



Service Employees 32BJ North Health Benefit Fund

140 Huguenot Street, New Rochelle, NY 10801-5210
TEL (914) 637-7000 FAX (914) 637-2138

TRUSTEES

Kyle Bragg, *Chairman*
Eugene S. Reisman, *Secretary*
Richard W. Berger
Judith I. Padow

SERVICE EMPLOYEES 32BJ NORTH HEALTH FUND SUMMARY OF MATERIAL MODIFICATIONS

PLAN NAME: Service Employees 32BJ North Health Benefit Fund, Tri-State Preferred North Plan (Plan)

DATE: June 10, 2010

This Summary of Material Modifications (SMM) supplements or modifies the information presented in your Summary Plan Description (SPD) dated October 1, 2007 with respect to the Plan. **Please keep this document with your copy of the SPD for future reference.**

Modifications:

Change in Definition of Dependent Pages 11 and 12: A spouse must live in the United States, Canada or Mexico unless he or she is a United States Citizen in order to be considered a dependent. In addition, for the purposes of satisfying the residency requirement, if a participant was never married to the other parent of the participant's dependent child, that child will be considered the participant's dependent regardless of where the child resides, as long as the child is the tax dependent of the member.

Implementation of Michelle's Law: Page 11: Effective January 1, 2010 the following language is added to the end of the fourth bullet point under the definition of "Children (except disabled children)":

If a dependent child, who is enrolled in Fund coverage under this section is on a medically necessary leave of absence from post-secondary school because of a serious injury or illness, coverage under this Plan will be extended, free of charge to the dependent during his/her leave of absence until the earlier of (i) the one-year anniversary of the date on which his/her leave of absence began, or (ii) the date on which the dependent child's coverage under the Plan would otherwise terminate. To be eligible for this extended coverage, the participant must provide the Fund with written certification from the dependent child's treating physician that his/her leave of absence from school is medically necessary and is as a result of a serious illness or injury. The extended coverage commences on the date such certification is received by the Fund, but will be retroactive to the date on which his/her leave of absence began. Extended coverage under this section is concurrent with, and not in addition to, coverage under COBRA (see page 80). This means that if the dependent child receives one-year of extended coverage under this section and, after the expiration of this one-year period, he/she is not eligible for active Fund coverage (e.g., he/she did not return to school, has attained age 23 or has

gotten married), the child can elect to continue coverage under COBRA, but only for a maximum of 24 months.

Addition of Special Enrollment Right Page 14: If, after your coverage under the Plan becomes effective, your dependent(s) lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) or become eligible for a state subsidy for enrollment in the Plan under Medicaid or CHIP, and you would like to enroll them in the Plan, it is your responsibility to notify the Fund immediately of such change and complete the appropriate form. If you notify the Fund within 60 days of the loss of Medicaid/CHIP or of your dependent's becoming eligible for the state subsidy, coverage for your dependent(s) will begin as of the date your dependent(s) lost eligibility for Medicaid/CHIP or the date they became eligible for the subsidy. If you do not notify the Fund within 60 days, coverage for your dependent(s) will begin as of the date you notify the Funds. Failure to notify the Funds of your dependents' loss of eligibility for Medicaid/CHIP or becoming eligible for the state subsidy could lead to a delay or denial in the payment of health benefits or the loss of a right to elect health continuation under COBRA.

Elimination of pre-certification requirement Pages 20 and 22: Effective March 1, 2010, pre-certification is no longer required for cardiac rehabilitation, home care, home infusion therapy and hospice.

Addition of Pre-certification Requirement for certain Outpatient and Diagnostic Tests Pages 20 and 23: Effective January 1, 2009, the following Outpatient and Diagnostic Tests require Pre-certification: CAT and PET exams and nuclear imaging studies.

Coverage of Bariatric Surgery only at Facilities Accredited by the American College of Surgeons Page 21: Effective January 1, 2009, bariatric surgery will only be covered at in-network facilities accredited by the American College of Surgeons. There is no out-of-network coverage.

Change in Frequency of Well Child Visits to Conform to the American Academy of Pediatrics Guidelines Page 23: The following frequency limits apply to well child visits; birth to age 1, 7 visits; age 1 through age 4, 6 visits; age 5 through age 11, 7 visits; age 12 through age 17, 6 visits; and age 18 through age 23, 2 visits.

Corrections of print errors Page 25: Out-of Network outpatient services for physical, occupational, speech or vision therapy are not covered. In addition, the Plan pays 100% for hearing aids up to \$550 per hearing aid regardless of whether the hearing aid is purchased from an In-Network or Out-of-Network vendor.

Addition of Pre-planned Home Birth as a Covered Service Page 27: Effective April 14, 2009, pre-planned home delivery of a child by a certified nurse-midwife is a covered service. The reimbursement rate for this service is at the contracted Empire BlueCross BlueShield Direct Point-of-Service (Direct POS) Obstetrician/Gynecologist global rate.

Elimination of Contraceptive Device Exclusion Page 30: Effective February 1, 2008, the medical coverage exclusion for contraceptive devices is eliminated. The Plan's medical coverage will now include contraceptive devices.

Addition of Rite Aid Pharmacy as a Way to Get Maintenance Drugs through the Mail (for the period June 1, 2008 to February 28, 2009, the pharmacy offering this benefit was Pathmark Retail Pharmacy) Pages 32-34: Effective March 1, 2009, you can fill your mail order prescription at

a Rite Aid Pharmacy in New York or New Jersey instead of mailing it to Medco Pharmacy. Simply drop off your 90-day prescription at a Rite Aid pharmacy. Make sure you have your Medco prescription drug ID card with you when you visit the Rite Aid pharmacy. The Rite Aid pharmacist will send this prescription to Medco Pharmacy for filling. As soon as your prescription is ready (usually within 8 to 10 days), you can return to that Rite Aid pharmacy to get your prescription. When you pick up your prescription at Rite Aid, you pay the pharmacist the appropriate co-payment--\$14 for a 90-day supply of a generic prescription drug or \$44 for a 90-day supply of a brand name prescription drug.

Elimination of EAP Page 35: Effective September 1, 2009, the EAP benefit on page 35 is eliminated and the section titled Employee Assistance Program is replaced with the following text:

Behavioral Health and Substance Abuse Benefit

Your Plan provides you and your eligible dependents with a behavioral health and substance abuse benefit which is administered by MHN. This benefit provides services for mental health or behavioral issues as well as assistance with substance abuse treatments. Services are available both in the hospital and on an outpatient basis. All behavioral health care and substance abuse services must be provided by an MHN participating hospital or provider. There is no coverage for services received from a non-participating MHN provider except in cases of an emergency.

Elimination of \$15 co-pay for first 8 Behavioral Health Visits Page 36: Effective September 1, 2009, the first paragraph under the subheading Outpatient is replaced with the following:

Outpatient. You are covered for up to 40 visits per year when you see an MHN participating provider on an outpatient basis. For outpatient treatment from a **network** provider, you will not have any co-payment for your first eight (8) visits during a Plan Year. For visits 9-40, you must pay a \$15 copayment per visit. If you use an **out-of-network** therapist or do not pre-certify care, no benefits are payable. Outpatient treatment may include individual and group psychotherapy, couples and family treatment, psychiatric and medication evaluations, and ongoing medication management, depending on the patient's needs. Outpatient services are subject to a limit of 40 visits per year.

Replacement of EAP and HMC References: Effective September 1, 2009, All references though out the entire SPD to HMC are replaced by MHN; to EAP are replaced by behavioral health or behavioral health benefit; and to EAP network are replaced by MHN Behavioral network. In addition, the definition of EAP is stricken from the Glossary.

Elimination of Prior Approval Requirement when using non-participating dental providers: Pages 43-47: Effective June 1, 2010, prior approval for dental services or treatment plans is not required when you use a non-participating dental provider. However, it is recommended that you still seek prior approval from the Fund for dental services and treatment plans with non-participating dental providers so you will know in advance whether your services will be covered and any out-of-pocket expenses you will be required to pay. A non-participating dental provider or the member can request prior approval for dental services and treatment plans from Administrative Services Only, Inc. (ASO), Building Service 32BJ Health Fund Dedicated Unit, P.O. Box 9011, Lynbrook, NY 11563-9011. If a non-participating dental provider or the member submits a request for prior approval for dental services or a treatment plan, and it is approved, it is valid for up to one year from the date the approval is issued. Changes to an approved treatment plan are not covered under the original approval. If changes are made to your treatment plan, you should submit them to ASO for a new prior approval."

Prior approval continues to be required for dental services and treatment plans when you use a participating dental provider. It is your participating dental provider's responsibility to obtain prior approval. If your participating dental provider fails to obtain the necessary prior approval, and your claim is denied due to this failure, you will not be responsible.

Change in Dental Claims Reviewer Pages 43 and 63: Effective October 1, 2008, dental claims must be filed with Administrative Services Only, Inc., Building Service 32BJ Health Fund Dedicated Unit, P.O. Box 9011, Lynbrook, NY 11563-9011.

Change in Retiree Health Benefits Pages 57 to 59: Effective December 1, 2008 for participants retiring on or after December 1, 2008 and effective January 1, 2009 for all retirees, the subsection entitled "RETIREE HEALTH BENEFITS" beginning on page 57 and ending on page 59 is deleted in its entirety and replaced with the following language:

RETIREE HEALTH BENEFITS

Eligibility

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

- (1) are covered by the Fund for health benefits at the time you begin to receive a pension benefit immediately after termination of **covered employment** from the Service Employees 32BJ North Pension Fund (North Pension Fund), and
- (2) are age 62 or older, and
- (3) have accrued a minimum of 20 years of pension service under the North Pension Fund. For the purpose of calculating 20 years of pension service, the number of weeks of severance payments required under a collective bargaining agreement or participation agreement are counted.

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

No other dependents are eligible for retiree health benefits.

Benefit

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

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

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

How The HRA Works

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

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

Annual and Lifetime Maximums

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

Administrative Fees

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

Termination

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

- (1) your spouse's death

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

If your spouse's benefit terminates because of your death, your divorce or legal separation, your spouse will be eligible to continue his/her retiree benefits under COBRA. Please see pages 80-84 regarding the COBRA rules.

Change in Dental Claim Appeals Reviewer Pages 72-76: Effective October 1, 2008, an appeal of a denied dental claim must be filed with Administrative Services Only, Inc., Building Service 32BJ Health Fund Dedicated Unit, P.O. Box 9011, Lynbrook, NY 11563-9011.

Clarification in Coordination of Benefits Language Page 73: The following language is added after the first paragraph: Your Plan uses the Non-Duplication of Benefits application of COB. This means that when this Plan is the secondary plan, it determines how much, if any, it would have paid had it been the primary plan and then subtracts whatever the primary plan paid as its benefit. This Plan will pay that difference, if any. If there is no difference, this Plan will not pay any benefits.

Addition of New Leave Types Page 79: Effective January 16, 2009 the following fourth bullet point is added to page 79 under the subsection entitled "During a Family and Medical Leave:

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

Effective October 28, 2009, the word active is stricken from the above text.

Effective January 28, 2008 the following sentence is added after the first set of bullet points on page 79 under the subsection entitled "During a Family and Medical Leave":

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

Enactment of COBRA Subsidy Pages 80-84: Effective February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium for Assistance Eligible Individuals (AEIs). If you qualify for the premium reduction, you need only pay 35% of the COBRA premium otherwise due under the Plan.

This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA coverage.

An AEI is a participant who experiences a qualifying event that is an involuntary termination of employment during the period beginning September 1, 2008 and ending May 31, 2010 and who is not

eligible for other group health coverage or Medicare. In order to establish eligibility for the premium reduction you must complete the “Application For Treatment As An Assistance Eligible Individual Form.” If you incur a qualifying event, this form will be mailed to you with the COBRA notice and election form. It is also available from Member Services. The Fund will review your application and make a determination as to whether or not you are eligible for a subsidized COBRA premium. If you are denied, you may have the right to have the denial reviewed by the Department of Labor on an expedited basis. For more information regarding reviews or for general information about the ARRA premium reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

If you are paying the reduced premium and you become eligible for other group health coverage or Medicare (even if you do not enroll in the other coverage or Medicare) you must notify the Fund by completing and returning the “Premium Reduction Ineligibility Notice.” This form is available in Member Services.

Clarification in Section titled General Information; subsection How Benefits May Be Reduced, Delayed or Lost Page 86: A fourth bullet is added:

- Cash checks within eighteen (18) months of issue date. The amounts of such un-cashed checks will be restored to the Fund assets and added to Net assets available for benefits on the Fund financial statement.

Clarification in Second Surgical Opinion Coverage Page 99: Footnote 10 is replaced with the following: Second surgical opinions are covered under the Plan. When you secure a second opinion from a participating provider you are responsible only for the appropriate co-payment. Should you secure a second opinion from a non-participating provider, you are responsible for any deductibles and coinsurances required under the Plan as well as charges that exceed the Plan’s allowed amount.

Elimination of Pre-certification for Air Ambulance in Emergency Situations Page 99, footnote 9 is replaced with the following effective September 1, 2009: Air ambulance is covered, without pre-certification, when the patient’s medical condition is such that the time needed to transport by land poses a threat to the patient’s survival or seriously endangers the patient’s health or the patient’s location is such that accessibility is only feasible by air transportation; and patient is transported to the nearest hospital with appropriate facilities for treatment; and there is a medical condition that is life threatening. Life threatening medical conditions include, but are not limited to, the following:

- Intracranial bleeding
- Cardiogenic shock
- Major burns requiring immediate treatment in a Burn Center
- Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit
- Multiple severe injuries
- Transplants
- Limb-threatening trauma
- High risk pregnancy
- Acute myocardial infarction; if this would enable the patient to receive a more timely medically necessary intervention (such as PTCA or fibrinolytic therapy)

Pre-certification of air ambulance is still required in non-emergency situations.

If you have any questions about this notice or want further information about the changes please contact Member Services at 1-212-388-3333 between the hours of 8:30AM and 5:00PM Monday through Friday.

The SPD is the official Plan document and controls the actual payment of benefits and the administration of this Plan. This SMM highlights the changes adopted by the Board of Trustees and does not replace the SPD.