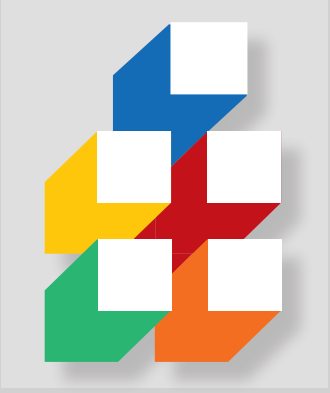
Building Service 32BJ Health Fund

Part Time Basic Plan



Summary Plan Description

May 1, 2021

Translation Notice

This booklet contains a summary in English of your rights and benefits under the Building Service 32BJ Health Fund Part Time Basic Plan. 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
32BJ Health Fund Part Time Basic Plan
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 Building Service 32BJ Health Fund Part Time Basic Plan. Si tiene alguna dificultad para entender cualquier parte de este folleto, llame al Centro de servicios para afiliados al 1-800-551-3225, o escriba a la dirección siguiente:

Member Services
32BJ Health Fund Part Time Basic Plan
25 West 18th Street
New York, NY 10011-4676

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

Niniejsza broszura zawiera opis, w języku angielskim, Twoich praw i świadczeń w ramach Planu Building Service 32BJ Health Fund Part Time Basic Plan. 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
32BJ Health Fund Part Time Basic Plan
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.

Kjo broshurë përmban një përmbledhje në anglisht, në lidhje me të drejtat dhe përfitimet tuaja të Planit nën Building Service 32BJ Health Fund Part Time Basic Plan. 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
32BJ Health Fund Part Time Basic Plan
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.

Building Service 32BJ

Health Fund

25 West 18th Street, New York, NY 10011-4676
Telephone: 1-800-551-3225

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Contents

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") Part Time Basic plan of benefits for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). 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 and your collective bargaining agreement, this SPD will control. Also, in the event there is any conflict between the terms and conditions for the Plan benefits as set forth in the SPD and any oral advice you receive from a Building Service 32BJ Benefit Funds employee, union representative or **employer**, the terms and conditions set forth in this booklet control.

- Save this booklet – put it in a safe place. If you lose your copy, you can ask Member Services for another or obtain one 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 Part Time Basic Plan, which includes dental, 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, and those contracts, as amended or issued from time to time, are incorporated herein by reference. 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 Plan pays the premiums required to keep the insurance policies in force, but the Plan does not directly pay any insured benefits. 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 dependents, the words "you" and "your" may also be used to refer to the patient.

- This booklet describes the provisions of the Plan in effect as of May 1, 2021, unless specified otherwise.
- This booklet covers participants in the Part Time Basic Plan.
- The level of contributions provided for in your collective bargaining agreement or participation agreement determines the plan for which you are eligible. In general, the Part Time Basic Plan covers certain participants who work part time.

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

Eligibility and Participation

When You Are Eligible

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

Most collective bargaining agreements and participation agreements require your **employer** to begin making contributions to the Plan on your behalf when you have completed 90 consecutive days of **covered employment** with the same **employer** working more than two days a week. If your collective bargaining agreement or participation agreement has an earlier start date for contributions, you will be eligible on that contribution start date. If your collective bargaining agreement or participation agreement is silent regarding the start date of contributions, contributions begin on your first day of **covered employment**. For this purpose, **covered employment** includes certain leaves of absence. Days of illness, pregnancy or injury count toward the 90-day waiting period. When you have completed that 90-day period working for your **employer**, you and your eligible dependent(s) become eligible for the benefits described in this booklet on your 91st day of **covered employment**.

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 10–12) and you have properly enrolled them.

When You Are No Longer Eligible

Your eligibility for the Plan ends on the earlier of the following dates:

- at the end of the 30th day after you no longer regularly work in **covered employment** (this does not apply if you are eligible for Fund-paid Health Extension), subject to COBRA rights (see pages 8–10 and pages 46–51),
- 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 you become eligible to participate, 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 will have to complete a new waiting period of 90* consecutive days of **covered employment** with the same **employer** before participation resumes.

* If your collective bargaining agreement or participation agreement has an earlier start date for contributions, you will be eligible on that contribution start date.

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 10–12) and you have properly enrolled them.

Extension of Dental Benefits

In certain circumstances, you may continue your dental coverage even after you stop working in **covered employment**. These circumstances are described on the following pages.

COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), group health plans are required to offer temporary continuation of health coverage, on an employee-pay-all basis, in certain situations when coverage would otherwise end. "Health coverage" includes the Plan's dental coverage. It does not include life insurance and accidental death & dismemberment ("AD&D"). (See pages 46–51 for more information about COBRA.)

Fund-paid Health Extension

If all eligibility requirements are met, the Fund will pay for dental 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. Coverage for Fund-paid Health Extension includes the Plan's dental benefit. Life insurance and AD&D are continued only for the first six months. (See page 30 for the Life Insurance Disability Extension.)

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

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

Fund-paid Health Extension for Disability

You may continue to be eligible for up to 6 months of coverage, provided you enroll for coverage, are unable to work and are receiving one of the following disability benefits:

- short-term disability (limited to 6 months), or
- Workers' Compensation (limited to 6 months if you are or become eligible for Medicare).

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

- you elect to discontinue coverage,
- you work at any job,
- 6 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. Medicare is primary to this Plan after 6 months on short-term disability or Workers' Compensation benefits.

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

To receive Fund-paid Health Extension for disability, you must apply and submit proof of disability no later than 60 days after the date coverage would have been lost, which is 90 days after you stop working due to a disability. You apply by completing the COBRA Continuation of Coverage Election Form, which is mailed to you. You also can obtain a copy of this form from Member Services. The Plan reserves the right to require proof of your continued disability from time to time. Fund-paid Health Extension for disability coverage will count toward the period in which you are entitled to continuing coverage under COBRA. (See pages 46–51 for COBRA information.)

Fund-paid Health Extension during 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 6 months or until your arbitration is decided, whichever occurs first. (See Fund-paid Health Extension on pages 8–10 and 46–51.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

FMLA and Other State Leave

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 page 45 for more information.) In addition, New York State, as well as other states or cities, may offer family leave during which your **employer** may be required to continue coverage. Consult your **employer** about leave requirements where you work and whether your **employer** provides coverage during those periods.

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 pages 45–46 for more information.) This extension of coverage will count toward the period in which you are entitled to continuing coverage under COBRA.

Dependent Eligibility

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

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

Dependency	Age Limitation	Requirements
Spouse	None	The person to whom you are legally married. (If you are legally separated* or divorced, your spouse is not covered.)
Children	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child is one of the following: • 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 completed.)	Until the earlier of 30 days after the child's 26th birthday or the end of the calendar year in which the child turns 26.	The child: • Is not married, • Has the same principal address as the participant,**** or as required under the terms of a "QMCSO" (see pages 52–53), and • Is claimed as a dependent on your tax return.****

* Generally, a legal separation is any legally binding agreement or court order 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.

** 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 14–15.) A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. However, if a child is placed for adoption with you, but the adoption does not become final, that child's coverage will end as of the date you no longer have a legal obligation to support that child. If you adopt a newborn child, the child is covered from birth as long as you take custody immediately after the child is released from the hospital and you file an adoption petition with the appropriate state authorities within 30 days after the infant's birth. However, adopted newborns will not be covered from birth if one of the child's biological parents covers the newborn's initial hospital stay, a notice revoking the adoption has been filed or a biological parent revokes consent to the adoption.

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

****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.

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* or divorce.
- Your child's eligibility ends on the earlier of the date your child (i) no longer satisfies the requirements for a dependent child as described on page 11, or (ii) 30 days after the child's 26th birthday, or (iii) the end of the calendar year in which the child turns 26.
- Eligibility of a spouse and children (including dependent children) ends 30 days after your death.

How to Enroll

Coverage for dependent(s) under the Plan is not automatic. You must enroll your eligible dependent(s) in the Plan.

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 become eligible for health benefits.

Please see Dependent Eligibility on pages 10–11 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 for whom you are legal guardian). In most cases, your dependent(s) coverage begins on the date he or she is first eligible. However, if you do not enroll your dependent(s) within 30 days from the date you first become eligible for health coverage under this Plan, your dependent(s) coverage will not begin until the date you notify the Fund and submit all required documents. 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 14–15 for further details.)

The Plan will pay claims for eligible expenses for dependents only after the Fund has received the required enrollment form and supporting documentation. If your form is 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(s). Failure to provide such information could result in a loss of coverage and a loss of the right to elect continuation of health coverage under COBRA.

Special Enrollment Rules

For participants working under a collective bargaining agreement that provides an annual open enrollment, depending upon the terms of that agreement, you may be permitted to enroll one or more of your dependent(s) (as defined on pages 10–11) in the same manner described above and under the section "How to Enroll" on pages 12–13 during the annual open enrollment period. After you make an election to enroll specific dependent(s) or to not enroll specific dependent(s), this election is generally fixed or locked in for the entire calendar year (January 1 to December 31). An exception applies if:

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

* Generally, a legal separation is any legally binding agreement or court order 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.

entire COBRA coverage period must have been completed for this rule to apply), or

- your dependent(s) lose eligibility for Medicaid or Children's Health Insurance Program ("CHIP") or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan.

In either of the first two circumstances, you may enroll yourself or you may enroll your dependent(s), during a special enrollment period that ends 30 days after the date of marriage, birth, adoption/placement, loss of other group health coverage or termination of **employer** contributions to another group health plan. If the special enrollment results from a loss of eligibility under Medicaid or CHIP, you may enroll your dependent(s) within 60 days after the date of termination of such coverage. If the special enrollment results from a child becoming eligible for state subsidy, you may enroll your dependent within 60 days after the date that such eligibility is determined.

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

Your Notification Responsibility

If, after your coverage under the Plan becomes effective, there is any change in your family status (e.g., marriage, legal separation, divorce, birth or adoption of a child), it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 30 days after 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. Please note, however, no benefits will be paid until you submit the required forms and supporting documentation to the Fund. 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 10–11.

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

If, after your coverage under the Plan becomes effective, your dependent(s) lose eligibility for Medicaid or Children's Health Insurance Program ("CHIP") or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan, you must notify the Fund within 60 days after the loss of Medicaid/CHIP or of your dependent(s) becoming eligible for the state subsidy. Coverage for your dependent(s) will begin as of the date your dependent(s) lose eligibility for Medicaid/CHIP or the date they become eligible for the subsidy. If you do not notify the Fund within 60 days, coverage for your dependent(s) will begin as of the date you notify the Fund.

Failure to notify the Fund of your dependent(s)' loss of eligibility for Medicaid/CHIP could result in the loss of a right to elect health continuation under COBRA. Failure to notify the Fund of your dependent(s) becoming eligible for the state subsidy could lead to a delay or denial in the payment of health benefits.

What Benefits Are Provided

The Fund provides dental, life insurance, and accidental death and dismemberment insurance. Each of these benefits is described in the sections that follow.

Dental Benefits

How the Plan Works

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

- A Delta Dental PPO participating dentist, or
- A non-Delta Dental PPO participating dentist.

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

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

Participating Delta Dental Providers

The Delta Dental Plan's dental benefits include a "**participating** dental **provider**" feature through Delta Dental. The Delta Dental PPO **network** is the Plan's **participating dental-provider network**. Dentists who participate in the Delta Dental PPO **network** have agreed to accept the amount that Delta Dental pays as either payment in full for diagnostic and preventive services or partial payment for other dental services.

- If you choose to receive your care from a **participating** PPO dental **provider**, you will not have to pay anything for covered dental care that is diagnostic or preventive, and
- For all other services, you will pay the difference between the Delta Dental PPO fee-schedule maximum allowance (or the dentist's charges, if less) and the Dental Plan's reimbursement.

Non-Participating Dentists

The Plan will pay for dental work performed by any properly accredited dentist, but the Plan will pay no more than what Delta Dental would have paid a Delta Dental PPO dentist. Your **non-participating** dentist can obtain Delta Dental's reimbursement allowance by submitting a predetermination request directly to Delta Dental before you begin any dental work.

You will be required to pay the dentist's full charges. You will file a claim with Delta Dental (see pages 31and 33) and will be reimbursed according to the Delta Dental PPO fee schedule for each procedure.

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

Predeterminations/Pretreatment Estimates

If you and your dentist are unsure of your benefit for a specific course of treatment, or if treatment costs are expected to exceed $300, Delta Dental recommends that you ask for a pretreatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pretreatment estimate requests are not required, but may be submitted for more complicated and expensive procedures, such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. You will receive an estimate of your out-of-pocket expenses, including copays, if any, and what Delta Dental will pay before treatment begins. Predeterminations are free and help you and your dentist make informed decisions about your treatment.

Annual Maximum

The Dental Plan provides coverage of up to $1,000 per participant or dependent age 19 and older per calendar year. There is no annual maximum for participants and dependents under age 19.

Frequency Limitations

Benefits are subject to the frequency limits shown on the Schedule of Covered Dental Services for the Dental Plan as shown on the following pages:

Schedule of Covered Dental Services (the "Schedule")

Covered dental services are subject to frequency limitations that are stated in that Schedule. The Plan does not cover benefits for procedures that are not in the Schedule, but may provide an alternate benefit if approved by Delta Dental. Whether you have to pay for those services and, if so, how much, depends on whether you choose to receive your dental care from a Delta Dental PPO **participating** dentist or from a **non-participating** dentist.

Preventive Services

Benefit	In-Network	Out-of-Network	Limitations
Dental prophylaxis (cleaning, scaling and polishing)	Plan pays 100%	Plan pays lesser of actual charges or 100% of the **allowed amount**.	Two in a calendar year.
Topical fluoride treatment			Two in any calendar year for patients under age 16.
Sealants (on the occlusal surface of a permanent non-restored molar and pre-molar tooth)			Once per tooth in any 24 consecutive months period for patients under age 16.
Space maintenance (passive-removable or fixed devices made for children to maintain the gap created by a missing tooth until a permanent tooth emerges)			Once in a lifetime per quadrant/arch for patients under age 16.

Diagnostic Services

Benefit	In-Network	Out-of-Network	Limitations
Oral exam, periodic, limited (problem focused), comprehensive or detailed and extensive (problem-focused)	Plan pays 100%	Plan pays lesser of actual charges or 100% of the **allowed amount** and the member pays any charges above the **allowed amount.**	Two in a calendar year.
X-rays: • full mouth, complete series, including bitewings or panoramic film			Once in any 36 consecutive months period.
• bitewings, back teeth			Two of any bitewing x-ray procedure in a calendar year.
• periapicals, single tooth			As necessary.
• occlusal film			Two per date of service.
• cephalometric film or photographic image obtained intra- or extra-orally (orthodontic coverage only)	Plan pays 100%	Not Covered	Once in a lifetime.

Simple Restorative Services

Benefit	In-Network	Out-of-Network	Limitations
• Amalgam (metal) fillings	Plan pays 80% and member pays 20%	Plan pays lesser of actual charges or 80% of the **allowed amount,** and the member pays 20% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth surface in any 24 consecutive months period.
• Resin (composite, tooth-colored) fillings on anterior teeth			

Endodontics

Benefit	In-Network	Out-of-Network	Limitations
• Root canal therapy • Retreatment of root canal • Apicoectomy/ Periradicular services (a post-operative film showing completed apicoectomy and retrograde, if placed, is required for payment) • Pulpotomy	Plan pays 80% and the member pays 20%	Plan pays lesser of actual charges or 80% of the **allowed amount,** and the member pays 20% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth in a lifetime.
• Hemisection • Apexification/ Recalcification • Pulp Capping			Only for children under age 19.

Periodontics

Benefit	In-Network	Out-of-Network	Limitations
• Gingivectomy or gingivoplasty • Osseous surgery	Plan pays 80% and member pays 20%	Plan pays lesser of actual charges or 80% of the **allowed amount,** and the member pays 20,% of the **allowed amount** and any charges above the **allowed amount**.	Once per quadrant in a 60 consecutive months period.
• Periodontal scaling and root planing			Once per quadrant within a 24 consecutive months period.
Periodontal maintenance (procedure is a benefit following active periodontal therapy once a 30-day post-operative period has been completed)			Two of any prophylaxis procedure in a calendar year.

Simple Extractions

Benefit	In-Network	Out-of-Network	Limitations
Nonsurgical removal of tooth or exposed roots (includes local anesthesia, necessary suturing and routine post-operative care)	Plan pays 80% and member pays 20%	Plan pays lesser of actual charges or 80% of the **allowed amount,** and the member pays 20% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth in a lifetime.

Oral and Maxillofacial Surgery*

Benefit	In-Network	Out-of-Network	Limitations
• Extractions • Removal of impacted tooth, residual tooth roots	Plan pays 80% and member pays 20%	Plan pays lesser of actual charges or 80% of the **allowed amount,** and the member pays 20% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth in a lifetime.
Alveoplasty (surgical preparation of ridge for dentures, with or without extractions)			Once per quadrant in a lifetime.
Frenulectomy			Once per arch in a lifetime.

* Oral surgery is limited to removal of teeth, preparation of the mouth for dentures, removal of tooth-generated cysts up to 1.25cm and incision and drainage of an intraoral or extraoral abscess.

Major Services

Benefit	In-Network	Out-of-Network	Limitations
Recementation of crown, inlay, onlay	Plan pays 50% and member pays 50%	Plan pays lesser of actual charges or 50% of the **allowed amount,** and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth per lifetime.
Prefabricated stainless steel/resin crown (for children only–deciduous teeth only)			Once per tooth in any 24 consecutive months period.
Inlays, onlays, and crowns, when tooth cannot be restored with regular filling(s) due to excessive decay or fracture			Once per tooth in any 60 consecutive months period.

Removable Prosthodontics

Benefit	In-Network	Out-of-Network	Limitations
Complete or immediate (full) upper and lower dentures or partial dentures, including six months of routine post-delivery care	Plan pays 50% and member pays 50%	Plan pays lesse of actual charges or 50% of the **allowed amount,** and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.	One denture per arch within any 60 consecutive months period.
Denture rebase or reline procedures, including six months of routine post-delivery care			Once per appliance in any 36 consecutive months period.
Interim maxillary and mandibular partial denture			Once per appliance in any 60 consecutive months period.
Tissue conditioning			Twice per arch in any 36 consecutive months period.

Fixed Prosthodontics

Benefit	In-Network	Out-of-Network	Limitations
Fixed partial dentures pontics	Plan pays 50% and member pays 50%	Plan pays lesser of actual charges or 50% of the **allowed amount,** and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth in any 60 consecutive months period.
Fixed partial denture retainers — inlays/onlays, crowns			

Repairs

Benefit	In-Network	Out-of- Network	Limitations
Crown repair	Plan pays 50% and the member pays 50%	Plan pays lesser of actual charges or 50% of the **allowed amount,** and the member pays 50% of the **allowed amount** and any charges above the **allowed amount**.	Once per tooth in any 24 consecutive months period.
Additions to partial dentures			
Replace broken teeth on denture			Twice in any 12 consecutive months period.

Emergency Treatment

Benefit	In-Network	Out-of-Network	Limitations
Palliative treatment to alleviate immediate discomfort (minor procedure only)	Plan pays 100%	Plan pays lesser of actual charges or 100% of the **allowed amount** and member pays any charges above the **allowed amount**.	Once per date of service.

Orthodontic Services*

Benefit	In-Network	Out-of-Network	Limitations
Orthodontics	Plan pays 50% up to lifetime maximum of $1,000 and member pays 50% and any amount above the maximum of $1,000	Not Covered	Only for children under age 19. $1,000 lifetime maximum. One course of treatment** in a lifetime.

* Benefits are payable only for treatment by orthodontists who are graduates of an advanced education program in orthodontics accredited by the American Dental Association.

** A course of treatment include braces, monthly visits and retainers.

Miscellaneous

Benefit	In-Network	Out-of-Network	Limitations
Occlusal guard	Plan pays 80%	Plan pays lesser of actual charges or 80% of the **allowed amount** and member pays any charges above the **allowed amount**.	One appliance in any 60 consecutive months period.

Alternate Benefit for Dental Coverage

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

What Is Not Covered

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

- any services performed before a patient becomes eligible for benefits or after a patient's eligibility terminates, even if a treatment plan has been approved.
- reimbursement for any services in excess of the frequency limitations specified in the Schedule of Covered Dental Services.
- orthodontic care for individuals 19 or older
- out-of-network orthodontic care for individuals under age 19
- charges in excess of the **allowed amounts**, or the annual maximum, or the lifetime maximum for orthodontic care
- treatment for accidental injury to natural teeth that is provided more than 12 months after the date of the accidental injury
- services or supplies that the Plan determines are experimental or investigative in nature, except to the extent provided by law
- services or treatments that the Plan determines do not have a reasonably favorable prognosis
- any treatment performed principally for cosmetic reasons, including, but not limited to, laminate, veneers and tooth bleaching
- special techniques, including precision dentures, overdenture, characterization or personalization of crowns, dentures, fillings or any other service. This includes, but is not limited to, precision attachments and stress-breakers. Full or partial dentures that require special techniques and time due to special problems, such as loss of supporting bone structure, are also excluded
- any procedure, appliance or restoration that alters the "bite," or the way the teeth meet (also referred to as occlusion and vertical dimension), and/or restore or maintain the bite, except as provided under orthodontic benefits. Such procedures include, but are not limited to, equilibration, periodontal splinting, full-mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for misalignment of teeth
- any procedures involving full-mouth reconstruction, or any services related to dental implants, including any surgical implant with a prosthetic device attached to it

- diagnosis and/or treatment of jaw-joint problems, including temporomandibular joint disorder ("TMJ") syndrome, craniomandibular disorders or other conditions of the joint linking the jaw bone and skull or the complex of muscles, nerves and other tissue related to that joint
- double or multiple abutments
- treatment to correct harmful habits, including, but not limited to, smoking and myofunctional therapy
- habit-breaking appliances, except under the orthodontics benefit
- services for plaque-control programs, oral hygiene instruction and dietary counseling
- services related to the replacement or repair of appliances or devices, including:
  - duplicate dentures
  - the replacement of lost, missing or stolen dentures and appliances less than five years from the date of insertion
  - replacement of existing dentures, bridges or appliances that can be repaired in accordance with dental standards
  - adjustments to a prosthetic device within the first 6 months of its placement
  - replacement or repair of orthodontic appliances
- drugs or medications used or dispensed in the dentist's office
- charges for novocaine, xylocaine or any similar local anesthetic when the charge is made separately from a covered dental expense
- additional fees charged by a dentist for hospital treatment
- services for which a participant has contractual rights to recover costs, whether a claim is asserted or not, under Workers' Compensation, or automobile, medical, personal-injury protection, homeowners or other no-fault insurance
- treatment of conditions caused by war or any act of war, whether declared or undeclared, or a condition contracted or an accident occurring while on full-time active duty in the armed forces of any country or combination of countries
- any portion of the charges for which benefits are payable under any other part of the Plan
- if a participant transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for the same procedure, the Plan will not pay benefits greater than what it would have paid if the service had been rendered by one dentist
- transportation to or from treatment
- expenses incurred for broken appointments
- fees for completing reports or for providing records
- any procedures not listed under the Schedule of Covered Dental Services

Coordination of Dental Benefits

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

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

1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent.

2. The program covering the enrollee as a dependent of an employee whose birthday falls earlier in the calendar year will determine its benefits before the program covering the enrollee as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period.

If the other program does not have the rule described in the above paragraph, but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.

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

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

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

6. In situations not described in items 1 through 5, the program under which the enrollee has been enrolled for the longest period of time will determine its benefits first. When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program.

When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this Plan exceed the amount of benefits payable under the other program.

7. When a dental procedure is eligible for coverage under both your hospital/medical plan and your dental plan, your hospital/medical plan will always be the primary payor.

Life Insurance Benefits

Your life insurance coverage is insured and administered by MetLife. The Plan pays the premiums required to keep the insurance policy in force, but the Plan does not directly pay any life insurance benefits.

Accordingly, your rights and the rights of your beneficiaries to life insurance benefits are defined and limited by the insurance policy that is in effect at the time of any covered loss. Coverage exclusions may apply. The terms of the insurance policy may change from time to time. If the information in this SPD is different from the terms of the policy, that insurance policy will govern your benefit rights. For a copy of the group certificate or for information on coverage exclusions, contact MetLife at 1-866-492-6983.

Benefit Amount

Your life insurance coverage is $10,000. Life insurance benefits are payable to your beneficiary if you die while coverage is in effect.

For a copy of the plan document, information on how to designate a beneficiary or to file a claim, contact MetLife at 1-866-492-6983 or visit mybenefits.metlife.com.

When Life Insurance Coverage Ends

Life insurance coverage ends 30 days after your **covered employment** ends, unless you have Fund-paid Health Extension due to disability or arbitration, as shown on the following page. After your group life insurance under the Plan ends, you may be able to convert it to an individual life insurance policy. Contact MetLife at 1-866-492-6983 for more information about converting life insurance.

Life Insurance Disability Extension

If you are disabled and receiving short-term disability or Workers' Compensation benefits, your life insurance will continue for 6 months from the date of disability, or until your disability ends, whichever happens first. If you are eligible for a Disability Pension under the Building Service 32BJ Pension Fund, your life insurance will continue until your disability ends or you reach age 65, whichever happens first. For as long as this extended coverage lasts, your life insurance 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 page 9. If you die before you submit proof of your disability, your beneficiary must submit proof of death and total disability w*ithin 90 days* after your death.

Notice of approval or denial of benefits will be sent to your designated beneficiary in writing. (See pages 38–43 for information on appealing a denied claim.)

Accidental Death & Dismemberment (AD&D) Benefits

Your accidental death and dismemberment ("AD&D") benefits coverage is insured and administered by MetLife. The Plan pays the premiums required to keep the insurance policy in force, but the Plan does not directly pay any AD&D benefits.

Accordingly, your rights and the rights of your beneficiaries to AD&D benefits are defined and limited by the insurance policy that is in effect at the time of any covered loss. Coverage exclusions may apply. The terms of the insurance policy may change from time-to-time. If the information in this SPD is different from the terms of the policy, that insurance policy will govern your benefit rights. For a copy of the group certificate or for information on coverage exclusions, contact MetLife at 1-866-492-6983.

AD&D insurance 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

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

When AD&D Coverage Ends

AD&D insurance coverage ends 30 days after your **covered employment** ends, except as provided if you have Fund-paid Health Extension due to disability or arbitration. Like your life insurance, your AD&D coverage may continue while you have Fund-paid Health Extension due to disability or arbitration. (See pages 8–10.)

Contact MetLife at 1-866-492-6983 for more information about your benefit, coverage exclusions or for a copy of your group certificate.

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 Dental Claims

When you see a Delta Dental **participating provider**, this provider will file all claims for you directly with Delta Dental, the administrator for the Plan's dental coverage. Delta Dental will pay the **participating** Delta Dental **providers** directly.

You have to file a claim when you receive care from dentists or other providers or facilities not in the Plan's participating dental provider network. You can obtain a claim form by visiting Delta Dental's website at www.deltadentalins.com/32bj or calling 1-800-589-4627. Refer to the table on page 33 for information on where to file your claim for benefits received **out-of-network**.

Here is what you need to know when filing a dental claim when you do not use a participating dental provider:

- only an original, fully completed claim form or other documents as required by Delta Dental will be accepted for review.
- all necessary diagnostic information must accompany the claim.
- when you are the patient, your original signature or signature on file is acceptable on all claims for payment. If the patient is a child, an original signature or signature on file of the child's parent or guardian is acceptable.
- **all claims must be received by Delta Dental within 180 days after the date of service. Claims received more than 180 days after the date of service will be denied.**
- payment for all services received from a **non-participating** dental provider will be made to you. It is your responsibility to pay the dentist directly for services you receive from a **non-participating** dentist. The Plan will not assign benefits to a **non-participating** dental **provider**, which means that the Plan will not pay the non-participanting dental provider directly.

The Plan reserves the right to withhold payment or request reimbursement from providers or participants for services that do not meet acceptable standards, as determined by its consultants or professional staff.

Filing Life Insurance and AD&D Claims

To file a claim for life insurance or AD&D benefits, your beneficiary must contact MetLife at 1-866-492-6983 or visit mybenefits.metlife.com.

Where to Send Claim Forms

Benefit	Filing Address
Dental (**non-participating providers** only; no claim forms are necessary for **participating providers**)	Delta Dental One Delta Drive PO Box 2105 Mechanicsburg, PA 17055-2105
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 dental claims and life/AD&D claims. These processes are described separately below. Please review this information to ensure that you, or your authorized representative are fully aware of these processes and what you need to do in order to comply.

Designating an Authorized Representative

In order to designate someone as your authorized representative to file a claim or an appeal on your behalf, you must submit an authorization, signed by you, which includes:

- Your name,
- Your identification number as shown on your Delta Dental card, if you are designating an authorized representative for your dental claim or appeal,
- 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 a claim and/or an appeal on your behalf.

Dental Claims

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

- *Pre-service Claims*. This is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before care is obtained. For properly filed pre-service claims, you and/or your provider 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.

  If the information above is not included, your claim will be denied.

  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 provider will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.

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

- *Urgent Care Claims*. This is a claim for dental care or treatment that, if the time periods for making pre-service claim determinations were applied, could jeopardize your life, health or ability to regain maximum function or, in the opinion of a **doctor**, result in your having unmanageable, severe pain.

  Whether your treatment is considered urgent care is determined by an individual acting on behalf of the Fund applying the judgment of a prudent person who possesses an average knowledge of health and medicine. Any claim that a **doctor** with knowledge of your medical condition determines is an urgent care claim shall automatically be treated as such.

  If you (or your authorized representative*) file an urgent care claim, you will be notified of the benefit determination as soon as possible, taking into account medical emergencies, but no later than *72 hours* after receipt of your claim.

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

  – The claims reviewer's receipt of the specified information or, if earlier,

  – The end of the period you were given to provide the requested information.

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

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

- Your name,
- Your specific medical condition or symptom, and
- A specific service, treatment or product for which approval is requested.

If the information above is not included, your claim will be denied.

- *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. 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 insurance or AD&D benefits, MetLife will make a decision on the claim and notify you or your beneficiary directly.

Notice of Decision

You will be provided with written notice of a denial of a claim. The denial notice will contain:

- the reason(s) for denial, whether denied, in whole or in part, or if any adverse benefit determination has been made (for example, the Plan pays less than 100% of the claim),
- the specific reference to the Plan provision(s) on which the denial has been based,
- a description of any additional information necessary to perfect the claim, and an explanation of why such information is necessary, and
- a description of the appeals process and time limits, as well as a statement of your right to bring a civil action under the Employee Retirement Income Security Act of 1974 ("ERISA") Section 502(a) no more than three years after the date an appeal has been denied.

For urgent care and pre-service claims, you will receive notice of the determination even when the claim has been approved. The timing for delivery of this notice depends on the type of claim as described on pages 39–40.

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 dental and life/AD&D claims.

The table below gives a brief overview of the levels of appeal available for each type of denied claim and with whom an appeal should be filed:

Type of Denied Claim	Level-one Appeal	Level-two Appeal
Dental	Delta Dental	Board of Trustees*
Life/AD&D	MetLife Insurance Company	Not applicable

* 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.

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 upon request, access to, or copies of, all documents, records or other information relevant to your appeal.

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 file an appeal requesting a review of a denied claim within 180 days of the date of the denial letter, you will waive your appeal right. You must file an appeal with the appropriate party and follow the process completely before you can bring an action in court. Failure to do so may prevent you from having any legal remedy.

Where to File a Level-One Appeal

Benefit	Write to:	Or Call
Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 Attn: Professional Services	Appeals, except for urgent care, 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.

* An appeal of an urgent care dental claim also may be filed by calling Delta Dental at 1-800-589-4627.

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.

Request for Expedited Appeal

If your claim involves urgent care for dental benefits, you can file an expedited appeal if your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that

is the subject of the claim. This appeal can be filed in writing or by calling the number set forth in the table under the section Where to File a Level-One Appeal on page 39. You can discuss the reviewer's determination and exchange any necessary information over the phone, via fax or any other quick way of sharing. You will receive a response *within 72 hours* of your request.

Pre-service or Concurrent Care Dental 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 Dental 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.

Request for Expedited Dental Appeal

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or, in the opinion of your **doctor**, would cause you severe pain which cannot be managed without the requested services or drugs. Delta's independent medical specialist, as applicable, in consultation with the treating **physician**, will decide if an expedited appeal is necessary. When an appeal is expedited, Delta will respond orally with a decision *within 72 hours*, and Delta will also send a written notice of the decision.

Voluntary Level of Appeal Dental Claims

Once you have received notice of the denial of your timely* level-one appeal of a dental claim, you have exhausted all required internal appeal options.

* The Appeals Committee does not hear voluntary appeals for claims for which the mandatory appeal was not timely filed. If Delta Dental denied your appeal as untimely, there is no voluntary appeal to the Board of Trustees' Appeals Committee.

Please note: there are no expedited appeals for post-service claims under the voluntary appeal procedure.

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

The voluntary level of appeal is available only after you (or your authorized representative) have pursued the appropriate mandatory appeals process required by the Plan, as described previously. This level of appeal is *completely voluntary*; it is not required by the Plan and is only available if you (or your authorized representative) request it. The Plan will not assert a failure to exhaust administrative remedies where you 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 authorized representative) because you (or your authorized representative) chose to use 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 benefit under the Plan. Upon your request, the Plan will provide you (or your authorized representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including your right to representation.

Your voluntary appeal must include your identification number, dates of service in question and any additional information that supports your appeal.

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

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

If you choose to pursue a claim in court after completing the voluntary appeal, the statute of limitations applicable to your claim, which is three years under the terms of the Plan, will be tolled (suspended) during the period of the voluntary appeals process.

Appeal Decision Notice

You will be notified of the decision of your appeal in writing within 5 days from the date your appeal is decided by the Appeals Committee. The written appeal decision notice will include all of the information set forth under the section Notice of Decision on page 37.

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 during which 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.

No Duplication of Health Coverage

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

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 copays 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 copays, 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

During a Family and Medical Leave ("FMLA"), you may be able to continue all of your coverage and other benefits offered through the Plan. In New York State, you may be eligible for Paid Family Leave. Other states may have similar leave requirements. Check with your **employer** to determine if you are eligible for the FMLA or other statutory leave that requires the **employer** to continue Fund contributions.

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

dental coverage for you, and your dependent(s), at your own expense for up to 24 months provided you enroll for coverage. This continuation coverage operates in the same way as COBRA. (See pages 8–10 and 46–51 for information on COBRA.) In addition, your dependent(s) may be eligible for health care under **TRICARE**.

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 **contributing 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 8 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 dental coverage.

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

If you are disabled and receiving (or are approved to receive) benefits under statutory short-term disability (limited to 6 months) or Workers' Compensation, the Plan provides coverage for up to 6 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 6 months from your date of termination. In these two cases of extended 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.

The table below 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:	**A Qualifying Event** (that results in a loss of health coverage):	**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.

* This is a continuation requirement of USERRA, not COBRA, and different rules may apply. Please contact Member Services with any questions.

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 of 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 47.)

*When Your **Employer** Must Notify the Fund*. Your **employer** is responsible for notifying the Fund of your death, termination of employment or reduction in hours of employment. Your **employer** must notify the Fund of one of these Qualifying Events within 30 days 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, under COBRA, 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% (or 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 6 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 47. It will stop *before* the end of the maximum period under any of the following circumstances:

- A COBRA recipient fails to make the required COBRA contributions on time.
- A COBRA recipient becomes enrolled in Medicare (Part A, Part B or both) after the date of the COBRA election, or becomes covered under another group plan.
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination that the COBRA recipient is no longer disabled. The COBRA recipient must notify Member Services within 30 days of any such final determination.

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

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

Other Health Plan Information You Should Know

Assignment of Plan Benefits

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

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

Although as described above, you may not assign to a provider your right to file an appeal under the Plan's Appeals Procedures or to file a suit for benefits under Section 502(a) of ERISA, you may allow a provider to act as your authorized representative in an appeal under the Plan's Appeals Procedures. In order to appoint a provider as your authorized representative, you must submit a legibly signed authorization with your appeal that includes all of the information set forth in the section Designating an Authorized Representative on page 33.

Qualified Medical Child Support Order

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 59.

No Liability for Practice of Medicine

The selection of a health care provider is solely your decision. 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. Therefore, neither the Fund, the Board nor any of their designees are responsible for, or will have any liability whatsoever for, the actions or inactions of any health care provider selected under this Plan, including, but not limited to, any negligence or medical or dental malpractice on the part of such health care provider.

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 participants. Anyone may request an additional copy of this Notice by contacting the Compliance Office at the address on page 59.

The Fund's Board of Trustees has 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 59.

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. Contact MetLife for information.

All Other Plan Benefits. You cannot convert dental 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 other **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 noncollectively bargained employees, if approved by the Trustees, by signing a participation agreement. Certain other **employers** (such as Local 32BJ itself, the 32BJ Benefit Funds and the Realty Advisory Board) 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, or
- cash checks within 18 months of the date issued. The amounts of such uncashed checks or other unclaimed funds are not subject to any escheat laws and remain assets of the Plan. Uncashed checks or other unclaimed funds 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 8–10 and 46–51).

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 44–45.)

Compliance with Federal Law

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

Plan Amendment or Termination

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

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

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

Plan Administration

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

The Plan is administered by the Board of Trustees, except those portions administered by insurers in fully insured arrangements. 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, as amended ("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 copies of documents other than this SPD.
- 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 8–10 and 46–51 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 38–43. 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 at 1-866-444-3272 or by visiting the Department of Labor's website at http://www.dol.gov.

Plan Facts

This SPD is the formal plan document for the Part Time Basic 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 that 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 39.

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 each **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, Customer Relations, 500 Schoolhouse Road, Johnstown, PA 15904 or upon the supervisory official of the Insurance Department of the state in which you reside.

Glossary

Allowed amount means the maximum the Fund will pay for a covered service. When you go to a **network provider**, the **allowed amount** is based on an agreement with the provider. When you do not go to a **network provider**, the **allowed amount** is based on the Fund's payment rate of allowed charges to a **network provider**.

Co-insurance means the 20% you pay toward basic and restorative services, such as fillings and extractions the 50% you pay toward major dental services such as fixed bridgework, crowns and dentures and the 50% you pay toward orthodontic services for children 19 and under such as diagnostic procedures and appliances to realign teeth.

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 that requires contributions to the 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 provider (M.D., D.O., D.C., D.P.M., or D.D.S.) 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.

In-network (or **participating) providers** are providers and suppliers who have contracted with the Fund, Delta Dental or with any other administrators under contract to the Fund, to provide services and supplies at a prenegotiated rate. Services provided must fall within the scope of their individual professional licenses.

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

Out-of-network (non-participating) provider/supplier means a **doctor** or other professional provider who is not in the Plan's **network** for dental services. **Out-of-network** benefits are benefits for **covered services** provided by **out-of-network providers** and suppliers.

Participating provider (see **in-network provider**).

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
• General information about your eligibility and benefits • Information on your hospital, medical, vision, dental and disability benefits and claims	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Visit the Welcome Center at 25 West 18th Street 8:30 am–6:00 pm Monday–Friday
• To find a 5 Star Center • To find a primary care physician • To find participating Empire BlueCross BlueShield providers	Member Services	Call 1-800-551-3225 8:30 am–5:00 pm Monday–Friday or Visit www.32bjfunds.org
• To find a participating dental plan provider	Delta Dental Customer Service	Call 1-800-589-4627 or Visit www.deltadentalins.com/32BJ.
To find a participating vision plan provider	Davis Vision	Call 1-800-999-5431 8:00 am–11 pm Monday–Friday Saturday, 9:00 am–4:00 pm Sunday, 12:00 pm–4:00 pm Visit www.davisvision.com/32bj
Information about your life insurance plan	MetLife	Call 1-866-492-6983 or Visit http://mybenefits.metlife.com
To pre-certify a hospital or medical stay	Empire BlueCross BlueShield	Providers call 1-800-982-8089
To pre-certify mental health or substance abuse stay	Empire BlueCross BlueShield	Providers call 1-855-531-6011
• To help prevent or report health insurance fraud (hospital or medical)	Empire Fraud Hotline	Call 1-800-423-7283 9:00 am–5:00 pm Monday–Friday
• Information about your prescription drug benefits, formulary listing or participating pharmacy	OptumRx	Call 1-844-569-4148 or Visit www.optumrx.com
• Immediate medical advice	Nurses Healthline	Call 1-877-825-5276 24 hours a day/7 days a week
• Help with family and personal problems, such as depression, alcohol and substance abuse, divorce, etc.	Empire BlueCross BlueShield	Call 1-212-388-3660

Building Service 32BJ Health Fund
Part Time Basic Plan
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