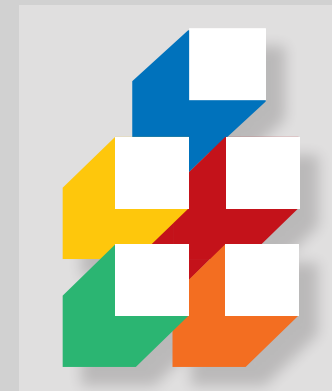




Building Service 32BJ Health Fund
New York City Schools
Part Time Plan



Summary Plan Description

April 24, 2015

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



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 Funds
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 Funds
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 Funds
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 premten. 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 Funds
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.

Contact Information

What do you need?	Who to contact	How
<ul style="list-style-type: none">• General information about your eligibility and benefits• Information on your vision benefits and claims	Member Services	Call Member Services at 1-800-551-3225, Monday–Friday 8:30 am–5:00 pm, or visit the Welcome Center at 25 West 18th Street, New York, NY 10011, Monday–Friday, 8:30 am–6:00 pm.
<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 Visit www.32bjfunds.org
<ul style="list-style-type: none">• Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com

**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”) NYC Schools Part Time 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 or union representative, 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.
- Words that appear in **boldface** print are defined in the Glossary.
- Throughout this booklet, the words “you” and “your” refer to participants whose employment makes them eligible for Plan benefits.

⁽¹⁾ This SPD is the plan document for the NYC Schools Part Time Plan, which includes vision, life insurance and accidental death and dismemberment benefits. Insurance contracts from MetLife are the plan documents for the Life and Accidental Death & Dismemberment Insurance 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 insurance contracts from MetLife.

The word “dependent” refers to a family member of a participant who is eligible for Plan benefits. In the sections describing the benefits payable to participants and dependent(s), the words “you” and “your” may also be used to refer to the patient.

- This booklet describes the provisions of the Plan in effect as of April 24, 2015 unless specified otherwise.
- The number of hours you regularly work determines the Plan for which you are eligible. In general, the NYC Schools Part Time Plan covers certain participants working in the New York City schools who work at least 20 but not more than 39* hours in each 14 day **pay period** (“**pay period**”).

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.

* If you regularly work more than 39 hours in **covered employment** in a **pay period**, you may be entitled to benefits under the Building Service 32BJ Suburban Plan. Eligibility requirements for that plan are described in the Metropolitan and Suburban Health Plans Summary Plan Description.

Frequently Asked Questions

1. What benefits does the Plan provide?

The Plan provides the following benefits:

- vision,
- life insurance, and
- accidental death and dismemberment.

Each of these benefits is described in detail later in this booklet.

2. Are my dependent(s) eligible?

Yes. In general, your covered dependent(s) include your spouse and your children until they reach 26 years of age. (See the table on pages 15–17 for a fuller description of dependent(s)).

3. What do I have to do to cover my dependent(s)?

- Fill out and return the appropriate form, and
- Provide documentation that proves the individual you want to enroll is your dependent. For example, you must provide a marriage certificate to cover your spouse or a birth certificate for a dependent child.

You can get forms from:

- The website www.32bjfunds.org
- Member Services by calling 1-800-551-3225.

4. What happens if I get married or have a baby?

You must:

- Notify the Fund within 30 days of the date of marriage or birth,
- Fill out and return the appropriate form, and
- Provide documentation proving the relationship.

If you notify the Fund within 30 days, your dependent will be covered from the date of the event (birth, adoption, marriage). If you do not notify the Fund within 30 days of the event, your spouse/child will only be covered prospectively from the date you notify the Fund.

5. How frequently can I get glasses and an eye exam?

Once every 24 months. Participants and dependent(s) under 19 are eligible for an eye exam once every 12 months.

6. What is my life insurance coverage?

\$25,000.

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

7. What happens to my coverage if I become disabled?

If you are eligible, unless provided otherwise in your collective bargaining agreement, the Fund will pay for up to 30 months of continued vision 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
- Be receiving one of the following benefits:
 - Short-Term Disability (“STD”)
 - Workers’ Compensation

8. What happens to my coverage when I lose my job?

If you are not reported on two consecutive **pay periods**, your eligibility will end as of the last day of the second **pay period** in which no hours were reported. You will be offered under the Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”), the opportunity to purchase vision coverage for up to 17 more months.

9. What happens to my family’s 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 vision coverage under COBRA for 35 more months by paying a monthly premium.

10. Who do I call if I have questions?

Call Member Services at 1-800-551-3225 Monday through Friday between the hours of 8:30 am to 5:00 pm.

Eligibility and Participation

When You Are Eligible

If your **employer** reports to the Fund that you are expected to regularly work at least 20 but not more than 39* hours in **covered employment** in each 14 day **pay period** (“**pay period**”), you are eligible for benefits once you have completed 90 consecutive calendar days. From this period on, you will be subject to the rules for on-going employees. You will maintain this level of coverage until you have completed the first 13 **pay period** measurement period as described below in the third paragraph. If you are not reported on two consecutive **pay periods**, your eligibility will end as of the last day of the second **pay period** in which no hours were reported. If you return to work within six **pay periods** from the last day of the first **pay period** in which no hours were reported, the level of coverage you were receiving will be restored for the remainder of the applicable coverage period.

If you are a new seasonal or variable hour employee or your **employer** fails to report your hire status, your hours will be measured over 13 **pay periods** starting with the first **pay period** in which you work. If you average 20 to 39 hours in **covered employment** in a **pay period** over 13 **pay periods**, you will become eligible on the first day of the **pay period** following a four **pay period** administrative period. You will maintain this level of coverage until you have completed the first 13 **pay period** measurement period as described below in the third paragraph. From this period on, you will be subject to the rules for on-going employees. If you are not reported on two consecutive **pay periods**, your eligibility will end as of the last day of the second **pay period** in which no hours were reported. If you return to work within six **pay periods** from the last day of the first **pay period** in which no hours were reported, the level of coverage you were receiving will be restored for the remainder of the applicable coverage period.

Having first achieved eligibility, average hours for on-going employees will be measured each year during two 13 **pay period** measurement periods. The first measurement period generally runs from the end of

* If you regularly work more than 39 hours in **covered employment** in a **pay period**, you may be entitled to benefits under the Building Service 32BJ Suburban Plan. Eligibility requirements for that plan are described in the Metropolitan and Suburban Health Plans Summary Plan Description.

February through the end of August, and the second measurement period generally runs from the end of August through the end of February. Each measurement period is immediately followed by a 13 **pay period** coverage period.

If you average 20 to 39 hours in **covered employment** in a **pay period** over the 13 **pay period** measurement period, you will become eligible for coverage immediately following 13 **pay period** coverage period. However, if you are not reported on two consecutive **pay periods**, your eligibility will end on the last day of the second **pay period** in which no hours were reported. If you return to work within six **pay periods** from the last day of the first **pay period** in which no hours were reported, the coverage you were receiving will be restored for the remainder of the applicable coverage period.

When You Are No Longer Eligible

Your eligibility for the Plan ends:

- if you are not reported on two consecutive **pay periods**, your eligibility will end as of the last day of the second **pay period** in which no hours were reported, subject to COBRA rights. (See pages 11–13 and pages 39–44.),
- 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 began 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.

As long as you are eligible, your dependent(s) are eligible, provided they meet the definition of “dependent” under the Plan (see Dependent Eligibility on pages 14–19) and you have properly enrolled them.

Extension of Vision Benefits

Vision 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 vision coverage. It does not include life insurance and Accidental Death & Dismemberment (“AD&D”). (See pages 39–44 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 coverage under COBRA. Fund-paid Health Extension includes the Plan's vision benefits. Life insurance and AD&D are continued only for the first six months. (See page 23 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 30 months of coverage (see Fund-paid Health Extension on page 8 and pages 12–13), 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 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,
- 30 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 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 39–44 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 12 – 13.) 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.

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 37-38 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 coverage. (See page 38 for more information.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

Dependent Eligibility

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).
Domestic Partner	None	<p>You and your same-sex domestic partner (unless the laws of the jurisdiction where you live provide for same-sex marriage):</p> <ul style="list-style-type: none"> • 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, • Are two individuals 18 years or older of the same-sex who: <ul style="list-style-type: none"> - Have been living together for at least 12 months, and - Are not married to anyone else, and are not related by blood in a manner that would bar marriage under the law, and - Are financially interdependent, and can show proof of such, and - Have a close and committed personal relationship and have not been registered as members of another domestic partnership within the last 12 months. <p>In order to establish eligibility for these benefits, you and your domestic partner will need to provide:</p> <ul style="list-style-type: none"> • A 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, • 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. <p>You are required to provide the highest level of certificate available in the jurisdiction where you live.</p> <p>Contact Member Services for an application or general information.</p> <p>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.</p>

Dependency	Age Limitation	Requirements
Domestic Partner (continued)	None	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: <ul style="list-style-type: none"> • Your biological child, • Your adopted* child or one placed with you in anticipation of adoption, • Your stepchild: this includes your spouse's biological or adopted child, or • Your domestic partner's biological or adopted child.
Children (disabled) over age 26	No age limit for coverage.	The child: <ul style="list-style-type: none"> • 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"—see page 45, and • Is dependent on the participant for over one-half of his or her annual support and is claimed as a dependent on your tax return**. <p>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.</p>

Dependency	Age Limitation	Requirements
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 page 45, 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 19–20.) 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 domestic partner's eligibility ends 30 days after the requirements for domestic partnership on pages 15–17 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 on pages 16–17, 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 dependent children ends 30 days after your death.

How to Enroll

Your coverage is 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 14–19 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

⁽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.

coverage will begin on the date he or she was first eligible. 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 19–20 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.

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 pages 16–17.

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

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 to the Plan's selection. 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 and dependent(s) 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⁽³⁾, 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, 2013, you have up to September 1, 2015 (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.

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.

⁽³⁾ Participants and dependent(s) under 19 are eligible for an eye exam once every 12 months.

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 benefits of the plan,
- non-prescription eyeglasses,
- adornment expenses, and
- **out-of-network** benefits for participants and dependent(s) 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 get a MetLife beneficiary form by going 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 immediately 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. For as long as this extended coverage lasts, your benefit level will be frozen at the level in effect at the time you became disabled.

The Fund reserves the right to re-certify disability as described on pages 12–13. 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 page 30 for information on appealing a denied claim.)

When Coverage Ends

Life insurance coverage ends if you are not reported on two consecutive **pay periods**. Your eligibility will end as of the last day of the second **pay period** in which no hours were reported, except as provided above or if you have Fund-paid Health Extension due to disability or arbitration. (See pages 11–13.) See pages 46–47 for information about converting your group life insurance to an individual life insurance policy.

Accidental Death & Dismemberment (AD&D) Benefits

Accidental Death & Dismemberment (“AD&D”) Insurance, which is administered by MetLife, applies to accidents on or off the job, at home or away from home. This is unlike Workers’ Compensation insurance, which covers you only on the job. You are eligible while in **covered employment** and for 30 days after your **covered employment** ends. Your AD&D benefit is in addition to your life insurance and is payable if you die or become dismembered as 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 \$25,000. 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 \$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.

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 may continue while you have Fund-paid Health Extension due to disability or arbitration. (See pages 11–14.)

Claims and Appeals Procedures

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

Claims for Benefits

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

- inquiries about the Plan's provisions or eligibility that are unrelated to any specific benefit claim, and
- a request for prior approval of a benefit that does not require prior approval by the Plan.

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 Davis Vision for reimbursement of eligible expenses. Refer to the table on page 27 for information on where to file your claim for benefits received **out-of-network**. 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. Claims filed more than 180 days after the date of service will be denied.**

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
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

Approval and Denial of Claims

There are separate claims denial and approval processes for Vision Claims and Life/AD&D Claims. These processes are described separately below. Please review this information to ensure that you are fully aware of these processes and what you need to do in order to comply.

Vision Claims

Vision Claims will be approved or denied depending on whether your claim is a pre-service, 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 not required for certain vision benefits. For properly filed pre-service claims, you and/or your **doctor** will be notified of a decision *within 15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the claims reviewer. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

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

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

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

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

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

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

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

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

Life and AD&D Claims

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.

Notice of Decision

You will be provided with written notice of a denial of a claim that sets forth the reason(s) for denial, whether denied in whole or in part, or if any adverse benefit determination is made (for example, the Plan pays less than 100% of the claim). For pre-service claims, you will receive notice of the determination even when the claim is approved. The timing for delivery of this notice depends on the type of claim as described on pages 27–29.

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 Vision Claims and Life/AD&D 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
Vision	Davis Vision	Board of Trustees*
Life/AD&D	MetLife Insurance Company	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 of the date of the denial, 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
Vision	Davis Vision, P.O. Box 791 Latham, NY 12110	Appeals are only accepted in writing
Life Insurance Accidental Death & Dismemberment	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

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.

Pre-Service or Concurrent Care Claim Appeal

If you file an appeal of a pre-service (service not yet received) or concurrent care (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 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.

Voluntary Level of Appeal

Vision Claims and Life/AD&D Claims

Once you have received notice of the denial of your timely⁽⁴⁾ level-one appeal of a Vision Claim or a Life/AD&D Claim, 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 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

⁽⁴⁾ 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.

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 the applicable reviewer as listed in the table under the section Appealing Denied Claims.

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 judgement 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) chooses 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.

Appeal Decision Notice

You will be notified in writing in 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 described in this booklet has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **In addition, no lawsuit may be started more than three years after the date on which the applicable appeal was denied.** If there is no decision on the appeal, no lawsuit may be started more than three years after the time when the Appeals Committee should have decided the appeal.

If you have any questions about the appeals process, please contact the 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 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.

Overpayments

- If you (or your dependent or beneficiary) are overpaid for a claim, you (or your dependent or beneficiary) must return the overpayment. The Fund will have the right to recover any payments made that were based on false or fraudulent information, as well as any payments made in error. Amounts recovered may include interest and costs. If repayment is not made, the Fund may deduct the overpayment amount from any future benefits from this Fund that you (or your dependent or beneficiary) would otherwise receive, or a lawsuit may be initiated to recover the overpayment.
- If payment is made on your (or your dependent's) behalf to a **doctor** or other provider of care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider.

If the refund is not received, the amount of the overpayment will be deducted from future benefits payable to the provider, or a lawsuit may be initiated to recover the overpayment.

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 vision 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 39–44 for information on COBRA.) In addition, your dependent(s) may be eligible for health care under **TRICARE**. This Plan will coordinate coverage with **TRICARE**. (See page 55.)

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 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 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 12–13 for additional information on Fund-paid Health Extension.)

The table on the following page 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, and your eligible dependent(s), 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 40.)

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 40. 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⁽⁵⁾.
- 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.

⁽⁵⁾ There are limitations on the Plan's imposing pre-existing condition exclusions, and those exclusions became prohibited in 2014.

Other Health Plan Information You Should Know

Assignment of Plan Benefits

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

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

A QMCSO usually results from a divorce or legal separation. Whenever Member Services gets a QMCSO, its qualified status is carefully reviewed by the Fund in accordance with QMCSO procedures adopted by the Board and Federal law. For more information on QMCSOs, or to obtain a copy of the Plan's QMCSO procedures free of charge, contact the Fund's Compliance Office at the address on page 54.

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 54.

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 54.

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. The amount of your life insurance coverage is \$25,000.

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.

All Other Plan Benefits. You cannot convert vision or AD&D benefits to individual coverage.

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 39–44).

If the Plan mistakenly pays more than you are eligible for, or pays benefits that were not authorized by the Plan, the Fund may seek any permissible remedy allowed by law to recover benefits paid in error. (Also see Overpayments on pages 36–37.)

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 39–44 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 26–34. 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 NYC Schools Part Time 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

Self funded, except MetLife insures the Life and AD&D insurance benefits. All contributions to the Trust Fund are made by **contributing employers** under the Plan in accordance with their written agreements. Benefits are administered by the organizations listed in the table on page 27.

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**

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.

Glossary

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

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

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

Doctor or **Physician** means a licensed and qualified ophthalmologist (M.D. or D.O.) who is authorized to practice medicine, perform surgery and/or prescribe drugs under the laws of the state or jurisdiction where the services are rendered, acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Network are providers and suppliers who have contracted with the Fund or with any other administrators under contract to the Fund, to provide services and supplies at a pre-negotiated rate. Services provided must fall within the scope of their individual professional licenses.

Out-of-network provider/supplier means a **doctor** or other professional provider who is not in the Plan’s **network** for vision services.

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

Pay period means the 14 day period which is used for payroll purposes.

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

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Contact Information

What do you need?	Who to contact	How
<ul style="list-style-type: none">• General information about your eligibility and benefits• Information on your vision benefits and claims	Member Services	Call Member Services at 1-800-551-3225, Monday–Friday 8:30 am–5:00 pm, or visit the Welcome Center at 25 West 18th Street, New York, NY 10011, Monday–Friday, 8:30 am–6:00 pm.
<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 Visit www.32bjfunds.org
<ul style="list-style-type: none">• Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com



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*
Susan Cowell, *Executive Director*
Angelo V. Dascoli, *Fund Director*

Summary of Material Modifications Building Service 32BJ Health Fund NYC Schools Part Time 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 NYC Schools Part Time Plan (Plan) dated April 24, 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.**

Conversion of Eligibility Measurement Period from Pay Periods to Weeks: Effective August 26, 2016, eligibility for benefits will be determined using a measurement period based on weeks rather than pay periods.

Page 6, the second bullet and asterisk are deleted in their entirety and replaced with the following:

- The number of hours you regularly work determines the Plan for which you are eligible. In general, the NYC Schools Part Time Plan covers certain participants working in the New York City schools who work at least 10 but less than 20* hours each week.

* If you regularly work 20 hours or more in covered employment in a week, you may be entitled to benefits under the Building Service 32BJ Suburban Plan. Eligibility requirements for that plan are described in the Metropolitan and Suburban Health Plans Summary Plan Description.

Page 8, FAQ 8 is deleted in its entirety and replaced with the following:

8. What happens to my coverage when I lose my job?

If you are not reported for four consecutive weeks, your eligibility will end as of the last day of the fourth week in which no hours were reported. You will be offered under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), the opportunity to purchase vision coverage for up to 17 more months.

Pages 9 and 10 are deleted in their entirety and replaced with the following:

Eligibility and Participation When You Are Eligible

If your **employer** reports to the Fund that you are expected to regularly work at least 10 but less than 20* hours in **covered employment** each week, you are eligible for benefits once you have completed 90 consecutive calendar days. From this period on, you will be subject to the rules for on-going employees. You will maintain this level of coverage until you have completed the first 26 week measurement period as described below in the third paragraph. If you are not reported for four consecutive weeks, your eligibility will end as of the last day of the fourth week in which no hours were reported. If you return to work within twelve weeks from the last day of the first week in which no hours were reported, the level of coverage you were receiving will be restored for the remainder of the applicable coverage period.

If you are a new seasonal or variable hour employee or your **employer** fails to report your hire status, your hours will be measured over 26 weeks starting with the first week in which you work. If you average 10 but less than 20 hours in **covered employment** in a week over 26 weeks, you will become eligible on the first day of the week following an eight week

administrative period. You will maintain this level of coverage until you have completed the first 26 week measurement period as described below in the third paragraph. From this period on, you will be subject to the rules for on-going employees. If you are not reported for four consecutive weeks, your eligibility will end as of the last day of the fourth week in which no hours were reported. If you return to work within twelve weeks from the last day of the first week in which no hours were reported, the level of coverage you were receiving will be restored for the remainder of the applicable coverage period.

Having first achieved eligibility, average hours for on-going employees will be measured each year during two 26 week measurement periods. The first measurement period generally runs from the end of February through the end of August, and the second measurement period generally runs from the end of August through the end of February. Each measurement period is immediately followed by a 26 week coverage period.

If you average at least 10 but less than 20 hours in **covered employment** in a week over the 26 week measurement period, you will become eligible for coverage immediately following the 26 week coverage period. However, if you are not reported for four consecutive weeks, your eligibility will end on the last day of the fourth week in which no hours were reported. If you return to work within twelve weeks from the last day of the first week in which no hours were reported, the coverage you were receiving will be restored for the remainder of the applicable coverage period.

* If you regularly work 20 hours or more in **covered employment** in a week, you may be entitled to benefits under the Building Service 32BJ Suburban Plan. Eligibility requirements for that plan are described in the Metropolitan and Suburban Health Plans Summary Plan Description.

When You Are No Longer Eligible

Your eligibility for the Plan ends:

- if you are not reported for four consecutive weeks, your eligibility will end as of the last day of the fourth week in which no hours were reported, subject to COBRA rights. (See pages 11–13 and pages 39–44.),
- 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.

Page 23, the section titled When Coverage Ends is deleted in its entirety and replaced with the following:

When Coverage Ends

Life insurance coverage ends if you are not reported for four consecutive weeks. Your eligibility will end as of the last day of the fourth week in which no hours were reported, except as provided above or if you have Fund-paid Health Extension due to disability or arbitration. (See pages 11–13.) See pages 46–47 for information about converting your group life insurance to an individual life insurance policy.

Page 55, the definition of **Pay period** is deleted in its entirety.

Change in Dependent Eligibility: Chart pages 15-17: Effective February 1, 2016, the chart under the section “Dependent Eligibility” is deleted in its entirety and replaced with the following chart:

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 26 th 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 26 th 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 page 81), 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 the section “Children (disabled) over age 26 was deleted in its entirety.

Page 18: The third bullet under the section “When Your Dependent(s) Are No Longer Eligible is deleted in its entirety and replaced with the following bullet:

- Eligibility of a spouse and children (including dependent children) ends 30 days after your death.

Clarifications in Vision Benefits Pages 20-21: 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 21: Under the section “Eligible Expenses”, a new bullet is added after the second bullet:

- and frames.

Page 22: Under the section “Excluded Expenses”, a new bullet is added after the second bullet:

- exam fitting fees for contact lenses,

Modification of Assignment of Plan Benefits Page 45: The first paragraph under the section Assignment of Plan Benefits is deleted in its entirety and replaced by the following:

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 of ERISA, you may allow a provider to act as your authorized representative in an appeal under the Plan's Appeals Procedures. 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.

Change in Davis Vision Website Address Back Cover: In the chart, the website information for Davis Vision is deleted and replaced with: www.davisvision.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.