



Service Employees 32BJ North Health Benefit Fund

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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: May 28, 2009

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.

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.

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 By Mail. 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 By Mail 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.

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 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.

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:

- 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 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. Contact the Fund Office for more information

Enactment of COBRA Subsidy Pages 80-84: Effective February 17, 2009, the American Recovery and Reinvestment Act of 2009 (AARA) 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 9 months, starting March 1, 2009. If your COBRA continuation coverage lasts for more than 9 months, you will have to pay the full amount to continue your COBRA coverage, 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 December 31, 2009 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 AARA 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 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.

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.