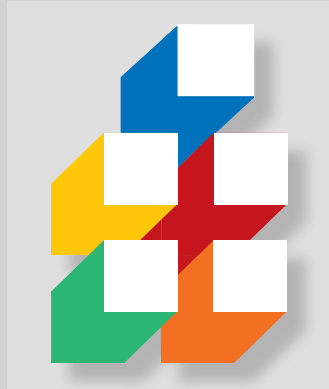




Building Service 32BJ Health Fund
Kaiser Permanente
Suburban Plan



Summary Plan Description

May 1, 2015



Translation Notice

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

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

The office hours are from 8:30 a.m. to 5:00 p.m., Monday through Friday. You may also visit www.32bjfunds.org.

Este folleto contiene un resumen en inglés de sus derechos y beneficios con el Plan del Building Service 32BJ Health Fund. Si tiene alguna dificultad para entender cualquier parte de este folleto, contacte al Centro de servicios para afiliados al 1-800-551-3225 para recibir asistencia, o escriba a la dirección siguiente:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

El horario de oficina es de 8:30 a.m. a 5:00 p.m., de lunes a viernes. También puede visitar www.32bjfunds.org.

Kjo broshurë përmban një përmbledhje në anglisht, në lidhje me të drejtat dhe përfitimet tuaja të Planit nën Building Service 32BJ Health Fund. Nëse keni vështirësi për të kuptuar ndonjë pjesë të kësaj broshure, kontaktoni Shërbimin e Anëtarit në numrin 1-800-551-3225 për ndihmë ose mund të shkruani tek:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

Orari zyrtar është nga ora 8:30 deri më 17:00, nga e hëna deri të premtën. Gjithashtu, ju mund të vizitoni faqen e Internetit www.32bjfunds.org.

Niniejsza broszura zawiera opis, w języku angielskim, Twoich praw i świadczeń w ramach Planu Building Service 32BJ Health Fund. W przypadku jakichkolwiek trudności ze zrozumieniem dowolnej części broszury, prosimy skontaktować się z Centrum obsługi członków pod numerem telefonu 1-800-551-3225 lub pisemnie na adres:

Member Services
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

Biuro czynne jest w godzinach od 8:30 do 17:00 od poniedziałku do piątku. Można również odwiedzić naszą stronę pod adresem www.32bjfunds.org.

Building Service 32BJ

Health Fund

25 West 18th Street, New York, NY 10011-4676

Telephone: 1-800-551-3225

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Important Notice

This booklet is both the Plan document and the Summary Plan Description (“SPD”) of the plan of benefits (“the Plan”) of the Building Service 32BJ Health Fund’s (“the Fund”) Kaiser Suburban Plan of benefits for purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. The terms contained herein constitute the terms of the Plan.⁽¹⁾ Your rights to benefits can only be determined by this SPD, as interpreted by official action of the Board of Trustees (“the Board”). You should refer to this booklet when you need information about your Plan benefits. In addition, the Board reserves the right, in its sole and absolute discretion, to amend the Plan at any time.

In the event of conflict or ambiguity between this SPD, the insurance contracts, or your collective bargaining agreement, this SPD will control. Also, in the event there is any conflict between the terms and conditions for the Plan benefits as set forth in the SPD and any oral advice you receive from a Building Service 32BJ Benefit Funds’ employee, union representative or employer, the terms and conditions set forth in this booklet control.

- Save this booklet – put it in a safe place. If you lose a copy, you can ask Member Services for another or obtain it from www.32bjfunds.org.
- If you change your name or address – notify Member Services immediately by calling 1-800-551-3225 so your records are up-to-date.
- 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 a Plan of benefits.

⁽¹⁾ This SPD is the plan document for the Kaiser Suburban Plan, which includes hospital, medical, mental health and substance abuse, prescription drug, dental, vision, life insurance, accidental death and dismemberment benefits, and short-term disability. The Evidence of Coverage (“EOC”) contract from Kaiser is the plan document for the hospital, medical, mental health and substance abuse and prescription drug benefits. Insurance contracts from MetLife and Guardian Life Insurance Company of America are the plan documents for the Life and Accidental Death & Dismemberment and Short-term Disability plans. The plans and the benefits they pay are limited by all the terms, exclusions, and limitations of those contracts in force at the time of the covered incident. The Board reserves the right to change insurance carriers and contracts. If the Board makes any such changes, the benefits coverage described in this SPD may not be accurate. You may request copies of the EOC and insurance contracts from Kaiser and MetLife.

- This booklet describes the provisions of the Plan in effect as of May 1, 2015 unless specified otherwise.
- The level of contributions provided for in your collective bargaining agreement or participation agreement determines the Plan and level of coverage (single or family) for which you are eligible. In general, the Kaiser Suburban Plan mainly covers participants who work in government buildings in the Capital Area District, including Washington, DC, Northern Virginia and Baltimore, Maryland.

While the Fund provides other plans, they are not described in this booklet. If you are unsure about which plan applies to you, contact Member Services for information.

Frequently Asked Questions

1. What benefits does the Plan provide?

The Plan provides a comprehensive program of benefits. The Kaiser Permanente SignatureSM Plan provides:

- hospital,
- medical,
- mental health and substance abuse, and
- prescription drug.

Those benefits are described in the Evidence of Coverage (“EOC”) document provided to you by Kaiser. For additional information on these benefits or to obtain a copy of the EOC, contact Kaiser at 301-468-6000.

The Plan also provides:

- dental through Delta Dental,
- vision through Davis Vision,
- life insurance and accidental death and dismemberment through MetLife, and
- Short-term Disability (“STD”) through Guardian Life Insurance Company of America.

These benefits are described in detail later in this booklet.

2. Are my dependent(s) eligible?

Generally not, unless your collective bargaining or participation agreement provides for family coverage. If covered, your covered dependent(s) include your spouse and your children until they reach 26 years of age. (See the table on pages 13–14 for a fuller description of dependent(s)). If you have dependent coverage in your collective bargaining agreement, contact Member Services at 1-800-551-3225 for more information about how to enroll dependents.

3. What is my life insurance coverage?

\$25,000.

There is no life insurance coverage for your dependent(s).

4. If I change 32BJ covered employers, what happens to my health coverage?

If you change covered employers and you have a break of 91 days or less in employment, your coverage will begin on your first day back at work. If there is more than a 91 day break in employment, your coverage will not begin until you complete 90 consecutive days of employment with your new covered employer.

5. If I leave the industry, how long can I stay on the health coverage?

Your coverage will continue at no cost for 30 days after your last day worked in **covered employment**.^{*} Prior to the expiration of the 30 days, you will be offered under the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”) the opportunity to purchase hospital, medical, mental health and substance abuse, prescription drug, dental and vision coverage for up to 17 more months.

6. What happens to my health coverage if I become disabled?

If you are eligible, the Fund will pay for up to 30 months of continued health coverage (Fund-paid Health Extension). To be eligible, you must:

- Have become disabled (either totally or totally and permanently) while working in **covered employment**,
- Be unable to work, and
- Be receiving (or be approved to receive) one of the following benefits:
 - Short-Term Disability (“STD”), or
 - Workers’ Compensation.

7. What happens to my family’s health coverage if I die?

If your family is enrolled/covered on the date of your death, their coverage will continue at no cost for 30 days. Prior to the expiration of the 30 days, your family will be offered the opportunity to continue coverage under COBRA for 35 more months by paying a monthly premium.

^{*} **Covered employment** is work in a classification for which your employer is required to make contributions to the Health Fund.

Eligibility and Participation

When You Are Eligible

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

Your employer will be required to begin making contributions to the Plan on your behalf when you have completed 90 consecutive days of **covered employment** with the same employer working full-time (as defined by your collective bargaining agreement or participation agreement), unless specified otherwise in your collective bargaining agreement or participation agreement. For this purpose, **covered employment** includes certain leaves of absence. Days of illness, pregnancy or injury count toward the 90-day waiting period. When you have completed that 90-day period working for your employer, you become eligible for the benefits described in this booklet on your 91st day of **covered employment**.

When You Are No Longer Eligible

Your eligibility for the Plan ends:

- at the end of the 30th day after you no longer regularly work full-time in **covered employment**, subject to COBRA rights (See pages 10–12 and pages 50–55.),
- on the date when your employer terminates its participation in the Plan, or
- on the date the Plan is terminated.

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

If You Come Back to Work

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

- *within 91 days*, your Plan participation starts again on your first day back at work, or
- *more than 91 days later*, you would have to complete 90 consecutive days of **covered employment** with the same employer before participation resumes.

If your contract provides for dependent coverage, they are eligible as long as you are eligible, provided they meet the definition of “dependent” under the Plan (see Dependent Eligibility on pages 12–15) and you have properly enrolled them.

Extension of Health Benefits

Health coverage may be continued while you are not working in the circumstances described on the following pages:

COBRA

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. “Health coverage” includes the Plan’s hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision coverage. This does not include life insurance and AD&D. (See pages 10–12 and pages 50–55 for more information about COBRA.)

Fund-paid Health Extension

If all eligibility requirements are met, the Fund will pay for health coverage in the following situations: disability, which must have occurred while you were in **covered employment**, and arbitration. All periods of Fund-paid Health Extension will count toward the period in which you are entitled to continuing

* **Contributing employer** is a person, company or other employing entity that has assigned a collective bargaining agreement with the union, and the agreement requires contributions to the Health Fund for work in **covered employment**.

coverage under COBRA. Fund-paid Health Extension includes the Plan’s hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision benefits. Life insurance and AD&D are also continued for the first six months. (See page 31 for the Life Insurance Disability Extension.)

To receive this extended coverage, return the documentation from the list in the Fund-paid Health Extension section of the COBRA election notice. If you fail to timely return the required documentation, you may lose eligibility for continuation of coverage under Fund-paid Health Extension. The required documents (e.g., proof of disability), must be returned to:

COBRA Department
Building Service 32BJ Benefit Funds
25 West 18th Street
New York, NY 10011-4676

Disability

You may continue to be eligible for up to six months of health coverage (see Fund-paid Health Extension on pages 10–11), provided you return the required documentation set forth in the Fund-paid Health Extension section of the COBRA election notice, are unable to work and are receiving (or are approved to receive) one of the following disability benefits:

- Short-Term Disability, or
- Workers’ Compensation.

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

- you elect to discontinue coverage,
- you work at any job,
- six months have passed after you stopped working due to disability,
- your Workers’ Compensation or Short-Term Disability ends,
- you receive the maximum benefits under Short-Term Disability or Workers’ Compensation, or
- you become eligible for Medicare as your primary insurer.

If you die while receiving extended health coverage, your dependent(s)’ eligibility will end 30 days after the date of your death.

To receive this extended coverage (Fund-paid Health Extension), you must submit proof of disability as described in the Fund-paid Health Extension section of the COBRA election notice no later than 60 days after the date coverage would have been lost (90 days after you stopped working due to a disability). The Plan reserves the right to require proof of your continued disability from time to time. This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA. (See pages 10–12 and pages 50–55 for COBRA information.)

Arbitration

If you are discharged* and the Union takes your grievance to arbitration seeking reinstatement to your job, your coverage will be extended for up to six months or until your arbitration is decided, whichever occurs first. (See Fund-paid Health Extension on pages 10–11.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

FMLA

You may be entitled to take up to a 26 week leave of absence from your job under the Family and Medical Leave Act (“FMLA”). You may be able to continue coverage during an FMLA leave. (See pages 48–49 for more information.)

Military Leave

If you are on active military duty, you have certain rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) provided you enroll for continuation of health coverage. (See pages 49–50 for more information. This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.)

* Indefinite suspensions or suspensions pending discharge are treated the same as discharges.

Dependent Eligibility

If your collective bargaining agreement or participation agreement provides for dependent coverage, eligible dependent(s) under the Plan are described on the following pages:

Dependency	Age Limitation	Requirements
Spouse	None	The person to whom you are legally married (if you are legally separated or divorced, your spouse is not covered).
Children	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child is one of the following: <ul style="list-style-type: none"> Your biological child, Your adopted* child or one placed with you in anticipation of adoption, or Your stepchild: this includes your spouse's biological or adopted child.
Children (dependent) – Your grandchild, niece or nephew ONLY if you are the legal guardian*** (if application for legal guardianship is pending, you must provide documentation that papers are filed and provide proof when legal process is complete)	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child: <ul style="list-style-type: none"> Is not married, Has the same principal address as the participant**, or as required under the terms of a “QMCSO”—see pages 55–56, and Is dependent on the participant for all of his or her annual support and maintenance and is claimed as a dependent on your tax return.**

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 forces of any country.

* 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 pages 17–18) 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.

** If you are legally separated or divorced, then your child may live with and/or be the tax dependent of the legally separated or divorced spouse. If you were never married to your child’s other parent, then the child may live with the other parent but must be your tax dependent.

*** Legal guardian(ship) includes legal custodian(ship).

When Your Dependent(s) Are No Longer Eligible

Your dependent(s) remain eligible for as long as you remain eligible except for the following:

- Your spouse’s eligibility ends 30 days after legal separation⁽²⁾ or divorce.
- Your child’s eligibility ends on the date your child no longer satisfies the requirements for a dependent child as described on page 14, 30 days after the child’s 26th birthday, or the end of the calendar year in which the child turns 26, whichever is earlier.
- Eligibility of a spouse and dependent children ends 30 days after your death.

How to Enroll

Coverage for dependent(s) under the Plan is not automatic.

If at the time you become eligible under the Plan you would like to enroll your eligible dependent(s), you must complete the appropriate form and submit it to the Fund within 30 days from the date you first became eligible for health benefits.

Please see Dependent Eligibility on pages 13–14 to determine whether your dependent(s) are eligible for enrollment. You will also be required to submit documents proving relationship status, including a marriage certificate (for your spouse), birth certificates and, if applicable, proof of dependency (for your grandchildren, nieces and nephews). In most cases, your dependent’s coverage will begin on the date he or she was first eligible.

⁽²⁾ Generally, a legal separation is any court order or agreement filed with the court under which the parties acknowledge they are living separately. Legal separation includes, but is not limited to, a divorce from bed and board, limited divorce, judicial separation, separate maintenance, inter-spousal agreement, marital property settlement agreement, and property settlement agreement.

However, if you do not enroll your dependent(s) within 30 days from the date you first became eligible for health coverage under this Plan, your dependent's coverage will not begin until the date you notify the Fund. After your coverage under the Plan begins, if you have a change in family status (e.g., get married, adopt a child) or wish to change existing dependent coverage for any reason, you must complete the appropriate form. Special rules apply regarding the effective date of your new dependent's coverage. (Please see Your Notification Responsibility on pages 17–18 for further details.)

Dependent claims for eligible expenses will be paid only after the Fund has received the appropriate form and supporting documentation. 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 your dependent. Failure to provide such information could result in a loss of coverage and a loss of the right to elect continuation of health coverage under COBRA.

Special Enrollment Rules

For participants working under a collective bargaining agreement that provides an annual open enrollment, depending upon the terms of that agreement, you may be permitted to enroll one or more of your dependent(s) (as defined on pages 13–14) in the same manner described under the section “How to Enroll” on pages 15–16. However, once you make an election to enroll specific dependent(s) or to not enroll specific dependent(s), this election is generally fixed or locked in for the entire Calendar Year (January 1st to December 31st). An exception applies if:

- you acquire a new dependent through marriage, birth, or adoption or placement for adoption, or
- you have a non-enrolled dependent who loses coverage under another group health plan (unless coverage was terminated for cause or because your dependent failed to pay premiums on a timely basis), or the employer stops contributing towards your dependent's coverage under the other plan.

If your dependent elected COBRA coverage, the entire COBRA coverage period must have been completed for this rule to apply. In either of these

circumstances, you may enroll your dependent during a special enrollment period that ends 30 days after the date of marriage, birth, adoption/ placement, loss of other group health coverage or termination of employer contributions to other group health plan.

There will be an open enrollment period before the end of each Calendar Year in which you can make a change in your enrolled dependent(s), or enroll a dependent(s) if none was previously enrolled (or if your previously enrolled dependent ceased to become eligible during the Calendar Year) for the next Calendar Year. If you do not take any action during the open enrollment period, your existing election will remain in effect for the next Calendar Year.

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 grandchild, niece or nephew no longer lives with you, marries or otherwise no longer satisfies the requirements for coverage as described on page 15.

If, after your coverage under the Plan becomes effective, your dependent(s) lose eligibility for Medicaid or Children's Health Insurance Program (“CHIP”) or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan, it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 60 days of the loss of Medicaid/CHIP or of your dependent(s) becoming eligible for the state subsidy, coverage for your dependent(s) will begin as of the date your dependent(s) lost eligibility for Medicaid/CHIP or the date they became eligible for the subsidy. If you do not notify the Fund within 60 days, coverage for your dependent(s) will begin as of the date you notify the Fund.

Failure to notify the Fund of your dependent(s)' 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.

Failure to notify the Fund of a change in family status could lead to a delay or denial in the payment of health benefits or the loss of a right to elect health continuation under COBRA. In addition, knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution.

What Benefits Are Provided

The Fund provides a comprehensive program of benefits including hospital, medical, mental health and substance abuse, prescription drug, dental, vision, life insurance, accidental death and dismemberment insurance and short-term disability benefits.

Hospital, Medical, Mental Health and Substance Abuse, and Prescription Drug Benefits

Hospital, medical, mental health and substance abuse and prescription drug benefits are provided by the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. under the Kaiser Permanente SignatureSM Plan. Those benefits are described in the EOC document provided to you by Kaiser. For additional information on these benefits or to obtain a copy of the EOC, contact Kaiser at 1-301-468-6000.

Dental Benefits

How the Plan Works

The Delta Plan provides coverage for necessary dental care received through:

- a Delta Dental Preferred Provider Organization (“PPO”) participating dentist, or
- a non-Delta Dental PPO participating dentist.

Necessary dental care is a service or supply that is required to identify or treat a dental condition, disease or injury. The fact that a dentist prescribes or approves a service or supply or a court orders a service or supply to be rendered does not make it dentally necessary. The service or supply must be all of the following:

- provided by a dentist, or solely in the case of cleaning or scaling of teeth, performed by a licensed, registered dental hygienist under the supervision and direction of a dentist,
- consistent with the symptoms, diagnosis or treatment of the condition, disease or injury,
- consistent with standards of good dental practice,
- not solely for the patient’s or the dentist’s convenience, and
- the most appropriate supply or level of service that can safely be provided to the patient.

Participating Delta Dental Providers

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

If you choose to receive your care from a participating dental provider, you will not have to pay anything for covered dental care.

Non-participating Dentists

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

You will be required to pay the dentist’s full charges. You will file a claim with Delta Dental (see Filing Dental Claims on pages 36–37 and Where to Send Claim Forms on page 38) and will be reimbursed according to the Delta Dental fee schedule for each procedure.

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

Pre-determinations/Pre-treatment Estimates

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

What Dental Services Are Covered

The Delta Plan covers a wide range of dental services, including:

- Preventive and diagnostic services, such as routine oral exams, cleanings, X-rays, topical fluoride applications, space maintainers and sealants. These services are covered 100%.
- Basic therapeutic services, such as extractions and oral surgery, intravenous conscious sedation when **medically necessary** for oral surgery, gum treatment, gum surgery, fillings and root canal therapy. These services are covered 100%.
- Major services, such as fixed bridgework, crowns and dentures. These services are covered 100%.

See the Schedule of Covered Dental Services on pages 21–25 for details. These services are reimbursed at 100% of the Delta Dental PPO **allowed amount** (or dentist's charges if less).

- Orthodontic services for children 19 and under, such as diagnostic procedures and appliances to realign teeth. There is a separate lifetime maximum on orthodontic services of \$1,000 per patient.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services.

Annual Maximum

The Delta Dental Plan provides coverage of up to \$1,000 per covered individual age 19 or older per calendar year.

Schedule of Covered Dental Services

Procedure	Limits
<p>Diagnostic*</p> <p>Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused)</p> <p>X-Rays:</p> <ul style="list-style-type: none"> • full mouth, complete series, including bitewings or panoramic film • bitewings, back teeth • periapicals, single tooth • occlusal film • cephalometric film (orthodontic coverage only) 	<p>Once every six months</p> <p>Once in any 36 consecutive months</p> <p>Four films every six months As necessary As necessary Once in a lifetime</p>
<p>Preventive*</p> <p>Dental prophylaxis (cleaning, scaling and polishing)</p> <p>Topical fluoride treatment</p> <p>Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)</p> <p>Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)</p>	<p>Once every six months</p> <p>Once in any calendar year for patients under age 16</p> <p>Once per tooth in any 24 consecutive months for patients under age 16</p> <p>Once per tooth for patients under age 16</p>
<p>Simple Restorative*</p> <p>Amalgam (metal) fillings</p> <p>Resin (composite, tooth-colored) fillings</p>	<p>Once per tooth surface in any 24 consecutive months</p> <p>Once per tooth surface in any 24 consecutive months</p>

*Reimbursed at 100% of the Delta Dental PPO **allowed amount** (or dentist's charges if less).

Schedule of Covered Dental Services (continued)

Procedure	Limits
Major Restorative*	
Recementation of crown	Once per tooth in any calendar year
Prefabricated stainless steel/resin crown (deciduous teeth only)	Once per tooth in any 60 consecutive months
Crowns when tooth cannot be restored with regular filling(s) due to excessive decay or fracture	Once per tooth in any 60 consecutive months
Endodontics*	
Root canal therapy	Once per tooth in a lifetime
Retreatment of root canal	Once per tooth in a lifetime
Apicoectomy (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment)	Once per tooth in a lifetime
Pulpotomy	Once per tooth in a lifetime
Periodontics*	
Gingivectomy or gingivoplasty	Once per quadrant in a lifetime
Osseous surgery (prior approval is required with a full-mouth series of X-rays and periodontal charting)	Once per quadrant in a lifetime
Periodontal scaling and root planning	Once per calendar year
Periodontal maintenance (covered only if the Plan also covered periodontal surgery and the maintenance procedure is performed by a periodontist)	Twice in any calendar year

* Reimbursed at 100% of the Delta Dental PPO **allowed amount** (or dentist's charges if less).

Schedule of Covered Dental Services (continued)

Procedure	Limits
Removable Prosthodontics*	
Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care	One denture per arch in any 60 consecutive months
Denture rebase or reline procedures, including six months of routine post-delivery care	One per appliance in any 36 consecutive months
Interim maxillary and mandibular partial denture (anterior teeth only); no other temporary or transitional denture is covered by the Dental Plan	Once per appliance in any 60 consecutive months
Fixed Prosthodontics*	
Fixed partial dentures and individual crowns	Once per tooth in any 60 consecutive months
Prefabricated post and core procedures related to fixed partial denture (X-rays showing completed endodontic procedure is required)	Once per tooth in any 60 consecutive months
Simple Extractions*	
Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Once per tooth

* Reimbursed at 100% of the Delta Dental PPO **allowed amount** (or dentist's charges if less).

Schedule of Covered Dental Services (continued)

Procedure	Limits
Oral and Maxillofacial Surgery*	
Removal of impacted tooth	Once per tooth in a lifetime
Alveoplasty (surgical preparation of ridge of dentures, with or without extractions)	Once per quadrant in a lifetime
Frenulectomy	Once per arch in a lifetime
Removal of exostosis (removal of overgrowth of bone)	Once per site in a lifetime
Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm and incision and drainage of an intraoral or extraoral abscess.	
Emergency Treatment*	
Palliative treatment to alleviate immediate discomfort (minor procedures only)	Twice in any calendar year
Repairs*	
Temporary crown (fractured tooth)	Once per tooth in a lifetime
Crown repair	Once per tooth in any 36 consecutive months
Overcrown	Once per tooth in any 60 consecutive months
Repairs to complete or partial dentures	Once per appliance in any calendar year
Recement fixed or partial dentures	Once per appliance in any calendar year
Additions to partial dentures	As needed
Orthodontics*	
Patients 19 years of age and under	One course of treatment in a lifetime, up to \$1,000 Initial diagnosis is a separate coverage
Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association. A "course of treatment" is defined as 30 consecutive months (24 months if 16 or older) of active orthodontic treatment, including braces, monthly visits and retainers.	

* Reimbursed at 100% of the Delta Dental PPO **allowed amount** (or dentist's charges if less).

Schedule of Covered Dental Services (continued)

Procedure	Limits
Miscellaneous	
Occlusal guard	One appliance in any 60 consecutive months

* Reimbursed at 100% of the Delta Dental PPO **allowed amount** (or dentist's charges if less).

Alternate Benefit for the Plan's Dental Coverage

There is often more than one way to treat a given dental problem. For example, a tooth could be repaired with an amalgam filling, a resin composite or a crown. If this is the case, the Plan will generally limit benefits to the least expensive method of treatment that is appropriate and that meets acceptable dental standards. For example, if your tooth can be filled with amalgam and you, or your dentist, decide to use a crown instead, the Plan pays benefits based on the amalgam. You will have to pay the difference.

What Is Not Covered

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

- any services performed before a patient becomes eligible for benefits or after a patient's eligibility terminates, even if a treatment plan has been approved
- reimbursement for any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services
- charges in excess of the **allowed amounts**, contact Delta Dental for the Schedule of Allowed Amounts for each covered service or the annual or lifetime amount
- treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accident
- services or supplies that the Plan determines are experimental or investigative in nature
- services or treatments that the Plan determines do not have a reasonably favorable prognosis
- any treatment performed principally for cosmetic reasons including, but not limited to, laminate, veneers and tooth bleaching
- special techniques, including precision dentures, overdenture, characterization or personalization of crowns, dentures, fillings or any other service. This includes, but is not limited to, precision attachments

and stress-breakers. Full or partial dentures that require special techniques and time due to special problems, such as loss of supporting bone structure, are also excluded.

- any procedures, appliances or restorations that alter the “bite”, or the way the teeth meet (also referred to as occlusion and vertical dimension) and/or restore or maintain the bite, except as provided under orthodontic benefits. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition, and restoration for misalignment of teeth.
- any procedures involving full-mouth reconstruction, or any services related to dental implants, including any surgical implant with a prosthetic device attached to it
- diagnosis and/or treatment of jaw joint problems, including temporomandibular joint disorder (“TMJ”) syndrome, craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull or the complex of muscles, nerves, and other tissue related to that joint
- double or multiple abutments
- treatment for self-inflicted injury or illness
- treatment to correct harmful habits including, but not limited to, smoking and myofunctional therapy
- habit-breaking appliances, except under the orthodontics benefit
- services for plaque-control programs, oral hygiene instruction, and dietary counseling
- services related to the replacement or repair of appliances or devices, including:
 - duplicate dentures, appliances or devices
 - the replacement of lost, missing or stolen dentures and appliances less than five years from the date of insertion or the payment date
 - replacement of existing dentures, bridges or appliances that can be made usable according to dental standards
 - adjustments to a prosthetic device within the first six months of its placement that were not included in the device’s original price
 - replacement or repair of orthodontic appliances
- drugs or medications used or dispensed in the dentist’s office (any prescriptions that are required may be covered by the Plan’s prescription drug benefits – see your EOC)
- charges for novocaine, xylocaine or any similar local anesthetic when the charge is made separately from a covered dental expense

- additional fees charged by a dentist for hospital treatment
- services for which a participant has contractual rights to recover cost, whether a claim is asserted or not, under Workers’ Compensation, or automobile, medical, personal injury protection, homeowners or other no-fault insurance
- treatment of conditions caused by war or any act of war, whether declared or undeclared, or a condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries
- any portion of the charges for which benefits are payable under any other part of the Plan
- if a participant transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for the same procedure, the Plan will not pay benefits greater than what it would have paid if the service had been rendered by one dentist
- transportation to or from treatment
- expenses incurred for broken appointments
- fees for completing reports or for providing records
- any procedures not listed under the Schedule of Covered Dental Services

Coordination of Dental Benefits Processing Policies/Rules

- When Delta Dental coverage is primary, Delta pays benefits under this Plan as if there is no other coverage.
- When Delta Dental is secondary, and there are remaining expenses of the type allowable under this Plan, Delta Dental will pay only the amount by which the benefits under this Plan exceed the amount of benefits payable under the other program.

The following rules will be followed to establish the order of determining the liability of this Plan or any other programs:

1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent.
2. The program covering the enrollee as a dependent of an employee whose birthday falls earlier in the calendar year will determine its benefits before the program covering the enrollee as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the

same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period. If the other program does not have the rule described in this paragraph, but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.

3. The program covering the enrollee having custody of the dependent will determine its benefits first; then the program of the spouse of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.

4. The program covering the enrollee as an employee or as a dependent of an employee will determine its benefits before one that covers the enrollee as a laid-off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.

5. If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is “excess” or always “secondary”, Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.

6. In situations not described in items 1 through 5, the program under which the enrollee has been enrolled for the longest period of time will determine its benefits first. When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program.

Vision Care Benefits

Your vision benefit is administered by Davis Vision, which maintains a national **network** of vision providers. If you need an eye exam, corrective lenses (including contact lenses) or frames, you can go to a **participating provider** or a non-participating provider. By using a **participating provider**, you can get an exam and glasses with no out-of-pocket cost, but your choice of frames will be limited. If you want frames and/or lenses that cost more than the Plan’s limit, you will pay the difference.

If you use a non-participating provider, you can get up to \$30 for eye exams, \$60 for lenses and \$60 for frames. You will be responsible for paying the charges in full and will be reimbursed up to the **allowed amounts**.

There is no **out-of-network** benefit for participants or dependents under age 19.

If you get contact lenses instead of frames and lenses, from either a participating or non-participating provider, the maximum reimbursement for the contact lenses is \$120. If you use a **participating provider**, your eye exam is free. If you use a non-participating provider, you can get up to \$30 for your eye exam. You will be responsible for paying any charges in excess of the maximum reimbursement.

These maximum benefits are payable within any 24-month period,* starting with the date you first incur a vision care expense (typically an eye exam). For example, if you get an eye exam on September 1, 2015, you have up to September 1, 2016 (assuming you remain eligible for Fund benefits) to receive the benefits cited above for the lenses and frames or contacts. Any unused vision care benefits cannot be carried over and used in a subsequent 24-month period.

You can access your vision Plan benefits by:

- Showing your Davis Vision card to a Davis Vision provider, or
- Visiting a non-participating provider and later submitting a vision Plan claim form to Davis Vision for reimbursement.

To find a **participating provider**, call Member Services at 1-800-999-5431.

*Participants and dependents under 19 are eligible for an eye exam once every 12 months.

Eligible Expenses

The Plan covers the following vision care expenses:

- eye examinations performed by a legally qualified and licensed ophthalmologist or optometrist, and
- prescribed corrective lenses you receive from a legally qualified and licensed optician, ophthalmologist or optometrist.

Excluded Expenses

The Plan's vision care coverage will not reimburse or make payments for expenses incurred for, caused by, or resulting from:

- ophthalmic treatment or services payable under the provisions of any other benefit of the Plan (ophthalmic treatment may be covered under hospital/medical benefits—refer to the EOC),
- non-prescription eyeglasses,
- adornment expenses, and
- **out-of-network** benefits for participants and dependents under age 19.

Life Insurance Benefits

Benefit Amount

Your life insurance coverage, which is administered by MetLife, is \$25,000. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

Naming a Beneficiary

Your beneficiary will be the person or persons you name in writing on a form that is kept on file at MetLife. Your beneficiary can be anyone you choose, and you can change your beneficiary designation at any time by completing and submitting a new form to MetLife. You can also go to www.32bjfunds.org, selecting the 32BJ Health Fund tab and clicking forms.

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

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

The Plan does not pay life insurance benefits to a designated beneficiary who is involved in any way in the purposeful death of the participant. In a case where this rule applies, if there is no named beneficiary who can receive the benefits, they will be paid in the order listed above.

Life Insurance Disability Extension

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

If you die before you submit proof of your disability, your beneficiary must submit proof of death and total disability *within 90 days* after your death.

Notice of approval or denial of benefits will be sent to your designated beneficiary in writing. (See pages 40–42 and pages 45–46 for information on appealing a denied claim.)

When Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, except as provided on the previous page or if you have Fund-paid Health Extension due to disability or arbitration. (See pages 10–12.) See page 57 for information about converting your group life insurance to an individual life insurance policy.

Accidental Death and Dismemberment (AD&D) Benefits

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

How AD&D Benefits Work

If you lose your life in an accident, or both hands at or above the wrist, or both feet at or above the ankle, or sight in both eyes, or any combination of hand, foot, and sight in one eye, the AD&D benefit payable to your beneficiary is \$10,000. If you lose one hand at or above the wrist, or one foot at or above the ankle, or sight in one eye, the AD&D benefit payable is \$5,000.

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

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

Contact MetLife to claim AD&D benefits.

What Is Not Covered

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

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity,
- infection, other than occurring in an external accidental wound,

- suicide or attempted suicide,
- intentionally self-inflicted injury,
- service in the armed forces of any country or international authority, except the United States National Guard,
- any incident related to travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; parachuting or other descent from an aircraft, except for self-preservation; travel in an aircraft or device used: for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the Earth’s atmosphere,
- committing or attempting to commit a felony,
- the voluntary intake or use by any means of any drug, medication or sedative, unless it is taken or used as prescribed by a physician, or an “over the counter” drug, medication or sedative taken as directed; alcohol in combination with any drug, medication, or sedative; or poison, gas, or fumes,
- war, whether declared or undeclared; or act of war, insurrection, rebellion or riot, or
- the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person’s blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Coverage Ends

AD&D insurance coverage ends 30 days after you terminate employment. Like your life insurance, your AD&D coverage can continue while you have Fund-paid Health Extension due to disability or arbitration (See pages 10–12.)

Short-Term Disability

Participants working in the Washington, DC Metropolitan area under collective bargaining agreements that require a contribution rate that covers short-term disability (“STD”) benefits are covered by the Fund for STD benefits as described in this section. Please call Member Services at 1-800-551-3225 or 1-212-388-3500 to determine your eligibility.

This plan provides a weekly income to you if you become totally disabled while working in **covered employment**. This means that you are unable to perform the duties of your regular job because of a covered accident or sickness and are under the care of a legally recognized treatment provider.

To be eligible for STD benefits, you must meet the following criteria:

- You must be considered disabled as defined by the STD plan,
- You are under the direct regular care of a non-related legally recognized treatment provider, and
- Your disability is not the result of a job related or on the job injury or illness.

STD Benefit Amount. The STD benefit payable from the Plan is as follows:

- 50% of your current weekly earnings up to a maximum of \$170/week.

When Benefits Begin. Benefits commence on the first day of disability due to an accident and the eighth day of disability following an illness. You may be eligible for up to 13 weeks of disability income benefits for your disability.

When Benefits End. Benefits end when any of the following events occur:

- You are no longer disabled,
- You are able to perform the major duties of your own job with reasonable accommodation, regardless of whether you return to your job,
- You return to gainful employment,
- You fail to provide proof of loss as required by the benefit administrator,
- You no longer receive regular and appropriate care for the condition you are claiming disability, or
- You have received the maximum number of weeks of STD.

Benefit Limitations and Exclusions. The following limitations and exclusions apply to this benefit:

- Your disability will not begin until you have visited a legally recognized treatment provider for the illness or injury that caused the disability.
- Each length of the disability is subject to certain disability duration standards based upon the diagnosis and may require additional medical documentation or examination as required by the benefit administrator.
- Two periods of disability due to the same or a related illness will be treated as a recurring disability if said disability recurs within 30 days after you were last entitled to benefits, provided all plan provisions are met.
- Benefits will only be paid during periods when loss of wages occurs.
- Gross weekly benefits may be reduced if you are receiving retirement benefits under the United States Social Security Act, as well as other sources of income listed in the STD plan.

Receiving STD Benefits. Your STD benefits are administered by the Guardian Life Insurance Company of America. Contact Guardian TeleGuard at 1-888-262-5670, Monday through Friday 8:00 am – 5:00 pm to apply for STD benefits.

Please note that this section serves only as an overview of the short-term disability benefit program and not a guarantee of payment or coverage. All claim determinations will require a full review by the plan administrator and will be subject to the terms and conditions set forth in the actual plan of insurance.

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 claim procedures. Please note that inquiries about the Plan’s

provisions or eligibility that are unrelated to any specific benefit claim are not considered claims for benefits.

Filing Hospital, Medical, Mental Health and Substance Abuse, or Prescription Drug Claims

There are no claims for hospital, medical, mental health and substance abuse, and prescription drug benefits provided by the Kaiser Permanente SignatureSM Plan.

Filing Dental Claims

When you see a participating dental provider, this provider will file all claims for you directly with Delta Dental. Delta Dental pays such providers directly as long as you authorize direct reimbursement.

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

You can obtain a Delta Dental claim form at www.deltadentalins.com. Here is what you need to know when you file a dental claim when you do not use a participating dental provider.

- Only an original, fully completed American Dental Association (“ADA”) claim form or approved treatment plan will be accepted for review.
- All necessary diagnostic information must accompany the claim.
- When you are the patient, your original signature or signature on file is acceptable on all claims for payment. If the patient is a child, an original signature or signature on file of the child's parent or guardian is acceptable.
- **All claims must be received by Delta Dental within 180 days after services were rendered.**
- You, or your dentist, can return the approved treatment plan (if it was secured before your treatment began) with the submission of your claim.
- If you, or your dentist, received an approved treatment plan or prior authorization prior to beginning your treatment, this approved treatment plan or prior authorization is only valid for one year from the date it was

issued. In addition, an approved treatment plan cannot be changed or used by any person other than the person to whom it was issued. Delta Dental reserves the right to withhold payment or request reimbursement from providers or participants for services that do not meet acceptable standards, as determined by its consultants or professional staff.

- The Fund does not accept assignment of payment to an **out-of-network** dentist. This means if you use an **out-of-network** dentist, the Fund will no longer make payment directly to that dentist. You will have to pay the dentist first, and you will be reimbursed according to the Plan's coverage limits.

Filing Vision Claims

If you use participating vision providers, you do not have to file claims. The providers will do it for you. If you do not use a participating vision provider, then you must file a vision claim with the Fund for reimbursement of eligible expenses. You can obtain a vision claim form from Member Services. **Vision claims should be filed as soon as possible, but never later than 180 days after the date of service.**

Filing Life Insurance and AD&D Claims

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

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

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

Where to Send Claim Forms

Benefit	Filing Address
Hospital, Medical, Mental Health and Substance Abuse and Prescription Drug (out-of-network only; no claim forms are necessary for in-network care)	Kaiser Permanente
Dental (non-participating providers only; no claim forms are necessary for participating providers)	Delta Dental of New York Attn: Claims Department P.O. Box 2105 Mechanicsburg, PA 17055
Vision (non-participating providers only; no claim forms are necessary for participating providers)	Davis Vision Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110
Life Insurance Accidental Death & Dismemberment	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100
Short-Term Disability*	Guardian TeleGuard at 1-888-262-5670

* All claims for short-term disability benefits must be filed by phone.

Approval and Denial of Claims

There are separate claims denial and approval processes for Dental and Vision, Life/AD&D and Short-term Disability 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.

Dental and Vision Claims

The time frames for deciding whether dental and vision 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 care is obtained. Prior approval of services is required for certain dental benefits. For properly filed pre-service claims, you, and/or your dentist, will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the claims reviewer. You

will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

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

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

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

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

- *Urgent dental care claims.* This is a claim for dental 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 dentist, result in your having unmanageable, severe pain.

Whether your dental 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 dentist with knowledge of your condition determines is an urgent care claim shall automatically be treated as such.

If you (or your authorized representative*) file an urgent dental care claim,

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

you will be notified of the benefit determination as soon as possible, taking into account emergencies, but no later than 72 hours after receipt of your claim.

However, if you do not give enough information for the dental 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 dental 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. 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 appealing denied claims.

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

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

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making

a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for *45 days* or until the date the claims reviewer receives your response to the request (whichever is earlier). Within *15 days* after the expiration of this time period, you will be notified of the decision.

Appealing Denied Claims

An appeal is a request by you, or your authorized representative, to have an adverse benefit determination reviewed and reconsidered. There are different appeals processes for medical, hospital, mental health or substance abuse, prescription drug, dental or vision benefits, life insurance, and AD&D and short-term disability claims.

Filing an Appeal of Denied Medical, Hospital, Mental Health and Substance Abuse, or Prescription Drug Claims

You must follow the procedures described in the Kaiser Permanente SignatureSM Plan EOC.

Filing an Appeal of Denied Dental, Vision, Life/AD&D and STD Claims

An appeal is a request by you, or your authorized representative, to have an adverse benefit determination reviewed and reconsidered. There are different appeals processes for dental and vision, life/AD&D and short-term disability claims. The table below gives a brief overview of with whom an appeal should be filed and the levels of appeal available for each type of denied claim:

Type of Denied Claim	Level-one Appeal	Level-two Appeal
Dental	Delta Dental	Board of Trustees*
Vision	Davis Vision	Board of Trustees*
Life/AD&D	MetLife	Board of Trustees*
Short-term Disability	Guardian	Board of Trustees*

*This level of appeal is voluntary.

Filing an Appeal

For all types of claims, you have *180 days* from the date of the original claim denial notification letter to file a level-one 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 an appeal, you will be provided, free of charge, access to, or copies of, all documents, records or other information relevant to your appeal (including, in the case of an appeal involving a disability determination, the identity of any medical or vocational experts whose advice the claims reviewer used in connection with the decision to deny your application).

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

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

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

If you do not request a review of a denied claim within 180 days, you will waive your right to a review of the denial. 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 a Level-One Appeal

Benefit	Write to:	Or Call
Dental	Delta Dental of New York Attn: Consultant Review or Appeals P.O. Box 2105 Mechanicsburg, PA 17055	Appeals are only accepted in writing*
Vision	Davis Vision P.O. Box 791 Latham, NY 12110	Appeals are only accepted in writing
Life/AD&D	MetLife Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 Fax: 1-570-558-8645	Appeals are only accepted in writing

Benefit	Write to:	Or Call
Short-term Disability	The Guardian Life Insurance Company of America Attn: Appeals Committee P.O. Box 14331 Lexington, KY 40512 Fax: 1-610-807-8270	Appeals are only accepted in writing

* An appeal of an urgent care dental claim may be filed orally by calling 1-516-394-9485.

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 dental care, you can file an expedited appeal if your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This appeal can be filed in writing or orally. You can discuss the reviewer’s determination and exchange any necessary information over the phone, via fax or any other quick way of sharing. You will receive a response *within 72 hours* of your request.

Pre-Service or Concurrent Dental or Vision 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 decided as soon as possible, but in any event prior to the cessation or reduction of the benefit.

Post-Service Dental or Vision Claim Appeal

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

Decision on Appeal

Under ERISA, if your claim is denied, in whole or in part, you, or your authorized representative, may request the adverse determination be reviewed and reconsidered by filing a written appeal with MetLife. Your appeal must be made within one hundred eighty (180) days of the date the claim is denied and be mailed to:

MetLife
P.O. Box 6100
Scranton, PA 18505

If you fail to appeal within one hundred eighty (180) days, you will waive your right to a review of the denial.

Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate to enable MetLife to give your appeal proper consideration. Upon your written request, MetLife will provide you with a copy of the records and/or reports that are relevant to your claim.

MetLife will carefully evaluate all the information and advise the claimant of its decision within sixty (60) days after the receipt of the appeal. If there are special circumstances requiring additional time to complete the review, we may take up to an additional sixty (60) days, but only after notifying the claimant of the special circumstances in writing.

STD Claim Appeal

If your claim is denied, Guardian will supply you with a written explanation of their decision, along with instructions on how to appeal their determination. You have up to 180 days to file an appeal of that decision. If you file an appeal of a denied claim for STD benefits, Guardian will make a decision on the appeal and notify you within 45 days of receipt of the appeal. If Guardian requires an extension of time due to matters beyond its control, Guardian is permitted an additional 45 days. Guardian will notify you prior to the expiration of the original 45 day period to advise if an extension is needed. A decision will be made by the end of the 90-day period and you will be notified in writing by Guardian.

Voluntary Second Level Appeal of a Dental, Vision, Life Insurance, AD&D or STD Claim

Once you receive notice of the denial of your timely dental, vision, life insurance, AD&D or STD appeal,⁽³⁾ you have exhausted all required internal appeal options.

If you disagree with the decision, you are free to file a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (“ERISA”). You may not start a lawsuit to obtain benefits until you have completed the mandatory appeals process and a final decision has been reached, or until the appropriate time frame described in the SPD has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **In addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied.** Alternately, you may file a voluntary appeal with the Appeals Committee of the Board of Trustees. This voluntary appeal must be filed *within 180 days* of the date of the appeal denial letter provided to you by MetLife.

The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan, as described previously. This level of appeal is *completely voluntary*; it is not required by the Plan and is only available if you (or your representative) request it. The Plan will not assert a failure to exhaust administrative remedies where you (or your authorized representative) elect to pursue a claim in court rather than through the voluntary level of appeal. The Plan will not impose fees or costs on you (or your representative) because you (or your authorized representative) choose to invoke the voluntary appeals process. Your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan. Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including your right to representation. Your voluntary appeal must include your identification number, dates of service in question and any additional information that supports your appeal. You (or

⁽³⁾ The Appeals Committee does not hear voluntary appeals for claims for which the mandatory appeals were not timely filed with the appropriate appeals reviewer. If your appeal was denied as untimely by the appeals reviewer, there is no voluntary appeal to the Board of Trustees’ Appeals Committee.

your authorized representative) can write to the Appeals Committee at the following address:

**Building Service 32BJ Health Fund
Board of Trustees – Appeals Committee
25 West 18th Street
New York, NY 10011-4676**

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, which is three years under the terms of the Plan, will be tolled (suspended) during the period of the voluntary appeals process.

You will be notified in writing within five days from the date your appeal is reviewed by the Appeals Committee of the decision of your appeal.

Further Action

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

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

If you have any questions about the appeals process, please contact the Building Service 32BJ Benefit Funds Compliance Office. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

Incompetence

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

Mailing Address

It is important that you notify Member Services at the Building Service 32BJ Benefit Funds 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.

Your Disclosures to the Fund: Fraud

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, or if you perform an act or practice constituting fraud, or make an intentional misrepresentation of material fact, you may be required to indemnify and repay the Fund for any losses or damages caused by your false statements, fraud or misrepresentation. In addition, if a claim has been submitted for payment or paid by the Fund as a result of false statements, fraud or misrepresentation, the Fund may seek reimbursement, may elect to pursue the matter by pressing criminal charges and may take any other action deemed reasonable. Knowingly claiming benefits for someone who is not eligible is considered fraud and could subject you to criminal prosecution.

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** or co-insurance is entering into a discount arrangement with you unless that provider has a preapproved written agreement with the Fund for that kind of waiver or refund. If you are not sure that your provider has such a preapproved written agreement, you may call Member Services at 1-800-551-3225 for assistance.

The Fund calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers, or refunds of **co-payments**, co-insurance or deductibles, where applicable to member's plan.

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
- certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status in support of a contingency operation.

In addition, FMLA allows up to 26 weeks of leave in a single 12-month period to care for a covered service member recovering from a serious injury or illness. Eligible employees are entitled to a combined total of up to 26 weeks of all types of FMLA leave during the single 12-month period.

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 dependent(s), the same as to active employees and their dependent(s).

Call Member Services regarding coverage during FMLA leave.

During Military Leave

If you are on active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you, and your dependent(s), 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 10–12 and pages 50–55 for information on COBRA.) In addition, your dependent(s) may be eligible for health care under **TRICARE**. This Plan will coordinate coverage with **TRICARE**. Please refer to the Kaiser Permanente SignatureSM Plan EOC.

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

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

Under COBRA

Under a Federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. “Health coverage” includes the Fund’s hospital, medical, mental health and substance abuse, prescription drug, dental and vision coverage.

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

If you are disabled and receiving benefits under short-term disability or Workers’ Compensation, the Plan provides coverage for up to six months as long as you remain disabled, are unable to work and you apply for coverage. If you are terminated by your employer and your termination is going to arbitration seeking reinstatement, the Plan provides coverage for up to six months. In these two cases of extended health coverage, you do not have to pay the premium since it is paid by the Fund. Keep in mind that the maximum period that you have COBRA coverage is reduced by any period of time you received Fund-paid Health Extension. (See pages 10–11 for additional information on Fund-paid Health Extension.

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

COBRA Continuation of Coverage

Coverage May Continue For:	If:	Maximum Duration of Coverage:
You and your eligible dependent(s)	Your covered employment terminates for reasons other than gross misconduct	18 months
You and your eligible dependent(s)	You become ineligible for coverage due to a reduction in your employment hours (e.g., leave of absence)	18 months
You and your eligible dependent(s)	You go on military leave	24 months
Your dependent(s)	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 dependent(s)	36 months
Your dependent(s)	You terminate your employment or you reduce your work hours less than 18 months after the date of your Medicare (Part A, Part 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). Once COBRA is elected, you cannot transfer between family and single coverage, unless you experience a qualified change in family status.

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

Multiple Qualifying Events. If your dependent(s) 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 dependent(s), 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, get legally 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 if notice of disability is provided to the Fund within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months coverage will increase to 150% of the full cost of coverage.

To make sure you get all of the COBRA coverage you are entitled to, contact Member Services whenever something happens that makes you or your dependent(s) 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(s), are responsible for notifying Member Services of your legal separation or divorce, a child losing dependent status under the Plan or if you become disabled (or you are no longer disabled), as determined by the Social

Security Administration. You (or your family member) must notify Member Services in writing of any of these events no later than 60 days after the event occurs or 60 days after the date coverage would have been lost under the Plan because of that event, whichever is later. Your notice must include the following information:

- name(s) of the individual(s) interested in COBRA continuation, and the relationship to the participant,
- date of the Qualifying Event, and
- type of Qualifying Event. (See the table of Qualifying Events on page 51.)

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 of the date of the Qualifying Event. Once notified, the Fund will send you a COBRA notice within 14 days.

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

Each of your eligible dependent(s) has an independent election right for COBRA coverage. This means that each dependent can decide whether or not to continue coverage under COBRA. If you elect family coverage, you, or your dependent(s), will only be able to convert to single coverage if either you, or your dependent(s), die, you and your spouse divorce or you, or your dependent(s), enroll in Medicare and the Fund terminates your COBRA coverage. If you elect single coverage, you will only be able to convert to family coverage if you marry, have a child or adopt a child.

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

Paying for COBRA coverage. If you, or your dependent(s), 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. If payment is not received on the first of the month, coverage will be terminated. However, if your payment is made within 30 days of the due date, coverage will be reinstated retroactive to the due date. Costs may change from year-to-year. Contact Member Services for more information about the cost of your COBRA coverage.

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

What COBRA coverage provides. COBRA generally offers the same health coverage that is made available to similarly situated employees or family members; however, Life/AD&D is not available, except as provided under Fund-paid Health Extension for up to six months. 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 51. 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, Part B or both) after the date of the COBRA election, or becomes covered under another group plan that does not have a pre-existing conditions clause that affects the COBRA recipient's coverage.
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the COBRA recipient is no longer disabled. The COBRA recipient must notify Member Services within 30 days of any such final determination.

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

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

Other Health Plan Information You Should Know

Assignment of Plan Benefits

To the extent permitted by law, your rights under this plan may not be voluntarily or involuntarily assigned, transferred or alienated. You cannot pledge the benefits owed to you for the purpose of obtaining a loan.

Rights under the Plan that cannot be assigned include your right to the services provided, the right to collect from the Plan for those services, the right to receive Plan documents and disclosures, the right to appeal benefits or claims determinations or the right to sue to enforce any such rights. However, the Plan reserves the right to pay all benefits due you to your health services provider and such payment shall extinguish any and all rights you may have under the Plan with respect to the services to which such payment relates.

Although as described above, you may not assign to a provider your right to file an appeal under the Plan's Appeals Procedures or to file a suit for benefits under Section 502(a) of ERISA, you may allow a provider to act as your authorized representative in an appeal under the Plan's Appeals Procedures.

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

A QMCSO usually results from a divorce or legal separation. Whenever Member Services gets a QMCSO, its qualified status is carefully reviewed by the Fund in accordance with QMCSO procedures adopted by the Board and Federal law. For more information on QMCSOs, or to obtain a copy of the Plan's QMCSO procedures free of charge, contact the Fund's Compliance Office at the address on page 66.

No Liability for Practice of Medicine

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

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

Privacy of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a Federal law that imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Fund maintains about you, and knowing how your health information may be used. A complete description of how the Fund uses your health information and your other rights under HIPAA's privacy rules is available in the Fund's "Notice of Privacy Practices", which is distributed to all named participants. Anyone may request an additional copy of this Notice by contacting the Compliance Office at the address on page 66.

The Fund's Board of Trustees adopted certain HIPAA privacy and security language that requires the Board of Trustees, in its role as Plan Sponsor of the Fund, to keep your health information private and secure. Any questions you may have about HIPAA may be directed to the Compliance Office at the address on page 66.

Converting to Individual Coverage

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

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

You may convert your group coverage only to a Whole Life, Universal Life or One-Year Non-Renewable Term policy. The amount converted to an individual policy cannot be more than the amount you had under the group policy.

Your individual policy will become effective 61 days after the termination of your coverage. Group life insurance protection continues in force; however, during the applicable period cited above, whether or not you exercise the conversion option. Contact MetLife for more information about converting life insurance.

AD&D Benefits. You cannot convert AD&D benefits to individual coverage.

Hospital, Medical, Mental Health and Substance Abuse, and Prescription Drug. If your eligibility terminates for any reason, you may be eligible to convert your Kaiser Permanente SignatureSM Plan coverage to individual coverage. Please refer to the EOC for information on whether you are eligible to convert to individual coverage and how to apply.

General Information

Employer Contributions

The Plan receives contributions in accordance with collective bargaining agreements between the Realty Advisory Board on Labor Relations, Inc., or various independent employers and your union. These collective bargaining agreements provide that employers contribute to the Fund on behalf of each covered employee. Employers that are parties to such collective bargaining agreements may also participate in the Fund on behalf of non-collectively bargained employees, if approved by the Trustees, by signing a participation agreement. Certain other employers (such as Local 32BJ itself and the 32BJ Benefit Funds) participate in the Fund on behalf of their employees by signing a participation agreement.

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

How Benefits May Be Reduced, Delayed or Lost

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

- file a claim for benefits properly or on time,
- furnish the information required to complete or verify a claim,

- have a current address on file with Member Services, and
- cash checks within 18 months of the date issued. The amounts of such uncashed checks will be restored to the Fund's assets and added to net assets available for benefits on the Fund's financial statements. You should also be aware that Plan benefits are not payable for enrolled dependent(s) who become ineligible due to age, marriage, divorce or legal separation (unless they elect and pay for COBRA benefits, as described on pages 10–12 and pages 50–55).

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.

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 dependent(s) 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 dependent(s), beneficiaries and any other individuals claiming benefits under the Plan.

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

**Board of Trustees
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676**

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

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

- Examine, without charge, at the Compliance Office, all documents governing the Plan, including insurance contracts, collective bargaining agreements, participation agreements and the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (“EBSA”).
- Obtain, upon written request to the Compliance Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, participation agreements, the latest annual report (Form 5500 series) and an updated SPD. The Fund may make a reasonable charge for the 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 dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You, or your dependent(s), may have to pay for such coverage. Review this booklet (see pages 10–12 and pages 50–55 for information about COBRA) and the documents governing the Plan on the rules governing your COBRA continuation rights.

Prudent Action by Plan Fiduciaries

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.

Enforce Your Rights

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 35–46. 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.

Assistance with Your Questions

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> or call their toll-free number at 1-866-444-3272.

Plan Facts

This SPD is the formal plan document for the Kaiser Suburban Plan of the Health Fund.

**Plan Name: Building Service 32BJ Health Fund
Employer Identification Number: 13-2928869
Plan Number: 501
Plan Year: July 1–June 30
Type of Plan: Welfare Plan**

Funding of Benefits and Type of Administration

Kaiser insures the hospital, medical, mental health and substance abuse, and prescription drug benefits. MetLife insures the Life and AD&D benefits. The dental (through Delta Dental) and vision (through Davis Vision) benefits are self-funded. 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 38.

Plan Sponsor and Administrator

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

**Board of Trustees
Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676**

Participating Employers

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

To contact the Compliance Office, write to:

**Compliance Office
Building Service 32BJ Benefit Funds
25 West 18th Street
New York, NY 10011-4676**

To contact the Health Fund, call:

1-800-551-3225

or write to:

**Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676**

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Agent for Service of Legal Process

The Board has been designated as the agent for the service of legal process. Legal process may be served at the Compliance Office or on the individual Trustees. For disputes arising under the portion of the Plan insured by MetLife, service of legal process may be made upon MetLife at their local offices or upon the supervisory official of the Insurance Department of the state in which you reside. For the portion of the Plan insured by Kaiser, service of legal process may be made upon Kaiser at their local offices or upon the supervisory official of the Insurance Department of the state in which you reside.

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Contact Information

What do you need?	Who to contact	How
<ul style="list-style-type: none"> General information about your Plan and your eligibility 	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday
<ul style="list-style-type: none"> Information about your hospital, medical, mental health and substance abuse, and prescription drug 	Kaiser	Inside the Washington, D.C. Metropolitan Area 1-301-468-6000 TTY 1-301-816-6344 Outside the Washington, D.C. Metropolitan Area 1-800-777-7902
<ul style="list-style-type: none"> Information about your life insurance or accidental death and dismemberment plan 	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com
<ul style="list-style-type: none"> To find a participating dental plan provider 	Delta Dental	Delta Dental Customer Service Call 1-800-932-0783 or Visit www.deltadentalins.com
<ul style="list-style-type: none"> To find a participating vision plan provider 	Davis Vision	Call 1-800-999-5431 8:00 am–11:00 pm Monday–Friday Saturday, 9:00 am–4:00 pm Sunday, 12:00 pm–4:00 pm or Visit www.davisvision.com/32bj

**Building Service 32BJ Health Fund
Kaiser Permanente Suburban Plan
25 West 18th Street
New York, New York 10011-4676
Telephone 1-800-551-3225
www.32bjfunds.org**



Building Service 32BJ Health Fund
25 West 18th Street
New York, NY 10011-4676

www.32bjfunds.org
800-551-3225 Benefits Information

Héctor J. Figueroa, *Chairman*
Howard I. Rothschild, *Secretary*
Peter Goldberger, *Executive Director*
Sara Rothstein, *Fund Director*

Summary of Material Modifications Building Service 32BJ Health Fund Kaiser Permanente Suburban Plan

The following is a list of changes and clarifications which have occurred since the printing of the Building Service 32BJ Health Fund Summary Plan Description (SPD) for the Kaiser Permanente Suburban Plan (Plan) dated May 1, 2015. This Summary of Material Modifications (SMM) supplements or modifies the information presented in your SPD. **Please keep this document with your copy of the SPD for future reference.**

Change in Executive Director, Building Service 32BJ Benefit Funds Page 1: Effective January 1, 2018, Peter Goldberger has replaced Susan Cowell as Executive Director of the Building Service 32BJ Benefit Funds.

Change in Director, Building Service 32BJ Health Fund Page 1: Effective May 19, 2018, Sara Rothstein has replaced Angelo V. Dascoli as Director of the Building Service 32BJ Health Fund.

Change in Fund Auditor Name Page 1: Effective August 31, 2017, Bond Beebe has joined Withum Smith + Brown, PC, and has changed its name to Withum Smith + Brown, PC.

Page 8, Question and Answer number 6 is deleted in its entirety and replaced with the following:

6. What happens to my health coverage if I become disabled?

If you are eligible, the Fund will pay for up to 30 months continued health coverage (Fund-paid Health Extension). To be eligible, you must:

- Have become disabled while working in **covered employment**
- Be unable to work
- Be receiving one of the following benefits:
 - Short-Term Disability (“STD”)
 - Workers’ Compensation

If you are eligible and are receiving STD, the Fund will pay for up to 13 weeks of continued health coverage. Once STD benefits end, up to an additional 13 weeks of continued health coverage may be paid for by the Fund if your **doctor** certifies that you continue to be disabled. If you are eligible and are receiving Workers’ Compensation, the Fund will pay for up to 30 months of continued health coverage.

Clarification on Cancellation of Coverage When Eligible for Medicare Page 9: the following new bullet is added after the second bullet in the list under the section “When You Are No Longer Eligible”:

- on the date you cancel your coverage with the Fund because you are eligible for Medicare,

Clarification of rules when Cancelling Coverage due to Medicare Eligibility Page 9: The following new section “Cancellation of Coverage due to Medicare Eligibility” is added immediately following the section “When You Are No Longer Eligible”:

If you (or your dependent(s)) 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 cancel your coverage under this Plan, you cannot elect back into this Plan. Additionally, if you cancel your coverage under this Plan, the Plan will not be allowed to offer you any benefits that would supplement Medicare’s benefits. When you cancel coverage under this Plan, all

benefit coverage is cancelled including medical, hospital, mental/behavioral health and substance abuse, prescription drug, dental, vision, Life Insurance & Accidental Death and Dismemberment, and Short-Term Disability.

Page 11, Under the section titled “Disability”, the parenthetical “(or are approved to receive)” in the first paragraph is deleted.

In addition, the following new paragraph is added after second bullet:

If you are eligible and are receiving STD, the Fund will pay for up to 13 weeks of continued health coverage. Once STD benefits end, up to an additional 13 weeks of continued health coverage may be paid for by the Fund if your **doctor** certifies that you continue to be disabled. If you are eligible and are receiving Workers’ Compensation, the Fund will pay for up to 30 months of continued health coverage.

And the 7th bullet is deleted and replaced with the following:

- your Workers’ Compensation, or Short-Term Disability, or 13 week extension of health coverage after STD ends,

Change in Guardian TeleGuard Telephone Hours **Page 35:** Under the subheading “Receiving STD Benefits”, the hours of operation for contacting Guardian TeleGuard are changed from Monday through Friday 8:00am—5:00pm to Monday through Friday 8:00am—8:00pm.

Addition of Section “No Duplication of Health Coverage”: **Page 47:** The following section is inserted after the section titled *Incompetence* and before the section titled *Mailing Address*:

No Duplication of Health Coverage

Even if more than one employer makes contributions on your behalf at the same time to this **Fund**, you will receive only one Plan of benefits. The Plan of benefits that you will receive is the Plan that is determined by the **Fund** to be the Plan that, in totality, offers you the greatest benefits.

Clarification of Payment Responsibility when Medicare is Primary and Health Fund is Secondary **Page 53:** the following paragraph is inserted immediately before the last paragraph:

If you are age 65 or older when you incur a Qualifying Event that requires an offer of COBRA coverage to you and your dependents, Medicare will be primary and this Plan will be secondary for you and any of your dependents who are age 65 or older. If you do not enroll in both Medicare Part A and Part B coverage, even though this Plan pays as secondary, you will be financially responsible for what Medicare would have paid, had you properly enrolled.

Clarifications to Certain Dental Benefit Provisions

Page 19: Under the section “Non-participating Dentists” the second sentence of the first paragraph is deleted and replaced with the following:

Your non-participating dentist can obtain Delta Dental’s reimbursement allowance by submitting a Pre-Determination request directly to Delta Dental before you begin any dental work.

Page 20: Under the section “What Dental Services Are Covered” the first sentence in the fourth bullet is deleted and replaced with the following:

- Orthodontic services for children under 19, such as diagnostic procedures and appliances to realign teeth. There is a separate lifetime maximum on orthodontic services of up to \$1,000 per patient.

Also, under the section “Annual Maximum” the following sentence is added:

There is a separate lifetime maximum of up to \$1,000 for orthodontic services for children under 19 years of age.

Pages 21-25: The Schedule of Covered Dental Services is deleted in its entirety and replaced with the following:

Schedule of Covered Dental Services

Procedure	Limits
<p>Diagnostic</p> <p>Oral exam, periodic, limited (problem-focused), comprehensive or detailed and extensive (problem-focused)</p> <p>X-rays:</p> <ul style="list-style-type: none"> • full mouth, complete series, including bitewings or panoramic film • bitewings, back teeth • periapicals, single tooth • occlusal film • cephalometric film (orthodontic coverage only) 	<p>Two in a calendar year</p> <p>Once in any 36 consecutive months period</p> <p>Two of any bitewing x-ray procedure in a calendar year</p> <p>As necessary</p> <p>Two per date of service</p> <p>Once in a lifetime</p>
<p>Preventive</p> <p>Dental prophylaxis (cleaning, scaling and polishing)</p> <p>Topical fluoride treatment</p> <p>Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)</p> <p>Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)</p>	<p>Two in a calendar year</p> <p>Two in any calendar year for patients under age 16</p> <p>Once per tooth in any 24 consecutive months period for patients under age 16</p> <p>Once in a lifetime per tooth for patients under age 16</p>
<p>Simple Restorative</p> <p>Amalgam (metal) fillings</p> <p>Resin (composite, tooth-colored) fillings on anterior teeth</p>	<p>Once per tooth surface in any 24 consecutive months</p> <p>Once per tooth surface in any 24 consecutive months</p>

Schedule of Covered Dental Services (continued)

Procedure	Limits
<p>Major Restorative</p> <p>Recementation of crown</p> <p>Prefabricated stainless steel/resin crown (for children only-deciduous teeth only)</p> <p>Inlays, Onlays, and Crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture</p>	<p>Once per tooth in any calendar year</p> <p>Once per tooth in any 24 consecutive months</p> <p>Once per tooth in any 60 consecutive months period</p>
<p>Endodontics</p> <p>Root canal therapy</p> <p>Retreatment of root canal</p> <p>Apicoectomy (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment)</p> <p>Pulpotomy</p>	<p>Once per tooth in a lifetime</p> <p>Once per tooth in a lifetime</p> <p>Once per tooth in a lifetime</p> <p>Once per tooth in a lifetime</p>
<p>Periodontics</p> <p>Gingivectomy or gingivoplasty</p> <p>Osseous surgery</p> <p>Periodontal scaling and root planing</p> <p>Periodontal maintenance (procedure is a benefit following active periodontal therapy once a 30 day post-operative period has completed.)</p>	<p>Once per quadrant in a 60 consecutive months period</p> <p>Once per quadrant in a 60 consecutive months period</p> <p>Once per quadrant within a 24-month period</p> <p>Two of any prophylaxis procedure in a calendar year</p>

Schedule of Covered Dental Services (continued)

Procedure	Limits
<p>Removable Prosthodontics</p> <p>Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care</p> <p>Denture rebase or reline procedures, including six months of routine post-delivery care</p> <p>Interim maxillary and mandibular partial denture (anterior teeth only); no other temporary or transitional denture is covered by the Delta Dental Plan</p>	<p>One denture per arch in any 60 consecutive months</p> <p>Once per appliance in any 36 consecutive months period</p> <p>Once per appliance in any 60 consecutive months period</p>
<p>Fixed Prosthodontics</p> <p>Fixed partial dentures and individual crowns</p> <p>Prefabricated post and core procedures related to fixed partial denture (X-ray showing completed endodontic procedure is required)</p>	<p>Once per tooth in any 60 consecutive months period</p> <p>Once per tooth in any 60 consecutive months period</p>
<p>Simple Extractions</p> <p>Non-surgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)</p>	<p>Once per tooth in a lifetime</p>
<p>Oral and Maxillofacial Surgery</p> <p>Removal of impacted tooth</p> <p>Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)</p> <p>Frenulectomy</p> <p>Removal of exostosis (removal of overgrowth of bone)</p>	<p>Once per tooth in a lifetime</p> <p>Once per quadrant in a lifetime</p> <p>Once per arch in a lifetime</p> <p>Once per site in a lifetime</p>
<p>Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm and incision and drainage of an intraoral or extraoral abscess.</p>	
<p>Emergency Treatment</p> <p>Palliative treatment to alleviate immediate discomfort (minor procedure only)</p>	<p>Once per date of service</p>

Schedule of Covered Dental Services (continued)

Procedure	Limits
Repairs	
Temporary crown (fractured tooth)	One crown procedure per tooth in a 60 consecutive months period
Crown repair	Once per tooth in any 24 consecutive months
Overcrown	Once per tooth in any 60 consecutive months
Repairs to complete or partial dentures	Once per appliance in any calendar year
Recement fixed or partial dentures	Once per appliance in any calendar year
Additions to partial dentures	Twice in any 12 consecutive months
Orthodontics	
Patients under 19 years of age	One course of treatment in a lifetime, up to \$1,000
Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association. A "course of treatment" includes braces, monthly visits and retainers.	
Miscellaneous	
Occlusal guard	One appliance in any 60 consecutive months period

Page 25: Under the section "What Is Not Covered" the third bullet is deleted and replaced with the following:

- charges in excess of the **allowed amounts**,

The fifth bullet is deleted and replaced with the following:

- services or supplies that the Plan determines are experimental or investigative in nature, except to the extent provided by law

And a new bullet is added before the third bullet:

- orthodontia services for individuals age 19 or older,

Clarifications in Vision Benefits Page 29: The fourth paragraph under the section "Vision Care Benefits" is deleted in its entirety and replaced with the following:

If you get contact lenses instead of frames and lenses, from either a participating or non-participating provider, the contact lens exam fitting fee is not covered and the maximum reimbursement for the contact lenses is \$120.

If you use a participating provider, your eye exam is free. If you use a non-participating provider, you can get up to \$30 for your eye exam. You will be responsible for paying any charges in excess of the maximum reimbursement.

Page 30: Under the section "Eligible Expenses", a new bullet is added after the second bullet:

- and frames.

Under the section "Excluded Expenses", a new bullet is added after the second bullet:

- exam fitting fees for contact lenses,

Clarification on Cancellation of Coverage When Eligible for Medicare Page 31: The following sentence is added after the first sentence in the paragraph under the section “When Coverage Ends”:

Life insurance also ends if you cancel your coverage under this Plan due to Medicare eligibility.

Clarification on Cancellation of Coverage When Eligible for Medicare Page 33: The following sentence is added after the sentence under the section “When Coverage Ends”:

AD&D also ends if you cancel your coverage under this Plan due to Medicare eligibility.

Page 36: Under the section “Filing Dental Claims”, Delta Dental’s website address in the second paragraph is deleted and replaced with the following:

www.deltadentalins.com/32BJ

In addition, the first bullet is deleted and replaced with the following:

- Only an original, fully completed claim form or approved treatment plan will be accepted for review.

Page 38: In the section “Where to Send Claim Forms”, the filing address for dental claims is deleted in its entirety and replaced with:

Delta Dental
PO Box 2105
Mechanicsburg, PA 17055-2105

Page 42: In the section “Where to File a Level-One Appeal”, under the column *Write to* the address for Delta Dental is deleted and replaced with:

Delta Dental
Attn: Professional Services
One Delta Drive
Mechanicsburg, PA 17055

In addition, under the chart, the phone number in the double asterisk for an urgent care dental claim, 1-516-394-9485, is deleted and replaced with 1-800-589-4627.

Modification of Assignment of Plan Benefits Page 55: The following is added to the end of the third paragraph under the section “Assignment of Plan Benefits”:

In order to appoint a provider as your authorized representative, you must submit a legibly signed authorization with your appeal that includes:

- Your name,
- Your identification number as shown on your Delta Dental or Davis Vision card, as applicable,
- Your date of birth,
- Your address,
- The full name of the party whom you are authorizing to act on your behalf,
- The date(s) for which the authorization applies, and
- A sentence which clearly states that the party is authorized to file an appeal on your behalf.

Correction of Delta Dental Contact Information Back Cover: In the chart, the contact information for Delta Dental is deleted and replaced with:
Delta Dental Customer Service
Call 1-800-589-4627 or
Visit www.deltadentalins.com/32BJ

If you have any questions about this notice or want further information about the changes please contact Member Services at 1-800-551-3225 between the hours of 8:30 AM and 5:00 PM Monday through Friday or visit us on-line at www.32bjfunds.org.