

**Service Employees
32 BJ North
HEALTH BENEFIT FUND**

140 Huguenot Street
New Rochelle, NY 10801-5210
Telephone 1-914-637-7000
www.32bjnorthfunds.com

**Summary Plan Description
32BJ North Health Benefit Fund
for the North Health Fund Program B**

January 1, 2009



Service Employees 32 BJ North
HEALTH BENEFIT FUND

TRANSLATION NOTICE

This booklet contains a summary in English of your Plan rights and benefits under the Service Employees 32BJ North Health Benefit Fund. If you have difficulty understanding any part of this booklet, contact Member Services at 1-914-637-7000 for assistance or write to:

Member Services
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801

The office hours are from 8:00 a.m. to 4:00 p.m., Monday through Friday. You may also visit www.32bjnorthfunds.com.

Este folleto contiene un resumen en inglés de sus derechos y beneficios con el Plan del Service Employees 32BJ North Health Benefit Fund. Si tiene alguna dificultad para entender cualquier parte de este folleto, contacte al Centro de servicios para afiliados al 1-914-637-7000 para recibir asistencia, o escriba a la dirección siguiente:

Member Services
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801

El horario de oficina es de 8:00 a.m. a 4:00 p.m., de lunes a viernes. También puede visitar www.32bjnorthfunds.com.

Kjo broshurë përmban një përmbledhje në anglisht, në lidhje me të drejtat dhe përfitimet tuaja të Planit nën Service Employees 32BJ North Health Benefit Fund. Nëse keni vështirësi të kuptuar ndonjë pjesë të kësaj broshure, kontaktoni Shërbimin e Anëtarit në numrin 1-914-637-7000 për ndihmë ose mund të shkruani tek:

Member Services
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801

Orari zyrtar është nga ora 8:00 deri më 16:00, nga e hëna deri të premten. Gjithashtu, ju mund të vizitoni faqen e Internetit www.32bjnorthfunds.com.

Niniejsza broszura zawiera opis, w języku angielskim, Twoich praw i świadczeń w ramach Planu Service Employees 32BJ North Health Benefit Fund. W przypadku jakichkolwiek trudności ze zrozumieniem dowolnej części broszury, prosimy skontaktować się z Centrum obsługi członków pod numerem telefonu 1-914-637-7000 lub pisemnie na adres:

Member Services
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801

Biuro czynne jest w godzinach od 8:00 do 16:00 od poniedziałku do piątku. Można również odwiedzić naszą stronę pod adresem www.32bjnorthfunds.com.

Service Employees 32BJ North

HEALTH BENEFIT FUND

140 Huguenot Street
New Rochelle, NY 10801
Telephone 1-914-637-7000

The Service Employees 32BJ North Health Benefit Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

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IMPORTANT NOTICE

This booklet is the Summary Plan Description (“SPD”) of the program of benefits (“the Plan”) of the Service Employees 32BJ North Health Benefit Fund (“the Fund”) with regard to the Hospital, Medical, Prescription Drug, and Retiree Health Benefits of the North Health Fund Program B. Your Life Insurance and Accidental Death and Personal Loss Coverage benefits are insured by Aetna Life Insurance Company and are summarized in the enclosed materials provided by Aetna. Your rights to benefits can only be determined by the Plan, 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 the Fund Office for another.
- If you change your name or address – notify the Fund Office 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, 2009, 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 Fund 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 North Health Fund Program B covers certain participants who work in small buildings in the Bronx (Council 7 or Independent) and some part time employees in Connecticut. While the Fund provides other programs of benefits, they are not described in this booklet. If you are unsure about which program applies to you, contact the Fund Office for information.

ELIGIBILITY AND PARTICIPATION

When You Are Eligible

Eligibility for benefits from the Plan depends upon the collective bargaining agreement or other written agreement that covers your work. Unless specified otherwise in your collective bargaining agreement or other agreement, eligibility is as follows.

Your employer will be required to begin making contributions to the Fund on your behalf when you have completed 90 consecutive days of **covered employment** with the same employer working full-time, unless specified otherwise in your collective bargaining agreement or other agreement. For this purpose, **covered employment** includes certain leaves of absence for which contributions are due under your collective bargaining agreement. Days of illness, pregnancy or injury count toward the 90 day waiting period. Your coverage begins on the 1st day of the month following the date that your employer is required to make contributions to the Fund, provided that you have returned your completed Enrollment Form to the Fund Office.

Additional eligibility requirements apply to Retiree Health Benefits. See pages 27–29 for more information.

Once you are initially eligible for benefits, you remain a participant as long as you are working in **covered employment**. You are considered to be in **covered employment**:

- during periods of active work
- during paid vacations
- while on jury duty
- while collecting workers' compensation or short-term disability benefits from an employer for the period employer contributions are required, up to 26 weeks from the last date worked.
- during periods of Family and Medical Leave Act (FMLA) leave. See page 45–46 for more information.

When You Are No Longer Eligible

Your eligibility under the Plan ends:

- at the end of the month in which you no longer regularly work in **covered employment**, subject to COBRA rights (see pages 46–50) including transfer to a job classification outside the jurisdiction of the collective bargaining agreement, layoff, leave of absence, or unpaid vacation.

- the earlier of when you have received 26 weeks of workers' compensation or short-term disability, for a period during which employer contributions were required, or when you have exhausted your benefits under workers' compensation or short-term disability for a period during which employer contributions were required
- on the date when your employer terminates its participation in the Plan, or
- on the date the Plan is terminated.

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Plan's hospital, medical, prescription drug, and retiree health coverage. See pages 46–50 for more information about COBRA.

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 page 46 for more information.

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 as determined by the Board of Trustees based on the facts and circumstances.

Dependent Eligibility

As long as you are eligible, your dependents are eligible, provided they meet the definition of “dependent” under the Plan as described on the following three pages.

If your collective bargaining agreement or participation agreement provides for dependent coverage, eligible dependents under the Plan are described below:

Dependency	Requirements
Lawful spouse	The person to whom you are legally married under the laws of the state in which you live, unless you and your spouse are legally separated pursuant to either a separation decree or separation agreement. If you are legally separated, your spouse is not eligible for coverage under the Plan.
Domestic partner	<p>You and your same-gender domestic partner:</p> <ul style="list-style-type: none"> • have a marriage certificate from a state in the U.S. or 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 a province in Canada where same-gender civil unions are valid, or • if neither marriage or civil union is available, affidavits attesting to your relationship, plus a domestic-partner registration under state or local law (if permitted where you live), and proof of financial interdependence. <p>You are required to provide the highest level of certificate available in the jurisdiction in which you reside.</p> <p>Contact the Fund Office 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	Requirements
<p>Children (except disabled children)</p>	<p>The child:</p> <ul style="list-style-type: none"> • is not married; • has the same principal residence as the participant for more than one-half of the calendar year, or as required under the terms of a QMCSO – see page 50. However, a child who does not have the same principal residence as the participant for more than one-half of the year will nevertheless be eligible for dependent coverage if: <ul style="list-style-type: none"> – the child receives one-half of his or her support from parents who are divorced or legally separated under a decree of divorce or separation; separated under the terms of a separation agreement; or have lived apart at all times for the last six months of the year; OR if the participant was never married to his dependent child’s other parent, the child lives with his custodial parent and the child is claimed as a dependent on the participants tax return; AND – one or both of the child’s parents have custody of the child for more than one-half of the year; and • is dependent on the participant for over one-half of his or her support during the calendar year, or as required by the terms of a QMCSO – see page 50. However, a child who is not dependent on the participant for over one-half of his or her support during the calendar year will nevertheless be eligible for dependent coverage if: <ul style="list-style-type: none"> – the child receives one-half of his or her support from parents who are divorced or legally separated under a decree of divorce or separation; separated under the terms of a separation agreement; or have lived apart at all times for the last six months of the year; AND – one or both of the child’s parents have custody of the child for more than one-half of the year; OR <p>AND</p> <ul style="list-style-type: none"> • has not attained age 19 (or has not attained age 23 and is a full-time student in an accredited high school, college, university or trade school), <p>AND</p> <ul style="list-style-type: none"> • has one of the following relationships to the participant: <ul style="list-style-type: none"> – your biological child – your adopted* child or a child placed with you in anticipation of adoption – your stepchild – your domestic partner’s child – eligible foster children (a child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction) – your sibling – your step-sibling – a descendent of any of the above except for a descendent of your domestic partner’s child.
<p>Children (disabled)</p>	<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. Contact the Fund Office for details.</p>

* Your adopted dependent child will be covered from the date that child is adopted or “placed for adoption” with you, whichever is earlier (but not before you become eligible), if you enroll the child within 30 days after the earlier of placement or adoption (see “Your Notification Responsibility” on page 12). 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 on the date of your legal separation or divorce. Your domestic partner's eligibility ends on the date the requirements for domestic partnership on page 8 are no longer satisfied.
- Your *child's* eligibility ends on the date your child marries or no longer satisfies the rules regarding residence or financial dependency that are described on page 9 or
 - *if not a full-time student*, on the date the child reaches age 19, or
 - *if a full-time student*,
 - on the date of the child's graduation from school, or, if earlier,
 - on the date the child leaves school, or, if earlier,
 - on the date the child reaches age 23.
- Your dependent's eligibility for dependent coverage ends on the date your dependent commences work in **covered employment** and becomes eligible for coverage under the Plan as a participant.
- Eligibility of a spouse, a domestic partner, and dependent children ends on the date of your death.

Note that:

- A dependent must live in the United States, Canada or Mexico unless he or she is a United States citizen.
- A child is not considered a dependent under the Plan if he or she is in the military or similar armed forces of any country.

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. “Health coverage” includes the Plan’s hospital, medical, prescription drug, and retiree health coverage. See pages 46–50 for more information about COBRA.

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 Service Employees 32BJ North Health Benefit 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 the Fund Office for information or a copy of the Enrollment Form.

Enroll your dependents as soon as they become eligible. Please see “Dependent Eligibility” on pages 8–9 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 which you can obtain by contacting the Fund Office. Special rules apply regarding the effective date of your new dependent’s coverage. Please see “Your Notification Responsibility” on page 12 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 hire 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.

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.

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 the ages of 19 and 23 and graduates or otherwise leaves school, or if your child marries or no longer satisfies the rules regarding residence or financial dependency that are described on page 9.

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 hospital and medical, prescription drug, life insurance, accidental death and personal loss coverage (AD&PLC), and retiree health benefits. Each of these benefits is described in the sections that follow.

HOSPITAL AND MEDICAL BENEFITS

Overview of Eligible Expenses

Provision	In-Network
How you can receive treatment	Go to any network provider. <i>If an emergency, go to the nearest emergency room.</i>
Basis for reimbursement	All in-network reimbursements are based on the allowed amount for medically necessary eligible expenses and subject to pre-certification and co-payments where required; network providers have agreed to accept the allowed amount as payment in full. Except for emergency care, out-of-network services are not covered.
Annual deductible	None
Co-payments (where applicable)	\$20 for each visit to a doctor or physical therapy provider \$100 for an emergency room visit \$30 per occurrence for ambulance services.
Annual maximum benefit	\$25,000 per person for all benefits; \$5,000 per person for hospital; \$3000 per person per surgery for inpatient doctor and surgeon
Lifetime maximum benefit	\$50,000 per person

About the MagnaCare Networks

The Plan provides hospital and medical benefits through the MagnaCare **network**. At the time this SPD was printed, this **network** includes over 59,000 provider locations and 240 hospitals in the metropolitan area.

MagnaCare ID Card. This card gives you access to thousands of **doctors**, surgeons, hospitals and other health care facilities in the **network**. It also gives you 24-hour phone access to a registered nurse who can help you with your health care decisions.

Nurse Helpline. For immediate medical advice, call the Nurse Helpline. This is free round-the-clock information. When you call, you can either speak to a registered nurse or select from over 1,100 audiotaped messages in English or Spanish on a wide variety of topics. To reach the tape library, press #1, then enter pin #1032. You may find it helpful to speak to a registered nurse when you need help assessing symptoms, deciding whether a trip to the emergency room is necessary or understanding a medical condition, procedure, prescription or diagnosis. You can reach the Nurse Helpline at 1-866-443-0116.

In-Network Benefits

You must use providers that participate in the MagnaCare **network**. When you use **network** providers there are no claims to file or track. The Plan does not cover any medical or hospital expenses that are incurred with a **doctor** or at a facility that is not in the MagnaCare **network** except in an **emergency**.

In-network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a **network** provider. The **network** provider will assess your medical needs and advise you on appropriate care, as well as take care of any necessary tests, pre-certifications or hospital admissions. When you use a **doctor**, hospital or other **in-network** provider, the Plan generally pays 100% of most charges up to the annual and lifetime maximum amounts. *You will be required to pay a \$20 co-payment for doctor visits and certain other services and supplies, such as outpatient physical therapy or chiropractic care.*

Coverage When You Are Away from Home

If you are away from home and there are no MagnaCare **network** providers near your location, the Fund will cover **emergency** treatment rendered at any hospital. No other services will be covered.

Benefit Maximums

There is an *annual* limit of \$25,000 and a lifetime limit of \$50,000 on hospital and medical benefits payable for each covered person. There are also limits on how much (and how often) the Plan will pay for certain covered expenses. If there are limits on a particular expense, those limits will be indicated under “**Covered Services**.” See pages 15–17.

Conditions for Hospital and Medical Expense Reimbursement

- Charges must be for **medically necessary** care. The Plan will pay benefits only for services, supplies and equipment that the Plan considers to be **medically necessary**.
- Charges must be incurred while the patient is covered. The Plan will not reimburse any expenses incurred by a person while the person is not covered under the Plan.

Covered Services

The following tables show different types of health care expenses and how they are covered.

In the Hospital¹ and Outpatient Treatment Centers

Benefit	Co-payment	The Plan pays up to the annual or lifetime maximum
Semi-private room and board (for obstetrical care, hospital stays are covered for at least 48 hours following normal delivery, or at least 96 hours following cesarean section)	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
In-hospital services of licensed doctors and surgeons	\$0	100% of allowable charges up to a maximum payment of \$3,000 per surgery
Outpatient ² surgery and care related to surgery (including operating and recovery rooms)	\$20	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
Anesthesia and oxygen	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
Blood and blood transfusions	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
Cardiac Care Unit (CCU) and Intensive Care Unit (ICU)	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
Chemotherapy and radiation therapy (inpatient)	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year for inpatient and outpatient
Kidney Dialysis ³	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
Emergency room ⁴ (no benefit if the condition is not an emergency)	\$100 co-payment (\$100 co-payment waived if admitted from the emergency room)	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year
Ambulance ⁵	\$30	Up to \$200 per occurrence
Hospice Care ⁶ Up to 210 days per lifetime	\$0	100% of allowable charges subject to the annual hospital maximum of \$5,000 per year for inpatient

See footnotes 1 – 6 on pages 60 – 62.

Care in the Doctor's Office

Benefit	Co-payment	The Plan pays up to the annual or lifetime maximum
Office visits	\$20	100%
Physical and Occupational Therapy ¹³	\$20	100%
Up to 30 visits per year		
Diagnostic procedures:	\$0	100%
<ul style="list-style-type: none"> • X-rays and other imaging • MRIs/MRAs/PETs • All lab tests 		
• Outpatient Hospital	\$100	100% up to \$5,000 hospital limit (excludes nuclear studies which may be performed in hospital)
• Pre-Surgical Testing	\$0	Subject to all maximums; must be performed in the same hospital as surgery
Chemotherapy and radiation therapy (outpatient)	\$0	100%
Podiatry for medically necessary foot care. After 1st visit, must be pre-certified.	\$20	100%

Preventive Medical Care

Benefits	Co-payment	The Plan pays up to the annual or lifetime maximum
Annual Physical ⁷ limited to one visit/year	\$20	100%
Well-woman care	\$0	100%
<ul style="list-style-type: none"> • Mammogram for women age 35–39, one baseline test is covered for women age 40 and older, test covered once per year • PAP smear once a year • Bone density test age 50 or over, if medically necessary 		
Well-child care ⁸ (including immunizations, up to age 19)	\$0	100%

See footnotes 7 – 8 on page 62 and footnote 13 on page 63.

Pregnancy and Maternity Care*

Benefit	Co-payment	The Plan pays up to the annual or lifetime maximum
Office visits for prenatal and postnatal care from a licensed doctor or certified midwife ⁹ , including diagnostic procedures	\$20 for 1st visit, then \$0	100%
Newborn in-hospital nursery care	\$0	100% included in the annual hospital maximum of \$5,000 per year
Obstetrical care (in the hospital or birthing center)	\$0	100% included in the annual hospital maximum of \$5,000 per year
Circumcision of newborn males within first 30 days of life	\$0	100%

* Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Durable Medical Equipment and Supplies¹⁰

Benefit	Co-payment	The Plan pays up to the annual or lifetime maximum
Scoliosis brace	\$0	100%

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

Such benefits are subject to the Plan's annual **deductible** and **coinsurance** provisions.

See footnotes 9 – 10 on page 62.

Excluded Hospital and Medical Expenses

The following expenses are not covered under the hospital or medical coverage. However, some of these expenses are covered under your prescription drug coverage. Check the other sections of this booklet to see if an expense not paid under hospital/medical is covered elsewhere under the Plan.

- expenses incurred before the patient's coverage began or after the patient's coverage ended
- treatment that is not **medically necessary**
- out-of-network services, except in an **emergency**
- expenses for behavioral health, including mental/nervous disorders and/or alcohol or substance abuse
- cosmetic treatment and surgery¹¹
- expenses for dental care
- chiropractic services or services provided by a chiropractor
- technology, treatments, procedures, drugs, biological products or medical devices that in MagnaCare's judgment are experimental, investigative, obsolete or ineffective¹². Also excluded is any hospitalization in connection with experimental or investigational treatments
- expenses for the diagnosis or treatment of infertility
- expenses for the treatment of alcoholism and/or substance abuse
- assisted reproductive technologies, including, but not limited to, in-vitro fertilization, artificial insemination, gamete and zygote intrafallopian tube transfer and intracytoplasmic sperm injection
- surgery and/or non-surgical treatment for gender change
- reversal of sterilization
- travel expenses, except as specified
- psychological testing for educational purposes for children or adults
- common first-aid supplies such as adhesive tape, gauze, antiseptics, ace bandages, and surgical appliances that are stock items, such as braces, elastic supports, semi-rigid cervical collars or surgical shoes
- expenses for acupressure, prayer, religious healing including services, and naturopathic, naprapathic, or homeopathic services or supplies
- expenses for memberships in, or visits to, health clubs, exercise programs, gymnasiums or other physical fitness facilities
- operating room fees for surgery, surgical trays and sterile packs done in a non-state-licensed facility including the **doctor's** office
- orthotics for foot care (including dispensing of surgical shoe(s) and pre- and post-operative X-rays)

See footnotes 11 – 12 on pages 62 – 63.

- hearing exams
- the following specific preventive care services:
 - screening tests done at your place of work at no cost to you
 - free screening services offered by a government health department
 - tests done by a mobile screening unit, unless a **doctor** not affiliated with the mobile unit prescribes the tests
- the following specific **emergency** services:
 - use of the emergency room to treat routine ailments because you have no regular **doctor** or because it is late at night (and the need for treatment does not meet the Plan's definition of **emergency** – see page 58).
 - use of the emergency room for follow-up visits
 - ambulette
- the following specific maternity care services:
 - days in the hospital that are not **medically necessary** (beyond the 48-hour/96-hour stays the Fund is required by law to cover)
 - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The additional cost does not count toward your deductible or co-insurance.)
 - private-duty nursing
 - expenses for pre-planned home delivery of a child
- the following specific inpatient hospital care expenses:
 - private-duty nursing
 - private room (If you use a private room, you pay the difference between the cost for the private room and a semi-private room. The difference does not count towards your deductible.)
 - diagnostic inpatient stays, unless connected with specific symptoms that if not treated on an inpatient basis could result in serious bodily harm or risk to life
 - any part of a hospital stay that is primarily custodial
 - elective cosmetic surgery or any related hospital expenses or treatment of any related complications
 - hospital services received in clinic settings that do not meet MagnaCare's definition of a hospital or other covered facility
- the following specific outpatient hospital care expenses:
 - routine medical care including, but not limited to, inoculation, vaccination, drug administration or injection, excluding chemotherapy
 - collection or storage of your own blood, blood products, semen or bone marrow

- physical medicine or rehabilitation services
- the following specific equipment:
 - air conditioners or purifiers
 - humidifiers or de-humidifiers
 - exercise equipment
 - swimming pools
- Skilled nursing facility care
- Home health care services
- the following specific physical, occupational, speech or vision therapy services:
 - therapy to maintain or prevent deterioration of the patient's current physical abilities
 - treatment for developmental delay, including speech therapy
- the following specific vision care services:
 - expenses for surgical correction of refractive error or refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK), photo-refractive keratotomy (PRK) and laser in situ keratomileusis 21 (LASIK) and its variants
 - eyeglasses, contact lenses and the examination for their fitting except following cataract surgery
 - routine vision care.
- the following services that may be covered elsewhere under the Plan:
 - all prescription drugs and over-the-counter drugs, self-administered injectables, vitamins, vitamin therapy, appetite suppressants, or any other type of medication, unless specifically indicated. However, see "Prescription Drug Benefits," pages 22–25, to find out how prescription drug expenses may be covered.
 - contraceptive devices (see "Prescription Drug Benefits," pages 22–25, to find out how oral contraceptives may be covered under the prescription drug program)
- the following miscellaneous health care services and expenses:
 - services of a nutritionist and nutritional therapy or counseling
 - services performed in nursing or convalescent homes; institutions primarily for rest or for the aged; rehabilitation facilities (except for physical therapy); spas; sanitariums; or infirmaries at schools, colleges or camps
 - injury or sickness that arises out of any occupation or employment for wage or profit for which there is Workers' Compensation or

- occupational disease law coverage (for information about subrogation of benefits, see pages 41–44)
- injury or sickness that arises out of any act of war (declared or undeclared) or military service of any country
 - injury or sickness that arises out of a criminal act by the covered person, or an intentionally self-inflicted injury that is not the result of mental illness
 - expenses for services or supplies for which a covered person receives payment or reimbursement from casualty insurance or as a result of legal action, or expenses for which the covered person has already been reimbursed by another party who was responsible because of negligence or other tort or wrongful act of that party (for information about subrogation of benefits, see pages 41–44)
 - expenses reimbursable under the “no-fault” provisions of a state law
 - services covered under government programs, except under Medicare, Medicaid or where otherwise noted
 - any hospital care received outside of the U.S. that is not **emergency** care
 - government hospital services, except specific services covered under a special agreement between MagnaCare and a governmental hospital or services in the United States Veterans’ Administration or Department of Defense hospitals for conditions not related to military service
 - treatment or care for temporomandibular disorder or temporomandibular joint disorder (TMJ) syndrome
 - services such as laboratory, X-ray and imaging, and pharmacy services from a facility in which the referring **doctor** or his or her immediate family member has a financial interest or relationship
 - services given by an unlicensed provider or performed outside the scope of the provider’s license
 - charges for services a relative provides
 - charges that exceed the maximum **allowed amount** for that service or supply
 - charges that exceed the annual or lifetime maximum
 - services performed at home, except for those services specifically noted in this booklet as covered either at home or in an **emergency**
 - services usually given without charge, even if charges are billed
 - services performed by hospital or institutional staff that are billed separately from other hospital or institutional services, except as otherwise specified in this booklet.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are administered by Medco Health Solutions, Inc. (“Medco”). The list of prescription drugs that are covered by your Plan is known as a “formulary.” Your Plan’s formulary includes a wide selection of generic and brand-name medications.

Your prescription benefit plan has an annual benefit maximum of \$500 every calendar year for you and your eligible dependents combined.

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 the most cost effective way to secure your prescription drugs for those who take maintenance drugs (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma).

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.

- 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.

When your **doctor** first prescribes a maintenance drug and you are concerned about not receiving the drugs in time, ask your **doctor** to write two prescriptions – one for a 30-day supply 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.

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.

In New York and New Jersey, you can fill your mail order prescription at a Rite Aid Retail Pharmacy store 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.

Please note that certain prescription drugs are not covered or require prior authorization. Your pharmacist can tell you if the prescription drug order you need to have filled is covered by the Plan and if it 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

* Pathmark provided this service until February 28, 2009; effective March 1, 2009, Rite Aid is the sole provider of the mail at retail option.

- 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:

- 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 (see footnote 11 on page 62 for more information)
- drugs used for weight loss unless you meet the Plan's medical criteria
- non-formulary drugs, unless your **doctor** can prove (i.e., clinical documentation; patient's drug therapy history) to Medco's satisfaction that the non-formulary drug is necessary (non-formulary drugs are drugs that are not on the Plan's list of approved drugs and medicines)
- therapeutic devices or appliances, support garments and other non-medical substances
- drugs intended for use in a **doctor's** office or another setting other than home use
- prescriptions that an eligible person is entitled to receive without charge under any Workers' Compensation law, or any municipal, state or Federal program

LIFE INSURANCE AND ACCIDENTAL DEATH & PERSONAL LOSS COVERAGE BENEFITS

Your life insurance and accidental death and personal loss coverage benefits are insured by Aetna. Detailed information about your life insurance and accidental death and personal loss coverage, including information about filing claims and appeals, is provided in the booklet provided by Aetna called “Your Group Plan” (Aetna Booklet). The Aetna Booklet is included with your SPD materials. If you need an additional copy of the Aetna Booklet, contact Aetna at 1-800-523-5065. The information provided below is only a summary of your schedule of benefits.

Your dependent spouse may also be eligible for benefits under this Plan as a dependent. Please see the Aetna Booklet for additional information regarding dependent spouse coverage.

Schedule of Life Insurance - Employees

Schedule

Classification	Principal Sum
All Employees	\$3,000

Schedule of Accidental Death and Personal Loss Coverage - Employees

Schedule

Classification	Principal Sum
All Employees	\$3,000

RETIREE HEALTH BENEFITS

Eligibility

You are eligible to receive retiree health benefits from the Fund if you:

(1) are covered by the Fund for health benefits at the time you begin to receive a pension benefit immediately after termination of **covered employment** from the Service Employees 32BJ North Pension Fund (North Pension Fund), and

(2) are age 62 or older, and

(3) have accrued a minimum of 20 years of service under the North Pension Fund. For the purpose of calculating 20 years of pension service, the number of weeks of severance payments required under a collective bargaining agreement or participation agreement are counted.

If you are eligible for retiree health benefits from the Fund, your spouse is eligible for retiree health benefits from the Fund if she/he is covered by the Fund for health benefits at the time you begin to receive a pension benefit.

No other dependents are eligible for retiree health benefits.

Benefit

The Plan will provide eligible retirees with a health debit card through WageWorks. This health debit card account creates a Health Reimbursement Arrangement (HRA).

The debit card is used to reimburse you for eligible health care expenses. All reimbursements of eligible health care expenses are subject to a \$5,000 lifetime maximum per person. The maximum lifetime reimbursement for a participant and a dependent spouse is \$5,000 each, whether or not both you and your dependent spouse were active participants in the Fund.

Eligible health care expenses are defined in IRS Publication 502, a list of which will be provided by WageWorks at the time the debit card is sent to you.

How The HRA Works

Once you receive the debit card from WageWorks, you may use it at your **doctor's** office, pharmacy or retail store to pay for eligible expenses. Once you have made a purchase on your WageWorks debit card, you must mail a copy of your receipt directly to WageWorks. If you fail to mail your receipt to WageWorks, or if you use your debit card for an expense that is not covered by the HRA, you will be required to repay the amount of the purchase to WageWorks. If you fail to repay this amount, WageWorks will offset future eligible expenses until it recoups the value of the payment. This means that WageWorks will not allow any deductions from your debit card for eligible expenses until the entire cost of an ineligible or undocumented expense has been recovered.

For any questions regarding the use of your debit card, your benefit balance, recent purchases or eligible expenses, you may call WageWorks toll free at 1-877-924-3967. An automated system is available 24 hours every day and representatives are available to speak with you directly between 8:00 A.M. EST and 8:00 P.M. EST, Monday through Friday, except federal holidays. You may also visit WageWorks' website at www.wageworks.com to help answer your questions.

Annual and Lifetime Maximums

If you are eligible for retiree health benefits, the Fund will provide you with an initial \$1,000 on your debit card, which you can use anytime during the Plan Year. Each Plan Year, you will receive an additional \$1,000 on your debit card, until you reach the \$5,000 lifetime maximum. If you exhaust your debit card balance prior to the end of a Plan Year, you will not have any additional amounts available until the start of the next Plan Year (assuming you are still within your \$5,000 lifetime maximum). If you spend less than your debit card balance in any Plan Year, the unused amount will be available for you to use in the next Plan Year. For example, participant X enrolls in the HRA. In year one, he receives a \$1,000 balance on his debit card, but only spends \$600. Therefore, in year two, he will have a \$1,400 balance (\$400 carried over from year one plus his \$1,000 benefit for year two). Unused balances will continue to be carried over until your HRA is terminated.

Administrative Fees

If you still have an amount available in your HRA after 60 months of eligibility for the HRA, the Fund will begin deducting a monthly administrative fee from your account, starting in the 61st month of participation. This amount will be continuously deducted each month until you have no remaining amount available. As of January 1, 2009, the monthly administrative fee is \$4.85. This fee is subject to change and you will be notified in writing of any change in the HRA administrative fee.

Termination

Your retiree health benefits will terminate on the earlier of your death or the exhaustion of your \$5,000 lifetime maximum. Your dependent spouse's retiree health benefits will terminate on the earliest of the following events:

- (1) your spouse's death
- (2) your death
- (3) your divorce or legal separation from your spouse
- (4) your spouse's exhaustion of his/her lifetime maximum

If your spouse's benefit terminates because of your death, your divorce or legal separation, your spouse will be eligible to continue his/her retiree benefits under COBRA. Please see pages 46–50 regarding the COBRA rules.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for Plan benefits. It also describes the procedure for you to follow if your claim is denied, in whole or in part, and you wish to appeal that decision.

Claims for Benefits

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

- inquiries about the Plan's provisions or eligibility that are unrelated to any specific benefit claim,
- a request for prior approval of a benefit that does not require prior approval by the Plan, and
- presentation of a prescription to be filled at a pharmacy that is part of

the Medco Health **network** of participating pharmacies. However, if you believe that your prescription has not been filled by a participating pharmacy in accordance with the terms of the Plan, in whole or in part, you may file a claim using the procedures described on the following pages.

Filing Hospital and Medical Claims

Remember when you use **network** providers, it is not necessary to file claim forms. Your health care providers will file all claims. Your health plan does not cover **out-of-network** providers.

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 with Medco, but never later than 12 months after the date the prescription was filled.**

If you have other coverage and Medco is the secondary payer, submit the original or a copy of the primary payer's Explanation of Benefits (EOB) with your itemized bill (see "Coordination of Benefits" on pages 39–41).

Filing Life Insurance and Accidental Death and Personal Loss Coverage (AD&PLC) Claims

Procedures for filing a Life Insurance or AD&PLC claim are included in the Aetna Booklet.

Filing Retiree HRA Claims

For retiree health benefit paper claims, you can get claim forms by contacting the Fund Office or on the WageWorks website at www.wageworks.com.

Where to Send Claim Forms

Claims Reviewers

Benefit	Filing Address
Medical/Hospital No claim forms are necessary	MagnaCare 825 East Gate Boulevard Garden City, NY 11530
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
Life Insurance Accidental Death & Personal Loss Coverage	Aetna Life Insurance See the Aetna Booklet for claims filing information
Retiree HRA Benefits – Paper claim forms not required	WageWorks Claims Administrator P.O. Box 14053 Lexington, KY 40511

Approval and Denial of Claims

There are separate claims denial and approval processes for Health Services Claims (hospital/medical, pharmacy, Life/AD&PLC Claims and Retiree Health Claims). These processes are described separately below. Please review this information to ensure that you are fully aware of these processes and what you need to do in order to comply.

Health Service Claims (hospital/medical, pharmacy)

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

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

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

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

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

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.

* 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.

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

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

If you do not follow the Plan's procedures for filing an urgent care claim, you will be notified *within 24 hours* of the failure and the proper procedures to follow. This notification may be oral, unless you request written notification. You will only receive notification of a procedural failure if your claim includes:

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

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

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

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

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

Retiree HRA Claims

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

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be decided based on the information previously provided.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) or if any adverse benefit determination is made (for example, the Plan pays less than one hundred percent of the claim). For urgent care and pre-service claims, you will receive notice of the determination even when the claim is approved. The timing for delivery of this notice depends on the type of claim as described on pages 31–34.

Appealing Denied Claims

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

Filing an Appeal

For all claims that are denied, in whole or in part, except Life and AD&PLC, you have 180 days to file an appeal following the notification of a denied claim. For a denied Life and AD&PLC claim, you have 60 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 the identity of any medical or vocational experts whose advice was obtained in connection with your appeal, without regard to whether the advice was relied upon in making the benefit determination).

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

When deciding an appeal of any adverse benefit determination that is based in whole or in part on medical judgement, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not **medically necessary** or appropriate, the reviewer will consult with a health care professional who has appropriate training and experience in the field involved in the medical judgement. This health care professional will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

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

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

Where to File an Appeal

Appeals Reviewers

Benefit	Write to:	Or Call
Medical and Hospital	Board of Trustees – Appeals Committee Service Employees 32BJ North Health Benefit Fund 140 Huguenot Street New Rochelle, NY 10801	914-637-7000
Pharmacy	Medco Health Solutions, Inc. Attention: Coverage Appeals 8111 Royal Ridge Parkway Irving, TX 75063-2820	1-800-318-7451
Life Insurance, Accidental Death and Personal Loss Coverage	See the Aetna Booklet for appeals filing information	
Retiree HRA	WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991	Appeals are only accepted in writing

Time Frames for Decisions on Appeals

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

Expedited Appeals for Urgent Care Claims

If your claim involves urgent care for medical, hospital or pharmacy 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, Concurrent or Post-Service Medical or Hospital Claim

If you appeal a pre-service, concurrent or post-service medical or hospital claim, that does not involve urgent care, the Board of Trustees will hear your appeal after their next scheduled quarterly meeting following receipt of your appeal, unless your appeal was received by the Fund within 30 days of the date of the meeting. In that case, your appeal will be heard at the second quarterly meeting following receipt of your appeal.

If special circumstances exist requiring an extension of time for review by the Trustees, you will be notified of the circumstances requiring the extension and the date on which a decision is expected. In no event will a decision be later than the third quarterly meeting after your appeal is received. The Trustees

will send you written notice of their decision (whether approved or denied) within 5 days of the decision.

Pre-Service or Concurrent Pharmacy 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 Pharmacy Claim Appeal

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

Voluntary Second Level Appeal of a Pharmacy Claim

If you have been notified regarding the outcome of your appeal of a pharmacy 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 representative) have pursued the appropriate mandatory appeal 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 appeal 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:

**Service Employees 32BJ North Health Benefit Fund
Board of Trustees – Appeals Committee
140 Huguenot Street
New Rochelle, NY 10801**

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 appeal process.

Notice of Appeal Denials

If your appeal is denied you will receive a notice that provides (a) the specific reason for the denial, (b) reference to the specific plan provision on which the denial is based, (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and (d) a statement of your right to bring an action in federal court under Section 502(a) of ERISA.

Life and Accidental Death & Personal Loss Coverage (AD&PLC) Appeal

Procedures for appealing a Life Insurance claim or AD&PLC claim are included in the Aetna Booklet.

Retiree HRA Claim Appeal

If you file an appeal of a Retiree HRA claim with WageWorks, you will be notified of a decision in writing by WageWorks *within 30 days* of receipt of your appeal.

Appeal Decision Notice

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

Further Action

All decisions on appeal will be final and binding on all parties, subject only to your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (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 appeal 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. The Trustees have established a three (3) year limitation period from the date your claim was denied within which you may file a lawsuit. You should refer to the Aetna Booklet for the limitations period for a Life Insurance or AD&PLC claim. If you have any questions about the appeal process, please contact the Fund Office.

INCOMPETENCE

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

MAILING ADDRESS

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

COORDINATION OF BENEFITS

You or your dependents may have health care coverage under two plans. For example, your spouse may have employer-provided health insurance or be enrolled in Medicare. When this happens, the two plans will coordinate their benefit payments so that the combined payments do not exceed the allowable charges (or actual cost, if less). This process, known as Coordination of Benefits (COB), establishes which plan pays first and which one pays second. The plan that pays first is the primary plan; the plan that pays second is the secondary plan. The primary plan will reimburse you first and the secondary plan will reimburse you for the remaining expenses to the maximum of the allowable charges for the **covered services**.

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

Except for situations like Medicare and **TRI-CARE** described on page 40, 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 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 have extended health coverage while receiving disability benefits) and you (or a dependent) are eligible for Medicare due to *age or disability* (according to the standards applied by Social Security), Medicare is primary and this Plan is secondary for each covered family member who is eligible for Medicare. Those covered family members who are not eligible for Medicare continue to receive primary coverage from this Plan.

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

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

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

no-fault carrier, such expenses may be reimbursed under this Plan, subject to the Plan's applicable maximums and other provisions.

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

Workers' Compensation. This Plan does not provide benefits for expenses covered by Workers' Compensation or occupational disease laws. If an employer disputes the application of Workers' Compensation law for the illness or injury for which expenses are incurred, the Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law (for information about subrogation and reimbursement of benefits, see pages 41–44).

YOUR DISCLOSURES TO THE FUND

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

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

SUBROGATION AND REIMBURSEMENT

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

you and your dependents may be required to sign necessary documents and to promptly notify the Fund of any legal action.

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

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

Any and all amounts received from any party or any other source by judgment, settlement, or otherwise, must be applied first to satisfy your reimbursement obligation to the Fund for the amount of medical expenses paid on your behalf or on your dependent's behalf. The Fund's lien is a lien of first priority for the entire recovery of funds paid on your behalf. Where the recovery from another party or any other source is partial or incomplete, the Fund's right to reimbursement takes priority over you 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 on page 43, and/or fail to restore to the Fund such funds as provided for on page 43, 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:

Board of Trustees
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, New York 10801

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** you receive. Failure to notify the Fund 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, costs and attorneys' fees. 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 plus interest, costs and attorneys' fees will be deducted from future benefits payable to the provider, or a lawsuit may be initiated to recover the overpayment.*

CONTINUED GROUP HEALTH COVERAGE

During a Family and Medical Leave

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

- the birth, adoption or placement with you for adoption of a child;
- to provide care for a spouse, child or parent who is seriously ill;
- your own serious illness; or
- a qualifying exigency that arises in connection with the active military service of your child, spouse, or parent. A qualifying exigency includes a) notification of military deployment within 7 days of the deployment date; b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; d) making financial and legal arrangements; e) attending counseling sessions; f) up to 5 days of rest and recuperation; g) attendance at post-deployment activities.

This provision is effective January 16, 2009.

You may be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service. Contact the Fund Office for more information.

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 the Fund Office 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 46–50 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 40).

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 the Fund Office for more details.

Under COBRA

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Fund's hospital, medical, prescription drug and retiree health 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 table 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 the Fund Office.

COBRA Continuation of Coverage

Coverage May Continue For:	If:	Maximum Duration of Coverage:
You and your eligible dependents	Your covered employment terminates for reasons other than gross misconduct	18 months
You and your eligible dependents	You become ineligible for coverage due to a reduction in your employment hours (e.g., leave of absence)	18 months
You and your eligible dependents	You go on military leave	24 months
Your dependents	You die	36 months
Your spouse and stepchild(ren)	You legally separate, divorce or your marriage is civilly annulled	36 months
Your dependent child(ren)	Your dependent children no longer qualify as dependents	36 months
Your dependents	You terminate your employment or you reduce your work hours less than 18 months after the date of your Medicare (Part A, 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 ends, 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 the Fund Office 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 the Fund Office 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 the Fund Office 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 47.)

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 Fund Office 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.

Failure to give timely notice. If a participant or dependent does not give written notice within 60 days of the date of the Qualifying Event, or a **contributing employer** within 30 days of a Qualifying Event and, as a result, the Fund pays a claim for a person whose coverage terminated due to a Qualifying Event, then that person or the **contributing employer**, as applicable, must reimburse the Fund for any claims that should not have been paid. If the person fails to reimburse the Fund, all amounts due may be deducted from other benefits payable on behalf of that person, his or her dependents or the participant, if that person is a dependent.

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 the Fund Office 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 the Fund Office for more information about the cost of your COBRA coverage.

If you fail to notify the Fund Office 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&PLC Insurance and Short-term Disability 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 table on page 47. 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 Fund Office 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 the Fund Office 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 Office at the address on page 57.

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 Fund Office at the address on page 57.

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 Fund Office at the address on page 57.

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 the Fund Office 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 MagnaCare 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

Procedures for converting to individual life insurance coverage are included in the Aetna Booklet.

All other plan benefits. You cannot convert hospital, medical, prescription drug or AD&PLC benefits to individual coverage.

GENERAL INFORMATION

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between Council 7, 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 Fund Office will provide you, upon written request, with information as to whether a particular employer is contributing to the Fund on behalf of participants working under a collective bargaining agreement or participation agreement and, if so, to which Plan the employer is contributing.

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in this booklet, but benefit payments also may be affected if you, your beneficiary or your provider of service, 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 the Fund Office

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 46–50).

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 “Subrogation”, pages 41–44 and “Overpayments”, pages 44–45).

Compliance with Federal Law

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

Plan Amendment or Termination

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

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

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

Plan Administration

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

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

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

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

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

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

Board of Trustees
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801

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

As a participant in the Service Employees 32BJ North Health Benefit 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 Fund Office and other specified locations, 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 Fund 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. The administrator may make a reasonable charge for copies.
- 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 46–50 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 30–38. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person

you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

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

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

PLAN FACTS

This booklet is the Summary Plan Description (SPD) of the plan of benefits (the Plan) of the Service Employees 32BJ North Health Benefit Fund (the Fund) with regard to the Hospital, Medical, Prescription Drug and Retiree Health Benefits of the B Program. Your Life Insurance and Accidental Death and Personal Loss Coverage benefits are insured by Aetna Life Insurance Company and are summarized in the enclosed materials provided by Aetna.

Plan Name:
Service Employees 32BJ North Health Benefit Fund
Employer Identification Number: 13-1699839
Plan Number: 501
Plan Year: January 1 – December 31
Type of Plan: Welfare Plan

Funding of Benefits and Type of Administration

Self funded, except for Aetna which insures the Life and Accidental Death & Personal Loss Coverage benefits. All contributions to the Trust Fund are made by **contributing employers** under the Plan in accordance with their written agreements. Benefits are administered by the organizations listed in the table on page 31.

Plan Sponsor and Administrator

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

**Board of Trustees
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801**

Participating Employers

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

To contact the Fund Office, write to:

**Fund Office
Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street
New Rochelle, NY 10801**

To contact the Health Fund, call:

1-914-637-7000

or write to:

**Service Employees 32BJ North Health Benefit Fund
140 Huguenot Street,
New Rochelle, NY 10801**

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 Fund Office or on the individual Trustees. For disputes arising under the portion of the Plan insured by Aetna, service of legal process may be made upon Aetna at their local offices or upon the supervisory official of the Insurance Department of the state in which you reside.

GLOSSARY

Allowed amount means the maximum the Fund will pay for a covered service. The **allowed amount** is based on an agreement with the 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**. The Plan then pays 100% of the remaining covered expenses.

Covered employment means work in a classification for which your employer is required to make contributions to the Fund.

Covered services are the services for which the Fund provides benefits under the terms of the Plan.

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.

Emergency means a condition whose symptoms are so serious that someone who is not a **doctor** – but who has average knowledge of health and medicine – could reasonably expect that, without immediate medical attention, the following would happen:

- the patient’s health would be placed in serious jeopardy
- there would be serious problems with the patient’s body functions, organs or parts
- there would be serious disfigurement, or
- the patient or those around him or her would be placed in serious jeopardy, in the event of a behavioral health **emergency**.

Severe chest pains, extensive bleeding and seizures are examples of **emergency** conditions.

In-network benefits are benefits for **covered services** delivered by providers and suppliers who have contracted with the Fund, MagnaCare or Medco or with any other administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services

provided must fall within the scope of their individual professional licenses.

Medically necessary, as determined by the applicable insurance carrier or the Fund, means services, supplies or equipment that satisfy all of the following criteria:

- are provided by a **doctor**, hospital or other provider of health services
- are consistent with the symptoms or diagnosis and treatment of an illness or injury; or are preventive in nature, such as annual physical examinations, well-woman care, well-child care and immunizations, and are specified by the Plan as covered
- are not experimental, except as specified otherwise in this booklet
- meet the standards of good medical practice
- meet the medical and surgical appropriateness requirements established under MagnaCare's medical policy guidelines
- provide the most appropriate level and type of service that can be safely provided to the patient
- are not solely for the convenience of the patient, the family or the provider, and
- are not primarily custodial.

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

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

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

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

FOOTNOTES

- 1** *Hospital/facility* is a fully licensed acute-care general facility that has all of the following on its own premises:
- a broad scope of major surgical, medical, therapeutic and diagnostic services available at all times to treat almost all illnesses, accidents and emergencies
 - 24-hour general nursing service with registered nurses who are on duty and present in the hospital at all times
 - a fully staffed operating room suitable for major surgery, together with anesthesia service and equipment (the hospital must perform major surgery frequently enough to maintain a high level of expertise with respect to such surgery in order to ensure quality care)
 - assigned **emergency** personnel and a “crash cart” to treat cardiac arrest and other medical emergencies
 - diagnostic radiology facilities
 - a pathology laboratory, and
 - an organized medical staff of licensed **doctors**.

For pregnancy and childbirth services, the definition of “hospital” includes any birthing center that has a participation agreement with MagnaCare.

For physical therapy purposes, the definition of a “hospital” may include a rehabilitation facility approved by MagnaCare.

For kidney dialysis treatment, a facility in New York State qualifies for **in-network** benefits if the facility has an operating certificate issued by the New York State Department of Health and participates with MagnaCare.

For certain specified benefits, the definition of a “hospital” or “facility” may include a hospital, hospital department or facility that has a special agreement with MagnaCare.

MagnaCare does not recognize as hospitals: nursing or convalescent homes and institutions, rehabilitation facilities (except as noted above), institutions primarily for rest or for the aged, spas, sanitariums, infirmaries at schools, colleges or camps, and any institution primarily for the treatment of drug addiction, alcoholism or behavioral care.

- 2** *Outpatient surgery* includes hospital surgical facilities, surgeons and surgical assistants, chemotherapy and radiation therapy, including medications, in a hospital outpatient department, **doctor’s** office or facility (medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy). Same-day, ambulatory or outpatient surgery (including invasive diagnostic procedures) means surgery that does not require an overnight stay in a hospital and:
- is performed in a same-day or hospital outpatient surgical facility

- requires the use of both surgical operating and postoperative recovery rooms
- does not require an inpatient hospital admission, and
- would justify an inpatient hospital admission in the absence of a same-day surgery program.

3 *Kidney dialysis treatment* (including hemodialysis and peritoneal dialysis) is covered in the following settings until Medicare becomes primary for end-stage renal disease dialysis (which occurs after 30 months):

- at home, when provided, supervised and arranged by a **doctor** and the patient has registered with an approved kidney disease treatment center (not covered: professional assistance to perform dialysis and any furniture, electrical, plumbing or other fixtures needed in the home to permit home dialysis treatment), or
- in a hospital-based or free-standing facility.

4 *Emergency room treatment* benefits are limited to the initial visit for **emergency** care. An **in-network** provider (not an emergency room of a participating hospital) must provide all follow-up care for you to receive maximum benefits. Also remember to contact MagnaCare Medical Management Program within 48 hours after an **emergency** hospital admission, as described on page 13, to pre-certify any continued stay in the hospital. If it is a non-participating hospital, you will need to file a claim in order to be reimbursed for your eligible expenses.

5 *Ambulance services* (land or air) are covered in an **emergency** and in other situations when it is medically appropriate (such as taking a patient home when the patient has a major fracture or needs oxygen during the trip home). Air ambulance service, which requires pre-certification, is covered only as a last resort (such as when you need to go to a distant hospital because the nearest hospital you can get to in a land ambulance cannot help you, or using land transportation would pose an immediate threat to your health).

6 *Hospice care* is for patients who are diagnosed as terminally ill (that is, they have a life expectancy of six months or less). Up to 210 days of hospice care at an **in-network** facility is covered in full. The Plan covers hospice services when the patient's **doctor** certifies that the patient is terminally ill and the hospice care is provided by a hospice organization certified by the state in which the hospice organization is located. Hospice care services include:

- up to 12 hours a day of intermittent nursing care by an RN or LPN
- medical care by the hospice **doctor**

- drugs and medications prescribed by the patient's **doctor** that are not experimental and are approved for use by the most recent "Physicians' Desk Reference"
- approved drugs and medications
- physical, occupational, speech and respiratory therapy when required
- lab tests, X-rays, chemotherapy and radiation therapy
- social and counseling services for the patient's family, including bereavement counseling visits for up to one year following the patient's death (if eligible)
- **medically necessary** transportation between home and hospital or hospice
- medical supplies and rental of durable medical equipment, and
- up to 14 hours of respite care a week.

7 *Preventive care* under the Plan includes routine physicals, subject to limits shown on page 16. Eligible expenses include X-rays, laboratory or other tests given in connection with the exam and materials for immunizations for infectious diseases. *Adults are covered for immunizations if **medically necessary**.*

8 *Well-child care* covers visits to a pediatrician, family practice **doctor**, nurse or licensed nurse practitioner. Regular checkups may include a physical examination, medical history review, developmental assessment, guidance on normal childhood development and laboratory tests. The tests may be performed in the office or a laboratory and must be within five days of the **doctor's** office visit. There are no maximum visits per year or co-pays for well child care to the age of 19, although these services will apply to the yearly and lifetime maximum. Covered immunizations include: Diphtheria, Tetanus and Pertussis (DtaP), Hepatitis B, Haemophilus Influenza Type B (Hib), Pneumococcus (Pev), Polio (IPV), Measles, Mumps and Rubella (MMR), Varicella (Chicken Pox,), Tetanus-Diphtheria (Td), Hepatitis A, Influenza for certain patients and other immunizations as determined by the American Academy of Pediatrics, Superintendent of Insurance and the Commissioner of Health in New York State or the state where your child lives.

9 Services of a certified nurse-*midwife* are covered if she or he is affiliated with or practicing in conjunction with a licensed facility and the services are provided under qualified medical direction.

10 *Durable medical equipment and supplies* applies only to a scoliosis brace. No other durable medical equipment purchases or rentals are covered.

11 *Cosmetic surgery* will be considered not **medically necessary** unless it is necessitated by injury, is for breast reconstruction after cancer surgery, or is necessary to lessen a disfiguring disease or a deformity arising from or directly related to a congenital abnormality. *Cosmetic treatment* includes any procedure that is directed at improving the patient's appearance and does

not meaningfully promote the proper function of the body or prevent or treat illness or disease.

12 *Experimental or “investigative”* means treatment that, for the particular diagnosis or treatment of the enrolled person’s condition, is not of proven benefit and not generally recognized by the medical community (as reflected in published literature). Government approval of a specific technology or treatment does not necessarily prove that it is appropriate or effective for a particular diagnosis or treatment of an enrolled person’s condition. A claims administrator may require that any or all of the following criteria be met to determine whether a technology, treatment, procedure, biological product, medical device or drug is experimental, investigative, obsolete or ineffective:

- there is final market approval by the U.S. Food and Drug Administration (FDA) for the patient’s particular diagnosis or condition, except for certain drugs prescribed for the treatment of cancer; once the FDA approves use of a medical device, drug or biological product for a particular diagnosis or condition, use for another diagnosis or condition may require that additional criteria be met
- published peer-reviewed medical literature must conclude that the technology has a definite positive effect on health outcomes
- published evidence must show that over time the treatment improves health outcomes (i.e., the beneficial effects outweigh any harmful effects), and
- published proof must show that the treatment at the least improves health outcomes or that it can be used in appropriate medical situations where the established treatment cannot be used. Published proof must show that the treatment improves health outcomes in standard medical practice, not just in an experimental laboratory setting.
- improves health outcomes in standard medical practice, not just in an experimental laboratory setting.

13 *Physical therapy* is covered for inpatient physical therapy if it immediately follows a regular hospital admission. Physical therapy, physical medicine and rehabilitation services – or any combination of these – are covered as long as the treatment is prescribed by your **doctor** and designed to improve or restore physical functioning within a reasonable period of time. If you receive therapy on an inpatient basis, it must be short-term. Occupational, speech and vision therapy are covered if prescribed by your **doctor** and provided by a licensed therapist (occupational, speech or vision, as applicable) in your home, in a therapist’s office or in an approved outpatient facility.

A total of 30 outpatient visits are covered per year for all therapy. You must receive any such services through a **network** provider in the home or office. Physical therapy provided in an outpatient department of a **network** facility is not covered. For outpatient physical therapy, you must pre-certify from the first visit.

CONTACT INFORMATION

What do you need?	Who to contact	How
<ul style="list-style-type: none">• Information about your eligibility for benefits• general information about your benefits	The Fund Office	Call 1-914-637-7000 Or visit the Fund Office at 140 Huguenot Street New Rochelle, NY 10801 8:00 am – 4:00 pm Monday – Friday
<ul style="list-style-type: none">• information on your hospital and medical benefits and claims• to find a primary care physician• to find participating MagnaCare providers	MagnaCare	Call 1-877-624-6219
<ul style="list-style-type: none">• information about your prescription drug benefits, formulary listing and participating pharmacy	Medco	Call 1-800-318-7451 or visit www.medco.com
<ul style="list-style-type: none">• immediate medical advice	Nurse Helpline	Call 1-866-443-0116
<ul style="list-style-type: none">• information about your life insurance plan or accidental death and personal loss coverage plan	Aetna	Call 1-800-523-5065