



## **Building Service 32BJ**

# **HEALTH FUND**

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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.

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# CONTENTS

	Page
<b>Your Rights And Other Important Plan Information</b> .....	5
<b>Plan Facts</b> .....	6
Funding of Benefits and Type of Administration .....	6
Plan Sponsor and Administrator .....	6
Agent for Service of Legal Process .....	7
Participating Employers .....	8
<b>Your Disclosures To The Fund</b> .....	8
<b>Fraud</b> .....	9
<b>Overpayments</b> .....	9
<b>Claims And Appeals Procedures</b> .....	9
Claims for Benefits .....	10
Filing Hospital and Medical Claims .....	10
Filing Dental Claims .....	10
Filing Pharmacy Claims .....	11
Filing Employee Assistance Program (EAP) Claims .....	11
Filing Vision Claims .....	12
Filing Pensioner's Death Benefit Claim .....	12
Filing Life Insurance and AD&D Claims .....	12
Where to Send Claim Forms .....	12
Approval and Denial of Claims .....	12
Health Service Claims (hospital/medical, EAP, pharmacy, dental and vision) .....	12
Life and AD&D Claims .....	15
Pensioner's Death Benefit Claims .....	15
Notice of Decision .....	15
Appealing Denied Claims .....	16
Filing an Appeal .....	16
Where to File an Appeal .....	16
Time Frames for Decisions on Appeals .....	17
Expedited Appeals for Urgent Care Claims .....	17
Pre-Service or Concurrent Medical, Hospital, Pharmacy, EAP or Dental Claim Appeal .....	17

	Page
Post-Service Medical, Hospital, Pharmacy, EAP, Dental, or Life and AD&D Claim Appeal . . . . .	17
Voluntary Second Level Appeal of a Medical, Hospital, Pharmacy, EAP, Dental, or Life and AD&D Claim . . . . .	17
Vision, or Pensioner’s Death Benefit Claim Appeal . . . . .	18
Appeal Decision Notice . . . . .	18
Further Action . . . . .	18
<b>Coordination Of Benefits</b> . . . . .	19
Medicare . . . . .	20
TRI-CARE . . . . .	20
No-fault Benefits . . . . .	21
Other Coverage Provided By State or Federal Law . . . . .	21
Workers’ Compensation . . . . .	21
<b>Subrogation And Reimbursement</b> . . . . .	21
<b>Continued Group Health Coverage</b> . . . . .	24
During a Family and Medical Leave . . . . .	24
During Military Leave . . . . .	24
Under Cobra . . . . .	25
COBRA Continuation of Coverage . . . . .	26
<b>Other Health Plan Information You Should Know</b> . . . . .	29
Assignment of Plan Benefits . . . . .	29
No Liability for Practice of Medicine . . . . .	29
Privacy of Protected Health Information . . . . .	29
Certificate of Creditable Coverage . . . . .	30
Converting to Individual Coverage . . . . .	30
How Benefits May Be Reduced, Delayed or Lost . . . . .	31
Compliance with Federal Law . . . . .	31
Plan Amendment or Termination . . . . .	31
Statement of Rights under the Employee Retirement Income Security Act of 1974 as Amended . . . . .	32



## SECTION II

### **YOUR RIGHTS AND OTHER IMPORTANT PLAN INFORMATION**

This is Section II of your Summary Plan Description (SPD) of the Building Service 32BJ Health Fund (the Fund). This section contains information about your rights and responsibilities under the Plan, and the Fund's rights. This information includes, among other items, sections describing Plan Facts, Your Disclosures to the Fund, Fraud, Overpayments, Coordination of Benefits, Subrogation and Reimbursement, Continued Group Health Coverage and Claims and Appeals. Note that not all information in this section may be applicable to you. For example, if you are not covered by a collective bargaining agreement which provides for hospital and medical coverage the section on how to file a hospital and medical claim would not apply to you.

**For information about your specific plan of benefits (the Plan), including what Hospital, Medical, Prescription, Vision, Life, Accidental Death and Dismemberment (AD&D), Employee Assistance Program (EAP) and Dental benefits, if any, are available to you, please refer to Section I. Sections I and II together are the formal plan document for your plan of benefits.**

- Save this booklet – put it in a safe place. If you lose a copy, you can ask Member Services at 1-800-551-3225 or 1-212-388-3500 for another or obtain it from [www.seiu32bj.org](http://www.seiu32bj.org).
- If you change your name or address – notify Member Services immediately so your records are up-to-date.
- Throughout this booklet, the words “you” and “your” refer to participants whose employment makes them eligible for a Plan of benefits. The word “dependent” refers to a family member of a participant who is eligible for a Plan of benefits.

# PLAN FACTS

**Plan Name: Building Service 32BJ Health Fund**

**Director, Building Service 32BJ Health Fund: Angelo Dascoli**

**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:**

The Plan is self-funded with the exception of the Employee Assistance Program (EAP) and Life and Accidental Death & Dismemberment benefits. All contributions to the Trust Fund are made by contributing employers under the Plan in accordance with their written agreements. 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. Benefits are administered by the organizations listed in the Contact Information table on the inside back cover of Section I of the SPD of your plan of benefits.

## **Plan Sponsor and Administrator:**

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

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 booklet, 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 the 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**

**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 portions of the Plan which are insured, service of legal process may be made in accordance with the table titled Contact Information, on the inside back cover of Section I of the SPD of your plan of benefits.

## **Participating Employers:**

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. 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**

## **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.

## **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.

## **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 and is filed in a timely manner with the applicable claims reviewer. 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 Plan's network of participating pharmacies<sup>1</sup>. 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 this Plan is the secondary payer, submit the the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill (See "Coordination of Benefits" on page 19.)
- 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 the dental claims reviewer. The dental claims reviewer will pay such providers directly as long as you authorize direct reimbursement.

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<sup>1</sup> *The Plan's network of participating pharmacies* can be obtained by contacting the pharmacy vendor found in the table titled Contact Information on the inside back cover of Section I of the SPD of your plan of benefits.

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 are acceptable on all claims for payment. If the patient is a child, an original signature or signature on file of the child's parent or guardian are acceptable.
- **All claims must be received by the dental claims reviewer 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.

### **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 this Plan 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 page 19.).

### **Filing Employee Assistance Program (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 this Plan 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 page 19.)

## **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 vision claims reviewer 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 Pensioner's Death Benefit Claim**

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 to the Life and AD&D claims reviewer. **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 the Life and AD&D claims reviewer.

## **Where to Send Claim Forms**

Please consult the table in Section I of the SPD of your plan of benefits for the names and addresses of the hospital and medical, dental, pharmacy, vision and Life and AD&D claims reviewers.

## **Approval and Denial of Claims**

There are separate claims denial and approval processes for Health Services Claims (hospital/medical, pharmacy, dental, EAP and vision) 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, EAP, pharmacy, 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, certain outpatient hospital benefits and for certain dental benefits. 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 applicable claims reviewer.

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 refileing 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 applicable 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 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 from the applicable claims reviewer on your post-service claim within *30 days* from receipt of the claim.

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\* 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.

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 applicable 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, the Life and AD&D claims reviewer will make a decision on the claim and notify the Fund of the decision within 90 days. If the Life and AD&D claims reviewer requires an extension of time due to matters beyond its control, they are permitted an additional 90 days. The Life and AD&D claims reviewer 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.

### **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) from the applicable claims reviewer. 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 12–15.

## **Appealing Denied Claims**

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

### **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 applicable 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 appeals 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 appeals 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 applicable appeals reviewer 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**

Please consult the table in Section I of the SPD of your plan of benefits for the names and addresses of the applicable appeals reviewers.

## **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 involved urgent care for medical, hospital, pharmacy, or dental 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, EAP, or Dental 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, EAP, Dental, or Life and AD&D Claim Appeal**

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

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

If you have been notified regarding the outcome of your appeal of a medical, hospital, pharmacy, EAP or dental claim, you have exhausted all required internal appeal options. If you disagree with the decision, you may file a voluntary appeal with the Appeals Committee. Voluntary appeals must be filed within 180 days following notification of the outcome of your mandatory appeal.

The voluntary level of appeal is available only after you (or your authorized 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, or 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**

The applicable appeals reviewer will notify you 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.**

## **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 pages 20–21, 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 receiving COBRA and you (or a dependent) become 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 below).

## **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 as listed in Section I of the SPD for your plan of benefits.

# 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 25–28 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 20).

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 following Fund benefits if they are offered under the Plan in which you participate, hospital, medical, 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.

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 <b>covered employment</b> 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 26).

*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 the COBRA Department 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 26. 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 the Member Service Center 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 8.

## **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 8.

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 8.

### **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 the hospital/medical claims reviewer 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 amount you had under your plan of benefits. 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 the organization listed in the Contact Information table for life insurance on

the inside back cover of Section I of the SPD of your plan of benefits for more information about converting your life insurance.

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

### **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 25–28).

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 9 and “Subrogation and Reimbursement,” page 21).

### **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.

### **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 25–28 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 16–19. 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>.









**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  
Section II**

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

**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 44<sup>th</sup> Street  
New York, NY 10036-5454

**Addition of 2 New Leave Types Page 24:** 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.

April 29, 2009