and:

- the requested services must provide for the diagnosis and/or active treatment of a current substance-abuse-related disorder or a condition listed as an Axis I disorder in the most recent edition of the “Diagnostic and Statistical Manual of Mental Disorders” by the American Psychiatric Association
- the proposed treatment plan must represent an active, necessary and appropriate intervention for the timely resolution of the patient’s symptoms and the restoration to baseline level of functioning (proposed services cannot be custodial in nature)
- the type, level and length of the proposed services and setting must be consistent with MHN’s level-of-care criteria and guidelines, and must be rendered in the least restrictive level of care in which the patient can be safely and effectively treated
- the proposed treatment must not be experimental in nature (that is, safety and efficacy must have been clearly demonstrated and widely accepted in the modern psychiatric literature)
- the proposed treatment plan must be shown in peer-reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to possible alternative treatment interventions, and

- the proposed treatment plan must utilize clinical services in an efficient manner when compared to alternative treatment interventions and must contribute to effective management of the patient’s benefits..

What Is Not Covered

Your **EAP** does not include coverage for any of the services, supplies or charges listed below. However, some of these items are covered under medical/hospital; check the medical/hospital section of this booklet (see pages 16 – 34).

- services received or expenses incurred before the patient’s coverage began or after the patient’s coverage ended, except as specifically stated herein
- outpatient treatment for any medically treated illness
- treatment or services for mental retardation or autism
- more than eight **EAP** counseling sessions per problem per year
- services by counselors who are not in the **EAP network**
- testing, treatment or counseling required by law or court
- formal psychological evaluations and fitness-for-duty opinions
- legal advice (although this is not covered under the Health Fund, it may be covered under the Building Service 32BJ Legal Services Fund if your collective bargaining agreement requires contributions to the Legal Services Fund; see the Legal Services Fund booklet for information)
- long-term hospitalization for residential or chronic care
- treatment of detoxification in newborns
- treatment of congenital and/or organic disorders (this includes, without limitation, Alzheimer’s disease, mental retardation (other than the initial diagnosis), organic brain disease, delirium, dementia, amnesic disorders and other cognitive disorders as defined in the “Diagnostic and Statistical Manual of Mental Disorders”)
- treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders
- treatment of obesity and eating disorders—other than the diagnosis of anorexia and bulimia nervosa as defined in the “Diagnostic and Statistical Manual of Mental Disorders”—unless otherwise required by law

- private hospital rooms and/or private duty nursing, unless **medically necessary** and authorized by MHN
- ancillary services such as:
 - vocational rehabilitation
 - behavioral training
 - speech or occupational therapy
 - sleep therapy
 - employment counseling
 - training or educational therapy for reading or learning disabilities
 - other education services
- testing, screening or treatment for:
 - learning disorders, expressive language disorders, mathematics disorder, phonological disorder and communication disorder
 - motor skills disorders and development coordination disorder
 - all disorders of infancy and early childhood, and development disorders including, but not limited to, communication disorders, pervasive developmental disorders, autistic disorder, Rett's disorder, Asperger's disorder (except as otherwise required by law)
 - disorders resulting from general medical conditions, including, but not limited to, catatonic disorder due to general medical condition, personality change due to general medical disorder, narcolepsy, stuttering, stereotypic movement disorders, sleep disorders, tic disorders, elimination disorder and sexual dysfunctions
 - personality disorders
 - pedophilia
 - primary sleep disorders, including primary hypersomnia, dyssomnia and insomnia
 - age-related cognitive decline
- treatment of conditions that are medical in nature, even when such conditions may have been caused by a mental disorder
- treatment by providers other than those within licensing categories that are recognized by MHN as providing **medically necessary** services in accordance with applicable medical community standards
- treatment rendered for conditions not listed as an Axis I disorder (V Code diagnoses listed as Axis I disorders are also excluded unless otherwise specified in the Plan)
- services beyond what is authorized by MHN's pre-certification and concurrent review procedures
- psychological testing (except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification) and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness, and automated computer-based reports
- all prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a provider in connection with inpatient treatment (if prescribed in the course of outpatient treatment, these may be covered under the prescription drug program—see pages 34 – 37)
- inpatient services, treatment, or supplies rendered in a non-emergency situation by a non-participating provider, unless authorized by MHN
- inpatient stays in excess of 30 days per year for behavioral and substance abuse treatment combined
- inpatient stays in excess of 30 days lifetime for substance abuse treatment
- outpatient care in excess of 40 visits per year for behavioral and substance abuse combined
- **emergency** behavioral or substance abuse hospital admissions that have not been pre-certified within 48 hours of admission
- emergency room services not provided by a psychiatrist directly related to the treatment of a **mental disorder** in accordance with the limitations listed above
- damage to a hospital or facility caused by the patient
- health care services, treatment or supplies determined to be experimental by MHN in accordance with accepted behavioral standards, except as otherwise required by law
- health care services, treatment or supplies:
 - provided as a result of Workers' Compensation law or similar legislation (see page 74)

- obtained through, or required by, any governmental agency or program
- caused by the conduct or omission of another party for which the patient has a claim for damages or relief or has been reimbursed (for information about subrogation of benefits, see pages 75 – 77)
- health care services, treatment or supplies for military service disabilities for which treatment is reasonably available under governmental health care programs
- treatment for biofeedback, acupuncture or hypnotherapy
- health care services, treatment or supplies rendered to the patient that are not **medically necessary** (this includes, but is not limited to, services, treatment or supplies primarily for rest or convalescence, custodial or domiciliary care as determined by MHN)
- services for which:
 - the person is not legally obligated to pay
 - no charge is made to the person
 - no charge would have been made to the person in the absence of insurance
- services in connection with conditions caused by an act of war
- conditions caused by release of nuclear energy, whether or not the result of war
- professional services received from a person who lives in the patient's home or who is related to the patient by blood or marriage
- any services or supplies to the extent they are covered and primary under Parts A or B of Medicare if the patient is either enrolled in Part A of Medicare (whether or not the patient is enrolled in Part B of Medicare), or is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System (whether or not the patient has actually enrolled in Medicare or claimed Medicare benefits)
- all other services, confinements, treatments or supplies not provided primarily for the treatment of the specific conditions described in the **EAP** section of this booklet, and/or
- all other services, confinements, treatments or supplies specifically included as **covered services** elsewhere in this Plan.

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,
- a participating dental provider, or
- a non-participating dentist.

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 48 – 50), subject to the frequency limitations that are stated in that Schedule. The Plan pays no benefits for procedures that are not on the Schedule, but may provide an alternate benefit if approved by the Fund. Whether you have to pay for those services and, if so, how much, depends on whether you choose to receive your dental care from the 32BJ Dental Center, from a participating dental provider or from a non-participating dentist.

The 32BJ Dental Center

The 32BJ Dental Center is equipped to provide a broad range of dental services, except those that require general anesthesia. If you receive your dental care from the 32BJ Dental Center, you will not have to pay for any of that care.

Participating Dental Providers

The Plan's dental benefits include a "participating dentist" feature. Dentists who are in the Plan's participating dental provider **network** have agreed to accept the amount that the Plan pays as payment in full for their dental services. If you choose to receive your care from a participating dental provider, you will not have to pay anything for covered dental care you receive, except for osseous surgery, for which you will have to make a \$125 co-payment for each quadrant.

Non-Participating Dentists

The Plan will pay for dental work performed by any properly accredited dentist, but the Plan will pay no more than the amount listed on its Schedule of Allowed Amounts. (Contact Member Services for a copy of the Schedule of Allowed Amounts.) If the dentist charges more than those amounts for your dental care, you will be responsible to pay the difference between what the dentist charges and what the Plan pays. Be sure to ask the dentist before you start treatment what the charges will be, so that you will know what your out-of-pocket expenses may be.

The Fund will pay the smaller of the dentist's actual charge for a covered dental service or the allowed amount for that procedure, as indicated in the Schedule of Allowed Amounts.

Prior Approval

Pre-approval is required for the following:

- Major Restorative procedures (page 48) for prefabricated stainless steel/resin crown (deciduous teeth only) and crowns.
- Removable Prosthodontics (page 49)
- Fixed Prosthodontics (page 49)
- Periodontics (page 49) for osseous surgery
- Oral and Maxillofacial Surgery (page 50) for removal of impacted tooth
- Orthodontics (page 50)
- All treatment plans that exceed \$1,500.

Pre-approval must be requested from Daniel H. Cook Associates, Inc., c/o the Building Service 32BJ Health Fund, Dental Claims, P.O. Box 676, New York, NY 10013-0819.

Your dentist must send a claim form for prior authorization to Daniel H. Cook Associates, Inc. before any treatment begins, except in the case of an emergency. If you start non-emergency treatment before you receive prior approval from the Fund, you may have to pay the full amount that the dentist charges.

- Prior approval is necessary even if your dentist is a participating dental provider.
- Prior approval is not necessary before receiving services from the 32BJ Dental Center.
- An approved treatment plan submitted by a dentist can be used only by that dentist and only within one year of the approval.
- Changes to your current approved treatment plan require submitting a new treatment plan for review and approval.

In order to submit a proposed treatment plan for review, your dentist should send all the information, including diagnostic quality X-rays, to:

Daniel H. Cook Associates, Inc.
C/o Building Service 32BJ Health Fund
Dental Claims
P.O. Box 676
New York, NY 10013-0819

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 medically necessary for oral surgery, gum treatment, fillings and root canal therapy
- Major services such as fixed bridgework, crowns, dentures, and gum surgery, and
- Orthodontic services such as diagnostic procedures and appliances to realign teeth. There is a separate lifetime maximum on orthodontic services of \$2,500 for one course of treatment.

See the Schedule of Covered Dental Services on pages 48 – 50 for details.

Schedule of Covered Dental Services

Procedure	Limits
Diagnostic	
Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused)	Once every 6 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, up to yearly combined maximum of \$28
• occlusal film	As necessary, up to yearly combined maximum of \$28
• cephalometric film (orthodontic coverage only)	Once in a lifetime
Preventive	
Dental prophylaxis (cleaning and polishing)	Once every 6 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

*Prior approval required.

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* (prior approval is required with a full-mouth series of X-rays and periodontal charting). In all cases, a participating periodontal specialist may require you to make a co-payment of \$125 per quadrant	Once per quadrant in a lifetime
Periodontal scaling and root planing	100% co-pay
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
Simple Extractions	
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Once per tooth

*Prior approval required.

Procedure	Limits
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
Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm and incision and drainage of an intraoral or extraoral abscess.	
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	
Orthodontics*	
Course of treatment	One course of treatment in a lifetime, up to \$2,500
Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association. A "course of treatment" is defined as 30 consecutive months of active orthodontic treatment including braces, monthly visits and retainers.	
Miscellaneous	
Occlusal guard	One appliance in any 60 consecutive months

*Prior approval required.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services on pages 48 – 50 for details.

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. For example, if your tooth can be filled with amalgam and you or your dentist decide to use a crown instead, the Plan pays benefits based on the amalgam. You will have to pay the difference.

What Is Not Covered

The Plan's dental coverage will not reimburse or make payments for the following:

- 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
- reimbursement for any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services
- charges in excess of the Allowed Amounts – contact Member Services for the Schedule of Allowed Amounts for dental care
- services that required prior approval, but are initiated without approval, with the exception of emergency treatment (e.g., single tooth root canal)
- 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
- double or 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, except under the orthodontics benefit
- 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 or the payment date
 - 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, and
- replacement or repair of orthodontic appliances.

- drugs or medications used or dispensed in the dentist's office (any prescriptions that are required may be covered by the Plan's prescription drug benefits – see pages 34 – 37)
- charges for novocaine, xylocaine or any similar local anesthetic when the charge is made separately from a covered dental expense
- additional fees charged by a dentist for hospital treatment
- 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
- expenses incurred for broken appointments
- fees for completing reports or for providing records, or
- any procedures not listed under the Schedule of Covered Dental Services.

Coordination of Dental Benefits

If you have dental coverage through another carrier, which serves as your primary dental insurer, prior approval is not required if you secured this approval through your primary dental insurer. See pages 71 – 74 for the rules that determine which carrier is primary.

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 for any charges in excess of the 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:

- showing your Empire ID card to a Vision Plan **participating provider**. The Plan has 4 **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. 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 1-800-551-3225.

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:

- expenses incurred for ophthalmic treatment or services payable under the provisions of any other benefit of the Plan. Your hospital/medical benefit plan may cover ophthalmic treatment, such as visits to an ophthalmologist's office or an outpatient surgical procedure for the diagnosis and/or treatment of eye conditions such as cataracts, glaucoma, or conjunctivitis. See pages 23-28
- non-prescription eyeglasses
- adornment expenses.

LIFE INSURANCE BENEFITS

Benefit Amount

Your life insurance coverage, which is administered by MetLife, is \$25,000 for Tri-State Preferred 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 go to www.seiu32bj.com, select the 32BJ Funds icon and click on MetLife under Important Links.

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 pages 66 – 71 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 page 86 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 that accident.

Loss	Benefit Payable
Life	\$25,000
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	\$25,000
One hand at or above the wrist; or one foot at or above the ankle; or sight in one eye	\$12,500

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 58. Your beneficiary will be the same as your life insurance beneficiary on file with MetLife, unless you choose otherwise.

"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

This section describes 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.

Claims for Benefits

A claim for benefits is a request for Plan benefits that is made in accordance with the Plan’s claims procedures. Please note that the following are **not** considered claims for benefits:

- inquiries about the Plan’s provisions or eligibility that are unrelated to any specific benefit claim,
- a request for prior approval of a benefit that does not require prior approval by the Plan, and
- presentation of a prescription to be filled at a pharmacy that is part of the Medco Health **network** of participating pharmacies. However, if you believe that your prescription has not been filled by a participating pharmacy in accordance with the terms of the Plan, in whole or in part, you may file a claim using the procedures described on the following pages.

Filing Hospital and Medical Claims

Remember if you use **network** providers, you do not have to file claims. The providers will do it for you. If you use **out-of-network** providers, here are some steps to take to make sure your hospital or medical claim gets processed accurately and on time.

- **File claims as soon as possible (and never later than 18 months after the date of service).**
- Complete all information requested on the form.
- Submit all claims in English or with an English translation. Claims not in English will not be processed and will be returned to you.
- Attach original bills or receipts. Photocopies will not be accepted.
- If you have other coverage and Empire is the secondary payer, submit the original or a copy of the primary payer’s Explanation of Benefits (EOB) with your itemized bill (see “Coordination of Benefits” on pages 71 – 74).
- Keep a copy of your claim form and all attachments for your records.

Filing Dental Claims

When you see a participating dental provider, this provider will file all claims for you directly with Daniel H. Cook Associates, Inc., the administrator for the Plan's dental coverage. Daniel H. Cook Associates, Inc. will pay such providers directly as long as you authorize direct reimbursement.

You have to file a claim when you receive care from dentists or other providers or facilities not in the Plan's participating dental provider **network**. Here is what you need to know when you file a dental claim when you do not use a participating dental provider.

- Only an original, fully completed ADA claim form or approved treatment plan will be accepted for review.
- All necessary diagnostic information must accompany the claim.
- When you are the patient, your original signature or signature on file is 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 is acceptable.
- **All claims must be received by Daniel H. Cook Associates, Inc. within 180 days after services were rendered.**
- You or your dentist must return the original approved treatment plan or prior authorization approval form with your claim.
- Approved treatment plans or prior authorization approval forms are valid only for one year from the date they are issued. In addition, they cannot be changed or used by any person other than the person to whom they are issued. The Plan reserves the right to withhold payment or request reimbursement from providers or participants for services that do not meet acceptable standards, as determined by its consultants or professional staff.
- Effective June 1, 2007, the Fund no longer accepts assignment of payment to an **out-of-network** dentist. This means that 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.

Filing Pharmacy Claims

If you use participating pharmacies or the mail order pharmacy, you do not have to file claims. The participating pharmacies or mail order pharmacy will do it for you. If you use an **out-of-network** pharmacy, then you must file a claim for benefits. **Pharmacy claims should be filed as soon as possible, but never later than 12 months after the date the prescription was filled.**

If you have other coverage and Medco is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill (see "Coordination of Benefits" on pages 71 – 74).

Filing EAP Claims

If you use **network** providers, you do not have to file claims. The providers will do it for you. If you do not use **network** providers, then no benefit is available.

If you have other coverage and MHN is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill (see "Coordination of Benefits" on pages 71-74).

Filing Vision Claims

If you use participating vision providers, you do not have to file claims. The providers will do it for you. If you do not use a participating vision provider, then you must file a vision claim with the Fund for reimbursement of eligible expenses. You can obtain a vision claim form from Member Services. **Vision claims should be filed as soon as possible, but never later than 12 months after the date of service.**

Filing for a Pensioner's Death Benefit

To file a claim for a pensioner's death benefit, your beneficiary must complete a claim form and submit a certified copy of your Death Certificate. To get an application, contact Member Services. **A claim for a pensioner's death benefit should be filed as soon as possible after the pensioner's death.**

Filing Life Insurance and AD&D Claims

To file a claim for a life insurance benefit, your beneficiary must complete a claim form and submit a certified copy of your Death Certificate. **A claim for life insurance should be filed as soon as possible after the participant's death.**

To file for an AD&D benefit, you must complete a claim form. In the event of your death, your beneficiary must submit a certified copy of the Death Certificate along with a completed claim form. **A claim for an AD&D benefit must be filed within 90 days after the loss is incurred.**

For both life insurance and AD&D claims you can get claim forms by contacting MetLife.

Where to Send Claim Forms

Benefit	Filing Address
Medical/Hospital (out-of-network only; no claim forms are necessary for in-network care)	Empire BlueCross BlueShield Attention: Institutional Claims Department (for hospital claims); or, Attention: Medical Claims Department (for medical/ambulance claims) P.O. Box 1407 Church Street Station New York, NY 10008-1407
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
Employee Assistance Plan (No claim forms are necessary)	Not Applicable
Dental (non-participating providers only; no claim forms are necessary for participating providers)	Daniel H. Cook Associates, Inc. c/o Building Service 32BJ Health Fund Dental Claims P.O. Box 676 New York, NY 10013-0819
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
Death Benefit for Pensioners	Building Service 32BJ Benefit Funds Attn: Retirement Services 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 (866) 492-6983

Approval and Denial of Claims

There are separate claims denial and approval processes for Health Services Claims (hospital/medical, pharmacy, **EAP**, dental and vision), Pensioner's Death Benefit Claims and Life/AD&D Claims. These processes are described separately below. Please review this information to ensure that you are fully aware of these processes and what you need to do in order to comply.

Health Service Claims (hospital/medical, pharmacy, EAP, dental and vision)

The time frames for deciding whether health service claims are accepted or denied depend on whether your claim is a pre-service, an urgent care, a concurrent care or a post-service claim.

- **Pre-service claims.** This is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Prior approval of services is required for inpatient hospital benefits (see page 21), certain outpatient hospital benefits (see page 21), **EAP** benefits (pages 38 – 39) and for certain dental benefits (see pages 46 – 47). For properly filed pre-service claims, you and/or your **doctor** or dentist will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the claims reviewer. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a pre-service claim, you will be notified as soon as possible, but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in refiling the claim. You will only receive notice of an improperly filed pre-service claim if the claim includes:

- your name
- your current address
- your specific medical condition or symptom, and
- a specific treatment, service or product for which approval is requested.

Unless the claim is refiled properly, it will not constitute a claim. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your **doctor** will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.

During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for *45 days* or until the date the claims reviewer receives your response to the request (whichever is earlier). The claims reviewer will then have *15 days* to make a decision on a pre-service claim and notify you of the determination.

- **Urgent care claims.** This is a claim for medical care or treatment that, if the time periods for making pre-service claim determinations were applied, could jeopardize your life, health or ability to regain maximum function, or, in the opinion of a **doctor**, result in your having unmanageable, severe pain.

Whether your treatment is considered urgent care is determined by an individual acting on behalf of the Fund applying the judgment of a prudent person who possesses an average knowledge of health and medicine. Any claim that a **doctor** with knowledge of your medical condition determines is an urgent care claim shall automatically be treated as such.

If you (or your authorized representative*) file an urgent care claim, you will be notified of the benefit determination as soon as possible, taking into account medical emergencies, but no later than 72 hours after receipt of your claim.

However, if you do not give enough information for the claims reviewer to determine whether, or to what extent, benefits are payable, you will receive a request for more information within 24 hours. You will then have up to 48 hours, taking into account the circumstances, to provide the specified information to the claims reviewer. You will then be notified of the benefit determination within 48 hours after:

- the claims reviewer's receipt of the specified information, or if earlier,
- the end of the period you were given to provide the requested information.

If you do not follow the Plan's procedures for filing an urgent care claim, you will be notified within 24 hours of the failure and the proper procedures to follow. This notification may be oral, unless you

* A health care professional with knowledge of your medical condition or someone to whom you have given authorization may act as an authorized representative in connection with urgent care.

request written notification. You will only receive notification of a procedural failure if your claim includes:

- your name
- your specific medical condition or symptom, and
- a specific service, treatment or product for which approval is requested.

- **Concurrent claims.** This is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if additional days are appropriate. Here the decision to reduce, end or extend treatment is made while the treatment is taking place.

Any request by a claimant to extend approved treatment will be acted upon by the claims reviewer within *24 hours* of receipt of the claim, provided the claim is received at least *24 hours* before the approved treatment expires.

- **Post-service claims.** This is a claim submitted for payment after health services and treatment have been obtained.

Ordinarily, you will receive a decision on your post-service claim within *30 days* from receipt of the claim. This period may be extended one time for up to *15 days* if the extension is necessary due to extraordinary matters. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a determination will be made.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for *45 days* or until the date the claims reviewer receives your response to the request (whichever is earlier). Within *15 days* after the expiration of this time period, you will be notified of the decision.

Life and AD&D Claims

If you or your beneficiary file a claim for either Life or AD&D benefits, MetLife will make a decision on the claim and notify you of the decision within 90 days. If MetLife requires an extension of time due to matters beyond its control, they are permitted an additional 90 days. MetLife will notify you, your authorized representative, your beneficiary or the executor of your estate, as applicable, before the expiration of the original 90-day period of the reason for the delay and when the decision will be made. A decision will be made within the 90-day extension period and you will be notified in writing by MetLife.

Pensioner's Death Benefit Claims

If your beneficiary files a claim for death benefits, the Fund will make a decision on the claim and notify your beneficiary within 90 days of receipt of the claim. If the Fund requires an extension of time due to matters beyond its control, the Fund is permitted an additional 90 days. The Fund will notify your beneficiary prior to the expiration of the original 90-day period of the reason for the delay and when the decision will be made. A decision will be made within the 90-day extension period.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) or if any adverse benefit determination is made (for example, the Plan pays less than one hundred percent of the claim). For urgent care and pre-service claims, you will receive notice of the determination even when the claim is approved. The timing for delivery of this notice depends on the type of claim as described on pages 63 – 66.

Appealing Denied Claims

An appeal is a request by you or your authorized representative to have an adverse benefit determination reviewed and reconsidered.

Filing an Appeal

You have 180 days to file an appeal following the notification of a denied claim.

Your appeal must include your identification number, dates of service in question and any relevant information in support of your appeal.

If you submit a written request, you will be provided access to or copies of all documents, records or other information relevant to your appeal (including, in the case of an appeal involving a disability determination, the identity of any medical or vocational experts whose advice the claims reviewer used in connection with the decision to deny your application).

A document, record or other information is relevant for review if it falls into any of the following categories:

- The claims reviewer relied on it in making a decision.
- It was submitted, considered or generated in the course of making a decision (regardless of whether it was relied on).
- It demonstrates compliance with the claims reviewer's administrative processes for ensuring consistent decision-making.
- It constitutes a statement of Plan policy regarding the denied treatment or service.

You (or your authorized representative) may submit issues, comments, documents and other information relating to the appeal (regardless of whether they were submitted with your original claim).

If you do not request a review of a denied claim within 180 days, you will waive your right to a review of the denial. However, the applicable reviewer may not enforce this waiver if you can prove that you have a good reason for missing this deadline, provided you ask the applicable reviewer in writing to review the denial and you do so within one year after the date shown on the notice of denial. You must file an appeal with the appropriate party and follow the process completely before you can bring an action in court. Failure to do so may prevent you from having any legal remedy.

Where to File an Appeal

Benefit	Write to:	Or Call
Medical and Hospital	Empire BlueCross BlueShield Medical Management Appeals Mail Drop R/6 O PO Box 11825 Albany, NY 12211-0825	1-866-316-3394
Pharmacy	Medco Health Solutions, Inc. Attention: Coverage Appeals 8111 Royal Ridge Parkway Irving, TX 75063-2820	1-800-318-7451
Employee Assistance Plan	MHN Appeals and Grievance Department 1600 Los Gamos Drive, Suite 300 San Rafael, CA 94903-1807	1-800-798-2150
Dental	Daniel H. Cook Associates, Inc. c/o Building Service 32BJ Health Fund Dental Appeals P.O. Box 676 New York, NY 10013-0819	Appeals are only accepted in writing**
Vision Death Benefit for Pensioners	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	1-866-492-6983

* 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 212-798-3060.

Time Frames for Decisions on Appeals

The time frame within which a decision on an appeal will be made depends on the type of claim for which you are filing an appeal.

Expedited Appeals for Urgent Care Claims

If your claim involves urgent care for medical, hospital, pharmacy, dental or **EAP** benefits, you can file an expedited appeal if your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to

regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This appeal can be filed in writing or orally. You can discuss the reviewer's determination and exchange any necessary information over the phone, via fax or any other quick way of sharing. You will receive a response within 72 hours of your request.

Pre-Service or Concurrent Medical, Hospital, Pharmacy, Dental or EAP Claim Appeal

If you file an appeal of a pre-service (service not yet received) or concurrent (service currently being received) claim that does not involve urgent care, a decision will be made and you will be notified *within 30 days* of the receipt of your appeal. An appeal of a cessation or reduction of a previously approved benefit will be made as soon as possible, but in any event prior to the cessation or reduction of the benefit.

Post-Service Medical, Hospital, Pharmacy, Dental or EAP Claim Appeal

If you file an appeal of a post-service claim, a decision will be made and you will be notified *within 60 days* of the receipt of your appeal.

Voluntary Second Level Appeal of a Medical, Hospital, Pharmacy, Dental, Life Insurance, AD&D or EAP Claim

Once you have been notified of the outcome of your appeal of a medical, hospital, pharmacy, dental, life insurance, AD&D or **EAP** claim, 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 provided to you by the applicable reviewer as listed on the chart on page 68.

The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan, as indicated previously. This second level of appeal is *completely voluntary*; it is not required by the Plan and is only available if you (or your representative) request it. The Plan will not assert a failure to exhaust administrative remedies where you or your authorized representative elect to pursue a claim in court rather than through the voluntary level of appeal. The Plan will not impose fees or costs on you (or your representative) because you or your authorized representative choose to invoke the voluntary appeals process. **Your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan.** Upon your request, the Plan will

provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including **your right to representation**.

Your voluntary appeal must include your identification number, dates of service in question, and any additional information that supports your appeal. You (or your authorized representative) can write to the Appeals Committee at the following address:

**Building Service 32BJ Health Fund
Board of Trustees – Appeals Committee
101 Avenue of the Americas
New York, NY 10013-1991**

If you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process.

Vision and Pensioner's Death Benefit Claim Appeal

If you file an appeal of a vision or pensioner's death benefit claim, a decision will be made at the next regularly scheduled meeting of the Appeals Committee following receipt of your appeal. However, if your request is received less than 30 days before the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached. Please note that there are no Expedited Appeals for Post-service Claims.

Appeal Decision Notice

You will be notified in writing of the decision of your appeal. The timing for delivery of this notice depends on the type of claim that was appealed.

Further Action

All decisions on appeal will be final and binding on all parties, subject only to your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the Plan's appeal procedures.

You may not start a lawsuit to obtain benefits until you have completed the mandatory appeals process and a final decision has been reached, or until the appropriate time frame described in this booklet has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **In addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied.**

If you have any questions about the appeals process, please contact the Compliance Office.

INCOMPETENCE

If someone who is entitled to benefits from the Plan is determined to be unable to care for his or her affairs because of illness, accident or incapacity, either mental or physical, any payment due may be made instead to someone else — such as a spouse or a legal custodian. The Fund will decide who is entitled to benefits in cases like this.

MAILING ADDRESS

It is important that you notify Member Services whenever your address changes. If you become unreachable, the Fund will hold any benefit payments due you, without interest, until payment can be made. You are considered unreachable if a letter sent to you by first-class mail to your last known address is returned.

COORDINATION OF BENEFITS

You or your dependents may have health care coverage under two plans. For example, your spouse may have employer-provided health insurance or be enrolled in Medicare. When this happens, the two plans will coordinate their benefit payments so that the combined payments do not exceed the allowable charges (or actual cost, if less). This process, known as Coordination of Benefits (COB), establishes which plan pays

first and which one pays second. The plan that pays first is the primary plan; the plan that pays second is the secondary plan. The primary plan will reimburse you first and the secondary plan will reimburse you for the remaining expenses to the maximum of the allowable charges for the **covered services**.

Coordination of benefits will ensure that you receive the maximum benefit allowed, while possibly reducing the cost of services to the Plan. You will not lose benefits and may gain benefits if your spouse's plan has better coverage in any area.

Except for the situations like Medicare and **TRI-CARE** described on page 73, the rules for determining which plan is primary are as follows:

- If the other plan does not have a coordination of benefits provision with regard to the particular expense, that plan is always primary.
- The plan that covers the patient as an active employee is primary and the plan that covers the patient as a dependent is secondary.
- If the patient is covered both as an active employee (or as a dependent of an active employee) and as either a laid-off employee or a retired employee, then the active employee's plan will be primary. However, if the other plan does not have this rule and the two plans do not agree as to which coverage is primary, then this rule will not apply.
- If the patient is a dependent child of parents who are not separated or divorced, then the plan covering the parent whose birthday falls earlier in the calendar year is primary and pays first. If the other plan does not use this "birthday rule," then that plan is primary unless the primary plan is already determined under the above rules.
- If the patient is a dependent child of parents who are legally separated or divorced, the plan of the parent with custody will be primary; the other parent's plan will be secondary. In the event the parent with custody has remarried, the plan of the parent (or stepparent) with custody will be primary and the plan of the parent without custody will be secondary. If there is a court decree giving one parent financial responsibility for the medical expenses, then that parent's plan becomes primary without regard to the other rules in this paragraph.
- If none of the above rules establishes which plan is the primary plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the primary plan.

If both you and your spouse are participants under this Plan, your benefits are coordinated in the same manner as anyone else (that is, as if you and your spouse were covered under different plans). You will not receive reimbursement for more than the allowable charges for the **covered services**, and you will not be reimbursed for required **co-payments**.

Medicare.

- 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 short-term disability or Workers' Compensation 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.

End-stage Renal Disease. For covered patients with end-stage renal disease, Medicare is the secondary payer of benefits during the first 30 months of treatment. After this 30-month period is over, Medicare permanently becomes the primary payer. Note that this Plan will pay as the secondary plan after the 30-month period even if you (or your dependent) fail to enroll in Medicare Part B.

TRI-CARE. If you or an eligible dependent are covered by this Plan and **TRI-CARE**, this Plan pays first and **TRI-CARE** pays second.

No-fault Benefits. If a person covered by this Plan has a claim, which involves a motor vehicle accident covered by the "no-fault" insurance law of any state, health care expenses must be reimbursed first by the no-fault insurance carrier. Only when the claimant has exhausted his or her health care benefits under the no-fault coverage will he or she be entitled to receive health care benefits under this Plan. If there are expenses for services that are covered under this Plan and which are not completely reimbursed by the no-fault carrier, such expenses may be reimbursed under this Plan, subject to the Plan's applicable maximums and other provisions.

Other Coverage Provided By State or Federal Law. If you are covered by both this Plan and any other insurance provided by any other state or Federal law, the insurance provided by any other state or Federal law pays first and this Plan pays second.

Workers' Compensation. This Plan does not provide benefits for expenses covered by Workers' Compensation or occupational disease laws. If an employer disputes the application of Workers' Compensation law for the illness or injury for which expenses are incurred, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law (for information about subrogation and reimbursement of benefits, see pages 75 – 77).

YOUR DISCLOSURES TO THE FUND

Everyone who is entitled to claim benefits from the Plan must furnish to the Fund all necessary information in writing as may be reasonably requested for the purpose of establishing, maintaining and administering the Plan. Failure to comply with such requests promptly and in good faith will be sufficient grounds for delaying or denying payment of benefits. The Board will be the sole judge of the standard of proof required in any case, and may periodically adopt such formulas, methods and procedures as the Board considers advisable.

The information you give to the Fund, including statements concerning your age and marital status, affects the determination of your benefits. If any of the information you provide is false, you may be required to indemnify and repay the Fund for any losses or damages caused by your false statements. In addition, if a claim has been submitted for payment or paid by the Fund as a result of false statements, the Fund may seek reimbursement and may elect to pursue the matter by pressing criminal charges. Knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution.

SUBROGATION AND REIMBURSEMENT

If another party or other source makes payments relating to a sickness or injury for which benefits have already been paid under the Plan, then the Fund is entitled to recover the amount of those benefits. You and your dependents may be required to sign a reimbursement agreement if you seek payment of medical expenses relating to the sickness or injury under the Plan before you have received the full amount you would recover through a judgment, settlement, insurance payment or other source. In addition, you and your dependents may be required to sign necessary documents and to promptly notify the Fund of any legal action.

If you or your dependents are injured as a result of negligence or other wrongful acts, whether caused by you, your dependents, or by another party, and you or your dependents apply to this Fund for benefits and receive such benefits, this Fund shall then have a first priority lien for the full amount of those benefits should you recover any monies from any party that caused, contributed to or aggravated the injuries or from any other source otherwise responsible for payment thereof. This first priority lien applies whether these monies come directly from your own insurance company, another person or his or her insurance company, or any other source (including, but not limited to, any person, corporation, entity, uninsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage, or no-fault automobile coverage, or any other insurance policy or plan).

This lien arises through operation of the Plan. No additional subrogation or reimbursement agreement is necessary. The Fund's lien is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from any source.

Any and all amounts received from any party or any other source by judgment, settlement, or otherwise, must be applied first to satisfy your reimbursement obligation to the Fund for the amount of medical expenses paid on your behalf or on your dependent's behalf. The Fund's lien is a lien of first priority for the entire recovery of funds paid on your behalf. Where the recovery from another party or any other source is partial or incomplete, the Fund's right to reimbursement takes priority over your or your dependent's right of recovery, regardless of whether or not you or your dependent have been made whole for his or her injuries or losses. The Fund does not recognize and is not bound by any application of the "make whole" doctrine.

The Board has the discretion to interpret any vague or ambiguous term or provision in favor of the Fund's subrogation or reimbursement rights.

By applying for and receiving benefits under the Fund, you agree:

- to restore to the Fund the full amount of the benefits that are paid to you and/or your dependents from the proceeds of any compromise, settlement, judgment and/or verdict, to the extent permitted by law
- that the proceeds of any compromise, settlement, judgment and/or verdict received from another party, an insurance carrier or any other source, if paid directly to you (or to any other person or entity), will be held by you (or such other person or entity) in constructive trust for the Fund. (The same rules apply to any other person to whom you assign your rights.) The recipient of such proceeds is a fiduciary of the Fund with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The Fund reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Fund's subrogation or reimbursement rights
- that any lien the Fund may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in an action to recover from another party or any other source, and these expenses may not be used to offset your obligation to restore the full amount of the lien to the Fund, and
- that any recovery will not be reduced by and is not subject to the application of the common fund doctrine for the recovery of attorney's fees.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of another party, or if injuries resulted from your own acts, or the acts of your dependents, you should contact your attorney for advice and counsel. However, this Fund cannot and does not pay for your attorney fees. The Fund does not require you to seek any recovery whatsoever against another party or any other source, and if you do not receive any recovery, you are not obligated in any way to reimburse the Fund for any of the benefits that you applied for and accepted. However, in the event that you do not pursue any and all third parties or any other responsible sources, the Fund is authorized to pursue, sue, compromise or settle (at the Board's discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims, and you agree to fully cooperate with the Fund in the prosecution of any such claims.

Should you seek to recover any monies from another party or any other source that caused, contributed to, aggravated your injuries, or is otherwise responsible, it is a rule of this Plan that you must give notice in writing of same to the Fund within ten days after either you or your attorney first attempt to recover such monies, or institute a lawsuit, or enter into settlement negotiations with another or take any other similar action. You must also cooperate with the Fund's reasonable requests concerning the Fund's subrogation and reimbursement rights and keep the Fund informed of any important developments in your action. You must also provide the Fund with any information or documents, upon request, that pertain to or are relevant to your actions. If litigation is commenced, you are required to give at least five days written notice to the Fund prior to any action to be taken as part of such litigation, including, but not limited to, any pretrial conferences or other court dates. Representatives of the Fund reserve the right to attend such pretrial conferences or other court proceedings.

In the event you fail to notify the Fund as provided for above, and/or fail to restore to the Fund such funds as provided for above, the Fund reserves the right, in addition to all other remedies available to it at law or equity, to withhold or offset any other monies that might be due you or your dependents from the Fund for past or future claims, until such time as the Fund's lien is discharged and/or satisfied.

For information about subrogation and any impact this may have on your health care claims, contact the Fund's subrogation administrator:

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

FRAUD

The Board reserves the right to cancel or rescind Fund coverage for any participant or enrolled dependent who willfully and knowingly engages in an activity intended to defraud the Fund. If a claim has been submitted for payment or paid by the Fund as a result of fraudulent representations, such as enrolling a dependent who is not eligible for coverage, the Fund will seek reimbursement and may elect to pursue the matter by pressing criminal charges.

The Fund regularly evaluates claims to detect fraud or false statements. The Fund must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds **co-payments** is entering into a discount arrangement with you. The Fund calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers, or refunds of **co-payments** or **deductibles** you receive. Failure to notify the Fund (through Member Services) of such price adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan.

OVERPAYMENTS

- If you (or your dependent or beneficiary) are overpaid for a claim, you (or your dependent or beneficiary) must return the overpayment. The Fund will have the right to recover any payments made that were based on false or fraudulent information, as well as any payments made in error. Amounts recovered may include interest and costs. If repayment is not made, the Fund may deduct the overpayment amount from any future benefits from this Fund that you or your dependent or beneficiary would otherwise receive, or a lawsuit may be initiated to recover the overpayment..
- If payment is made on your (or a dependent's) behalf to a hospital, **doctor** or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment will be deducted from future benefits payable to the provider, or a lawsuit may be initiated to recover the overpayment.

CONTINUED GROUP HEALTH COVERAGE

During a Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows up to 12 weeks of unpaid leave during any 12-month period due to:

- the birth, adoption or placement with you for adoption of a child
- to provide care for a spouse, child or parent who is seriously ill, or
- your own serious illness.

During FMLA leave, you can continue all of your medical coverage and other benefits offered through the Plan. You are generally eligible for a leave under the FMLA if you:

- have worked for the same **contributing employer** for at least 12 months
- have worked at least 1,250 hours over the previous 12 months, and
- work at a location where at least 50 employees are employed by the employer within 75 miles.

Check with your employer to determine if you are eligible for FMLA.

The Fund will maintain the employee's eligibility status until the end of the leave, provided the **contributing employer** properly grants the leave under the FMLA and the **contributing employer** makes the required notification and payment to the Fund. Of course, any changes in the Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your dependents, the same as to active employees and their dependents. Call Member Services regarding coverage during FMLA leave.

During Military Leave

If you are on active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you and your dependents at your own expense for up to 24 months provided you enroll for coverage. This continuation coverage operates in the same way as COBRA. (See pages 80 – 84 for information on COBRA.) In addition, your dependents may be eligible for health care under the Civilian Health & Medical Program of the Uniformed Services (**TRI-CARE**). This Plan will coordinate coverage with **TRI-CARE** (see page 73).

When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating employer, provided that you return to employment within one of the following time frames:

- 90 days from the date of discharge if the period of military service is more than 180 days
- 14 days from the date of discharge if the period of military service was 31 days or more, but less than 180 days

- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Contact Member Services for more details.

Under 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 Fund’s hospital, medical, **EAP**, dental, prescription drug and vision coverage.

You do not have to prove that you are in good health to choose COBRA continuation coverage — but you do have to meet the Plan’s COBRA eligibility requirements and you must apply for coverage. The Fund reserves the right to end your COBRA coverage retroactively if you are determined to be ineligible.

If provided by your collective bargaining agreement or participation agreement, and you are disabled and receiving (or are approved to receive) benefits under statutory short-term disability, Workers’ Compensation or a Disability Pension from the Building Service 32BJ Pension Fund, the Plan provides coverage for up to 30 months as long as you remain disabled, are unable to work and apply for coverage. If you are terminated by your employer and your termination is going to arbitration seeking reinstatement, the Plan provides coverage for up to six months. In these two cases of extended COBRA coverage, you do not have to pay the premium since it is paid by the Fund. Keep in mind that the maximum period that you have COBRA coverage is reduced by any period of time you received Fund-paid COBRA coverage.

The following chart shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue. Please keep in mind that the following information is a summary of the law and is therefore general in nature. If you have any questions about COBRA, please contact Member Services.

COBRA Continuation of Coverage

Coverage May Continue For:	If:	Maximum Duration of Coverage:
You and your eligible dependents	Your covered employment terminates for reasons other than gross misconduct	18 months
You and your eligible dependents	You become ineligible for coverage due to a reduction in your employment hours (e.g., leave of absence)	18 months
You and your eligible dependents	You go on military leave	24 months
Your dependents	You die	36 months
Your spouse and stepchild(ren)	You legally separate, divorce or your marriage is civilly annulled	36 months
Your dependent child(ren)	Your dependent children no longer qualify as dependents	36 months
Your dependents	You terminate your employment or you reduce your work hours less than 18 months after the date of your Medicare (Part A or B or both) entitlement	36 months from the date of Medicare entitlement

If you marry, have a newborn child or have a child placed with you for adoption while you are covered under COBRA, you may enroll that spouse or dependent child for coverage for the balance of the COBRA continuation period, on the same terms available to active participants. The same rules about dependent status and qualifying changes in family status that apply to active participants will apply to you and/or your dependent(s).

FMLA leave. If you do not return to active employment after your FMLA leave of absence, you become eligible for COBRA continuation as a result of your termination of employment. For COBRA purposes, your employment is considered “terminated” at the end of the FMLA leave or the date that you give notice to your employer that you will not be returning to active employment, whichever happens first.

Multiple Qualifying Events. If your dependents qualify for COBRA coverage in more than one way, they may be eligible for a longer continuation coverage period up to 36 months from the date they first qualified. For example, if you terminate employment, you and your enrolled dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child stops being eligible for dependent coverage under the Plan (a second Qualifying Event), your child may be eligible for an additional period of continued coverage.

The two periods combined cannot exceed a total of 36 months from the date of your termination (the first Qualifying Event). A second Qualifying Event may also occur if you become legally separated or divorced, or die.

Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of *Title II or XVI of the Social Security Act*. This additional 11 months is available to you and your eligible dependents if notice of disability is provided to the Fund within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months coverage will increase to 150% of the full cost of coverage.

To make sure you get all of the COBRA coverage you are entitled to, contact Member Services whenever something happens that makes you or your dependents eligible for COBRA coverage.

Notifying the Fund of a Qualifying Event. Under the law, in order to have a right to elect COBRA coverage, you or your dependent are responsible for notifying Member Services of your legal separation or divorce, a child losing dependent status under the Plan, or if you become disabled (or you are no longer disabled) as determined by the Social Security Administration. You (or your family member) must notify Member Services in writing of any of these events no later than 60 days after the event occurs or 60 days after the date coverage would have been lost under the Plan because of that event, whichever is later. Your notice must include the following information:

- name(s) of the individual(s) interested in COBRA continuation, and the relationship to the participant
- date of the Qualifying Event, and
- type of Qualifying Event (see the table of Qualifying Events on page 81).

When your employer must notify the Fund. Your employer is responsible for notifying the Fund of your death, termination of employment or reduction in hours of employment. Your employer must notify the Fund of one of these Qualifying Events within 30 days after the date of the loss of coverage. Once notified, the Fund will send you a COBRA notice within 30 days.

Making a COBRA election. Once the Fund is notified of your Qualifying Event, you will receive a COBRA notice and an election form. In order to elect COBRA, you or your dependent(s) must submit the COBRA election form to Member Services within 60 days after the date you would lose health coverage under the Fund or 60 days after the date of the COBRA notice, whichever is later.

Each of your eligible dependents has an independent election right for COBRA coverage. This means that each dependent can decide whether or not to continue coverage under COBRA.

Anyone who elects COBRA continuation coverage must promptly notify Member Services of address changes.

Paying for COBRA coverage. If you or your dependents elect to continue coverage, you or they must pay the full cost of the coverage elected. The Fund is permitted to charge you the full cost of coverage for active employees and families plus an additional 2% (and up to an additional 50% for the 11-month disability extension). The first payment is due no later than 45 days after the election to receive coverage (and it will cover the period from the date you would lose coverage until the date of payment). Thereafter, payments are due on the first of each month and are considered to be on time if they are made within 30 days of the due date. Costs may change from year to year. Contact Member Services for more information about the cost of your COBRA coverage.

If you fail to notify Member Services of your decision to elect COBRA continuation coverage or if you fail to make the required payment, your Plan coverage will end (and cannot be reinstated).

What COBRA coverage provides. COBRA generally offers the same coverage that is made available to similarly situated employees or family members, but Life/AD&D Insurance is not available. If, during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to COBRA recipients.

When COBRA coverage ends. COBRA coverage ordinarily ends after the maximum coverage period shown in the chart on page 81. It will stop *before* the end of the maximum period under any of the following circumstances:

- A COBRA recipient fails to make the required COBRA contributions on time.
- A COBRA recipient becomes enrolled in Medicare (Part A, B or both) after the date of the COBRA election, or becomes covered under another group plan that does not have a pre-existing conditions clause that affects the COBRA recipient's coverage.
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the COBRA recipient is no longer disabled. The COBRA recipient must notify Member Services within 30 days of any such final determination.

If COBRA is terminated prior to the end of the original period, you will be notified.

Once your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

OTHER HEALTH PLAN INFORMATION YOU SHOULD KNOW

Assignment of Plan Benefits

You cannot assign or transfer benefits to anyone other than a health services provider (which you do by completing a claim form, which the provider of care will submit to the Plan, or by completing a form the Fund will provide). You cannot pledge the benefits owed to you for the purpose of obtaining a loan.

Benefits or payments under the Plan are not otherwise assignable or transferable, except as the law requires. Benefits also are not subject to any creditor's claim or to legal process by any creditor of any covered individual, except under a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order issued by a state court or agency that requires an employee to provide coverage under group health plans to a child.

A QMCSO usually results from a divorce or legal separation. Whenever Member Services gets a QMCSO, its qualified status is carefully reviewed by the Fund in accordance with QMCSO procedures adopted by the Board and Federal law. For more information on QMCSOs, or to obtain a copy of the Plan's QMCSO procedures free of charge, contact the Fund's Compliance Office at the address on page 93.

No Liability for Practice of Medicine

Neither the Fund, the Board nor any of their designees:

- are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider, and
- will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Privacy of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Fund maintains about you, and knowing how your health information may be used. A complete description of how the Fund uses your health information, and your other rights under HIPAA's privacy rules is available in the Fund's "Notice of Privacy Practices," which is distributed to all named participants. Anyone may request an additional copy of this Notice by contacting the Compliance Office at the address on page 93.

In April 2003, the Fund's Board of Trustees adopted certain HIPAA privacy and security language that requires the Board of Trustees, in its role as Plan Sponsor of the Fund, to keep your health information private and secure. Any questions you may have about HIPAA may be directed to the Compliance Office at the address on page 93.

Certificate of Creditable Coverage

If you lose medical coverage, the Fund will issue you a Certificate of Creditable Coverage free of charge showing how long you were covered under this Plan. This Certificate enables you to receive credit toward any pre-existing condition exclusion under a new group plan or insurance policy.

This Certificate is available to you upon request by contacting Member Services at any point while you are covered under the Plan and up to 24 months after coverage ceases.

Please be advised that in any event, you will also automatically be provided with a certificate of creditable coverage from the Fund and Empire when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases.

Converting to Individual Coverage

Life Insurance. After your group life insurance under the Plan ends, you may convert it to an individual life insurance policy, as long as you apply for converted coverage within:

- 31 days from the date benefits were terminated, or
- 45 days from the date notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated. (This time period is separate and apart from the Plan's COBRA provisions.)

You may convert your group coverage only to a Whole Life, Universal Life or One-Year Non-Renewable Term policy. The amount converted to an individual policy cannot be more than the \$25,000 you had under the group Plan. Your individual policy will become effective 61 days after the termination of your coverage. Group life insurance protection continues in force, however, during the applicable period cited above, whether or not you exercise the conversion option. Contact MetLife for more information about converting life insurance.

All Other Plan Benefits. You cannot convert hospital, medical, prescription drug, **EAP**, dental, vision or AD&D benefits to individual coverage.

GENERAL INFORMATION

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between the Realty Advisory Board on Labor Relations, Inc., or various independent employers, and your union. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered employee. Employers that are parties to such collective bargaining agreements may also participate in the Fund on behalf of non-collectively bargained employees, if approved by the Trustees, by signing a participation agreement.

The Compliance Office will provide you, upon written request, with information as to whether a particular employer is contributing to the Fund on behalf of participants working under a collective bargaining agreement or participation agreement, and if so, to which Plan the employer is contributing.

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in this booklet, but benefit payments also may be affected if you, your beneficiary or your provider of services, as applicable, do not:

- file a claim for benefits properly or on time
- furnish the information required to complete or verify a claim
- have a current address on file with Member Services

You should also be aware that Plan benefits are not payable for enrolled dependents who become ineligible due to age, marriage, divorce or legal separation (unless they elect and pay for COBRA benefits, as described on pages 80 – 84).

If the Plan mistakenly pays more than you are eligible for, or pays benefits that were not authorized by the Plan, the Fund may seek any permissible remedy allowed by law to recover benefits paid in error (also see "Overpayments," page 78 and "Subrogation," pages 75 – 77).

Compliance with Federal Law

The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current tax law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, Federal law takes precedence over state law.

Plan Amendment or Termination

The Board intends to continue the Plan indefinitely, but reserves the right to amend or terminate it in its sole discretion. If the Plan is terminated or otherwise amended, it will not affect your right to receive reimbursement for eligible expenses you have incurred prior to termination or amendment.

Upon a full termination of the Plan, Plan assets will be applied to provide benefits in accordance with the applicable provisions of the Trust Agreement and Federal law.

Keep in mind that the benefits provided under the Plan are not vested. This is true for retirees as well as active employees. Therefore, at any time the Board can end or amend benefits, including retiree benefits, in its sole and absolute discretion.

Plan Administration

The Plan is what the law calls a “health and welfare” benefits program. Benefits are provided from the Fund’s assets. Those assets are accumulated under the provisions of the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to covered participants and dependents and defraying reasonable administrative expenses.

The Plan is administered by the Board of Trustees. The Board governs this Plan in accordance with an Agreement and Declaration of Trust. The Board and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan established under the Trust Agreement, and to decide all matters arising in connection with the operation or administration of the Plan established under the Trust. Without limiting the generality of the foregoing, the Board and/or its duly authorized designees, including the Appeals Committee with regard to benefit claim appeals, shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan
- formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan

- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan
- resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, as described in this SPD, the Trust Agreement or other Plan documents
- process and approve or deny benefit claims and rule on any benefit exclusions, and
- determine the standard of proof required in any case.

All determinations and interpretations made by the Board and/or its duly authorized designee(s) shall be final and binding upon all participants, eligible dependents, beneficiaries and any other individuals claiming benefits under the Plan.

The Board has delegated certain administrative and operational functions to the Fund staff, other organizations and to the Appeals Committee. Most of your day-to-day questions can be answered by Member Services staff. If you wish to contact the Board, please write to:

**Board of Trustees
Building Service 32BJ Health Fund
101 Avenue of the Americas
New York, NY 10013-1991**

Statement of Rights under the Employee Retirement Income Security Act of 1974 as Amended

As a participant in the Building Service 32BJ Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Compliance Office, all documents governing the Plan, including insurance contracts, collective bargaining agreements, participation agreements and the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (“EBSA”).
- Obtain, upon written request to the Compliance Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, participation agreements, the latest annual report (Form 5500 series) and an updated Summary Plan Description.

- Receive a summary of the Plan's annual financial report. The Board is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Coverage. You may continue group health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. See pages 80 – 84 for information about COBRA. If you change medical plans and wish to have any pre-existing conditions covered, you will need a certificate of creditable coverage. You can get this free of charge from your group health plan or health insurance company when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted the Plan's appeal process. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. You may not file a lawsuit until you have followed the appeal procedures described on pages 66 – 68. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of EBSA, U.S. Department of Labor, listed in your telephone directory, or the:

**Division of Technical Assistance and Inquiries
Employee Benefits Security Administration (EBSA)
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210**

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA or by visiting the Department of Labor's website: <http://www.dol.gov>.

PLAN FACTS

This Summary Plan Description is the formal plan document for the Tri-State Preferred Plan of the Health Fund.

Plan Name: Building Service 32BJ Health Fund

Employer Identification Number: 13-2928869

Plan Number: 501

Plan Year: July 1 – June 30

Type of Plan: Welfare Plan

Funding of Benefits and Type of Administration

Self funded, except MHN insures the **EAP** and MetLife insures the Life and Accidental Death & Dismemberment benefits. Benefits are administered by the organizations listed in the table on page 68.

Plan Sponsor and Administrator

The Plan is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees. The office of the Board may be contacted at:

**Board of Trustees
Building Service 32BJ Health Fund
101 Avenue of the Americas
New York, NY 10013-1991**

Participating Employers

The Compliance Office will provide you, upon written request, with information as to whether a particular employer is contributing to the Plan on behalf of employees working under a written agreement, as well as the address of such employer. Additionally, a complete list of employers and unions sponsoring the Plan may be obtained upon written request to the Compliance Office and is available for examination at the Compliance Office.

To contact the Compliance Office, write to:

**Compliance Office
Building Service 32BJ Benefit Funds
101 Avenue of the Americas
New York, NY 10013-1991**

To contact the Health Fund, call:

1-800-551-3225

or write to:

**Building Service 32BJ Health Fund
101 Avenue of the Americas
New York, NY 10013-1991**

Agent for Service of Legal Process

The Board has been designated as the agent for the service of legal process. Legal process may be served at the Compliance Office or on the individual Trustees. For disputes arising under the portion of the Plan insured by MetLife, service of legal process may be made upon MetLife at their local offices or upon the supervisory official of the Insurance Department of the state in which you reside. For disputes arising under the portion of the Plan insured by MHN, service of legal process may be made upon MHN, 1600 Los Gamos Drive, Suite 300, San Rafael, CA 94903-1807.

GLOSSARY

Allowed amount means the maximum the Fund will pay for a covered service. When you go **in-network**, the allowed amount is based on an agreement with the provider. When you go **out-of-network**, the allowed amount is based on the Fund's payment rate of allowed charges to a **network** provider.

Ambulette means ground transportation to or from a licensed medical facility. This is covered only as a home health care expense, meaning you need to be eligible for home health care in order to receive coverage for the ambulette.

Co-insurance means the 50% you pay toward eligible **out-of-network** medical expenses.

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** when you use **in-network** providers. 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.

EAP means the Employee Assistance Program and includes benefits for behavioral and substance abuse treatment.

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, Empire, MHN, 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.

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 Empire BlueCross BlueShield 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.

For EAP purposes, medically necessary is subject to additional conditions. See pages 39 – 41 for information.

Mental disorder means a mental or nervous condition that meets all of the following conditions:

- it is a clinically significant behavioral or psychological syndrome or pattern
- it is associated with a painful symptom, such as distress
- it impairs a patient's ability to function in one or more major life activities, and
- it is a condition listed as an Axis I disorder (excluding V Codes) in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" by the American Psychiatric Association.

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

Out-of-network provider/supplier means a **doctor**, other professional provider, or durable medical equipment, home health care or home infusion supplier who is not in the Plan's **network** for medical/hospital, vision, dental or behavioral health services. Out-of-network benefits are benefits for **covered services** provided by out-of-network providers and suppliers.

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

TRI-CARE (formerly CHAMPUS) is the health services and support program for U.S. Military Personnel on active duty, U.S. Military retirees, and their families.

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 either Empire or, for PPO participants, another BlueCross and/or BlueShield plan.

For physical therapy purposes, the definition of a "hospital" may include a rehabilitation facility either approved by Empire or participating with Empire or, for PPO participants, another BlueCross and/or BlueShield plan other than specified above.

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 Empire or another BlueCross and/or BlueShield plan. In other states, the facility must participate with another BlueCross and/or BlueShield plan and be certified by the state using criteria similar to New York's. **Out-of-network** benefits will not be paid.

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 Empire.

Empire 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-network** only 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 60 days of inpatient care per person per year. However, you must use an **in-network** facility and your **doctor** must provide a referral and written treatment plan, a projected length of stay and an explanation of the needed services and the intended benefits of care. Care must be provided under the direct supervision of a **doctor**, registered nurse, physical therapist or other health care professional.

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 210 days of hospice care is covered in full **in-network** only; there are no **out-of-network** hospice benefits. 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 200 home health care visits per person per year (**in-network** and **out-of-network** combined), as long as your **doctor** certifies that home health care is **medically necessary** and approves a written treatment plan. Up to four hours of care by an RN, a home health aide or a physical therapist count as one home health care visit. Benefits are payable for up to three visits a day. Home health care services include:

- part-time nursing care by an RN or LPN
- part-time home health aid services
- restorative physical, occupational or speech therapy
- medications, medical equipment and medical supplies prescribed by a **doctor**
- laboratory tests, and
- **ambulette** service when arranged by the Fund's Health Services Department.

If you use a home health care agency in the Empire Direct POS **network**, the agency is responsible for calling Health Services to pre-certify. If you use an **out-of-network** home health care agency, you are responsible for calling; otherwise, a pre-certification penalty will apply.

- 7** *Home infusion therapy*, a service sometimes provided during home health care visits, is available only **in-network**. The **network** provider must pre-certify by calling the Health Services Program. An Empire Direct POS **network** home health care agency or home infusion supplier may not bill you for **covered services**. If you receive a bill from one of these providers, contact Member Services.
- 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 the Health Services Program within 48 hours after an **emergency** hospital admission, as described on page 21, to pre-certify any continued stay in the hospital. If you have an **emergency** outside the Empire Direct POS Operating Area (see page 17), show your Empire ID Card at the emergency room. If the hospital participates with another BlueCross and/or BlueShield program, your claim will be processed by the local BlueCross plan. 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** *Second surgical opinions* are covered under the Plan at the full cost when you go through the Health Services Program for them. To confirm a cancer diagnosis or course of treatment, second or third opinions are paid as if they are **in-network** even if you use an **out-of-network** specialist. Please note that the specialist who provides the second or third opinion cannot perform the surgery.
- 11** *Diabetes coverage* includes diet information, management and supplies (such as blood glucose monitors, testing strips and syringes) prescribed by an authorized provider.
- 12** *Preventive care* under the Plan includes routine physicals, subject to limits shown on page 26. 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.*
- 13** *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, as shown on page 26. 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 & 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.
- 14** 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.
- 15** *Physical therapy* is covered for up to 30 days of covered inpatient physical therapy per person per year (**in-network** and **out-of-network** combined). 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 30 outpatient visits are covered per year for physical therapy. Speech, vision and occupational therapy combined are covered for up to 30 visits per year. You must receive any such services through a **network** provider in the home, office or the outpatient department of a **network** facility. For outpatient physical therapy, you must pre-certify from the first visit.

16 Durable medical equipment and supplies means buying, renting and/or repairing prosthetics (such as artificial limbs), orthotics and other durable medical equipment and supplies—but you generally must go **in-network** for them. The only exceptions are glucometers and disposable medical supplies, such as syringes, which are covered up to the **allowed amount** whether you get them from an **in-network** or **out-of-network** supplier. In addition to the items listed above, the Plan covers:

- prosthetics/orthotics and durable medical equipment from **in-network** suppliers, when prescribed by a **doctor** and approved by the Health Services 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.

The **Network** supplier must pre-certify the rental or purchase of durable medical equipment. 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.

17 Nutritional supplements include enteral formulas, which are covered if the patient has a written order from a **doctor** that states the formula is **medically necessary** and effective, and that without it the patient would become malnourished, suffer from serious physical disorders or die. Modified solid-food products will be covered for the treatment of certain inherited diseases if the patient has a written order from a **doctor**.

18 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.

19 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.

CONTACT INFORMATION

What do you need?	Who to contact	How
<ul style="list-style-type: none"> • General Information about your eligibility and benefits • Information on your hospital, medical, vision, dental and disability benefits and claims 	Member Services	Call 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 or visit your union office in Newark, NJ or New Rochelle, NY
<ul style="list-style-type: none"> • To find a primary care physician • To find participating Empire providers 	Health Fund	Call 1-800-551-3225 or Visit www.empireblue.com (for Empire Hospital/Medical only)
<ul style="list-style-type: none"> • To find a participating vision plan provider or participating dental plan provider 	Health Fund	Call 1-800-551-3225
<ul style="list-style-type: none"> • To pre-certify a hospital or medical service 	Health Services	Call 1-866-230-3225
<ul style="list-style-type: none"> • To help prevent or report health insurance fraud (medical or hospital) 	Empire Fraud Hotline	Call 1-800-423-7283 9:00 am - 5:00 pm Monday - Friday
<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 	Nurses Healthline	Call 1-877-825-5276 24 hours a 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"> • Help with family and personal problems like depression, alcohol and substance abuse, divorce, etc. 	Employee Assistance Program (EAP)	Call 1-800-798-2150



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
Tri-State Preferred 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 Tri-State Preferred Plan dated February 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 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.

Change in Definition of Dependent Page 13: 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 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-certification Requirement for certain Outpatient and diagnostic Tests Pages 21 and 25: Effective January 1, 2009, the following Outpatient and Diagnostic Tests require Pre-certification: CAT and PET exams and nuclear imaging studies.

Coverage of Bariatric Surgery only at Facilities Accredited by the American College of Surgeons Page 23:

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 26:

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 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.

Clarification of Excluded Hospital and Medical Expenses that may be Covered elsewhere under the Plan Page 32:

The following services that may be covered elsewhere under the Plan are excluded: dental treatment, except surgical removal of impacted teeth or treatment of sound natural teeth injured by accident if treated within 12 months of the injury; behavioral health care services, including inpatient and outpatient behavioral care, as well as inpatient and outpatient substance abuse treatment (detoxification and rehabilitation); a skilled nursing facility that primarily treats drug addiction or alcoholism; and false teeth.

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 34-36:

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.

Change in Dental Pre-Approval Provider Pages 46 and 47: 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 Dental Claims Receiver Page 60: Effective October 1, 2008, dental claims must be received by Administrative Services Only, Inc. within 180 days after services were rendered.

Change in Dental Claims Reviewer Page 62: 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 62 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

Change in Where to File a Dental Claim Appeal Page 68: 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.

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 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.

Enactment of COBRA Subsidy Pages 80-84: Effective February 17, 2009, the American Recovery and Reinvestment Act of 2009 (AARA) 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 9 months. If your COBRA continuation coverage lasts for more than 9 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 not 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 December 31, 2009 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 9 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.

Clarification in Second Surgical Opinion Coverage Page 100: 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.