SDC-LEAGUE HEALTH PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2022

STAGE DIRECTORS AND CHOREOGRAPHERS SOCIETY

AND

THE BROADWAY LEAGUE

HEALTH FUND

321 West 44th Street
Suite 804
New York, NY 10036
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Website: sdcleaguefunds.org
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Gould Kobrick & Schlapp, P.C.

July 2022

Dear Participant:

We are pleased to provide you with this book summarizing your benefits under the SDC-League (Stage Directors and Choreographers Society and The Broadway League) Health Fund (the "Fund"). The program of benefits offered by the Fund is referred to in this book as the "Plan." This book, which serves as the "Summary Plan Description," is provided to you so that you will be aware of the benefits provided under the Plan and how those benefits are administered. This book, together with the Certificates of Coverage/Insurance from the applicable insurance companies constitute the Plan Document. The benefits described in this book are the result of continuous efforts by the Board of Trustees (the "Trustees") to offer an excellent program of benefits that will help in meeting your health coverage needs and those of your family.

We urge you to read this description carefully so that you will understand the Plan as it applies to you. You should also share this book with your family and keep it in a safe place for future reference. You (and your covered family members) should refer to this book whenever you need information about your health benefits coverage. If you lose or misplace this book, please contact the Fund Office for another copy.

As described in this book, the Plan provides the following types of coverage for you and your eligible family members:

- Hospital, Medical, Prescription Drug and Dental Coverage (Option A); or
- Medical Spending Account Coverage (Option B).

This book also provides you with basic information about the Plan's eligibility requirements, coordination of benefits, information regarding how to file a claim and claims review procedures, and your rights and responsibilities under the Employee Retirement Income Security Act of 1974 as amended (ERISA), the primary law which governs the provision of benefits under the Fund. Throughout this book key terms are capitalized. Such terms will either be defined in the *Definitions* section on page 66 or in the section with which the term first appears.

After reviewing this book, if you have any questions about your benefits, please call the Fund Office at (212) 869-8129 or (800) 317-9373.

We believe that the Plan provides an excellent package of benefits and we ask you to use these benefits wisely. Your prudent use of these benefits should enable the Trustees to continue to provide you with a high quality plan of health benefits.

Sincerely,

The Board of Trustees
SDC-League Health Fund

IMPORTANT INFORMATION ABOUT THE PLAN

The primary purpose of this book is to provide you with a non-technical summary of the most important features of the Plan in order to assist you in comprehending the scope and meaning of the Plan. Accordingly, this book provides only a general explanation of the benefits available under the Plan and the manner in which such benefits are administered—it does not contain an exhaustive list of benefits provided under the Plan or all of the exclusions and limitations applicable to your coverage. You should check the Certificate of Coverage/Insurance applicable to you or contact the applicable insurance company providing benefits under the Plan and/or the Fund Office, prior to incurring a medical expense in order to be sure you have coverage for any specific medical expense. To obtain the most recent copy of your Certificate of Coverage/Insurance, you may contact the Fund Office.

Please understand that no general explanation, including this book, can adequately provide all the details of the Plan. Accordingly, this book is not a substitute for the official Plan documents (such as the Trust Agreement establishing the Fund, the rules of the Plan, or the Plan's insurance contracts or Certificates of Coverage/Insurance with Aetna, Kaiser or any other insurer) that set forth the details of the benefits provided under the Plan, nor does this book in any way change or otherwise interpret the terms of the official Plan documents. In the case of a conflict or inconsistency between this book and the official Plan documents, the official Plan documents will govern in all cases. Your rights can be determined only by referring to the full text of these documents, which are available for your inspection at the Fund Office during normal business hours.

The Trustees reserve the right to amend, modify or terminate the Plan, in whole or in part, at any time (even after a participant retires and may receive benefits under the Plan as a retiree) and for any reason with respect to active or retired participants and their dependents who are or may become covered. If the program is amended or terminated, the ability of employees, retirees or their family members to participate in and receive benefits from the Plan may be modified or terminated in any manner (with or without prior notice)—whether or not the employee, retiree or family member is receiving benefits under the Plan at the time. Under no circumstances will any benefits under the Plan become vested or non-forfeitable with respect to active or retired employees.

The Plan is maintained and operated according to collective bargaining agreements between contributing employers and the Stage Directors and Choreographers Society ("SDC"). However, please note also that no individuals, other than the Board of Trustees (acting collectively), have any authority to interpret the Plan (or official Plan documents), to make any promises to you about it, or to change the provisions of the Plan. The Trustees have the exclusive right and power, in their sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan (including, without limitation, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies, or omissions concerning the Plan or the program of benefits). All determinations by the Trustees are final and binding on all persons.

This book is not a contract of employment—it neither guarantees employment or continued employment with your employer or with any contributing employer, nor does it diminish in any way the right of contributing employers to terminate the employment of any employee, or their participation in the Plan (subject, of course, to the applicable collective bargaining agreement).

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ELIGIBILITY

Who is Eligible

If you are employed under a Stage Directors and Choreographers Society ("SDC") contract that requires your employer to contribute to the Plan on your behalf, and those contributions meet minimum eligibility requirements (described below), you are eligible to participate in the Plan.

Minimum Contribution Requirements	
Option A	$1,650 (in a 6 month period)
Option B	$1,650 (in a 6 month period)

This amount is subject to change.

When You Become Eligible

Coverage under the Plan for participants who meet the eligibility requirements described below will begin on the first day of the third month following the end of a Contribution Period. Accordingly, if the first rehearsal date(s) for the production(s) for which initial contributions are due falls between January 1 and June 30, or an ongoing production is required to pay weekly contributions on your behalf to the Fund for weeks ending between January 1 and June 30, and adequate contributions are made on your behalf during the same period, your eligibility will commence on September 1 and continue for six months until February 28 (or February 29th if applicable) when your eligibility for active coverage will cease if adequate additional contributions have not accrued on your behalf. If adequate contributions are due on your behalf for the period of July 1 through December 31, and the first rehearsal date(s) (or week ending date in the case of ongoing productions) for the production(s) for which initial contributions are due falls between July 1 and December 31, your eligibility will commence on March 1 and continue for six months until August 31 when your eligibility for active coverage will cease if adequate additional contributions have not accrued on your behalf. *Note that the start date for your eligibility will be based upon both an adequate contribution requirement and the start date of your rehearsal period(s) as indicated on your SDC contract, regardless of when the contributions due on your behalf are paid. Please call the Fund Office at (212) 869-8129 for the specific dollar amount of contributions required for eligibility.*

Contribution Period **First rehearsal date(s) for production(s) for which adequate contributions are due:**	Coverage Period **Six months from first day of third month following end of Contribution Period:**
January 1st – June 30th	September 1st – February 28th (or February 29th if applicable)
July 1st – December 31st	March 1st- August 31st

Length of Coverage

You will be covered under the Plan as an active participant for six full months from the first day of the third month following the applicable Contribution Period, provided that you meet the eligibility requirements described in the *When You Become Eligible* section on page 1.

If the contributions made or to be made on your behalf are at least $3,300 in the applicable six-month Contribution Period, you will be covered under the Plan as an active participant for 12 months from the first day of the third month following the Contribution Period.

Eligibility of Dependents and Domestic Partners

For the purposes of this Plan, the following persons are considered Eligible Dependents and are eligible for dependent coverage:

Your legal spouse to whom you are legally married or your Domestic Partner (provided that the appropriate documentation is filed with the Fund Office establishing Domestic Partnership) and your dependent children, which includes:

- Biological child(ren)
- Adopted child(ren), including children placed for adoption. Proof of placement for adoption and age will be required. "Placed for adoption" means the assumption and retention by you (the employee) of legal obligation for such child in anticipation of adoption of such child.
- Stepchild(ren) and child(ren) of Domestic Partners.
- Children covered under a Qualified Medical Child Support Order (QMCSO): You may also cover dependent children for whom Plan coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN). A copy of this Plan's QMCSO procedures is available free of charge from the Fund Office.

Dependent children are generally eligible until the end of the month in which they reach the age of 26 (New York state has a different rule, see *New York State Law Information* on page 21 for more information). However, an unmarried child who cannot work, and depends on you solely for support because of a mental, developmental or physical disability or illness that existed prior to age 26 can be considered your Eligible Dependent regardless of their age. You must provide proof to the Fund Office that your child's disability began before he/she reached age 26. In the case of a child who is already enrolled as an Eligible Dependent, you must do so no later than 31 days after the child's 26th birthday.

Note that the Plan requires you to pay the portion of the premium that is attributable to coverage for your Dependents and/or your Domestic Partner. Dependent and/or Domestic Partner coverage will cease at the end of the month for which you last paid the required premium.

HOW YOU ENROLL AND PAYING FOR COVERAGE

Initial Enrollment

When you become eligible for coverage, you will be sent an Option Election Form. The Option Election Form will indicate the Option(s) for which you are eligible (and the cost of Option A if you are eligible for those benefits). You must return the Option Election Form to the Fund Office within 30 days of notification of eligibility, indicating your preference of either Option A for Hospital, Medical and Dental coverage, or Option B for the Medical Spending Account.

- **Option A:** If you elect Option A, your Option Election Form and the Insurance Enrollment Form must be returned to the Fund Office along with a payment (either by check or on the Fund website) for your participant Contribution, payable to the SDC-League Health Fund. A participant Contribution amounting to 15% of the underlying insurance premium will be charged to all Option A participants for each quarter of eligibility. Those electing family participation (spouse, Domestic Partner, and/or child coverage) will be charged the full cost of the underlying cost of the family portion of the premium, plus 15% of the underlying individual premium.

    - **Participants who elect Individual Option A Coverage:** Payment of the 15% participant share of the premium must be paid quarterly and received by the SDC-League Health Fund by no later than the 15th of the month in which the billing quarter begins. Any payment received after the 15th but before the 1st of the second month of the quarter will be subject to a late charge of $100. **If payment is not received in full, including any applicable late charges, before the 1st day of the second month of the quarter, the participant's health insurance will be terminated retroactive to the first day of the quarter as a result of non-payment of premiums, and the participant will be responsible for any medical costs incurred on or after that date**. Billing quarters begin March 1, June 1, September 1, and December 1.

    - **Participants who elect Dependent/Family Option A Coverage:** Payment of the 15% participant share of the premium and 100% of the dependent share of the premium must be paid monthly and received by the SDC-League Health Fund by no later than the 15th of each coverage month. Any payment received after the 15th but before the 1st of the following month will be subject to a late charge of $100**. If payment is not received in full, including any applicable late charges, before the 1st of the following month, the participant and dependent(s) health insurance will be terminated retroactive to the first day of the month as a result of non-payment of premiums, and the participant will be responsible for any medical costs incurred on or after that date.**

Coverage for all participants who fail to pay timely will default to Option B, the medical spending account, under the Plan, for limited "excepted benefits" only. In order to be eligible for the full benefits under Option B, each participant will have to certify that they are enrolled in another employer sponsored group health plan that meets minimum value standards under the Affordable Care Act. If a participant does not provide the certification or does not have other employer sponsored group health coverage, then they will be eligible for reimbursement of "excepted benefits" only under Option B, which includes reimbursement of medically necessary dental and vision expenses.

If a participant defaults to Option B in the middle of a six-month coverage period, the $2,200 reimbursement maximum under Option B will be prorated to account for the period the participant is on Option B. For example, if a participant is eligible and elects Option A for the March 1 to August 31 period but as of July 1 has only paid for the March 1 to May 31 quarter, coverage will default to Option B effective June 1 and the participant will be eligible to submit up to $1,100 in expenses for dates of service that fall in the June 1 to August 31 period. The $1,100 is half the normal $2,200 amount allowed because the participant is on Option B for 3 months of the 6 month coverage period.

You will be sent the appropriate enrollment materials, which must be completed and returned to the Fund Office in a timely manner. To enroll for coverage beginning on March 1st, your enrollment form must be received no later than March 30th. For coverage beginning September 1st, your enrollment form must be received no later than September 30th. Failure to comply with these deadlines may result in the loss of your eligibility to receive benefits through Option A for the applicable six-month coverage period.

- **Option B:** If you elect Option B, you will be sent Medical Spending Account ("MSA") claim forms to submit with your receipts for direct reimbursement by the Fund. No participant contribution is necessary if you elect Option B. Please note that there are special rules as to when you are eligible for reimbursement from Option B which are described in the *OPTION B ($2,200 Semi-Annual Medical Spending Account* section on page 24. Note, in order to obtain reimbursement of MSA reimbursable expenses, the MSA must be integrated with a group health plan that provides Minimum Value coverage. **You are not eligible for reimbursement of medical expenses under the MSA unless you are actually enrolled in a group health plan**. Proof of other group health coverage that provides Minimum Value is required, in a manner to be determined by the Trustees.

Enrolling Your Dependents

If you have eligible dependents, you must enroll them when you are first eligible in order for them to be covered and provide the necessary proof of dependent status as listed below. If the Fund Office does not receive a completed enrollment form and the documentation listed below, your dependents will not be eligible for benefits. If you acquire a new dependent after you are initially eligible for benefits, you will also need to complete an enrollment form, pay the required premium and provide proof of dependent status in order to add your new dependent to your coverage.

If you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period, you will not be able to enroll yourself (if benefits eligible) and/or them until the next Enrollment Period unless there is a Special Enrollment opportunity. If there is a Special Enrollment opportunity, payment must be made before you or your Eligible Dependent can be enrolled.

Proof of Dependent Status. Specific documentation, as listed below, to substantiate Dependent status is required to become eligible for coverage under the Plan. *Note that the enrollment process will not be complete until you provide the required proof of dependent status. Claims submitted to the Plan for the dependents will not be considered for payment until such proof is provided. Please note that because of federal requirements, you are required to provide the social security number of any dependent that you wish to enroll in the Plan.*

- **Spouse/Marriage:** A copy of the certified marriage certificate.

- **Child/Birth:** A copy of the certified birth certificate showing the child is the biological child of the employee.

- **Stepchild/Child of Domestic Partner:** A copy of the birth certificate listing your spouse (or domestic partner) as a parent; a copy of the marriage certificate or Domestic Partnership between you and the biological parent; a copy of the stepchild's Social Security card; and a copy of the divorce decree (if applicable) between the biological parents to determine which parent is responsible to provide medical coverage.

- **Adoption or placement for adoption**: A court order signed by the judge showing that employee has adopted or intends to adopt the child and the child's birth certificate.

- **Disabled Dependent Child:** A current written statement from the child's Physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled, that the disability existed before the attainment of the Plan's age limit, that the child is incapable of self-sustaining employment as a result of that disability, and that the child is dependent on you and/or your spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child, including proof that the child is claimed as a dependent for federal income tax purposes.

- **Domestic Partner:** If you are seeking coverage for your Domestic Partner, you must submit:

    - an affidavit attesting to the Domestic Partnership status;

    - a declaration of financial interdependence between you and your Domestic Partner and two items of proof of such financial interdependence (such as a joint lease or mortgage and a joint bank account); and

- if you reside in a municipality that offers a domestic partnership registry, proof that you and your Domestic Partner have registered as domestic partners. Refer to the *Definitions* section on page 66 for more detail regarding the requirements in order to establish Domestic Partnership.

If you elect coverage for a Domestic Partner, the contributions you make toward the cost of this coverage and any children of the Domestic Partner must be deducted on an after-tax basis, in accordance with certain applicable state law regulations. In addition, the amount your employer pays toward the cost of your Domestic Partner coverage and coverage for the children of domestic partners must be imputed as income and therefore is taxable to you. If you have questions about the state tax implications of covering a domestic partner or child of a Domestic Partner contact the Fund Office.

Special Enrollment

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after your coverage or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your Dependents may also enroll in this plan if you (or your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your Dependents may also enroll in this Plan if you (or your Dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, please contact the Fund Office, 321 West 44th Street, Suite 804, New York, NY 10036, Health@SDCweb.org, or by phone at (212) 869-8129.

Effective Date of Coverage following Special Enrollment. If you return your completed enrollment form, payment, and all the necessary proof to the Fund Office within 30 days of the date you were notified that you were first eligible for coverage, the date of the special enrollment event, or within 60 days of the date you lose Medicaid eligibility or become eligible for a premium assistance program, coverage will be effective retroactive to the date you were first eligible or the date you added the new Dependent (or from the date of the loss of other coverage) or the date you lost Medicaid eligibility or became eligible for a premium assistance program.

You may enroll after 31 (or 60) days, however if you do, coverage will not be effective until Fund Office receives your completed enrollment material.

Please note, if you fail to comply with these requirements, Dependent claims will be delayed or denied until you submit proper proof certifying valid eligibility for Dependent coverage, for the period in which the claim occurred.

There are also some special enrollment rules that pertain to the insured Medical and Hospital benefits. Please refer to the Certificate of Coverage for details on those enrollment rules.

Paying for Coverage. For Option A, as long as you are eligible for benefits, you are not required to pay premiums for individual coverage under the Plan beyond the 15% participant contributions.

You are required to pay for coverage for your Dependent(s) and Domestic Partner. Coverage costs vary depending on the insurance carrier (Aetna or Kaiser) that provides your benefits and the number of Dependents you elect to cover. The cost of coverage is also subject to change. You will be notified regarding the applicable cost when you enroll for coverage. In addition to the underlying cost of the Dependent/Domestic Partner portion of the premium, you will be charged 15% of the applicable Aetna or Kaiser individual premium.

Your Personal Information

To ensure that your benefits can be administered appropriately, you are responsible for providing the Fund Office with appropriate information under any of the following circumstances:

- You (or a covered Dependent or Domestic Partner) change address*
- You become entitled to Medicare
- Any other event that may affect your eligibility for benefits or the benefits provided under the Plan.

If you choose to pay for Dependent or Domestic Partner coverage, you are responsible for providing the Fund Office with appropriate information under any of the following circumstances:

- You get married, divorced or legally separated or enter into or dissolve a domestic partnership*
- You or your spouse gives birth or adopts a child*

* You must notify the Fund Office in writing immediately if your family status changes. Eligibility may be affected or you may lose benefits if you fail to notify the Fund Office in writing within 30 days of the change in family status. See the section entitled *Special Enrollment* on page 6 for more information regarding enrollment and coverage for Dependents.

- Your spouse has or obtains other health coverage or loses other health coverage that he or she had at the time you enrolled for coverage*
- Your spouse or Dependent child becomes entitled to Medicare
- Your Dependent child reaches age 26.

In addition, your spouse or another family member must notify the Fund Office immediately in the event of your death.

Information and Proof. Upon the request of the Trustees or the Fund Office, you may be required to furnish information or proof necessary to determine your (or a Dependent's or Domestic Partner's) right to benefits under the Plan. If you (or your Dependent or Domestic Partner) fail to submit the requested information or proof, make a false statement material to your claim, or furnish fraudulent or incorrect information material to your claim, benefits under the Plan may be denied, suspended or discontinued, as appropriate. This includes failure to timely notify the Fund Office of the termination of a Domestic Partnership.

The Trustees have the right to recover any excess benefit payments made in reliance on any false or fraudulent information or proof submitted by you or your Dependent(s) or Domestic Partner and submission of such information or proof may subject you (or your Dependent or Domestic Partner) to disciplinary and/or civil action.

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions or premiums (including COBRA premiums) are not timely paid, or in cases of fraud or intentional misrepresentation of material fact. In cases of fraud or intentional misrepresentation of material fact, the Plan will provide you with 30-days advanced notice. Failure to notify the Fund Office of a Dependent's loss of Dependent status (including divorce, legal separation or a child losing eligibility) constitutes a failure to pay COBRA premiums. In these cases, coverage will be terminated retroactive to the date of the event.

In the event a participant or his or her Dependent receives benefits, as a result of a misleading representation or any type of false information or other fraudulent representations to the Fund, such person's coverage will be terminated and such person will be liable to repay all amounts paid by the Fund. "Fraud" includes such person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a claim submitted to the Fund for payment.

Qualified Medical Child Support Order (QMCSO)

Federal Law requires group health plans, such as the Plan, to honor Qualified Medical Child Support Orders ("QMCSOs"). In general, QMCSOs are state court (or administrative agency) orders requiring a parent to provide medical support to a child, for example, in cases of legal separation or divorce where the child would otherwise not be eligible for coverage under the plan.

A QMCSO may require the Fund to make coverage available to your child even though, for income tax or Fund purposes, the child is not your Dependent due to divorce or legal separation. In order to qualify as a QMCSO, the medical child support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- specifies your name and last known address, and the child's name and last known address;
- provides a reasonable description of the type of coverage to be provided by the Fund, or the manner in which the type of coverage is to be determined;
- states the period to which it applies; and
- specifies each plan to which it applies.

The QMCSO may not require the Fund to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Plan. Upon approval of a QMCSO, the Fund is required to pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the Plan.

You and the affected child will be notified if an order is received and will be provided with a copy of the Fund's QMCSO procedures. You and your Dependents can obtain, without charge, a copy of such procedures from the Fund Office. A child covered under the Fund pursuant to a QMCSO will be treated as a Dependent under the Fund.

WHEN COVERAGE TERMINATES

Your coverage under the Plan will end on the earliest of:

- The last day of the six-month coverage period for which you were eligible. However, if adequate additional contributions accrued on your behalf during the preceding Contribution Period, you will have no lapse in active coverage and will be covered for the next six-month coverage period.
    - For example, if you met the eligibility requirements for coverage during the Contribution Period of January 1 through June 30, then your active coverage will begin on September 1 and end on February 28 (or February 29th if applicable). However, if adequate additional contributions accrued on your behalf during the Contribution Period of July 1 through December 31, then your active coverage will not terminate on February 28 (or February 29th if applicable). Rather, your active coverage will continue until August 31.
- You fail to pay the required premiums on a timely basis as described in this document.
- You enter active military service that lasts more than 31 days (see the *Military Duty in the United States Armed Forces* section on page 11 for more information on USERRA).
- When the Fund ceases to provide any group health care coverage for your class of employee.
- Your death.

Coverage for your Dependents and/or Domestic Partner will terminate on the earliest of:

- *For your Spouse and/or children:* when your (the participant's) coverage ends or you fail to pay the required premiums in a timely manner as described in this document;
- *For a Child:* the end of the month in which the child turns age 26;
- *For a Disabled Child:* the earliest of the date on which a disabled child who is over the maximum age for Dependent coverage: (i) is no longer is considered disabled or when any exam or proof of the continuing handicap requested by the Fund is refused; (ii) marries; (iii) is no longer chiefly dependent on you (the employee) for support and maintenance; or (iv) becomes employed.
- *For a Spouse (and stepchildren, if applicable):* the date you and your spouse divorce or are legally separated.
- *For a Domestic Partner (and any children of a Domestic Partner):* the date the domestic partnership is dissolved

CONTINUATION OF COVERAGE

Military Duty in the United States Armed Forces

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee goes into active military service for 31 days of less, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the first day of absence greater than 31 days.

The Plan will offer the employee USERRA continuation coverage only after the Fund Office has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Plan Administrator (contact information is in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage.

Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage: If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave. If contributions for coverage are not required of an active employee before a USERRA leave, then an employee going on military leave cannot be required to make contributions for coverage during the first 31 days of a USERRA leave.

If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the first day of absence greater than 31 days. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the *COBRA Continuation Coverage (Self-Pay)* section on page 13 for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces: When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

USERRA allows the employee to use accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When an employee's accumulated eligibility is exhausted, the employee may pay for USERRA coverage under the self-pay rules of this Plan.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Office.

Continuation Coverage During Leave Under the Family Medical Leave Act (FMLA)

You are entitled by law to up to 12 weeks of unpaid leave under the FMLA for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill or for your own illness or 24 weeks of unpaid leave under the FMLA to care for a service member. You are entitled to continue your group health plan coverage under the Plan during that leave period. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your employer.

However, if you do not return to work after your FMLA leave period ends, you may be required to repay the amount that was paid toward your coverage. If you do not return to covered employment after your leave ends, you are entitled to COBRA continuation coverage, as described in the section of this book entitled *COBRA Continuation Coverage*. Questions regarding your entitlement to this leave should be referred to your employer. Questions about the continuation of group health coverage under the Plan should be referred to the Fund Office.

COBRA Continuation Coverage (Self-Pay)

Entitlement to COBRA Continuation Coverage. In compliance with a federal law commonly known as COBRA, this Plan offers its eligible participants and their covered Dependents (called "qualified beneficiaries" by the law) the opportunity to elect temporary continuation of group health coverage when that coverage would otherwise end because of certain events (called "qualifying events"). This continuation coverage is called "COBRA Continuation coverage" or simply "COBRA." The Fund Office is the COBRA Administrator.

Other Health Coverage Alternatives to COBRA. Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit **www.healthcare.gov**. You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Benefit Description. Participants and their eligible Dependents have the right in many cases to continue to receive health benefits provided by the Plan on a self-paid basis if they fail to continue to qualify for employer-provided benefits. Under the law, participants and their eligible Dependents who are covered by the Plan when a "qualifying event" (as described below) occurs are considered "qualified beneficiaries."

Qualifying events are those shown in the chart below. COBRA Continuation coverage is available for a maximum of 18 or 36 months in the event coverage terminates, as follows:

Qualifying Event	Employee	Spouse	Dependent Child(ren)
Employee's termination of employment (for other than gross misconduct)	18 months*	18 months*	18 months*
Failure of the employer to make the required contributions (making the employee ineligible for coverage)	18 months*	18 months*	18 months*
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Dependent child ceases to have Dependent status	N/A	N/A	36 months

*This 18 month period may be extended to 29 months if a disability occurs under certain circumstances, or 36 months if certain second qualifying events occur. These issues are described in detail below.

Providing Notice of Qualifying Events. Your employer should notify the Fund Office of an employee's death, termination of employment or entitlement to Medicare. However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Fund Office.

As a covered employee or qualified beneficiary, you are responsible for providing the Fund Office with timely notice of certain qualifying events. You must provide notice of the following qualifying events:

- The divorce or legal separation of a covered employee from his or her spouse.
- A Dependent ceasing to be eligible to be covered under the Plan as a Dependent of a participant.
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA and during the first 18 months of COBRA Continuation coverage. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation or child losing Dependent status.

In addition to these qualifying events, there are two other situations where a qualified beneficiary is responsible for providing the Fund Office with notice within the timeframe noted in this section:

- When a qualified beneficiary entitled to receive COBRA Continuation coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If the disability starts before the 60th day of COBRA Continuation coverage and continues until the end of the 18 month coverage period, the qualified beneficiary may be eligible for an 11-month extension of the 18 month coverage period, for a total of 29 months of COBRA.
- When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Office is notified of any of the five occurrences listed above. Failure to provide this notice in the form and timeframes described below may prevent you and/or your Dependent(s) from obtaining or extending COBRA Continuation coverage.

How Should A Notice Be Provided? Notice of any of the five situations listed above must be provided in writing. You must send a letter to the Fund Office containing the following information: your name, the event listed above of which you are providing notice, the date of the event, the date on which the participant and/or beneficiary will lose coverage, and any supporting documentation (e.g., divorce decree, birth certificate, death certificate, or SSA determination).

To Whom Should the Notice Be Sent? Written notice should be sent to the Fund Office at 321 W 44th St., Suite 804, New York, NY 10036.

When Should the Notice Be Sent? If you are providing notice due to a divorce or legal separation, a Dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent within 60 days of the later of the date of the SSA Disability Determination or the date upon which coverage would be lost under the Plan as a result of the qualifying event, but no later than the end of the first 18 months of COBRA Continuation coverage.

If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you are no longer disabled.

In any event, the 60 or 30 day time period to provide the required notice will not begin until you have been informed of the responsibility to provide the notice and the Plan's notice procedures through the furnishing of this summary plan description or a general (initial) notice by the Plan.

If notice is not received by the Fund Office by the end of the applicable period described in this section, you and/or your spouse and/or Dependent will not be entitled to elect COBRA Continuation coverage.

Who Can Provide a Notice? Notice may be provided by the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if a participant, spouse and child are all covered by the Plan, and the child ceases to become a Dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

Once you or your employer have/has notified the Fund Office, the Plan will send you information about COBRA Continuation coverage.

When the Fund Administrator has been provided notice of an initial qualifying event, a second qualifying event or a request for an extension on account of disability, but the request for COBRA or additional COBRA Continuation coverage is denied, the Fund Office will send the involved individual a written notice stating the reason why the individual is not entitled to the requested COBRA Continuation coverage. This notice will be provided within 14 days of receipt of notice of the qualifying event.

How to Elect Continuation Coverage. When your employment terminates or the employer contributions made on your behalf fail to meet the minimum contributions required for eligibility in the Plan so that you are no longer entitled to coverage under the Plan, or the Fund Office is notified on a timely basis that you died, divorced or were legally separated or that a Dependent child lost Dependent status, you and/or your Dependent(s) will be notified that you and/or they have the right to continue their health care coverage. You and/or your Dependent(s) will then have 60 days from the date of notification, or, if later, the date that coverage is lost to apply for COBRA Continuation coverage. If you and/or your Dependent(s) do not apply within that time, health care coverage will not be continued under COBRA.

If you elect COBRA Continuation coverage, the Plan will provide you with coverage that is identical to the coverage you had under the Plan when the qualifying event occurred, but you must pay for it. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA Continuation coverage. For example, both the employee and the employee's spouse may elect COBRA, or only one of them may choose to do so. A parent or legal guardian may elect COBRA for a minor child. If COBRA Continuation coverage is elected, the Plan is required to provide coverage that is identical to the current coverage under the Plan that is provided for similarly situated participants and their eligible Dependents. If there is a change in health coverage provided by the Plan to similarly situated active employees and their families, that change will be made in your COBRA Continuation coverage.

Self-Paid Premium. The Plan will set premium payments according to federal law, which provides that the self-paid premium required by the Plan may cover the full cost to the Plan for the benefits plus a 2% administrative fee for a total of 102 % (in the case of an extension of COBRA Continuation coverage due to a disability, 150%). If the cost changes, the Plan will revise and notify you in advance of the adjusted premium you are required to pay.

The amount you and/or your covered Dependent(s) must pay for COBRA Continuation coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amount due starting with the date COBRA was elected. After you make your first payment for COBRA, you will be required to pay for COBRA for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA are due by the first day of the calendar month for which coverage is to be provided. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan may send periodic notices of payments due for these coverage periods, but is not required to do so.

There is a grace period of 30 days to pay any periodic payment (except for the first payment, which has an extended 45 day grace period, as discussed above).

HOWEVER, IF THE PLAN DOES NOT RECEIVE PAYMENT BY THE END OF THE GRACE PERIOD, COBRA CONTINUATION COVERAGE WILL TERMINATE AS OF THE FIRST DAY OF THE APPLICABLE COVERAGE PERIOD.

Extension of COBRA Continuation Coverage

Entitlement to Social Security Disability Income Benefits. If you, your spouse or any of your covered Dependent(s) are entitled to COBRA Continuation coverage for an 18-month period, that period can be extended for a covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if:

- the disability occurred on or before the start of COBRA Continuation coverage, or within the first 60 days of COBRA Continuation coverage;

- the disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration within the 18-month COBRA continuation period; and

- you or the disabled person provide notice and a copy of such determination to the Fund Office within the 60 day period described above under the section entitled *When Should the Notice Be Sent?,* but no later than before the end of the first 18-month period.

This extended period of COBRA Continuation coverage will end at the earliest of the end of 29 months from the date the qualified beneficiary would have lost coverage under the Plan, the date the disabled individual becomes entitled to Medicare, or as of the month that begins more than 30 days after the determination that the individual is no longer entitled to Social Security disability benefits. A copy of any Social Security notice terminating the disability benefits must be forwarded to the Fund Office within 30 days of the notification.

Second Qualifying Event During an 18 Month COBRA Continuation Period. If, during an 18-month period of COBRA Continuation coverage resulting from a loss of coverage because of your termination of employment or the employer contributions made on your behalf fail to meet the minimum contributions required for eligibility in the Plan, you die, become entitled to Medicare, become divorced or legally separated, or if a covered child ceases to be a Dependent child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months. These events can be a second qualifying event only if they would have caused the qualifying beneficiary to lose coverage under the Plan if the first qualifying event had not occurred, and only if the notice described above under the section entitled *When Should the Notice Be Sent?* is provided in a timely fashion, with supporting documentation if necessary.

This extended period of COBRA Continuation coverage is not available to anyone who became your spouse after the termination of employment or the employer contributions made on your behalf fail to meet the minimum contributions required for eligibility in the Plan. However, this extended period of COBRA Continuation coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation coverage.

When the qualifying event is the end of employment or the fact that employer contributions made on your behalf fail to meet the minimum contributions required for eligibility in the Plan, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

The participant whose employment terminated or whose employer failed to make the contributions required for eligibility in the Plan is not entitled to COBRA Continuation coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation coverage on account of disability as described above).

Generally speaking, in no case is anyone else entitled to COBRA Continuation coverage for more than a total of 36 months.

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 31 days (or as applicable 60 days) after your group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Adding a spouse or Dependent may cause an increase in the amount you must pay for COBRA Continuation coverage. Please contact the Fund Office for details.

PLEASE REMEMBER THAT THE PLAN MAY, BUT IS NOT REQUIRED TO, SEND MONTHLY BILLS OR REMINDERS TO COVERED PARTICIPANTS OR DEPENDENTS.

Termination of COBRA Continuation Coverage. COBRA Continuation coverage will terminate before the end of the applicable maximum period if:

- The required premium is not paid on time;
- A qualified beneficiary becomes covered under another group health plan.
- The individual becomes entitled to Medicare (Part A, Part B or both) after electing COBRA.
- The date the group health Plan terminates as to the eligible group of which you were a participant. If the coverage is replaced, your coverage will be continued under the new Plan.
- The qualified beneficiary's COBRA Continuation coverage was extended due to disability and the Social Security Administration had determined that the qualified beneficiary is no longer disabled.

If COBRA Continuation coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the Fund Office's determination that COBRA will terminate. The notice will set forth the reason why COBRA Continuation coverage will be terminated early, the date of termination, and your rights to alternative individual or group coverage.

Full details of COBRA Continuation coverage will be furnished to you or your Dependent(s) when the Fund Office receives notice that one of the qualifying events has occurred. Therefore, we urge employees and Dependent(s) to contact the Fund Office as soon as possible after one of those events.

Other COBRA Issues

Keep the Fund Office Informed of Address Changes. In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under the Employee Retirement Income Security Act, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **https://www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should keep a copy, for your records, of any notices you send to the Fund Office. The Fund Office is the COBRA administrator.

Conversion of Health Coverage

COBRA requires that at the end of the applicable COBRA continuation coverage period, you (and your eligible dependents) must be allowed to enroll in an individual conversion plan, if the applicable insurer provides one. Under the present arrangement, individual conversion coverage is provided by Aetna or Kaiser Permanente, whichever is applicable.

You must contact the applicable Plan insurer (Aetna or Kaiser Permanente) directly on or before the date your coverage terminates in order to determine whether conversion coverage is available under your particular circumstances. Note that your time period for electing conversion coverage is limited (e.g., if your coverage is provided in New York, you may have up to 45 days from your coverage termination date in which to elect conversion coverage). Do not delay in contacting the applicable Plan insurer.

NY State Continuation Assistance Demonstration Program for Entertainment Industry Employees

The Continuation Assistance Demonstration Program for Entertainment Industry Employees is a program created to assist eligible entertainment industry employees in maintaining health insurance during episodic employment.

Applicants who are accepted into this program can receive assistance equal to 75% of their COBRA/continuation premiums. Applicants cannot receive more than 12 months of premium assistance in a 5-year period.

Eligibility Requirements. To participate in this program, you must meet all of the following requirements:

- you must be a New York State resident;
- you must be eligible for, or already covered by, COBRA/continuation coverage through a collectively bargained plan covering entertainment industry employees;
- you must not already be receiving continuation assistance through a Department of Health program;
- you must not be eligible for Medicare;
- you must not be eligible for employer sponsored coverage; and
- you must meet the household income limitation, as set forth below (Note: Amounts updated annually. Pregnant women count as 2 people.):

Family Size	Monthly Household Income
1	Up to $4,530
2	Up to $6,103
3	Up to $7,677
4	Up to $9,250
5	Up to $10,823
Extra Person	Add $1,573

Once you are accepted into the program, you will not lose your eligibility if your income increases above the household income limitation during the time you are receiving assistance through this program.

However, you will lose your eligibility for the premium subsidy if any of the following were to occur:

- your continuation coverage/COBRA ends;
- you move out of New York State;
- you become eligible for Medicare; or
- you become eligible for employer insurance.

The program is subject to New York State funding and is not guaranteed. If funding by New York State ceases, you will be responsible for paying the full amount of your COBRA continuation premium.

New York State Law Information

New York State Continuation Coverage. New York law enables COBRA participants in the state of New York to receive up to a total of 36 months of group health insurance coverage. Once the normal 18 months of COBRA ceases for a participant enrolled in the Aetna plan, the participant will get an additional 18 months of New York State coverage, for that plan only, as long as they continue to pay the premium payments.

New York State Age 29 Dependent Coverage Extension. The New York State "Age 29" law may allow your child to maintain coverage under your health plan until the end of the month of their 30th birthday. Additionally, if your child previously lost benefits because they reached your plan's age limit, he or she may be able to re-enroll.

There are eligibility rules for extended coverage under the "Age 29" law. Your child cannot be:

- Married.
- Older than 29 years of age.
- Insured by or eligible for health benefits through their own employer.
- Living or working outside of New York or our service area.
- Covered by Medicare.

Medicare Coverage

At age 65, you become eligible for Medicare coverage. If you do not sign up for Medicare when you are first eligible, there may be a waiting period for Medicare benefits after you do sign up. In addition, the Medicare Part B premium cost will be higher than that paid by those who signed up as soon as they were eligible. Any employee or spouse near the age of 65 should file for Medicare coverage in order to avoid a delay and additional premium payments (under Part B of Medicare).

HEALTH CARE OPTIONS AVAILABLE TO YOU

Under the Plan, eligible participants may elect to participate either under **Option A** or **Option B**. Option A provides a basic comprehensive hospital and medical insurance plan.

A quarterly participant contribution amounting to 15% of the current premium is charged for Option A coverage. Family coverage for spouses and/or children, as well as Domestic Partner coverage is available on a fully self-pay basis.

Option B provides a $2,200 semi-annual direct pay medical spending account. No participant contribution is charged for Option B. The full range of reimbursable medical benefits is available to those who provide evidence and certification that they are covered under another employer-sponsored group health insurance plan that meets Minimum Value standards under the Affordable Care Act (the "ACA"). Plans purchased privately, through the ACA Marketplace, or Medicare do not qualify as employer-sponsored group health plans.

If you fail to elect coverage, fail to pay premiums under your Option A election, or fail to provide proof of other Minimum Value group health coverage, you will default to Option B for "limited excepted benefits" only. You will still have access to the $2,200 Option B account, but your benefits will be limited to medically necessary dental and optical costs ("excepted benefits"), including lenses and frames. It is important to note that this "excepted benefits" plan does not constitute "minimum essential coverage" as defined in the ACA.

Declining Coverage. Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. As such, you may pass up the opportunity to enroll in (decline/opt out of) medical and dental expense coverage under this Plan for yourself, but to do so, you must submit to the Fund Office the completed portion of the enrollment form that pertains to declining coverage. Remember that a Dependent may not be enrolled for coverage unless the employee is also enrolled.

The opportunity to decline coverage is only available at one of the Plan's enrollment periods: Initial or Special Enrollment. If, at a later date, you want the coverage you declined for yourself you may enroll only under the Special Enrollment provisions (when applicable).

Note that no additional compensation is paid to you if you waive/decline benefit coverage.

OPTION A (Hospital, Medical and Dental Insurance)

Major medical and hospitalization coverage is made available through one of two insurance options offered by the Plan: Aetna Managed Choice and Kaiser Permanente Traditional Plan.

With the Aetna Managed Choice platform, if you utilize in-network doctors and facilities, your out-of-pocket costs will be modest, with flat dollar primary care and specialist co-payments, and a three-tier prescription drug plan. While we encourage you to utilize Aetna's In-Network providers, you also have the option of seeing doctors who are outside the Aetna network, subject to the Plan's cost sharing requirements and Aetna's determination of reasonable and customary charges. To find a list of in-network providers, you are encouraged to visit **http://www.aetna.com/docfind** or call (888) 982-3862.

The Fund has also made arrangements with Kaiser Permanente in Los Angeles and certain other areas where Kaiser is available. If you live in a California area where Kaiser is available, you can elect to have either Kaiser or Aetna be your Option A provider. Under the Kaiser Permanente Traditional Plan, you are required to receive care from in-network providers, except in certain instances of true medical emergencies. To find a list of in-network providers, you are encouraged to visit **www.kp.org** or call (800) 278-3296

Regardless of which Option A insurer you choose, when you enroll in coverage you will be provided with a Certificate of Coverage for the applicable insurance company. The Certificate of Coverage explains in detail the benefits offered as well as how the plan works. A brief summary of the plan provisions can also be found on the Summary of Benefits and Coverage, which is sent to you annually at the start of the insurance policy year.

Family coverage for spouses and/or children, as well as Domestic Partner coverage is available on a self-pay basis — the participant pays the portion of the premium allocated to the spouse, children, or Domestic Partner.

For participants electing to self-pay for spouse or partner and/or dependent coverage, the employee contribution will be 15% of the Aetna or Kaiser individual premium amount, plus the additional underlying premium cost for spouse and/or dependent coverage under Aetna or Kaiser.

OPTION B ($2,200 Semi-Annual Medical Spending Account)

Option B provides for a $2,200 semi-annual Medical Spending Account (MSA). Option B is available to participants only. It is not available to spouses, Dependents, or Domestic Partners. The MSA is funded with employer contributions only. You may not contribute to your own MSA. Under no circumstances will the benefits of the MSA be funded with salary reduction contributions, employer flex credit contributions or otherwise under a cafeteria plan. The MSA is intended to qualify as an integrated health reimbursement arrangement (HRA) under §105 and §106 of the Internal Revenue Code of 1986, as amended, IRS Notice 2015-87 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective.

The Plan will set up a notional account for each participant to track account balances by participant for record-keeping purposes in order to keep track of contributions and available reimbursement amounts. However, the Plan will not create a separate fund or otherwise segregate assets for purposes of paying a MSA benefit. A participant's MSA will be debited for any reimbursement of medical care expenses incurred during the six-month coverage period. The amount available for reimbursement of medical care expenses is $2,200 per Coverage Period reduced by any reimbursements debited from the account.

Nothing herein will be construed to require the Plan to maintain any trust fund or to segregate any amount for the benefit of any participant, and no participant or other person will have any claim against, right to, security or other interest in any fund, account or asset of the Health Plan from which any payment under the MSA may be made.

Integration. In order to obtain reimbursement of MSA reimbursable expenses, the MSA must be "integrated" with a group health plan that provides Minimum Value coverage. You are not eligible for reimbursement of medical expenses under the MSA unless you are actually enrolled in a group health plan. Proof of other group health plan coverage that provides Minimum Value is required, in a manner to be determined by the Trustees. If proof is not provided, benefits will be restricted, as described below.

In general, any out-of-pocket medical expense which is not reimbursed by your primary insurance carrier, and which is included within the Internal Revenue Service's definition of a deductible medical expense, qualifies for reimbursement. A complete listing of these qualifying expenses is outlined in IRS publication 502 and may be obtained from the IRS or by calling the Fund Office at (212) 869-8129.

While you may file claims for up to $2,200 in any one category, your total combined reimbursement may not exceed $2,200 for services rendered within a six-month coverage period. These sums will be paid directly to eligible participants upon submission of a claim form provided by the Fund Office, along with a paid receipt showing the name and address of the provider, the date of service, and the item or service purchased. Only expenses not reimbursed by another plan, policy, or insurance coverage of any kind may be submitted for reimbursement, and reimbursements may only be made for expenses incurred by participants (not by spouses, Dependents, or Domestic Partners). Whenever possible, an explanation of benefits (EOB) from your primary insurance carrier must be submitted along with your claim form. If your claim is submitted without an EOB from your primary insurance carrier, the Plan may request that you submit the EOB in order to determine the amount eligible for reimbursement.

Categories of reimbursement under Option B include:

- Dental
- Optical
- Chiropractic

- Mental Health (services must be performed by a psychiatrist, licensed psychologist, or licensed social worker)

- Wellness (preventive exams and procedures and vaccinations)

- Other Health Expenses (those which qualify as deductible expenses on your personal income taxes, as outlined in IRS publication 502, available from the Fund Office or the IRS). Examples of qualifying Other Health Expenses include: abortion, acupuncture, alcoholism treatment (including meals and lodging at a treatment center), ambulance services, birth control pills, contact lenses and materials (cleaning solution, etc.), crutches, drug addiction treatment, health institute treatment, health institute treatment (with physician prescription and statement), hearing aids, laboratory fees, Medicare Part B premiums, mental health care, nursing services, osteopaths, oxygen, prescription drugs, smoking cessation programs, sterilization, and transportation that is primarily for and essential to medical care (this includes actual bus, subway and/or taxi fares; if transportation is by car, ten cents per mile is allowed).

- Deductibles, copayments and other out-of-pocket expenses incurred under other plans or insurance coverage. An explanation of benefits should be submitted with your claim for reimbursement of deductibles, copayments and coinsurance payments.

As indicated above, if you are not currently covered by another employer-sponsored group health plan that meets Minimum Value standards under the Affordable Care Act, you will only be eligible for reimbursement of "excepted benefits," which are medically necessary dental and optical benefits, including lenses and frames.

Exclusions – Medical Expenses That Are Not Reimbursable. No expense shall be payable from this Plan unless they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs. No benefits will be payable for premiums for any health coverage (including COBRA and long- term care service). In no event are premiums for individual health insurance a permissible plan benefit, whether purchased in the individual insurance market or in a Health Insurance Marketplace.

Opt-Out. You may permanently opt out of and waive future reimbursements from the MSA at the start of a six-month coverage period, in a manner determined by the Trustees. Note that no additional compensation is paid to you if you waive/decline benefit coverage.

CLAIMS AND CLAIMS REVIEW

This section describes the procedures for filing claims for benefits from the SDC-League Health Plan (the Plan). It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits.

The Plan's internal claims and appeal procedures are designed to provide you with a full, fair, and fast claim review so that Plan provisions are applied consistently with respect to you and other similarly situated participants and Dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For medical and prescription drug benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

Option A: How to File a Claim with Aetna or Kaiser Permanente

In order to file a claim for benefits offered under this Plan, you must submit the appropriate completed claim form(s) with the applicable Plan insurer when you, your covered Dependents or your covered Domestic Partner have incurred out-of-network expenses that may be covered under the Plan. The necessary claim forms are available from the Fund Office or from the applicable Plan insurer (in general, claim forms are not necessary for in-network services). Where your benefits are provided through Aetna Managed Choice or Kaiser Permanente, the Board of Trustees has delegated to Aetna or Kaiser primary responsibility with respect to administration of your benefit claims, and any request for additional review will be handled by these companies, as the duly authorized designees of the Board of Trustees. Please refer to your Aetna or Kaiser Permanente plan materials for further details.

Option B: How to File a Claim for the Option B Medical Spending Account

A claim is a request for a Plan benefit made by you or your authorized representative in accordance with the Plan's reasonable claims procedures. MSA claims are administered directly through the Fund. Please note that MSA claims are available to the participant only, not to Dependents, spouses or Domestic Partners.

What Must Be Filed. In order to file a claim for benefits offered under the Option B Medical Spending Account, you must submit the appropriate completed claim form, obtained from the Fund Office. The following information must be included in order for your request for benefits to be a claim, and for the Fund Office to be able to process your claim:

- A completed and signed claim form that describes the person or persons on whose behalf expenses have been incurred, a description of the expense incurred, the date the expense was incurred and the amount of the requested reimbursement that includes:
    - Your name, address, and phone number(s)
    - Your SDC Member ID number
    - Your primary insurance carrier's name, group number, address, and phone number
    - Date(s) of service
    - Name, address, and phone number of the Service Provider
    - If treatment is due to an accident, accident details
    - Participant's signature
- A written statement from the participant that the expense has not been reimbursed and is not reimbursable under any other source; with either a
    - Copy of the Explanation of Benefits (EOB) for the expenses you are requesting reimbursement for;
    - Bills, invoices, or other statements from an independent third party (e.g., physician or other health care provider) showing that the eligible medical care expenses have been incurred and the amounts of such expense, together with any additional documentation that the Fund Office may request; or
    - Proof of payment for the expense with post-tax dollars.

No reimbursement of eligible health care expenses will be made if such expenses have been reimbursed by any other health care insurance, plan, provider or entity. If only a portion of an expense has been reimbursed elsewhere (e.g., because the other plan imposes copayments or deductibles), the MSA can reimburse the remaining portion of such expense if it otherwise meets the requirements herein. Reimbursements are payable only to you, the participant, not to an insurance company or medical provider.

Whenever possible, an explanation of benefits from your primary insurance carrier MUST be included with your claim. Check the claim form to be certain that all applicable portions are completed. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

When Claims Must Be Filed. Claims must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred. If claims are not filed within the one year period, they will be denied.

Where To File Medical Spending Account Claims. Your claim will be considered filed as soon as it is received at the Fund Office. Claims should be filed at the following address:

SDC-League Health Fund
321 West 44th Street, Suite 804New York, NY 10036
Phone: (212) 869-8129
Fax: (212) 302-6195
Health@SDCweb.org

Authorized Representatives. An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Post-Service Claims. Only Post-Service Claims may be submitted for reimbursement by the Fund under the Option B Medical Spending Account. A Post-Service Claim is a claim submitted for payment after health services and treatment have been obtained. Ordinarily, you will be notified of the decision on your claim within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. 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 the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information 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 until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on your claim and notify you of the determination.

Notice of Decision. If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of Adverse Determination must:

- Identify the claim involved (e.g., date of service, health care Provider, claim amount if applicable, denial code and its corresponding meaning);

- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review);

- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;

- Reference the specific Plan provision(s) on which the denial is based;

- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

- Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;

- Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;

- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request; and

- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Request for Review of Denied Claim. If your claim under the Option B Medical Spending Account is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days after you receive notice of denial. As discussed above, review of claims provided by the Plan's insurers will be handled by the applicable insurance company.

Review Process. Your or your authorized representative's request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

    - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

    - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination

Timing of Notice of Decision on Appeal. Ordinarily, decisions on appeals involving claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Review. The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision.
- Reference to the specific Plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge
- You and the Fund may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Officer and your State insurance regulatory agency.
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Limitation on When a Lawsuit May Be Started. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue a lawsuit under Section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. However, any such lawsuit must be filed within one year from the date of the Plan's notice of denial of the appeal or other final adverse determination, and also within any statute of limitations which may apply.

General. If you have any questions about these procedures, please contact the Fund Office at (800) 317-9373 or (212) 869-8129 during normal business hours, Monday through Friday.

As a reminder, the Board of Trustees, 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, including this book, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board of Trustees, and/or its duly authorized designee(s), 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 Fund;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund 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 Fund;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this book, the Trust Agreement or other plan documents;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

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

If the Fund pays benefits in excess of expenses actually incurred or in excess of allowable amounts due to error, fraud or other reasons, the Fund is authorized and reserves the right to recover such overpayment, plus interest and costs, through whatever means are necessary, including, but not limited to, deduction of the amounts owed from future claims, legal action and/or termination of eligibility to participate in the Fund.

External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible For The External Review Process. Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, as determined by the IRO.
- The denial is due to a rescission of coverage, i.e., the retroactive elimination of coverage, regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For The External Review Process. The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your Dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure have not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as dental).
- Claims that relate to benefits that the Plan provides through insurance. Such claims are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process. Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review Of A Standard (Non-Urgent Care) Claim. Your request for external review of a standard (not Urgent Care) claim must be made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, send written request to:

SDC-League Health Fund
321 West 44th Street
Suite 804
New York, NY 10036
Health@SDCweb.org

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The Plan. Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.

- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review Of A Standard (Not Urgent Care) Claim By The IRO. If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.

- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.

- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review Of An Urgent Care Claim. You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, send a written request to:

SDC-League Health Fund
321 West 44th Street
Suite 804
New York, NY 10036
Health@SDCweb.org

Preliminary Review Of An Urgent Care Claim By The Plan. Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review Of An Urgent Care Claim By The IRO. Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made? If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, as discussed below:

The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause after he or she gives you written notice of the Plan's finding that you or your covered Dependent:

- Engaged in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan. Keeping an ineligible Dependent enrolled under the Plan (for example, an ex-spouse, overage or ineligible Dependent child, etc.) is considered fraud; or

- Allowed anyone else to use the identification card that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or

- Altered any prescription furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

For example, you must immediately notify the Plan Administrator in writing, of any change in eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility. A failure to notify the Plan of such a change in status will be deemed an act of omission constituting fraud or an intentional misrepresentation of a fact by the participant and ineligible Dependent.

The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent(s) engaged in conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner. If your coverage is terminated for this reason, it will be terminated on a going forward basis.

The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 15 days after it gives you written notice of its finding that you have failed to pay your premium payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period.

DUPLICATE COVERAGE OF HOSPITAL, MEDICAL AND DENTAL EXPENSES

Please note that the insurers maintain coordination of benefits and subrogation rules that pertain to those benefits.

How Duplicate Coverage Occurs

Many families with more than one person working are covered by more than one group health plan. **You must notify the Fund Office (and the applicable insurer) about all your sources of coverage when you submit a claim**. You will be required to provide the Fund (and/or the applicable insurer) with information regarding the coverage available and/or received from other sources. For example, if you are covered by Aetna under Option A, you must complete the "other carrier" section on the enrollment form for each Covered Person. If you fail to adequately complete such section, you may be required to complete a Coordination of Benefits questionnaire within a certain time period in order to be entitled to begin (or to continue) coverage with Aetna or Kaiser Permanente.

This section is applicable where you, your covered Dependents or your covered Domestic Partner may be entitled to hospital, medical and/or dental benefits through this Fund, as well as from some other source (such as any other group health care plan, Medicare, workers' compensation, coverage provided by a federal, state or local government or agency, coverage under any motor vehicle no-fault coverage (or any other motor vehicle coverage) for medical expenses or loss of earnings that is required by law, or recovery you may receive from a negligent or wrongful third party).

This Fund operates under certain rules that prevent it from paying benefits that, together with the benefits from other sources would allow you to recover more than 100% of the hospital, medical and/or dental expenses you incur. In many instances, you may recover less than 100% of those hospital, medical and or dental expenses from the additional sources. In some instances, this Fund will not provide coverage if you can recover from some other source. In other instances, this Fund will advance its benefits, but only subject to its right to recover them if and when you (or your covered Dependent or Domestic Partner) actually recover some or all of your losses from a third party. This section summarizes the rules that apply when coverage is available from other sources.

Coverage Under More Than One Group Health Plan: Coordination of Benefits (COB)

When and How Coordination of Benefits Applies. This Coordination of Benefits (COB) provision applies to this Fund when you or your covered Dependent has health coverage under more than one plan. The Order of Benefit Determination Rules below determines which plan will pay as the Primary Plan. The Primary Plan pays first without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense. You should refer to the applicable plan administrator for details.

Getting Started - Important Terms. When used in this COB provision, the following words and phrases have the meaning explained herein:

"Allowable Expense" means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. The following are examples of expenses and services that are not Allowable Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private room is medically necessary in terms of generally accepted medical practices, or one of the plans routinely provides coverage of hospital private rooms) is not an Allowable Expense.

- If a person is covered by one plan that computes its benefit payments on the basis of recognized charges and another plan that provides its benefits or services on the basis of negotiated charges, the Primary Plan's payment arrangements shall be the Allowable Expense for all the plans. However, if the Secondary Plan has a negotiated fee or payment amount different from the Primary Plan and if the provider contract permits, that negotiated fee will be the Allowable Expense used by the Secondary Plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an Allowable Expense and a benefit paid.

"Closed Panel Plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

A "plan" means any plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, policyholder organization plans, or participant benefit organization plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Fund is any part of the policy that provides benefits for health care expenses.

"Primary Plan/Secondary Plan." COB operates so that one of the plans (called the "Primary Plan") will pay its benefits first as if the other plan (called the "Secondary Plan") did not exist. The Secondary Plan may then pay additional benefits. **In no event will the combined benefits paid by the primary and Secondary Plans exceed 100% of the expenses that are incurred and are covered by the plans**. As a result, sometimes, the combined benefits that are paid will be less than the total expenses incurred.

The order of benefit determination rules state whether this Fund is a Primary Plan or Secondary Plan as to another plan covering the person.

- When this Fund is a Primary Plan, its benefits are determined before those of the other plan and without considering the other Plan's benefits.
- When this Fund is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

- When there are more than two plans covering the person, This Fund may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan(s).

Which Plan Pays First: Order of Benefit Determination Rules. To find out whether the regular benefits under this Fund will be reduced, the order in which the various plans will pay benefits must first be figured. This Fund uses the order of benefit determination rules described below. Any plan that does not have COB rules will always pay its benefits first — that is, such a plan will always be the Primary Plan.

If all the plans have COB rules, payment is determined in accordance with the following rules. If the first rule does not establish the order of benefits, the next rules apply, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

a. The plan that covers a person as an active employee, retiree, member or subscriber (that is, other than as a Dependent) pays first; the plan that covers the same person as a Dependent pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

a. When two plans cover the same child as a Dependent of different parents (who are not divorced or separated), the plan that covers the parent whose birthday falls earlier in the year pays first; the plan that covers the parent whose birthday falls later in the year pays second.

b. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; the plan that has covered the other parent for the shorter period of time pays second.

c. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.

d. If the other plan does not have this rule but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

e. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, then that plan pays first. However, this provisions does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

f. If the parents are divorced or separated and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

(i) The plan of the Custodial Parent pays first;

(ii) The plan of the spouse of the Custodial Parent pays second; and

(iii) The plan of the non-Custodial Parent pays third.

Rule 3: Active/Laid-Off or Retired Employee

a. The plan that covers a person as an employee who is neither laid-off nor retired (i.e., an active employee) (or as that active employee's Dependent or Domestic Partner) pays first; and the plan that covers the same person as a laid-off or retired employee (or as that laid-off or retired employee's Dependent or Domestic Partner) pays second. For the purposes of this rule an employee who is no longer working for an employer is deemed to be a laid-off or retired employee (and not an active employee).

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. If a person is covered as a laid-off or retired employee under one plan and as a Dependent of an active employee under another plan, the order of benefits is determined by Rule 1, rather than by this rule.

Rule 4: Longer/Shorter Length of Coverage

a. If none of the previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; the plan that covered that person for the shorter period of time pays second.

b. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended. Thus, the start of a new plan does **not** include a change:

- in the amount or scope of a plan's benefits;
- in the entity that pays, provides or administers the plan's benefits; or
- from one type of plan to another (such as from a single employer plan to a multiple employer plan).

c. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 5: Above Rules Don't Cover

a. If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this Fund will not pay more than it would have paid had it be the Primary Plan.

Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Fund and other plans. Aetna, Kaiser Permanente, and the Fund (for Option B MSA benefits) has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Medicare and Other Government Plans

Medicare. Medicare, when used in this Summary Plan Description, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes a Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under Medicare because you:
    - Refused Medicare;
    - Dropped Medicare; or
    - Failed to make a proper request for Medicare.

If you are eligible for Medicare, the Fund coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this Fund is the primary payor, which means that the Fund pays benefits before Medicare pays benefits. Under other circumstances, the Fund is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First. The Fund is the primary payor when your coverage for the Fund's benefits is based on your employment. The Fund will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

- Solely due to age if the Fund is subject to the Social Security Act requirements for Medicare with respect to working aged;

- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the Fund's benefits were payable on a secondary basis;

- Solely due to any disability other than end stage renal disease; but only if the plan meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of a policyholder with 100 or more participants).

The Fund is the secondary payor in all other circumstances.

How Coordination with Medicare Works

When the Fund is Primary. The Fund pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary. Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna or Kaiser Permanente for consideration.

Aetna or Kaiser Permanente will calculate the benefits the plan would pay in the absence of Medicare:

- If the result is more than the benefit paid by Medicare, the Fund will pay the difference, up to 100% of plan expenses. Plan expenses are any medically necessary health expenses which are covered, in whole or in part, under the Fund.

- If the result is less than the benefit paid by Medicare, the Fund will not pay a benefit, except as required by law.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under Medicare will be applied under the Fund in the order received by Aetna or Kaiser Permanente. Aetna or Kaiser Permanente will apply the largest charge first when two or more charges are received at the same time.

Aetna or Kaiser Permanente will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information. Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under this Fund and other plans. Aetna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

Medicaid. If you are covered by both this Fund and Medicaid, this Fund pays first and Medicaid pays second.

CHAMPUS. If you are covered by both this Fund and CHAMPUS, this Fund pays first and CHAMPUS pays second.

Motor Vehicle No-Fault Coverage Required by Law. In general, the Fund excludes coverage if benefits are available under motor vehicle no fault insurance.

If you are covered for medical and/or dental benefits by both this Fund and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Fund pays second. If you are covered for loss of earnings by both this Fund and any motor vehicle no-fault coverage that is required by law, the benefits payable by this Fund on account of disability will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle no-fault coverage.

Other Coverage Provided by State or Federal Law. If you are covered by both this Fund and any other coverage provided pursuant to any other state or federal law, the coverage provided by any other state or federal law pays first and this Fund pays second.

Workers' Compensation

This Plan does not provide benefits if the medical or dental expenses are covered by workers' compensation or occupational disease law.

If the Employer contests the application of workers' compensation law for the sickness, illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you, your covered Dependent and/or your covered Domestic Partner must execute a subrogation and reimbursement agreement acceptable to the Fund or its designee in its sole and absolute discretion.

Administration in Duplicate Coverage Situations

To administer duplicate coverage situations, the Fund (or its duly authorized designee, which may include the applicable plan insurer) reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you or your health care provider furnish any necessary information (which may include, but is not necessarily limited to, information regarding the nature and scope of coverage available and/or received and the cause or origin of the sickness, illness, injury or condition);
- reimburse any plan that made payments that this Fund should have made; or
- recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you, your Dependent or Domestic Partner.

If this Fund should have paid benefits that were paid by any other plan, this Fund may pay the party that made the other payments in the amount that the Board of Trustees (or its designee(s)) determines to be proper under the terms of the Plan. Any amounts so paid will be considered to be benefits through this Fund, and this Fund will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical and/or dental expenses that were incurred. However, any person who claims benefits through this Fund must provide the Fund with all the information the Fund needs to apply the COB rules or otherwise administer Fund benefits where duplicate coverage is available.

Subrogation and Right of Recovery

The provisions of this section applies to all current or former plan participants and also to the parents, guardian, or other representative of a Dependent child who incurs claims and is or has been covered by the Fund. The Fund's right to recover (whether by subrogation or reimbursement) shall apply to you, the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Fund pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Fund.

The Fund's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no fault automobile coverage or any first party insurance coverage).

The Fund is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Fund's subrogation and reimbursement interest are fully satisfied.

Subrogation. The right of subrogation means the Fund is entitled to pursue any claims that you may have in order to recover the benefits paid by the Fund. Immediately upon paying or providing any benefit under the Fund, the Fund shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Fund. The Fund may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Fund is not required **to pay you part of any recovery it may obtain, even if it files suit in your name.**

As used in this Summary Plan Description "subrogation" means the right of the Fund to be substituted in place of a covered person with respect to the covered person's lawful claim, demand, or right of action against any party. A third party which negligently or wrongfully caused the covered person's injury or illness is called the "Tortfeasor."

Reimbursement. If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Fund first from such payment for all amounts the Fund has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust. By accepting benefits from the Fund (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Fund. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Fund's subrogation and reimbursement interest are fully satisfied.

Lien Rights. Further, the Fund will automatically have a lien to the extent of benefits paid by the Fund for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Fund paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Fund including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Fund.

Assignment. In order to secure the Fund's recovery rights, you agree to assign to the Fund any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Fund's subrogation and reimbursement claims. This assignment allows the Fund to pursue any claim you may have, whether or not you choose to pursue the claim.

Cooperation with the Fund. You agree to cooperate fully with the Fund's efforts to recover benefits paid. It is your duty to notify the Fund within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Fund or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given to you or your agents prior to receipt. Further, you and your agents agree to provide notice to the Fund prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Fund, the Fund Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Fund may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Fund in pursuit of its subrogation rights or failure to reimburse the Fund from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Fund is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Fund's subrogation or recovery interest or prejudice the Fund's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Fund or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Fund's subrogation and reimbursement interest.

You acknowledge that the Fund has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Fund reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Fund has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq., to share your personal health information in exercising its subrogation and reimbursement rights.

The Fund may start any legal action or administrative proceeding it deems necessary to protect its right to recover Fund benefits that have been paid, and may try or settle any such action or proceeding in the name of and with the full cooperation of the covered persons. However, in doing so, the Fund will not represent, or provide legal representation for, any covered person with respect to that covered person's damages to the extent those damages exceed any Fund benefits paid.

The Fund requires covered persons to notify and consult with the Fund and the Fund Administrator (or its duly authorized designee) before starting any legal action or administrative proceeding that may relate to or involve recovery of any payments of Fund benefits. The covered persons also must keep the Fund and the Fund Administrator (or its duly authorized designee) informed of all material developments with respect to any such claims, actions, or proceedings. The Fund may intervene in any such claims, actions, or proceedings started by any covered persons.

All Recovered Proceeds Are to Be Applied to the Fund. By accepting benefits from the Fund, you acknowledge that the Fund's recovery rights are a first priority claim and are to be repaid to the Fund before you receive any recovery for your damages. The Fund shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Fund will result in a recovery which is insufficient to make you "whole" or to compensate you in part or in whole for the damages sustained. Accordingly, the Fund does not recognize the "Make Whole Doctrine." The Fund is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim, and the Fund's claim shall not be reduced or otherwise offset for such costs and expenses. Accordingly, the Fund specifically rejects the "Common Fund" doctrine for the recovery of attorney fees.

The Covered Persons, jointly and severally, will reimburse the Fund for all Plan benefits paid, applying any and all amounts paid or payable to them by any third party or insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of expenses for which Plan benefits were paid.

The terms of this entire subrogation and right of recovery provision shall apply and the Fund is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Fund provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Fund is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Fund's claim will not be reduced due to your own negligence.

If the covered persons fail to reimburse the Fund, the Fund may apply any future Fund benefits that may become payable on behalf of the covered person to the amount not reimbursed.

While the Fund requires Covered Persons' cooperation with the Fund, as set forth above, the Fund does not require you to seek any recovery against a third party.

Interpretation. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Fund shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction. By accepting benefits from the Fund, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Fund may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Fund incurs in successful attempts to recover amounts to which the Fund is entitled.

PLAN INFORMATION

Name of Fund. The SDC-League Health Fund

Type of Plan. The SDC-League Health Fund provides hospital, medical, prescription drug and dental benefits.

Plan Administrator. The Board of Trustees

Union Trustees

Ms. Laura Penn
SDC
321 West 44th Street
Suite 804
New York, NY 10036
(212) 391-1070

Ms. Karen Azenberg
SDC
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Ms. Sarna Lapine
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Ms. Kathleen Marshall
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Employer Trustees

Mr. Christopher Brockmeyer
The Broadway League
729 Seventh Avenue
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Ms. Alison Corinotis
The Broadway League
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Ms. Carol Fishman
Playwrights Horizons
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Mr. Devin Keudell
Bespoke Theatricals
230 West 41st Street
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(212) 221-1122

Ms. Stephanie Grassi, Esq. P.C.
League of Resident Theatres (LORT)
General Counsel
561 Seventh Avenue
11th Floor
New York, NY 10018
(201) 335-8616

Ms. Kristy Cummings
SDC
321 West 44th Street
Suite 804
New York, NY 10036
(212) 391-1070

Mr. Stephen Rothman
SDC
321 West 44th Street
Suite 804
New York, NY 10036
(212) 391-1070

Type of Administration. Although the Board of Trustees is legally designated as the Plan Administrator of the Fund, the Board of Trustees has delegated many of the day-to-day administrative functions to the Fund's Administrator. To contact the Fund Administrator, also known as the Fund Office, call or write to:

The SDC-League Health Fund
321 West 44th Street
Suite 804
New York, NY 10036
Telephone: (212) 869-8129 or (800) 317-9373
Website: **sdcleaguefunds.org**
Email: Health@SDCWeb.org

Collective Bargaining Agreements. The SDC-League Health Fund is established and maintained pursuant to the terms of collective bargaining agreements between the Stage Directors and Choreographers Society and The Broadway League, Inc. and other participating employers. These agreements set forth the conditions under which employers are required to contribute to the Fund and the rate(s) of such contributions.

A copy of any applicable collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Fund Office. Copies of collective bargaining agreements are also available for inspection by participants and beneficiaries at the Fund Office during regular business hours, and online at **www.SDCweb.org**. There may be a reasonable charge for the copies, as permitted by law.

Contributing Employers. In most cases, your Union can tell you whether your employer is a contributing employer. If there is any uncertainty in this regard, you can examine a complete list of the employers that sponsor the Fund at the Fund Office. Alternatively, a complete list of the employers contributing to the Fund may be obtained on written request.

Source of Contributions. The primary source of financing for benefits provided by the Fund and for the expense of Fund operations is employer contributions. Contributions to the Fund are made by participating employers in amounts determined by the applicable collective bargaining

agreement (or other written agreements(s)). The Fund may require employees to contribute to the cost of their coverage, and employees are required to pay the full cost of coverage for their Dependent(s) and their Domestic Partner, if applicable. This contribution arrangement may change at any time.

Funding Medium for the Accumulation of Plan Assets. Contributions (to the extent they are not used to purchase insurance coverage described below) and investment earnings, are accumulated in a Trust Fund that is maintained pursuant to a Trust Agreement entered into among the Board of Trustees of the Fund. Benefits are provided from the Fund's assets, which are invested according to investment guidelines and objectives adopted by the Board of Trustees. The Fund is partially insured and partially self-funded, as described below.

Insured Benefits. Contributions to the Fund may be used to purchase insurance coverage(s) to help ensure that the Fund will meet its obligations to provide certain benefits described in this book. Not all benefits described in this book are insured by an insurer (see description of self-insured benefits below). Where benefits are insured by an insurer, such benefits are payable in accordance with the provisions of the insurance policy issued by the insurer and are guaranteed by such insurer. The insurer has full financial responsibility and liability for the payment of the benefits provided under the insurance policy. Each insurer also provides certain administrative services to the Fund such as processing and paying claims for benefits. You may contact the applicable insurers at their respective addresses:

For Hospital, Medical, Prescription Drug, and Dental Benefits:

For participants enrolled in coverage through Aetna:

Aetna Health Insurance Company
151 Farmington Avenue
Hartford, CT 06156

For participants enrolled in coverage through Kaiser Permanente (available in Southern California and the San Francisco area only):

Kaiser Permanente
393 East Walnut Street
5th Floor
Pasadena, CA 91188

Self-Insured Benefits. The benefits provided under the Option B Medical Spending Account are self-insured. This means that the Fund has not purchased insurance coverage(s) to guarantee the payment of these benefits and all such benefits are paid directly out of the Fund.

Agent for Service of Legal Process. The Board of Trustees is designated as the agent for service of legal process, at the address of the Fund Office. Service of legal process may also be made upon an individual Trustee, at the addresses listed in this book. The business telephone number of the Board of Trustees is (212) 869-8129. For disputes arising under those portions of the Plan insured by Aetna or Kaiser Permanente, service of legal process may be made upon the insurer at the address above, one of its local offices, or upon the supervisory official of the State Insurance Department.

Fiscal/Plan Year. The financial records of the Fund are maintained on the basis of a fiscal year that begins September 1 and ends August 31. The Plan Year also ends on August 31.

Plan Identification Numbers. When filing various reports with the Department of Labor and the Internal Revenue Service ("IRS"), certain numbers are used to identify the SDC-League Health Fund:

- The Employer Identification Number: 13-2958267
- The Plan Number: 001

Plan Amendment, Modification or Termination of Plan. The Board of Trustees hopes to continue the Plan. However, the Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate any or all of the provisions of this Plan (including any related documents or policies), in whole or in part, at any time and for any reason, with respect to any employee or their spouse or Dependents who are, or may become, covered under the Fund (as an employee, retiree, or Dependent of either). Among other things, this shall empower the Board of Trustees to do the following:

- change the eligibility rules;
- diminish the amount of benefits;
- increase or require deductibles or coinsurance;
- eliminate particular types of benefits;
- substitute certain benefits for others;
- impose or decrease maximums on the amounts of benefits payable; and
- if deemed necessary by the Board of Trustees, require contributions or increase contributions from participants and beneficiaries as a condition of eligibility.

If the Plan is modified or terminated, the ability of participants (including retirees, both present and future) and/or their family members to participate in and receive benefits from the Fund may be modified or terminated.

Without limiting any other Plan provisions for the discontinuance of insurance coverage, your coverage shall terminate when the Plan terminates, or when you are no longer eligible to receive benefits under the Plan, whichever occurs first.

Statement of Rights of Participants Under ERISA

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

- examine without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Fund, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Fund, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- receive a summary of the plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

- continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

If your claim for a welfare 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 the Fund documents or the latest annual report from the Fund 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 Fund 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 Fund 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. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan'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. 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. However, no legal action may be commenced or maintained against the Fund prior to your exhaustion of the Fund's claims procedures described in this Summary Plan Description.

If you have any questions about your plan, you should contact the Fund 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 Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration's publications hotline at (866) 444-3272.

Other Important Notices

Notice Regarding the Newborns' and Mothers' Health Protection Act of 1996. Please be advised that group health plans offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Genetic Information Non-Discrimination Act ("GINA"). GINA prohibits discrimination by group health plans, such as this Plan, based on an individual's genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, this Plan is also prohibited from setting premium and contribution rates for the employer group on the basis of genetic information of an individual enrolled in the plan.

Notwithstanding any provision of this Plan to contrary, this Plan shall be operated and maintained in a manner consistent with GINA.

Notice Regarding the Women's Health and Cancer Rights Act of 1998. Please be advised that group health plans that provide for medical and surgical benefits in connection with a mastectomy must also provide benefits for certain reconstructive surgery. This covers all stages of reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and care related to physical complications of all stages of mastectomy, including lymphedemas.

To the extent permitted by applicable law, such coverage may be subject to annual deductibles, benefit maximums, coinsurance and copayment provisions as may be deemed appropriate and as are consistent with those established for other medical and surgical benefits under the Plan.

Mental Health Parity and Addiction Equity Act. The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is federal law which requires that health insurance coverage of mental illnesses and disorders and chemical dependencies be treated the same as for physical illnesses and disorders. However, the Fund is allowed to specify inpatient day limits, and limitations on outpatient treatments.

To comply with MHPAEA, Fund coverage for mental health and chemical dependency benefits will be provided at the same benefit levels as the medical coverage. Accordingly, please refer to the appropriate group health and insurance book and certificate of coverage for any limits that may apply to your coverage election.

Patient Protection Rights of the Affordable Care Act. The Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Fund Office at (212) 869-8129.

Nondiscrimination in Health Care. In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan (or issuer). The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Clinical Trials. Under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. For further details refer to the Certificate of Coverage.

HIPAA Privacy Rights. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. The Health Information Technology for Economic and Clinical Health (HITECH) Act is a related federal law that expanded the HIPAA privacy, security, and enforcement requirements. As a group health plan subject to ERISA, the Fund will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Fund administration, or as required or permitted by law. A description of the Fund uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Fund's Notice of Privacy Practices, which is furnished to all Fund participants and can also be accessed on the Funds site at: **www.SDCLeagueFunds.org**. The notice must also be provided upon request, and within 60 days of a material revision to the notice. The Fund also will comply with applicable requirements under the HITECH Act, which include providing notice to affected individuals if the Fund or its business associates discover a breach involving unsecured protected health information. If you wish to request a copy of the notice or if you have any questions regarding these rules, please contact the Fund Office.

If you are enrolled in Option A, you will also receive a notice from your insurer that outlines your rights under those options.

Confidentiality of Health Care Information. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans protect the confidentiality of your Protected Health Information ("PHI"). A summary of your rights under HIPAA can be found in the Plan's privacy notice, which will be distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, at the Fund Office.

This Plan, and the Plan Sponsor (the Plan Sponsor is the Board of Trustees), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

The Plan also hires professionals and other companies to assist it in providing health care benefits. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

A. Use and disclosure of Protected Health Information (PHI): The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below:

   "Treatment" is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

   "Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of Plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

   1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participant's claim);

   2. Coordination of benefits;

   3. Adjudication of health benefit claims (including appeals and other payment disputes);

   4. Subrogation of health benefit claims;

   5. COBRA contributions;

   6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

   7. Billing, collection activities and related health care data processing;

   8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

   9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, patient safety activities, contacting health care providers and patients with information about treatment alternatives and related functions;

3. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

4. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

7. Business management and general administrative activities of the entity, including, but not limited to:

    a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,

    b. Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

c. Resolution of internal grievances, and

d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

B. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the following: the trustees for use in disability appeals, the fund staff when processing a claim for pension benefits, contributing employers, the union, workers' compensation carriers, and the pension and disability insurers.

C. For purposes of this section the Board of Trustees is the "Plan Sponsor." The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information,

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,

4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual,

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

6. Make PHI available to the individual in accordance with the access requirements of HIPAA,

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

8. Make available the information required to provide an accounting of disclosures,

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA,

10. If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible, and

11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

    1. The Administrative Manager,

    2. Staff designated by the Administrative Manager based on their job title and function. Fund staff have access to individually identifiable health information, including claims information, in the Fund's computer system. Fund staff do not view information on a participant's disability pension for welfare fund purposes, and do not view information on a participant's disability pension for welfare fund purposes.

E. The persons described in section D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

F. If the persons described in section D do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

G. For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

H. The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

Under Federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

I. The Plan Sponsor has:

1. Implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensured that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

3. Ensured that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

4. Will report to the Plan any security incident of which it becomes aware concerning electronic protected health information.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA. The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Plan Sponsor to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Plan Sponsor is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Plan Sponsor to provide notification to the media.

For purposes of this section, a breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under HITECH, which compromises the security or privacy of the protected health information.

If your unsecured PHI is breached, the Plan Sponsor will notify you without unreasonable delay and in no case no later than 60 calendar days after discover of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Fund up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Plan Sponsor or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Plan Sponsor has improperly followed the breach notification process.

DEFINITIONS

Term	Definition
Contribution Period	The six-month period (either January 1 to June 30, or July 1 to December 31) for which a participating employer is required to make a predetermined level of contributions to the Plan on your behalf.
Copayment	The amount you are required to pay directly to a provider at the time Covered Services are rendered.
Covered Person	Any person who is eligible for and receives coverage under this Plan.
Covered Services	Medically necessary services paid for or arranged for you under the terms and conditions of your insurance plan.
Dependents	Your spouse and your dependent children. Please refer to the section entitled *Dependent Eligibility* on page 2 for information regarding whether a Dependent is eligible for coverage under the Plan.
Domestic Partnership (Domestic Partner)	Two unmarried adults (both of whom are 18 years or older), neither of whom is married or legally separated who: (i) have resided with each other for six months prior to the application for benefits and who intend to live continuously with each other indefinitely; (ii) are not related by blood or closer that the law would permit marriage; (iii) are financially dependent on each other; (iv) have an exclusive close and committed relationship with each other; (v) have not terminated the domestic partnership; (vi) where the participant lives in a municipality that offers a domestic partner registry (such as New York), the domestic partners register (and show proof to the Fund Office that they have registered) as domestic partners; and (vi) neither individual has registered as a member of another domestic partnership within the last six months. Notwithstanding the above, a Domestic Partner may also be a person who is your same-sex "spouse" as defined under the law of the jurisdiction (including any foreign nation) in which you were married.
Family Member(s)	The term Family Member(s) collectively refers to your Dependent(s) and/or Domestic Partner, whichever are applicable.
Fund or Health Fund	The SDC-League Health Fund established and maintained pursuant to the SDC-League Health Fund Trust Agreement.

Term	Definition
Medical Emergency	Aa medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the afflicted person with such a condition in serious jeopardy; (b) serious impairment to the person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.
Precertification	An authorization that you must receive before you can obtain certain covered services.
Primary Care	Benefits and services provided by your Primary Care Physician. The Summary of Benefits and Coverage (SBC), available online at **www.SDCLeagueFunds.org**, reviews the types of benefits.
Urgent Care	Medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not a Medical Emergency. Urgent Care may be rendered in a Physician's office or Urgent Care Center.
Urgent Care Center	Aa licensed facility (except Hospitals) which provides Urgent Care.

STAGE DIRECTORS AND CHOREOGRAPHERS SOCIETY AND
THE BROADWAY LEAGUE HEALTH FUND
321 West 44th Street
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New York, NY 10036
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Website: sdcleaguefunds.org
Email: Health@SDCWeb.org

January 1, 2022

SDCLeagueFunds.org • 321 West 44th Street, Suite 804, New York, NY 10036 • TEL 212.869.8129 • FAX 212.302.6195

SUMMARY OF MATERIAL MODIFICATION
SDC-LEAGUE HEALTH FUND

Travel Benefit Effective July 1, 2022

The following summary describes changes to the SDC-League Health Fund's plan of benefits that will take effect July 1, 2022. This summary is intended to satisfy the requirements for issuance of a Summary of Material Modification (SMM) under the Employee Retirement Security Act of 1974, as amended ("ERISA"). You should take time to read this material carefully and keep it with a copy of the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, or if you need another copy of the SPD, please contact Caitlin Higgins or Suzette Porte at the Fund Office at 321 W. 44th St., Suite 804, New York, NY 10036, or by phone at 212-869-8129, or by email at CHiggins@SDCweb.org or SPorte@SDCweb.org.

The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* created inequity in access to abortion by forcing individuals living or working in certain states to have to travel to another state to receive certain health care services. The Trustees of the SDC-League Health Fund (the "Fund" or "Plan") have added a travel benefit to the Plan to address this.

Effective July 1, 2022, if an enrolled participant or enrolled dependent covered by the Aetna or Kaiser Permanente Plans under Option A or a participant enrolled in the full Option B Plan[1] needs to travel out of state to obtain an abortion or mental/behavioral health or substance use disorder treatment because that care is not legally permissible:

1. in the state where that individual resides; or
2. in the state where that individual is working in covered employment;

the Fund will reimburse reasonable travel expenses for that individual plus one medically appropriate support companion, as outlined below (such treatment being referred to as the "Treatment").

What type of care is covered:

Travel primarily for, and essential to, obtaining a Treatment that is covered by the Plan and from a provider covered by the individual's plan option (Aetna or Kaiser for Option A participants, or the primary employer sponsored medical plan for those enrolled in Option B).

What expenses are covered:

Transportation: The following transportation expenses will be covered:

1. Reimbursement for 100% of the actual cost for round trip "coach" airfare;
2. Reimbursement for 100% of the actual cost for travel via trains, subways, buses, taxis, ride shares, or other public transportation (at coach/economy class where applicable), including reasonable local travel between the place of lodging and place of Treatment;
3. Mileage reimbursement for use of a personal vehicle at the applicable business rate set forth by the Internal Revenue Service and updated from time to time (e.g., 62.5 cents/mile in 2022) and parking fees and/or tolls (note that reimbursement per mile for car travel above the IRS medical transportation rate, currently 22 cents, is taxable); and
4. Reasonable rental car costs (budget or economy car only).

[1] Participants who elect Option B and certify they are enrolled in an employer sponsored group health plan that meets minimum value standards under the ACA during the enrollment period

Lodging: Reasonable rates up to $300 per night for up to 3 nights. Note that amounts above the IRS cap on lodging are taxable. The cap is currently $50 per night for an individual and $100 per night if accompanied by a companion.

What is the benefit limit:

The annual maximum benefit is $5,000.

What is not covered:

1. Anything other than the lodging and transportation expenses listed above, such as meals, personal care items and car maintenance.
2. Travel due to network inadequacy.
3. Travel outside the U.S.
4. Travel to a obtain a procedure from a provider that is not covered under your plan option.

Coordination of benefits:

The Travel Benefit is not subject to plan deductibles or coinsurance, however this Travel Benefit is intended to be secondary to any Travel Benefit reimbursements from your primary insurance, and therefore may require submission of additional support documents such as an Explanation of Benefits from your insurer.

How to receive reimbursement:

When seeking reimbursement of travel expenses eligible for reimbursement under this benefit, please contact the Fund Office at 212-869-8129 or Health@SDCweb.org, or contact Caitlin Higgins at 212-391-1070 x 226 or CHiggins@SDCweb.org or Suzette Porte at 212-391-1070 x 227 or SPorte@SDCweb.org.

The Fund Office will provide you with a current claim form and outline the support documents required. Support documents required may include invoices, receipts, the Explanation of Benefits from your primary insurance, or other documents required to confirm the charges and the Treatment and need for travel.

Reimbursement will be issued as soon as administratively feasible following receipt of all required forms and documents.

For questions or additional information:

If you have any questions about the information in this notice or about your health coverage under the Plan, please contact Caitlin Higgins or Suzette Porte at 212-869-8129 or CHiggins@SDCweb.org or SPorte@SDCweb.org, or email Health@SDCweb.org.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any discrepancy should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan document are at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

SDC-LEAGUE Health Fund
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SUMMARY OF MATERIAL MODIFICATIONS

SDC-LEAGUE HEALTH FUND

Changes to Medical Benefits Under Option A Pursuant to the No Surprises Act

Effective September 1, 2022

The following summary describes changes to the SDC-League Health Fund's plan of benefits that will take effect September 1, 2022. This summary is intended to satisfy the requirements for issuance of a Summary of Material Modification (SMM) under the Employee Retirement Security Act of 1974, as amended ("ERISA"). You should take time to read this material carefully and keep it with a copy of the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, or if you need another copy of the SPD, please contact Caitlin Higgins or Suzette Porte at the Fund Office at 321 W. 44th Street, Suite 804, New York, NY 10036, or by telephone at 212-869-8129, or by email at CHiggins@SDCweb.org or SPorte@SDCweb.org.

The Board of Trustees of the SDC-League Health Fund ("Fund" or "Plan") is pleased to announce the following changes to medical benefits provided to participants and their covered dependents, in accordance with the federal No Surprises Act. These changes are effective September 1, 2022. Please note the changes discussed in this SMM pertain to the Option A medical plan benefits under Aetna Managed Choice and Kaiser Permanente Plans as applicable.

Background Regarding the Balance Billing Protections of the No Surprises Act

The No Surprises Act (the "Act") is intended to protect medical patients from "balance billing" for Out-of-Network Emergency Services, Out-of-Network air ambulance services, and certain Non-Emergency Services performed by an Out-of-Network provider at an In-Network facility (unless, where permitted, the patient gives "informed consent" under the Act's rules) (collectively "No Surprise Services").

In general, balance billing occurs when you see a health care provider or visit a health care facility that is not in the Plan's network, and you are charged the difference between what the Plan agreed to pay the provider or facility, and the full amount charged for a service. "Surprise billing" is an unexpected balance bill that happens when you cannot control who is involved in your care—when you have an emergency, or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network provider.

As described in more detail below, Plan participants and covered dependents who receive "No Surprise Services" (defined in the glossary below) will be responsible for paying only their In-Network cost sharing for those services. In accordance with the Act, the provider is not permitted to balance bill the patient for No Surprise Services, and the Plan will only pay Out-of-Network providers for such No Surprise Services in accordance with the Plan's provisions regarding

payment determined in accordance with the Act. To locate an In-Network medical provider, visit https://www.aetna.com/individuals-families/find-a-doctor for the Aetna Managed Choice network or https://healthy.kaiserpermanente.org/doctors-locations for the Kaiser Permanente.

Capitalized terms used in this notice, such as "No Surprise Services" and "Emergency Services," are defined in the Glossary at the end of this notice.

BENEFIT CHANGES

Emergency Services

As required by the Act, the Plan will cover Emergency Services that qualify as No Surprise Services, in accordance with the following requirements:

1. No Prior Authorization Requirement. The services will be covered by the Plan without the need for any prior authorization determination, even if the Emergency Services are provided on an Out-of-Network basis;

2. Coverage Regardless of Network Status. The services will be covered by the Plan without regard to whether the health care provider or facility furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable.

3. Administrative Requirements/Limitations. The Plan will not impose any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;

4. Cost-Sharing Requirements. The Plan will not impose cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network provider or In-Network emergency facility;

5. Cost-Sharing Calculations (Use of "Recognized Amount"). The Plan will calculate the participant cost-sharing requirement (such as any applicable co-insurance) for Out-of-Network Emergency Services as if the total amount that would have been charged for such Emergency Services were equal to the Recognized Amount for the services (not the higher billed amount).

6. Deductibles and Out-of-Pocket Maximums. The Plan will count cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your In-Network deductible and out-of-pocket limit in the same manner as those received from an In-Network Provider.

In light of the Act's new rules, if you have an Emergency Medical Condition and get Emergency Services from an Out-of-Network provider or facility, the most the provider or facility may bill you is the Plan's In-Network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these Emergency Services.

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

As required by the Act, the Plan will cover Non-Emergency Services performed by an Out-of-Network provider at an In-Network Health Care Facility in accordance with the following requirements (to the extent that those Non-Emergency Services qualify as No Surprise Services):

1. Cost-Sharing Requirements. The Plan will impose a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the Non-Emergency Services or related items had been furnished by an In-Network Provider;

2. Cost-Sharing Calculations (Use of "Recognized Amount"). The Plan will calculate the participant cost-sharing requirement (such as any applicable co-insurance) as if the total amount that would have been charged for the Non-Emergency Services and related items by such Out-of-Network provider were equal to the Recognized Amount for such items and services (not the higher billed amount).

3. Deductibles and Out-of-Pocket Maximums. The Plan will count any cost-sharing payments you make toward any deductible and out-of-pocket limits applied under the Option A Aetna and Kaiser Permanente Plans in the same manner as if such cost-sharing payments were made with respect to Non-Emergency Services and related items furnished by an In-Network provider.

Notice and Consent Exception: However, the Plan will cover Non-Emergency services or related items performed by an Out-of-Network provider at an In-Network facility based on your Out-of-Network coverage (i.e., at the Out-of-Network rate and rules) if:

a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by the Act, informing you (i) that the provider is an Out-of-Network Provider with respect to the Plan, (ii) of the good faith estimated charges for your treatment and any advance limitations that the Option A Aetna and Kaiser Permanente Plans may put on your treatment, (iii) of the names of any In-Network Providers at the facility who are able to treat you, and (iv) that you may elect to be referred to one of the In-Network Providers listed; and

b. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

This "notice and consent" exception does not apply to Ancillary Services or to items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

In light of the Act's new rules, the most that an Out-of-Network provider may bill you for non-emergency No Surprise Services is the Plan's In-Network cost-sharing amounts, unless the notice and consent exception applies and is satisfied. Moreover, unless that exception applies and is satisfied, Out-of-Network providers cannot balance bill you for No Surprise Services, and they may not ask you to give up your right to be protected from being balance billed after the fact.

Out-of-Network Air Ambulance Services

As required by the Act, the Plan will cover Out-of-Network air ambulance services (to the extent covered by the Plan) with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if such services had been furnished by an In-Network provider. In general, you cannot be balance billed for Out-of-Network air ambulance services. The Act does not apply to ground ambulances, which are subject to the normal terms of the SPD.

Continuing Care Patients

If you are a Continuing Care Patient and either the Option A Aetna or the Option A Kaiser Permanente Plans terminate its contract with an In-Network Provider or facility providing services to you, or your benefits are terminated because of a change in terms of the provider's and/or facility's participation in the Plan's network you will be :

1. Notified in a timely manner of the contract termination (or change in participation terms) and of your right to elect continued transitional care from the provider or facility; and
2. Provided with ninety (90) days of continued coverage at the In-Network cost sharing to allow for a transition of care to a different In-Network Provider (provided you remain enrolled in the Plan's coverage).

External Review for No Surprise Services Claims

Currently, the Plan provides that after you exhaust your internal appeals, you can file a request for external review with the Plan under certain circumstances. Beginning September 1, 2022, external review will also be available for adverse benefit determinations based on compliance with the surprise billing protections under the Act or its implementing regulations. Where your benefits are provided through Aetna Managed Choice or Kaiser Permanente, the Board of Trustees has delegated to Aetna or Kaiser primary responsibility with respect to administration of your benefit claims, and any request for additional review will be handled by these companies, as the duly authorized designees of the Board of Trustees. Please contact Aetna or Kaiser Permanente for a copy of the Plan's External Review procedures for claims covered by the Act.

Provider Directory

To help you find care from In-Network Providers and facilities, Aetna and Kaiser Permanente maintain a provider directory. Aetna and Kaiser Permanente are responsible for updating these directories every ninety (90) days as required by the No Surprises Act. If you receive inaccurate information from Aetna or Kaiser Permanente about a provider or facility's network status, you will be liable only for In-Network cost-sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the provider or facility that you have selected is In-Network at the time you receive services.

GLOSSARY

The following additional definitions apply for purposes of the changes described in this notice:

Ancillary Services means the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

2. Items and services provided by assistant surgeons, hospitalists, and intensivists;

3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by an Out-of-Network/nonparticipating provider if there is no In-Network/participating provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition", (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in

1. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ or part; or

3. Placing the health of an individual (or, with respect to a pregnant woman, her unborn child) in serious jeopardy.

Emergency Services means the following with respect to an Emergency Medical Condition:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department (some urgent care facilities, but not all, qualify), as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

3. Post-Stabilization Services, which are services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

    a. The provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance; and

    b. You are supplied with a written notice, as required by the Act, that the provider is an Out-of-Network Provider with respect to the Option A Aetna and Kaiser Permanente Plans, of the good faith estimated charges for your treatment and any advance limitations that the Health Fund may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

    c. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Health Care Facility (for Non-Emergency Services) means each of following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

No Surprise Services means the following, to the extent covered under the Option A Aetna and Kaiser Permanente Plans:

1. Out-of-Network Emergency Services;

2. Out-of-Network air ambulance services;

3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology, neonatology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and

4. Other Out-of-Network Non-Emergency Services performed by an Out-of-Network Provider at an In-Network health care facility with respect to which the provider does not comply with the Act's notice and consent requirements.

Recognized Amount means one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

3. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount ("QPA").

For air ambulance services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the Provider or facility or the QPA.

Qualifying Payment Amount or QPA generally means the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR 716-6(c).

Serious and Complex Condition means one of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or

2. In the case of a chronic illness or condition, a condition that is the following:

    a. Life-threatening, degenerative, potentially disabling, or congenital; and

    b. Requires specialized medical care over a prolonged period of time.

If you have any questions about these changes, or about any aspect of the Fund, please contact the Fund Office by calling 212-869-8129 or emailing Health@SDCweb.org.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. Except to the extent that this SMM modifies the Plan, if any discrepancy should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement and the full Plan document are at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

www.SDCLeagueFunds.org • 321 West 44th Street Ste 804 New York, NY 10036 •212.869.8129 •Health@SDCweb.org

SUMMARY OF MATERIAL MODIFICATIONS
SDC-LEAGUE HEALTH FUND

The following summary describes changes to the SDC-League Health Fund's plan of benefits that will take effect on or after May 1, 2024 as noted below. This summary is intended to satisfy the requirements for issuance of a Summary of Material Modification (SMM) under the Employee Retirement Security Act of 1974, as amended ("ERISA"). You should take time to read this material carefully and keep it with a copy of the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, or if you need another copy of the SPD, please contact Caitlin Higgins or Suzette Porte at the Fund Office at 321 W. 44th Street, Suite 804, New York, NY 10036, or by telephone at 212-869-8129, or by email at CHiggins@SDCweb.org or SPorte@SDCweb.org.

Option A and Option B Eligibility Rule Changes Effective July 1, 2024

The SDC-League Health Fund (the "Fund" or "Plan") has used a strategic approach over the last decade of adjusting the contribution threshold to qualify for health coverage to track with health contribution increases negotiated under various Collective Bargaining Agreements (CBAs) with your employers. Due to recent increases negotiated across the CBAs, the Trustees of the Fund have increased the contribution threshold for both Option A and Option B coverage beginning with the July 1 to December 31, 2024 six-month contribution period as follows:

- From $1,650 to **$1,800** for six months of coverage
- From $3,300 to **$3,600** for one year of coverage

Coverage periods beginning March 1 are based on the prior July to December contribution cycle and coverage periods beginning September 1 are based on the prior January to June contribution cycle. The July 1 to December 31, 2024 contribution cycle will therefore determine eligibility coverage beginning March 1, 2025.

Option A Participant Contribution Change Effective June 1, 2024

Participants enrolled in Option A currently contribute 15% of the premium billed to the Plan by Aetna or Kaiser Permanente on a quarterly basis. The Trustees of the Fund are pleased to announce, effective June 1, 2024, the participant quarterly contribution rate will be reduced from 15% to 12.5% of the premium. The quarterly contributions for Participant Only coverage will therefore change as follows:

Plan	Current Quarterly Participant Contribution	Participant Contribution Effective June 1, 2024
Rate	15%	**12.5%**
Option A - Aetna	$870.00	**$726.00**
Option A - Kaiser Permanente (CA Only)	$459.00	**$384.00**
Option B	$0	**$0**

The quarterly participant contribution for the June to August 2024 quarter is due by June 15, 2024. Participants may still pay the contribution between June 16th and 30th, however a $100 late fee will apply during that period.

For participants who have dependents enrolled in the Plan and pay the contribution monthly with their dependent self-pay premium, the Participant Plus One Dependent and Family premiums will change as follows:

Plan and Coverage Type	Current Monthly Premium	Monthly Premium Effective June 1, 2024
Aetna – Participant Plus One Dependent	$2,417.00	**$2,370.00**
Aetna - Family	$4,660.00	**$4,613.00**
Kaiser Permanente – Participant Plus One Dependent	$1,173.00	**$1,147.00**
Kaiser Permanente - Family	$2,019.00	**$1,994.00**

Please note that premiums are subject to change every year when the Plan renews with Aetna and Kaiser Permanente.

Parental Leave Coverage Extension Effective September 1, 2024

The Trustees of the Plan recognize that the Family Medical Leave Act (FMLA) generally does not apply to employment under SDC contracts given the short-term nature of employment. This often results in loss of coverage under the SDC-League Health Fund for new parents taking parental leave. To support Participants expanding their families, the Trustees have approved a parental leave coverage extension. Such coverage extension is described below.

Participants eligible for coverage under the Plan who are unable to maintain coverage as a result of taking parental leave to care for a child as a result of the birth of a child or placement of a child for adoption shall be credited with the amount of contributions required to meet the contribution threshold to qualify for coverage for the following "Coverage Extension Period":

1. The six-month coverage period during which the participant or their spouse or partner is expected to give birth, become a parent through surrogacy, or have a child placed with them for adoption; and
2. The six-month coverage period immediately following the coverage period in which the birth of the child occurs or when the child is placed for adoption.

The first Coverage Extension Period under this benefit will begin September 1, 2024. A Participant who is the birthing parent, partner or spouse of a birthing parent, adoptive parent, partner or spouse of an adoptive parent, or who becomes a parent through surrogacy may apply for this Parental Leave Benefit to be covered for the Coverage Extension Period described above.

To qualify for this benefit, the Participant must:

1. Be eligible for health coverage in the six-month coverage period immediately prior to the Coverage Extension Period so that coverage is continuous;
2. Provide the Fund Office with all required enrollment documentation and documentation of the pregnancy, surrogacy, birth, or placement for adoption prior to the enrollment deadline for the Coverage Extension Period; and
3. Pay all required participant health contributions by the payment deadlines.

If a Participant qualifies for coverage by accruing sufficient employer contributions for either or both Coverage Extension Periods, there will be no additional extension of coverage under this benefit. If the Participant chooses to enroll the baby or child in the Plan during the Coverage Extension Period, they will

be responsible for the dependent premiums normally required under the Plan and must meet the requirements and deadlines for Special Enrollment.

A Participant must again become eligible for coverage by having sufficient employer contributions in a six-month contribution period following a Coverage Extension Period before a Participant can claim a subsequent Parental Leave Extension. A Participant who does not qualify for the coverage period immediately following the Coverage Extension Period will be offered the opportunity to continue coverage on a self-pay basis under COBRA.

Child or Newborn Dependent Self-Pay Premium Waived for Initial 30-Day Period Following Birth or Placement for Adoption Effective May 1, 2024

Currently Option A participants contribute 100% of the cost of the dependent premium to cover any dependents under the Plan. This includes the premiums for the 30 days immediately following the birth of a child or placement of a child for adoption. The Trustees acknowledge this cost under the Plan is significant and circumstances do not always allow Participants to find adequate coverage elsewhere within that initial 30-day period. As a result, effective May 1, 2024, the Plan will pay the cost of the dependent premium attributable to adding the newborn baby or child placed for adoption for the first 30 days. The Participant will still be responsible for submitting all required paperwork to the Fund Office within 30 days of the birth or placement of the child for adoption. See the Special Enrollment information in your Summary Plan Description for more information or contact the Fund Office if you are interested in enrolling a newborn or a child placed for adoption. If a Participant wishes to enroll the dependent child beyond the initial 30-day period, the Participant will be responsible for the dependent premiums outlined earlier in this notice beginning in the calendar month immediately following the initial 30-day coverage period.

Contact Information for Questions or Additional Information

If you have any questions about the information in this notice, about your health coverage under the Plan, or how to submit the documentation for the above outlined parental leave benefit or self-pay premium waiver for newborns and children placed for adoption, please contact Caitlin Higgins or Suzette Porte at 212-869-8129 or CHiggins@SDCweb.org or SPorte@SDCweb.org, or email Health@SDCweb.org.

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