

TRANSLATION NOTICE

This booklet contains a summary in English of your Plan rights and benefits under the Building Service 32BJ Health Fund. If you have difficulty understanding any part of this booklet, contact Member Services at 1-800-551-3225 for assistance or write to:

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

You may also visit www.seiu32bj.org. The office hours are from 8:30 a.m. to 5:00 p.m. Monday through Friday.

Este folleto contiene un resumen en inglés de sus derechos y beneficios con el Building Service 32BJ Health Fund. Si tiene alguna dificultad para entender cualquier parte de este folleto, contacte al Member Services (Centro de Servicios para los Miembros) al 1-800-551-3225 para obtener asistencia, o escriba a la dirección siguiente:

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

Usted también puede visitar www.seiu32bj.org. El horario de atención es desde las 8:30 a.m. hasta las 5:00 p.m. de lunes a viernes.

Building Service 32BJ

HEALTH FUND

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

IMPORTANT NOTICE

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

- Save this booklet – put it in a safe place. If you lose a copy, you can ask Member Services for another or obtain it from www.seiu32bj.org.
- If you change your name or address – notify Member Services immediately so your records are up-to-date.
- Words that appear in **boldface** print are defined in the Glossary.
- Throughout this booklet, the words “you” and “your” refer to participants whose employment makes them eligible for Plan benefits. The word “dependent” refers to a family member of a participant who is eligible for Plan benefits. In the sections describing the benefits payable to participants and dependents, the words “you” and “your” may also be used to refer to the patient.
- This booklet describes the provisions of the Plan in effect as of January 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 Rx Plus Plan covers part-time employees who work *outside New York City*, for example, in Washington, DC or Hartford, CT. 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** 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**.

When You Are No Longer Eligible

Your eligibility for the Plan ends:

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

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

If You Come Back to Work

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

- *within 90 days*, your Plan participation starts again on your first day back at work, or
- *more than 90 days later*, you would have to complete 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 9–11).

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 prescription drug, dental and vision coverage. See Section II for more information about COBRA

Disability

If provided in your collective bargaining agreement or participation agreement, you may continue to be eligible for up to six (6) 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, or
- Workers’ Compensation.

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

- if you work at any job
- 6 months after you stopped working due to a disability
- when you receive the maximum benefits under short-term disability or Workers’ Compensation, 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 apply and submit proof of disability no later than 60 days after the date coverage would have been lost (90 days after you stopped working due to a disability). You can obtain an application form from Member Services. The Plan reserves the right to require proof of your continued disability from time to time. This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA. See Section II for COBRA information.

Arbitration

If you are discharged and the Union takes your grievance to arbitration seeking reinstatement to your job, your health coverage will be extended for up to six months or until your arbitration is decided, which-

ever occurs first. This extension of coverage 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 Section II for more information.

Military Leave

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

Dependent Eligibility

If your collective bargaining agreement or participation agreement provides for dependent coverage, eligible dependents under the Plan are described on the following pages.

| 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). |
| <i>Domestic partner</i> | | <p>You and your same-gender domestic partner:</p> <ul style="list-style-type: none"> • have a marriage certificate from a state in the U.S. or province in Canada where same-gender marriages are valid, or • have a civil union certificate from a state in the U.S. or province in Canada where same-gender civil unions are valid, or • are two individuals 18 years or older of the same gender who: <ul style="list-style-type: none"> – have been living together for at least 12 months; and – are not married to anyone else, and are not related by blood in a manner that would bar marriage under the law; and – are financially interdependent, and can show proof of such; and – have a close and committed personal relationship and have not been registered as members of another domestic partnership within the last 12 months. <p>In order to establish eligibility for these benefits, you and your domestic partner will need to provide:</p> <ul style="list-style-type: none"> • a marriage certificate from a state in the U.S. or a province in Canada where same-gender marriages are valid, or • a civil union certificate from a state in the U.S. or province in Canada where same-gender civil unions are valid, or • if neither marriage or civil union is available, affidavits attesting your relationship, plus a domestic-partner registration under state or local law (if permitted where you live), and proof of financial interdependence. <p>You are required to provide the highest level of certificate available in the jurisdiction where you reside.</p> <p>Contact Member Services for an application or general information.</p> <p>There may be significant tax consequences for covering your domestic partner. Contact a tax advisor for tax advice.</p> <p>If you lose coverage due to a qualifying event, you and your domestic partner may elect to continue coverage on a self-pay basis through COBRA. Domestic partners will not have an independent right to COBRA continuation coverage unless the qualifying event is the participant’s death.</p> |

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

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

- is not a United States citizen *and* lives outside the United States, Canada or Mexico, or
- is in the military or similar forces of any country.
- * If you are legally separated or divorced, then your child may live with and/or be the tax dependent of the legally separated or divorced spouse.
- ** Your adopted dependent child will be covered from the date that child is adopted or “placed for adoption” with you, whichever is earlier (but not before you become eligible), if you enroll the child within 30 days after the earlier of placement or adoption (see “Your Notification Responsibility” on page 12–13). A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. However, if a child is placed for adoption with you, but the adoption does not become final, that child’s coverage will end as of the date you no longer have a legal obligation to support that child. If you adopt a newborn child, the child is covered from birth as long as you take custody immediately after the child is released from the hospital and you file an adoption petition with the appropriate state authorities within 30 days after the infant’s birth. However, adopted newborns will not be covered from birth if one of the child’s biological parents covers the newborn’s initial hospital stay, a notice revoking the adoption has been filed or a biological parent revokes consent to the adoption.

When Your Dependents Are No Longer Eligible

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

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

How to Enroll

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

Enroll your dependents as soon as they become eligible. Please see “Dependent Eligibility” on pages 9–11 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 pages 12–13 for further details.

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

Your Notification Responsibility

If, after your coverage under the Plan becomes effective, there is any change in your family status (e.g., marriage, legal separation, divorce, birth or adoption of a child), it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 30 days of marriage or birth or adoption of a child, coverage for your new spouse or child will begin as of the date of marriage or date of

birth or adoption. If you do not notify the Fund within 30 days, coverage for your new spouse or child will begin as of the date you notify the Fund. No benefits will be paid until you provide the Fund with the necessary supporting documentation. Also, be sure to notify the Fund if your child is between age 19 and 23 and graduates or otherwise leaves school, or if your child marries or no longer satisfies the rules regarding residence or financial dependency that are described on pages 9–11.

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 program of benefits, including prescription drug, dental, vision, life insurance and accidental death and dismemberment benefits. Each of these benefits is described in the sections that follow.

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). Every calendar year, you and your eligible dependents each have a \$2,000 maximum drug benefit available through Medco Mail. Once the Plan has paid \$2,000 in any calendar year for your mail order drugs (excluding insulin), you are required to participate in Medco's maintenance drug program in order to be covered for any additional mail order prescriptions beyond the \$2,000 limit. This \$2,000 limit does not apply to any acute medications received at the pharmacy or insulin prescriptions received by mail.

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

- \$14.00 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, fill in the patient profile sections of the Mail Order Pharmacy Order Form, which you can get from Member Services or by calling Medco at 1-800-318-7451. Be sure to complete as much of the information requested as possible. You must provide your unique Medco identification number, name of the person or persons for whom you are sending prescriptions, and the address to whom the medication should be sent. Provide any allergy or history

information so that the pharmacist will be aware of any potential drug conflict.

- Complete the Mail Order Pharmacy Order Form for each new prescription.
- Enclose your maintenance drug prescription, the Mail Order Pharmacy Order Form and your payment in the pre-addressed mail service envelope. You must make the necessary **co-payment** for your mail order or your prescription may not be filled. Your medications are delivered to you at home postage-paid by United Parcel Service or by U.S. mail. Allow 10 to 14 days after the prescription is filled for delivery of your medicine.
- A new order form and envelope will be sent to you with each delivery. These forms are also available from Member Services.

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

Please note that certain prescription drugs 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

Excluded Drugs

The following are *not* covered under the Plan:

- cough and cold preparations
- non-sedating antihistamines
- gastrointestinal drugs, including H2 blockers and proton pump inhibitors (PPIs)
- dermatological agents like retinoids, keratolytics, rosacea, emollients and hypopigmentation agents
- drugs for erectile dysfunction
- injectable drugs (except insulin)
- over-the-counter drugs and vitamins
- prescription drugs that require prior authorization and for which you have not received prior authorization
- drugs used in clinical trials or experimental studies
- drugs used for infertility treatment
- birth control devices
- drugs prescribed for **cosmetic** purposes
- drugs used for weight loss unless you meet the Plan's medical criteria
- non-formulary drugs, unless your **doctor** can prove (i.e., clinical documentation; patient's drug therapy history) to Medco's satisfaction that the non-formulary drug is necessary (non-formulary drugs are drugs that are not on the Plan's list of approved drugs and medicines)
- therapeutic devices or appliances, support garments and other non-medical substances
- drugs intended for use in a **doctor's** office or another setting other than home use
- prescriptions that an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state or Federal program.

DENTAL BENEFITS

How the Plan Works

The Plan provides coverage for necessary dental care received through:

- a Delta Dental PPO participating dentist, or
- a non-Delta Dental PPO 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 20–22), subject to 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 Delta Dental of New York, Inc. (Delta Dental) on behalf of 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 a Delta Dental participating PPO dental provider or from a non-participating dentist.

Annual Maximum

The Dental Plan provides coverage of up to \$1,000 per covered individual per calendar year. There is a separate lifetime maximum of up to \$1,000 for orthodontic services for dependent children.

Participating Dental Providers

The Plan's dental benefits include a “participating dental provider” feature through Delta Dental. The Delta Dental PPO is the Plan's participating dental provider **network**. Dentists who participate in the Delta Dental PPO have agreed to accept the amount that Delta Dental pays as

either payment in full for diagnostic and preventive services or partial payment for other 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 that is diagnostic or preventive
- for all other services, you will pay the difference between the fee schedule Delta Dental pays and the applicable maximum plan allowance under the Delta Dental PPO.

Non-Participating Dentists

The Plan will pay for dental work performed by any properly accredited dentist, but the Plan will pay no more than what Delta Dental would have paid a participating Delta Dental PPO dentist. Contact Delta Dental's Customer Service at 1-800-932-0783 to find out what their reimbursement is for each dental procedure/service you require.

You will be required to pay the dentist's full charges. You will file a claim with Delta Dental (see page 30) and will be reimbursed according to the Delta Dental fee schedule for each procedure.

The Fund will pay the smaller of the dentist's actual charge for a covered dental service or the **allowed amount** for that procedure according to Delta Dental's PPO fee schedule.

Predeterminations/Pre-treatment Estimates

Determine costs ahead of time by asking your Delta Dental participating dentist to submit the treatment plan to Delta Dental for a predetermination of benefits before any treatment is provided. Delta Dental will verify your specific plan coverage and the cost of the treatment and provide an estimate of your coinsurance and what Delta Dental will pay. Predeterminations are free and help you and your dentist make informed decisions about the cost of your treatment.

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, space maintainers and sealants

- Basic therapeutic services such as extractions and oral surgery, intravenous conscious sedation when **medically necessary** for oral surgery, gum treatment, gum surgery, fillings and root canal therapy
- Major services such as fixed bridgework, crowns, and dentures
- Orthodontic services such as diagnostic procedures and appliances to realign teeth. There is a separate lifetime maximum on orthodontic services of \$1,000 per patient.

See the Schedule of Covered Dental Services on pages 20–22 for details.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services on pages 20–22.

Schedule of Covered Dental Services

| Procedure | Limits |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| Diagnostic* | |
| Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused) | Once every six months |
| X-rays: | |
| <ul style="list-style-type: none"> • full mouth, complete series, including bitewings or panoramic film | Once in any 36 consecutive months |
| <ul style="list-style-type: none"> • bitewings, back teeth | Four films every six months |
| <ul style="list-style-type: none"> • periapicals, single tooth | As medically necessary |
| <ul style="list-style-type: none"> • occlusal film | As medically necessary |
| <ul style="list-style-type: none"> • cephalometric film (orthodontic coverage only) | Once in a lifetime |
| Preventive* | |
| Dental prophylaxis (cleaning and polishing) | Once every six months |
| Topical fluoride treatment | Once in any calendar year for patients under age 16 |
| Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth) | Once per tooth in any 24 consecutive months for patients under age 16 |
| Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges) | Once per tooth for patients under age 16 |
| Simple Restorative** | |
| Amalgam (metal) fillings | Once per tooth surface in any 24 consecutive months |
| Resin (composite, tooth-colored) fillings | Once per tooth surface in any 24 consecutive months |
| Major Restorative** | |
| Recementation of crown | Once per tooth in any calendar year |
| Prefabricated stainless steel/resin crown (deciduous teeth only) | Once per tooth in any 60 consecutive months |
| Crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture | Once per tooth in any 60 consecutive months |

Procedure**Limits****Endodontics****

| | |
|----------------------------------------------------------------------------------------------------------------------|------------------------------|
| Root canal therapy | Once per tooth in a lifetime |
| Retreatment of root canal | Once per tooth in a lifetime |
| Apicoectomy (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment) | Once per tooth in a lifetime |
| Pulpotomy | Once per tooth in a lifetime |

Periodontics**

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| Gingivectomy or gingivoplasty | Once per quadrant in a lifetime |
| Osseous surgery | Once per quadrant in a lifetime |
| Periodontal scaling and root planing | Once per calendar year |
| 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 |
|--------------------------------------------------------------------------------------------------------------------------------|----------------|

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 |
| Recement fixed or partial dentures | Once per appliance in any calendar year |
| Additions to partial dentures | Two procedures in a calendar year |

Orthodontics***

| | |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Course of Treatment | For dependent children (19 years of age or less) for one course of treatment in a lifetime, up to \$1,000 lifetime Initial diagnosis is a separate coverage. |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Miscellaneous**

| | |
|----------------|--------------------------------------------|
| Occlusal guard | One appliance in any 60 consecutive months |
|----------------|--------------------------------------------|

* Reimbursed at 100% of the Delta Dental PPO **Allowed Amount** (or the dentist's charges if less)

** Reimbursed based on the Delta Dental PPO **Allowed Amount** for that specific procedure (or the dentist's charges if less)

*** Reimbursed at 50% of the Delta Dental PPO **Allowed Amount** (or the dentist's charges if less)

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 Delta Dental **Allowed Amounts** – contact Delta Dental Member Services for **allowed amounts** for each covered service – or the annual or lifetime maximum.
- 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 13–16)
- 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 Section II 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 any charges in excess of this maximum reimbursement.

These maximum benefits are payable within any 24-month period, starting with the date you first incur a vision care expense (typically an eye exam). For example, if you get an eye exam on February 1, 2008, you have up to February 1, 2010 (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:

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

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

To find a **participating provider**, call 1-800-551-3225.

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:

- ophthalmic treatment or services payable under the provisions of any other benefit of the Plan
- non-prescription eyeglasses
- adornment expenses.

LIFE INSURANCE BENEFITS

Benefit Amount

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

Naming a Beneficiary

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

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

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

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

Life Insurance Disability Extension

If you are disabled and receiving statutory short-term disability or Workers' Compensation benefits, your life insurance will continue for six months from the date of disability, or until your disability ends, whichever happens first.

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 30–31 for information on appealing a denied claim).

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

When Coverage Ends

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

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

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

How AD&D Benefits Work

Your AD&D Insurance coverage is shown in the following chart. Benefits are payable to your beneficiary if you die, or to you if you have an accident and suffer one of the specific injuries listed in the chart on the following page. Benefits will not be paid if your death or injury was caused by anything excluded under "What Is Not Covered" on page 29. Your beneficiary will be the same as your life insurance beneficiary on file with MetLife, unless you choose otherwise.

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

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

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

Contact MetLife to claim AD&D benefits.

What Is Not Covered

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

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

When Coverage Ends

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

CLAIMS AND APPEALS PROCEDURES

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

Claims Reviewers

| Benefit | Filing Address |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Pharmacy (non-participating providers only; no claim forms are necessary for participating providers) | Medco Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512-4711 |
| Dental (non-participating providers only; no claim forms are necessary for participating providers) | Delta Dental One Delta Drive Mechanicsburg, PA 17055 Attn: Claims Department |
| Vision (non-participating providers only; no claim forms are necessary for participating providers) | Building Service 32BJ Health Fund Health Benefits Processing Group 101 Avenue of the Americas New York, NY 10013-1991 |
| Life Insurance Accidental Death & Dismemberment | MetLife Recordkeeping P.O. Box 6169 Utica, NY 13504-6169 1-866-492-6983 |

APPEALS REVIEWERS

| Benefit | Write to: | Or Call |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| Pharmacy | Medco Health Solutions, Inc. Attention: Coverage Appeals 8111 Royal Ridge Parkway Irving, TX 75063-2820 | 1-800-318-7451 |
| Dental | Delta Dental One Delta Drive Mechanicsburg, PA 17055 Attn: Dental Affairs Committee | Appeals are only accepted in writing |
| Vision | Building Service 32BJ Health Fund* Board of Trustees Appeals Committee 101 Avenue of the Americas New York, NY 10013-1991 | Appeals are only accepted in writing |
| Life | MetLife P.O. Box 3016 Utica, NY 13504-6169 | Appeals are only accepted in writing |

* 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.

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.

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 **network** providers. The Plan then pays 100% of remaining covered expenses.

Cosmetic means any treatment 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.

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.

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.

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

- provide the most appropriate level and type of service that can be safely provided to the patient, and
- are not solely for the convenience of the patient, the family or the provider.

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

Network benefits are benefits for **covered services** delivered by providers and suppliers who have contracted with Medco, Delta Dental 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.

Out-of-network provider/supplier means a **doctor**, other professional provider, or durable medical equipment, who is not in the Plan's **network** for vision or dental. **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.

CONTACT INFORMATION

| What do you need? | Who to contact | How |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• General information about your benefits• Information on your vision claims | Member Services | Call 1-800-551-3225 8:30 am – 5:00 pm Monday – Friday |
| <ul style="list-style-type: none">• To find a participating vision plan provider | Health Fund | Call 1-800-551-3225 |
| <ul style="list-style-type: none">• Information on dental claims or help in finding a dentist | Delta Dental | Call 1-800-932-0783 or Visit www.deltadentalins.com |
| <ul style="list-style-type: none">• Information about your prescription drug benefits, formulary listing or participating pharmacy | Medco | Call 1-800-318-7451 or Visit www.medco.com |
| <ul style="list-style-type: none">• Information about your life insurance plan | MetLife | Call 1-866-492-6983 or Visit www.metlife.com |



Building Service 32BJ Health Fund

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

www.seiu32bj.org

212-388-3500 Benefits Information

212-388-2000 General Information

Building Service 32BJ Health Fund Tri-State Rx Plus 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 Rx Plus Plan dated January 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 8: 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 11: 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 Pages 12 and 13: 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 Annual Maximum on Prescription Drug Benefit Page 13: Effective January 1, 2009, the prescription drug benefit has an annual maximum of \$5,000. Every calendar year you and your eligible dependents each have a \$5,000 maximum drug benefit. Once the Plan has paid \$2,000 in any calendar year for you or one of your dependents, you are required to participate in Medco's prescription drug management program in order to be covered for any additional prescription drugs, up to the \$5,000 annual maximum.

Elimination of Mandatory Mail Order Program for Maintenance Drugs Pages 14 and 15: Effective June 1, 2008, you are no longer required to order your maintenance drugs through Medco's Mail Order program. However, mail order is the most cost effective way to get your maintenance drugs.

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 14 and 15: 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.

Addition of Omeprazole to Formulary Page 16: Effective May 1, 2008, the Fund excludes only brand name gastrointestinal drugs.

Change in Mailing Address for Life Insurance and Accidental Death & Dismemberment Claims and Appeals Pages 30 and 31: 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

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.