Building Service 32BJ

Health Fund

25 West 18th Street, New York, NY 10011-4676
Telephone 1-212-388-3500 or 1-800-551-3225

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

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Your Rights And Other Important Plan Facts

This booklet contains information about your eligibility for benefits, waiting periods, your life insurance, your rights and responsibilities under the Plan, and the Fund's rights. This information includes, among other items, sections describing Plan Facts, Your Disclosures to the Fund, Fraud, Overpayments, Coordination of Benefits, Subrogation and Reimbursement, Continued Group Health Coverage and Claims and Appeals. Note that not all information in this section may be applicable to you.

- Save this booklet – put it in a safe place. If you lose a copy, you can ask Member Services at 1-800-551-3225 or 1-212-388-3500 for another or obtain it from www.seiu32bj.org.
- If you change your name or address – notify Member Services immediately so your records are up-to-date.
- Throughout this booklet, the words "you" and "your" refer to participants whose employment makes them eligible for a Plan of benefits. The word "dependent" refers to a family member of a participant who is eligible for a Plan of benefits.
- This booklet describes the provisions of the Plan in effect as of July 1, 2011 unless specified otherwise.
- In the event there is any conflict between the terms and conditions for the Plan benefits as set forth in this booklet and any oral advice you receive from the Building Service 32BJ Benefit Funds employee or union representative, the terms and conditions set forth in this booklet shall control.

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 7–9 and pages 21–24),
- on the date when your employer terminates its participation in the Plan, or
- on the date the Plan is terminated.

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

If You Come Back to Work

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

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

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. Contact Member Services for information on dependent coverage.

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

** **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**.

Extension of Health Benefits

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

COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Plan's hospital, medical, behavioral health and substance abuse, prescription drug, dental and vision coverage. This does not include life insurance and AD&D. See pages 7–9 and pages 21–24 for more information about COBRA.

Fund-paid COBRA

If all eligibility requirements are met, the Fund will pay for COBRA coverage in the following situations: disability (which must have occurred while you were in **covered employment**) and arbitration. All periods of Fund-paid COBRA will count toward the period in which you are entitled to continuing coverage under COBRA. Coverage for Fund-paid COBRA includes the Plan's hospital, medical, behavioral health and substance abuse, prescription drug, dental, vision, life and AD&D* coverage.

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

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 COBRA in the section above), provided you enroll for coverage, are unable to work and are receiving (or are approved to receive) one of the following disability benefits:

- short-term disability, or
- Workers' Compensation.

* If on Short-Term Disability (STD) or Workers' Compensation (WC), life insurance, but not AD&D, will continue for six months from the date of disability.

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

- if you work at any job,
- if you elect to discontinue coverage,
- if your Workers' Compensation or short-term disability benefit ends,
- six months after you stopped working due to a disability,
- when you receive the maximum benefits under short-term disability or Workers' Compensation, or
- when you become eligible for Medicare as your primary insurer.

To receive this extended coverage (Fund-paid COBRA), you must apply and submit proof of disability no later than 60 days after the date coverage would have been lost (90 days after you stopped working due to a disability). You apply by completing the Continuation of Coverage COBRA Election Form which is mailed to you. In addition, you can obtain a copy of this form from Member services. The Plan reserves the right to require proof of your continued disability from time-to-time. This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA. See pages 7–9 and pages 21–24 for COBRA information.

Arbitration

If you are discharged* and the Union takes your grievance to arbitration seeking reinstatement to your job, the Fund will pay for your COBRA coverage for up to six months or until your arbitration is decided, whichever occurs first. This Fund-paid COBRA will count toward the period in which you are entitled to continuing coverage under COBRA.

FMLA

You may be entitled to take up to a 12-week leave of absence from your job under the Family and Medical Leave Act (FMLA). You may be able to continue coverage during an FMLA leave. See pages 19–20 for more information.

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

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 20–21 for more information. This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

Short-Term Disability

Short-Term Disability (STD) Benefits If You Work in the Washington, DC Metropolitan Area and Are Enrolled in the Kaiser Permanente Health Plan through the Fund.

Your eligibility for STD benefits is determined by your collective bargaining agreement. 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 occupation because of a covered accident or sickness and are under the care of a physician.

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

- you must be totally disabled and unable to work in covered employment,
- you are not doing any other work for pay or profit,
- you are under the direct regular care of a non-related legally qualified physician,
- you are not receiving unemployment compensation, Workers' Compensation benefits or any other similar type of compensation, or
- you are not entitled to, eligible for, or currently receiving a Pension benefit from any SEIU Pension Benefit Fund.

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 eighth day of continuous disability following an illness or accident. You may be eligible for up to 13 weeks of disability income benefits for your disability.

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

- Your disability will not begin until you have visited a legally qualified physician 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 by the Fund's medical doctor.
- Two periods of disability due to the same illness or injury will be considered as one period of disability unless you return to work in covered employment for at least two weeks.
- Two periods of disability that are unrelated illnesses or injuries will be considered as one period of disability unless you return to work in covered employment for at least one day.
- Benefits will only be paid during periods when loss of wages occurs.
- Weekly indemnity benefits for STD end on your retirement date under an SEIU pension plan.

Receiving STD Benefits. Contact the Benefit Administrator, Zurich American Insurance Company (located in Melville, NY), for STD benefits at 1-800-887-9111 extension 6228 to apply for STD benefits.

Life Insurance Benefits

Benefit Amount

Your life insurance coverage, which is administered by MetLife, is $10,000, or $25,000 for 32BJ Kaiser Permanente Plan participants. The amount depends upon your collective bargaining agreement. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

Naming a Beneficiary

Your beneficiary will be the person or persons you name in writing on a form that is kept on file at MetLife. Your beneficiary can be anyone you choose, and you can change your beneficiary designation at any time by completing and submitting a new form to MetLife. You can also go to www.seiu32bj.org, select the 32BJ Funds icon and click on MetLife under Important Links.

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

1) your wife or husband, if living

2) your living children, equally

3) your living parents, equally, and

4) if none of the above, to your estate.

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

You must submit proof of your disability within nine months of the date you became disabled. If you first apply for benefits after this nine month period, it will be presumed that your disability did not commence while you were working in **covered employment**, unless you can provide the Fund with clear and convincing evidence otherwise. If you die before you submit proof of your disability, your beneficiary must submit proof of death and total disability within 90 days after your death.

Notice of approval or denial of benefits will be sent to your designated beneficiary in writing (see pages 14–15 for information on appealing a denied claim).

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

When Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, except as provided above or if you have Fund-paid COBRA due to disability or arbitration (see pages 7–9 and pages 21–24). See pages 26–27 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

Your AD&D insurance coverage is shown in the following chart. Benefits are payable to your beneficiary if you die, or to you if you have an accident and suffer one of the specific injuries listed in the chart below. Benefits will not be paid if your death or injury was caused by anything excluded under "What Is Not Covered" on pages 12–13. Your beneficiary will be the same as your life insurance beneficiary on file with MetLife, unless you choose otherwise. See pages 10–11 for more information about naming a beneficiary.

Loss	Benefit Payable
Life	$10,000 or $25,000
Both hands at or above the wrist; or both feet at or above the ankle; or sight in both eyes; or any combination of hand, foot and sight in one eye	$10,000 or $25,000
One hand at or above the wrist; or one foot at or above the ankle; or sight in one eye	$5,000 or $12,500

"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.

What Is Not Covered

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

- physical or mental illness, or diagnosis of or treatment for the illness,
- an infection, unless it is caused by an external wound that can be seen and that was sustained in an accident,

- suicide or attempted suicide,
- injuring oneself on purpose,
- the use of any drug or medicine,
- a war, or a warlike action in time of peace,
- committing or trying to commit a felony or other odious crime, or an assault, or
- the injured party was intoxicated at the time of the incident and was operating a vehicle or other device involved in the incident. "Intoxicated" means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Coverage Ends

AD&D insurance coverage ends 30 days after you terminate employment. Like your life insurance, your AD&D coverage can continue while you have Fund-paid COBRA due to disability or arbitration (see pages 7-9 and pages 21-24).

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; Approval and Denial of Claims

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.

In general, there are no claims for medical, hospital, or prescription drug benefits provided by the Kaiser Permanente Signature health care coverage plan. However, depending on your collective bargaining agreement you may be able to submit claims for vision or dental benefits. These services are provided directly to all participants in accordance with the procedures described in your Explanation of Coverage booklet.

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

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

All claims for life insurance or AD&D benefits must be made in writing to:

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
Fax 1-570-558-8645

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

Appealing Denied Claims

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

For appeals of the denial of medical, hospital or prescription drug benefits, you must follow the procedures described in the Kaiser Permanente Signature health care plan Explanation of Coverage booklet.

Appeals of denial of life insurance claims must be made within 180 days from the date of the original denial letter. An appeal must include your identification number and any relevant information in support of the appeal.

All appeals must be made in writing to:

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
Fax 1-570-558-8645

Voluntary Second Level Appeal of a Life Insurance and AD&D Claim

Once you have been notified regarding the outcome of your appeal, you have exhausted all required internal appeal options. If you disagree with the decision, you are free to file a civil action under Section 502(a) of ERISA (see pages 28–30 for more information about ERISA). No lawsuit may be started more than three years after the date of the appeal denial letter. Alternately, you may file a voluntary appeal with the Appeals Committee. Voluntary appeals must be filed within 180 days following notification of the outcome of your mandatory appeal.

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

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

Building Service 32BJ Health Fund
Board of Trustees – Appeals Committee
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 in court will be tolled (suspended) during the period of the voluntary appeals process.

You will be notified in writing of the decision on your appeal.

Further Action

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.

Plan Facts

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

Funding of Benefits and Type of Administration

Your benefits under the Plan are insured under a contract between the Plan and Kaiser Permanente in the case of health benefits and MetLife in the case of life insurance and AD&D benefits. All contributions to the Trust Fund are made by **contributing employers** under the Plan in accordance with their written agreements. Benefits are administered by Kaiser Permanente, except for life insurance and AD&D which are administered by MetLife.

Plan Sponsor and Administrator

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

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

The Board governs this Plan in accordance with an Agreement and Declaration of Trust. The Board and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan established under the Trust Agreement, and to decide all matters arising in connection with the operation or administration of the Plan established under the Trust.

Without limiting the generality of the foregoing, the Board and/or its duly authorized designees, including the Appeals Committee with regard to benefit claim appeals, shall have the sole and absolute discretionary authority to:

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan,
- formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with the terms of the Plan,
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan,
- resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, as described in this booklet, the Trust Agreement or other Plan documents,

- process and approve or deny benefit claims and rule on any benefit exclusions, and
- determine the standard of proof required in any case.

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

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

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

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.

Participating Employers

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 written agreement, as well as the address of the 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

Your Disclosures To The Fund

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

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

Fraud

The Board reserves the right to cancel or rescind Fund coverage for any participant or enrolled dependent who willfully and knowingly engages in an activity intended to defraud the Fund. If a claim has been submitted for payment 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.

Continued Group Health Coverage

During a Family and Medical Leave

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

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

FMLA allows up to 12 weeks of leave for certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status, in support of a contingency operation.

FMLA also 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 incurred in the line of duty on active duty. Eligible employees are entitled to a combined total of up to 26 weeks of all types of FMLA leave during the single 12-month period.

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

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

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

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

During Military Leave

If you are on active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you and your dependents at your own expense for up to 24 months provided you enroll for coverage. This continuation coverage operates in the same way as COBRA. See pages 7–9 and pages 21–24 for information on COBRA.

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 following Fund benefits if they are offered under the Plan in which you participate: hospital, medical, dental, prescription drug and vision coverage.

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

If you are disabled and receiving (or are approved to receive) benefits under short-term disability or Workers' Compensation, the Plan provides coverage for up to six months (unless provided otherwise by your collective bargaining agreement or participation agreement) 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 COBRA coverage, you do not have to pay the premium since it is paid by the Fund. Keep in mind that the maximum period that you have COBRA coverage is reduced by any period of time you received Fund-paid COBRA coverage.

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

COBRA Continuation of Coverage

Coverage May Continue For:	If	Maximum Duration of Coverage:
You	Your **covered employment** terminates for reasons other than gross misconduct	18 months
You	You become ineligible for coverage due to a reduction in your employment hours (e.g., leave of absence)	18 months
You	You go on military leave	24 months

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.

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 dependents eligible for COBRA coverage.

Notifying the Fund of a Qualifying Event. Under the law, in order to have a right to elect COBRA coverage, you are responsible for notifying Member Services 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 of the individual interested in COBRA continuation,
- date of the Qualifying Event, and
- type of Qualifying Event (see the table of Qualifying Events on page 22).

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

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

If you elect COBRA continuation coverage, you must promptly notify Member Services of address changes.

Paying for COBRA coverage. If you elect to continue coverage, you must pay the full cost of the coverage elected. The Fund is permitted to charge you the full cost of coverage for active employees plus an additional 2% (and up to an additional 50% for the 11-month disability extension). The first payment is due no later than 45 days after the election to receive coverage (and it will cover the period from the date you would lose coverage until the date of payment). Thereafter, payments are due

on the first of each month and are considered to be on time if they are made within 30 days of the due date. Costs may change from year-to-year. Contact Member Services for more information about the cost of your COBRA coverage.

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

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

When COBRA coverage ends. COBRA coverage ordinarily ends after the maximum coverage period shown in the chart on page 22. It will stop *before* the end of the maximum period under any of the following circumstances:

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

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

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

Other Health Plan Information You Should Know

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

Benefits or payments under the Plan are not otherwise assignable or transferable, except as the law requires. Benefits also are not subject to any creditor's claim or to legal process by any creditor of any covered individual.

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 18.

In April 2003, the Fund's Board of Trustees adopted certain HIPAA privacy and security language that requires the Board of Trustees, in its role as Plan Sponsor of the Fund, to keep your health information private and secure. Any questions you may have about HIPAA may be directed to the Compliance Office at the address on page 18.

Certificate of Creditable Coverage

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

This Certificate is available to you upon request by contacting Kaiser Permanente Member Services at 1-800-777-7902 at any point while you are covered under the Plan and up to 24 months after coverage ceases.

Please be advised that in any event, you will also automatically be provided with a Certificate of Creditable Coverage from Kaiser Permanente when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases.

Converting to Individual Coverage

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

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

You may convert your group coverage only to a Whole Life, Universal Life or One-Year Non-Renewable Term policy. The amount converted to an

individual policy cannot be more than the amount you had under your plan of benefits. Your individual policy will become effective 61 days after the termination of your coverage. Group life insurance protection continues in force, however, during the applicable period cited above, whether or not you exercise the conversion option. Contact the organization listed in the Contact Information table for life insurance on the inside back cover of Section I of the SPD of your plan of benefits for more information about converting your life insurance.

All Other Plan Benefits. You cannot convert hospital and medical benefits to individual coverage.

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in this booklet or in your Explanation of Coverage.

Compliance with Federal Law

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

Plan Amendment or Termination

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

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

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

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

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

- Examine, without charge, at the Compliance Office, all documents governing the Plan, including insurance contracts, collective bargaining agreements, participation agreements and the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Compliance Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, participation agreements, the latest annual report (Form 5500 series) and an updated Summary Plan Description.
- Receive a summary of the Plan's annual financial report. The Board is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Coverage. You may continue group health coverage if there is a loss of coverage under the Plan as a result of a Qualifying Event. See pages 7–9 and pages 21–24 for information about

COBRA. If you change medical plans and wish to have any pre-existing conditions covered, you will need a Certificate of Creditable Coverage. You can get this free of charge from your group health plan or health insurance company when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

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

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

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

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's appeal process. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. You may not file a lawsuit until you have followed the appeal procedures described on pages 14–16. The court will decide who should pay court costs and legal fees. If you are

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

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

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

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

Contact Information

For information about health benefits, call Member Services at 1-800-551-3225 or 1-212-388-3500, log on to www.32bjfunds.com/health/index.asp or write to Member Services at:

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

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

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

Summary of Material Modifications
Building Service 32BJ Health Fund
Kaiser Permanente 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 Plan dated July 1, 2011. This Summary of Material Modifications (SMM) supplements or modifies the information presented in your SPD with respect to the Plan. **Please keep this document with your copy of the SPD for future reference.**

Address Change: Effective November 14, 2011, the address 101 Avenue of the Americas, New York, NY 10013-1991, wherever it appears, is replaced with the following address:

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

Change in Union Trustee Page 1: Effective August 21, 2012, Shirley Aldebol replaces Brian Lambert as Union Trustee:

Shirley Aldebol
Vice President
SEIU Local 32BJ
25 West 18th Street
New York, NY 10011-1991

Change in Union Trustee Page 1: Effective October 4, 2012, Larry Engelstein replaces Michael J. Fishman as Union Trustee:

Larry Engelstein
Executive Vice President
SEIU Local 32BJ
25 West 18th Street
New York, NY 10011-1991

Changes in Union Trustee Titles Page 1: Effective October 4, 2012, Hector Figueroa is President of SEIU Local 32BJ; and Kevin J. Doyle is Special Advisor to the President of SEIU Local 32BJ.

Change in Accountants Page 1: Effective July 1, 2013, Bond Beebe replaces BDO USA, LLP as accountants.

Change in Beneficiary Terminology for Life Insurance Benefits Page 10: delete 1) your wife or husband, if living and replace with 1) your Lawful Spouse, if living

<u>Print Omission</u> Page 19: The following paragraphs are added after the last paragraph under the heading*: Fraud*:

> 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, coinsurance** or **deductibles,** where applicable to member's plan**.**

<u>Change in Terminology and Clarification of Process:</u> The term Fund-paid COBRA is replaced everywhere it appears throughout the SPD with the term Fund-paid Health Extension. In addition, employees who wish to receive coverage under the Fund-paid Health Extension do not need to complete the COBRA Continuation of Election Form, however they continue to need to apply and submit the required proof.

Page 23: The second sentence of the paragraph subtitled "*When your **employer** must notify the Fund,"* is deleted and replaced with the following sentence:

Your **employer** must notify the Fund of one of these Qualifying Events within 30 days of the date of the Qualifying Event.

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.

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

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

Summary of Material Modifications
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Change in Accountants Page 1: Effective July 1, 2013, Bond Beebe replaces BDO USA, LLP as accountants.

Family Coverage Page 9: The following text is inserted before the section titled Short-Term Disability and after the section titled Military Leave:

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

Dependency	**Age Limitation**	**Requirements**
Spouse	None	The person to whom you are legally married (if you are legally separated or divorced, your spouse is not covered).
Domestic Partner	None	You and your same-sex domestic partner (unless the laws of the jurisdiction where you live provide for same-sex marriage): o Have a civil union certificate from a state in the U.S. or province in Canada where same-sex civil unions are valid or, if civil union certificates are not available in the jurisdiction where you live, o Are two individuals 18 years or older of the same-sex who: - Have been living together for at least 12 months; and - Are not married to anyone else, and are not related by blood in a manner that would bar marriage under the law; and - Are financially interdependent, and can show proof of such; and - Have a close and committed personal relationship and have not been registered as members of another domestic partnership within the last 12 months. In order to establish eligibility for these benefits, you and your domestic partner will need to provide: o A civil union certificate from a state in the U.S. or province in Canada where same-sex civil unions are valid or, if civil union certificates are not available in the jurisdiction where you live, o Affidavits attesting to your relationship, plus a domestic partner registration under state or local law (if permitted in the jurisdiction where you live), and proof of financial interdependence. You are required to provide the highest level of certificate available in the jurisdiction where you live. Contact Member Services for an application or general information. There may be significant tax consequences for covering your domestic partner or, in some states, for covering your same-sex spouse. Contact a tax advisor for tax advice. If you lose coverage due to a qualifying event, you and your domestic partner may elect to continue coverage on a self-pay basis. Domestic partners will have an independent right to continue coverage on a self-pay basis only in the event of the participant's death.

Children (except disabled 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: • Your biological child • Your adopted** child or one placed with you in anticipation of adoption • Your stepchild: this includes your spouse's biological or adopted child • Your domestic partner's biological or adopted child
Children (disabled) over age 26	No age limit for coverage.	The child: • Is totally and permanently disabled • Became disabled while, or before becoming, an eligible dependent, • Is not married, • Has the same principal address as the participant*, or as required under the terms of a "QMCSO" • Is dependent on the participant for over one-half of his or her annual support and is claimed as a dependent on your tax return* You must apply for a disabled child's dependent coverage extension and provide proof of the child's total and permanent disability no later than 60 days after the date the child would have otherwise lost eligibility, and you must remain covered under the Plan. You will be notified of your adult disabled child's eligibility for continuing coverage. You must enroll your adult disabled child within 60 days of receiving confirmation of your adult child's eligibility. Failure to enroll at this time means your disabled adult child loses his or her special eligibility. If your child becomes eligible for extended coverage as a result of disability, you will be required to pay a monthly premium to cover part of the coverage cost. Contact Member Services.
Children (dependent) - Your grandchild, niece or nephew ONLY if you are the legal guardian*** (if application for legal guardianship is pending, you must provide	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 not married • Has the same principal address as the participant, or as required under the terms of a "QMCSO" • Is dependent on the participant for all his or her annual support and maintenance and is claimed as a dependent on your tax return

documentation that papers are filed and provide proof when legal process is complete)		

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.

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

When Your Dependents Are No Longer Eligible

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

- Your *spouse's* eligibility ends 30 days after legal separation* or divorce.
- Your domestic partner's eligibility ends 30 days after the requirements for domestic partnership as described in the previous chart are no longer satisfied.
- Your *child's* eligibility ends on the date your child no longer satisfies the requirements for a dependent child as described in the previous chart, 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, a domestic partner and children ends 30 days after your death.

* 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.

How to Enroll

Coverage for dependents under the Plan is not automatic.

Enroll your dependents as soon as they become eligible. Please see "Dependent Eligibility" above to determine when your dependents are eligible. If at the time you become eligible under the Plan your dependents are eligible for benefits, you must complete the "Dependent Information" section of the Enrollment Form. You will be required to submit documents proving dependent status including a marriage certificate (for your spouse), birth certificates and, if applicable, proof of 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. However, if you do not enroll your eligible dependents when you first complete the Enrollment Form, your dependent's coverage will not begin until the date you notify the Fund. No benefits will be paid until you provide the Fund with your eligible dependent's information and supporting documentation. After your coverage under the Plan begins, if you have a change in family status (e.g., get married, adopt a child) or wish to change existing dependent coverage for any reason, you must complete the appropriate form. Special rules apply regarding the effective date of your new dependent's coverage. Please see "Your Notification Responsibility" below for further details.

Dependent claims for eligible expenses will be paid only after the Fund has received your completed Enrollment 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 a dependent. Failure to provide such information could result in a loss of coverage.

Your Notification Responsibility

If, after your coverage under the Plan becomes effective, there is any change in your family status (e.g., marriage, legal separation, divorce, birth or adoption of a child), it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 30 days of marriage or birth or adoption of a child, coverage for your new spouse or child will begin as of the date of marriage or date of birth or adoption. If you do not notify the Fund within 30 days, coverage for your new spouse or child will begin as of the date you notify the Fund. No benefits will be paid until you provide the Fund with the necessary supporting documentation. Also, be sure to notify the Fund if your grandchild, niece or nephew no longer lives with you, marries or otherwise no longer satisfies the coverage requirements as described in the chart above.

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

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.

Clarification: Page 9: The Short-Term Disability (STD) section is deleted in its entirety because STD benefits are not provided under your collective bargaining agreement.

Change in Beneficiary Terminology for Life Insurance Benefits Page 10: delete 1) your wife or husband, if living and replace with 1) your Lawful Spouse, if living

Print Omission Page 19: The following paragraphs are added after the last paragraph under the heading*: Fraud*:

> 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, coinsurance** or **deductibles,** where applicable to member's plan**.**

Addition of QMCSO language Page 25: Under the heading Other Health Plan Information You Should Know, the existing two paragraphs are deleted and the following new section is added:

Assignment of Plan Benefits

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

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

A QMCSO usually results from a divorce or legal separation. Whenever the Fund receives a QMCSO, its qualified status is carefully reviewed by the Department of Eligibility 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 18.

Change in Terminology and Clarification of Process: The term Fund-paid COBRA is replaced everywhere it appears throughout the SPD with the term Fund-paid Health Extension. In addition, employees who wish to receive coverage under the Fund-paid Health Extension do not need to complete the COBRA Continuation of Election Form, however they continue to need to apply and submit the required proof.

Page 23: The second sentence of the paragraph subtitled "*When your **employer** must notify the Fund,"* is deleted and replaced with the following sentence:

Your **employer** must notify the Fund of one of these Qualifying Events within 30 days of the date of the Qualifying Event.

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.