

**THE SDC-LEAGUE HEALTH PLAN**

**Summary Plan Description**

**(Revised as of January 1, 2012)**

**STAGE DIRECTORS AND CHOREOGRAPHERS SOCIETY  
AND  
THE BROADWAY LEAGUE**

**HEALTH FUND**

1501 Broadway, Suite 1701, New York, NY 10036  
Telephone: 212-869-8129 or 800-317-9373

**BOARD OF TRUSTEES**

**UNION TRUSTEES**

Pamela Berlin  
Sue Lawless  
Laura Penn  
Stephen Rothman

**EMPLOYER TRUSTEES**

Christopher Brockmeyer  
Harry Weintraub  
Allan Williams

**UNION ALTERNATES**

Karen Azenberg  
Edie Cowan  
Mauro Melleno

**EMPLOYER ALTERNATES**

David Anderson  
Alicia Parker  
Stuart Thompson

**CO-COUNSEL**

Proskauer Rose LLP  
Pryor Cashman Sherman & Flynn LLP

**CONSULTANTS AND ACTUARIES**

The Segal Company

**FUND AUDITOR**

Gould Kobrick & Schlapp, P.C.

**FUND ADMINISTRATOR**

John Everson

Dear Member:

We are pleased to provide you with this booklet 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 booklet as the "Plan". This booklet, which serves as both the Plan document and 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. The benefits described in this booklet 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 booklet with your family and keep it in a safe place for future reference. You (and your covered family members) should refer to this booklet whenever you need information about your health benefits coverage. If you lose or misplace this booklet, please contact the Fund Office for another copy.

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

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

This booklet 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 booklet key terms are capitalized. Such terms will either be defined in the Definitions Section or in the section with which the term first appears.

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

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 booklet 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 booklet 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 with the Plan Administrator, and/or the applicable insurance company providing benefits under the Plan, prior to incurring a medical expense in order to be sure you have coverage for any specific medical expense.*

*Please understand that no general explanation, including this booklet, can adequately provide all the details of the Plan. Accordingly, this booklet 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 with Oxford, Kaiser or any other insurer) that set forth the details of the benefits provided under the Plan, nor does this booklet in any way change or otherwise interpret the terms of the official Plan documents. In the case of a conflict or inconsistency between this booklet 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 booklet 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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## 1. 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 Dependant 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\*
- You or your spouse gives birth or adopts a child\*
- You become financially responsible for a stepchild\*
- 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 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

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- \* 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 Periods" for more information regarding enrollment and coverage for Dependents.

Upon the request of the Trustees or the Fund Administrator, 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 Administrator 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.

## 2. ELIGIBILITY

### a. 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. You are also eligible to participate in the Plan if you are an employee of SDC or the Fund Office.

### b. 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 fourth month following the end of a Contribution Period. Accordingly, if adequate contributions are due on your behalf for the period of January 1 through June 30, and the first rehearsal date(s) for the production(s) for which adequate contributions are due falls between January 1 and June 30, your eligibility will commence on October 1 and continue for six months until March 31 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) for the production(s) for which adequate contributions are due falls between July 1 and December 31, your eligibility will commence on April 1 and continue for six months until September 30 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.*

In the case of an on-going production which pays periodic contributions on your behalf to the Plan after opening, you will be eligible for benefits on the first day of the fourth month following the end of a Contribution Period if adequate contributions were due on your behalf from the producer for the Contribution Period.

### c. Length of Eligibility

You will be covered under the Plan as an active participant for six full months from the first day of the fourth month following the applicable Contribution Period, provided that you meet the eligibility requirements described in Section 2b above. If the contributions made or to be made on your behalf are at least two times the required predetermined level 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 fourth month following the Contribution Period.

### d. Eligibility of Dependents and Domestic Partners

Eligible Dependents include your legal spouse and your dependent children. Same-sex Domestic Partners are eligible for coverage under the Plan, provided that the appropriate documentation is filed with the Fund Office establishing Domestic Partnership.

If you are seeking coverage for your Domestic Partner, you must submit (i) an affidavit attesting to the Domestic Partnership status; (ii) 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 (iii) 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 section of this booklet entitled "Definitions" for more detail regarding the requirements in order to establish Domestic Partnership.

Dependent children of your Domestic Partner are also eligible for coverage under the Plan on the same basis as your Dependent children.

**e. Length of Dependent and Domestic Partner Eligibility**

Your dependent children are eligible for coverage under the Plan until they reach the age of 26. Benefits discontinue at the end of the calendar year.

Once your spouse or Domestic Partner establishes eligibility for coverage under the Plan, they will remain eligible for coverage as long as they are your spouse or Domestic Partner and as long as you are eligible for coverage.

***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.***

### **3. HOW YOU ENROLL FOR COVERAGE**

When you become eligible for coverage, you will be sent an Option Election Form which you must return to the Fund Office, indicating your preference of either Option A for Hospital, Medical and Dental coverage, or Option B for the Medical Spending Account.

If you elect Option A, your form must be returned to the Fund Office along with a check 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 single Option A participants for each quarter of eligibility. Those electing family participation (spouse, domestic partner, and/or child coverage) will be charged the underlying cost of the family portion of the premium, plus 15% of the underlying individual premium. Payment will be due on the first day of each calendar quarter, and must be received in the Fund Office no later than 30<sup>th</sup> day of the first month of each calendar quarter. Option A coverage (for Oxford, Kaiser or Premium Reimbursement) will be terminated if the payment is not made on time, and the Participant will default to Option B. 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 April 1<sup>st</sup>, your enrollment form must be received no later than April 29<sup>th</sup>. For coverage beginning October 1<sup>st</sup>, your enrollment form must be received no later than October 30<sup>th</sup>. Failure to comply may result in the loss of your eligibility to receive benefits through Option A for the applicable six-month eligibility period.

If you elect Option B, you will be sent Medical Spending Account claim forms to submit with your receipts for direct reimbursement by the Fund. No Participant Contribution is necessary if you elect Option B.

#### **a. Newborn/Adopted Children**

A Dependent child born (or adoptive child placed in your custody) after the effective date of your coverage is eligible for coverage under the Plan and coverage is effective from the date of birth (or placement). However, you must timely notify the Fund Office of the birth (or placement) and the child must be properly enrolled in the Plan within 30 days of the birth (or placement). You may be required to submit proof of your legal responsibility for such child.

#### **b. Special Enrollment Periods**

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 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.

Effective April 1, 2009, 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.

Effective April 1, 2009, 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 Mr. John Everson, the Fund Administrator, at the Fund Office, 1501 Broadway, Suite 1701, New York, NY 10036, or (212) 869-8129.

**c. 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. A child covered under the Fund pursuant to a QMCSO will be treated as a Dependent under the Fund.

#### **4. PAYING FOR COVERAGE**

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 (Oxford 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/Partner portion of the premium, you will be charged 15% of the applicable Oxford or Kaiser individual premium.

## 5. WHEN COVERAGE TERMINATES

Your active coverage under the Plan will end on 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 October 1st and end on March 31. 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 March 31. Rather, your active coverage will continue until September 30.

Coverage for your Dependents and/or Domestic Partner will terminate on the last day of their eligibility for such coverage or the last day for which you pay for such coverage, whichever occurs first.

### **a. Military Duty in the United States Armed Forces**

If you enter the armed forces of the United States, you will be offered the opportunity to continue coverage through the Fund for yourself and your Dependents pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) for a period of up to 24 months during your military service. If the period of military service is less than 31 days, your coverage (and your Dependent's coverage) will continue during the period of military service without any additional charge (note that you will continue to be required to pay for your Dependent's coverage). If the period of military service is 31 days or more, you will be required to pay the applicable COBRA premium to continue coverage. If you do not elect to continue coverage during the period of military service you will be entitled to have your coverage reinstated on the date you return to covered employment with one of the Employers. No exclusion or waiting period (that would not have been subject to had you not entered military service) will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed services that end honorably.

### **b. 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. You are entitled to continue your group health plan coverage under the Plan during that leave period. 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 booklet 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 Administrator.

**c. COBRA Continuation Coverage (Self-Pay)**

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.”

This section includes the following:

- Benefit Description
- Initiating COBRA Continuation coverage
- COBRA Continuation coverage
- Self-Paid Premium
- Extension of COBRA Continuation coverage
- Adding New Dependents and Loss of Other Group Coverage while Enrolled in COBRA
- Termination of COBRA Continuation coverage
- Other COBRA Issues

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 disability occurs under certain circumstances, or 36 months if certain second qualifying events occur. These issues are described in detail below.**

#### INITIATING COBRA CONTINUATION COVERAGE:

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

- (1) The divorce or legal separation of a covered employee from his or her spouse.
- (2) A Dependent ceasing to be eligible to be covered under the Plan as a Dependent of a participant.
- (3) 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 Administrator with notice within the timeframe noted in this section:

- (4) 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 60<sup>th</sup> 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.
- (5) When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Administrator 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 Administrator 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).

*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 Administrator 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.

Your Employer should notify the Fund Administrator of an employee's death, termination of employment or entitlement to Medicare. However, you or your family should also notify the Fund Administrator 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 Administrator. Once you or your Employer have/has notified the Fund Administrator, 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 Administrator 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 COBRA 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 Administrator 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 coverages. 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.

#### COBRA CONTINUATION COVERAGE:

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 medical and/or dental 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 percent (in the case of an extension of COBRA Continuation coverage due to a disability, 150 percent). 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.

**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 Administrator 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 Administrator 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 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.

#### Adding New Dependents and Loss of Other Group Coverage while Enrolled in COBRA:

If, while you are enrolled for COBRA Continuation coverage, you marry, have a newborn child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA Continuation coverage.

Any qualified beneficiary can add a new spouse or child to his or her COBRA Continuation coverage. However, the only newly added family members who have the rights of a qualified beneficiary, such as the right to stay on COBRA Continuation coverage longer in certain circumstances, are children born to, adopted, or placed for adoption with the covered employee.

If, while you are enrolled for COBRA Continuation coverage, your spouse or Dependent loses coverage under another group health plan, you may enroll the spouse or Dependent for coverage for the balance of the period of COBRA Continuation coverage. The spouse or Dependent must have been eligible but not enrolled for coverage under the terms of this Plan and, when enrollment was previously offered under the Plan and declined, the spouse or Dependent must have been covered under another group health plan or have had other health insurance. The loss of coverage must be due to exhaustion of COBRA Continuation coverage under the other plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of

coverage for cause.

In any event, you must enroll the new spouse or Dependent, or the spouse or Dependent who has lost coverage under another group health plan, within 30 days of the event allowing for this "special enrollment" (*i.e.*, marriage, birth, adoption, placement for adoption or the exhaustion or termination of other coverage).

You must notify the Fund Administrator in writing of the termination of other coverage in order to add your Dependent(s). Adding a spouse or Dependent may cause an increase in the amount you must pay for COBRA Continuation coverage. Please contact the Fund Administrator 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 that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. If the plan does impose a pre-existing condition exclusion, then the individual may be allowed to continue his or her COBRA for the applicable maximum period or wait until the other Plan's pre-existing condition exclusion no longer applies to that individual. Contact the Fund Administrator for details.
- The individual becomes entitled to Medicare.
- The date the group health Plan terminates as to the eligible group of which you were a member. 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 SSA 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 Administrator will send you a written notice as soon as practicable following the Fund Administrator'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.

You do not have to show that you are insurable to choose COBRA continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Board of Trustees and the applicable Plan insurer reserve the right to terminate your continuation coverage retroactively if you are determined to be ineligible.

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

possible after one of those events.

#### Other COBRA Issues:

##### *Confirmation of Coverage Before Election of or Payment for COBRA Continuation Coverage*

If a provider requests confirmation of coverage and you, your spouse or Dependent child(ren) have elected COBRA Continuation coverage and the amount required for COBRA Continuation coverage has not been paid while the grace period is still in effect or you, your spouse or Dependent child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

##### *Keep the Fund Administrator Informed of Address Changes*

In order to protect your family's rights, you should keep the Fund Administrator 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 Administrator.

##### *Your Decision Concerning COBRA Continuation Coverage*

In considering whether to elect COBRA Continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not receive COBRA Continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA Continuation coverage if you receive COBRA for the maximum time available to you.

#### **d. Conversion of Health Coverage**

##### *Conversion 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 Oxford or Kaiser Permanente, whichever is applicable.

You must contact the applicable Plan insurer (Oxford 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.

**e. Certification of Coverage When Coverage Ends**

When your coverage under the Plan ends, you and/or your covered Dependents or Domestic Partner are entitled by law to a Certificate of Creditable Coverage. This Certificate indicates the period of time you and/or your Dependents or Domestic Partner were covered under the Plan. You may need to present the Certificate to the administrator of a group health plan or individual insurance coverage that you (and/or your Dependents or Domestic Partner) become covered under after Plan coverage ends in order to reduce or eliminate any exclusion or limitation on coverage for pre-existing conditions that may apply under that new plan.

The Certificate generally will be provided to you as soon as administratively feasible after the Plan knows (or making reasonable efforts, should know) that coverage (either active employee coverage or COBRA continuation coverage) for you and/or your covered Dependent(s) or Domestic Partner has ended. If you (or any of your covered Dependent(s)) elect COBRA continuation coverage, a second certificate will be sent to you and/or your covered Dependent(s) as soon as administratively feasible after COBRA continuation coverage ends.

In addition, a request for a Certificate may be made by (or on behalf of) any individual who loses coverage under the Plan, provided that the request is received by the Fund Office within two years after the individual's coverage (active Plan coverage or COBRA continuation coverage) ceases.

**f. 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 10% 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).

**6. 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. Option B provides a \$2,200 semi-annual (\$4,400 annual maximum) direct pay medical spending account. Option B is intended primarily for those who are already covered under another basic health insurance plan.

**a. OPTION A (Hospital and Medical Insurance)**

For participants residing in the New York, New Jersey and Connecticut metropolitan area coverage is made available through Oxford Health Plans. For participants residing in Southern California and the San Francisco areas HMO coverage is available through Kaiser Permanente.

If you enroll for coverage through Kaiser, you will receive a separate description of your benefits along with a directory of participating providers.

For participants residing in other areas, premium reimbursement may be arranged. Under such an arrangement participants may purchase individual health insurance policies, and the Fund will reimburse the cost of their premiums, not to exceed the current cost of premiums paid for members residing in the New York area. In order to receive reimbursement, Participants must furnish the Fund Administrator with written evidence of the type of coverage, the premium due and proof that the premium was paid. 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. Claims for premium reimbursement must be submitted within one year of the month for which coverage was purchased.

For participants who elect individual coverage, a Participant Contribution amounting to 15% of the current Oxford or Kaiser premium will be charged.

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

Got Premium Reimbursement participants, the Fund will reimburse you for 85% of the individual premium rate, and the participant will be responsible for the remaining 15% of the individual premium amount. The maximum individual premium that will be recognized is the current Oxford individual premium rate.

Option A coverage (for Oxford, Kaiser or Premium Reimbursement) will be terminated if the payment is not made on time, and the Participant will default to Option B.

## **OXFORD FREEDOM PLAN**

### **How the Plan Works**

As a "Point of Service" Plan, the Oxford Freedom Plan provides you with the option of obtaining medical services on either an In-Network or Out-of-Network basis. In-Network services are provided by your Primary Care Physician or through referrals to a Network Specialist. This is described in more detail below. Out-of-Network services are also available, subject to deductible and co-insurance payments as outlined in the Summary of Benefits below.

### **The Primary Care Physician**

Each person who enrolls in the Plan is required to select a Primary Care Physician (PCP). The PCP selected by you becomes your personal Physician and health care advisor who will maintain

**[a. OPTION A (continued)]**

a record of your medical history and health care needs. Your PCP is responsible for coordinating your care and will become familiar with the overall status of your health.

Your PCP is also your key to obtaining the care you need. Whenever you require health care services, you must first contact your PCP. He or she will provide or arrange for the Covered Services you need. Your PCP provides "Primary Care" and "Preventive Care." Primary Care includes routine office visits for treatment of illness and injury as well as Preventive Care. If your PCP determines that you need to see a Network Specialist, he or she will arrange for you to obtain Specialty Care. Please remember, Primary and Preventive Care that is not provided by your PCP will not be covered under the Plan.

In addition to a PCP, covered females may select a Network OB/GYN or a Network Nurse Midwife to provide their OB/GYN care. They may see their selected Provider of OB/GYN care without a referral from their PCP.

**Network Specialists as PCPs**

Members who have a life-threatening condition or disease and Members who have a degenerative and disabling condition or disease may request to elect a Network Specialist as their PCP. The designated Network Specialist will be responsible for providing and coordinating all of the Covered Person's Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures and provide referrals and medical services in the same capacity as a PCP. This election is available only if the condition or disease requires specialized medical care over a prolonged period of time. Please contact Oxford or the Fund Office for further details if this applies to you or your covered Dependents or Domestic Partner.

**Specialty Care**

If your PCP cannot provide a specific medical service that you need, he or she will give you a referral to a Network Specialist. As part of the referral process, your PCP must complete a referral form. You will be given the form to take with you to your appointment with the Network Specialist. Once you have obtained the referral, you may visit the Network Specialist. **You cannot obtain In-Network Specialty Care without a referral from your PCP.** If you see a Network Specialist without a referral, neither the visit nor the services will be covered by the Plan, even if the specialist is a Network Specialist.

**[a. OPTION A (continued)]**

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**OXFORD FREEDOM PLAN SUMMARY OF BENEFITS**

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<b>COVERED BENEFITS &amp; SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><u>Primary and Preventive Care</u></b>		
Physician Office and Home Visits	No charge for Preventive Care Visits  \$25 Copayment per visit for treatment of illness or injury (not applicable to Preventive Care)  Two Well-Woman Examinations per calendar year, Pap tests, and age appropriate mammograms are covered at no charge.	Preventive care is available only to Members age 19 and under and is subject to deductible and 30% coinsurance.  Office or home visits for treatment of illness or injury are covered, subject to the applicable deductible and 30% coinsurance. Some procedures require precertification.  Female Members may receive an annual or age appropriate mammogram subject to 30% coinsurance and the applicable deductible. Well-woman examinations are not covered.
Inpatient Hospital Visits	No charge	Covered, subject to the applicable deductible and 30% coinsurance.
Diabetes Education and Self-Management	\$25 copayment per office visit	Covered, subject to the applicable deductible and 30% coinsurance.
Diabetic Supplies	The lesser of the PCP office copayment or 20% of the cost of the item.	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required for the purchase of an insulin pump.
<b><u>Specialty Care</u></b>		
Physician Office and Home Visits	\$25 copayment per office visit	Covered, subject to the applicable deductible and 30% coinsurance. Some procedures require precertification.
Inpatient Hospital Visit	No charge	Covered, subject to the applicable deductible and 30% coinsurance.
Obstetrical Services (including prenatal and postnatal)	\$25 copayment per initial office visit	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Elective termination of pregnancy	No charge. Coverage is up to a maximum of \$350 per procedure.	Covered, subject to the applicable deductible and 30% coinsurance and up to a maximum of \$350 per procedure.
Treatment of Infertility		
Specialist Office Visits	\$25 copayment per office visit	NO COVERAGE
Outpatient Services	No charge	NO COVERAGE
		Covered, subject to the applicable

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**[a. OPTION A (continued)]**

Allergy Testing and Treatment	\$25 copayment per office visit	deductible and 30% coinsurance.
Rehabilitation Services (Physical, Speech, and Occupational Therapy)		
Outpatient	\$25 co-payment per office visit	Covered, subject to the applicable deductible and 30% coinsurance.
Inpatient	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Oral Surgery	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Pediatric Preventive Dental (through age 11)	No charge	The services of Non-Network dentists are covered under the terms of the Certificate.
Laboratory Procedures and X-rays	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required for PETscans, MRA's and endoscopic procedures.
Diagnostic Mammography	No charge	Covered, subject to the applicable deductible and 30% coinsurance.
Prosthetic Devices	No charge (external and internal devices)	No charge for internal prosthetic device. Surgery is subject to the applicable deductible and coinsurance.  External devices are subject to deductible and 30% coinsurance. Precertification is required before purchase.
Transplants	Transplants performed at In-Network facilities that are specifically approved and designated by Oxford are covered, subject to the inpatient hospital copayment. Transplants performed at facilities that are not specifically approved by Oxford are not covered.	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Home Health Services	\$25 copayment per office visit	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Chiropractic Services	\$25 copayment per office visit	Covered, subject to the applicable deductible and 30% coinsurance.
Second Opinions	At your request, \$25 copayment per office visit. At Oxfords or the Plan	Covered, subject to the applicable deductible and 30% coinsurance.

**[a. OPTION A (continued)]**

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	Administrator's request, no charge.	
Durable Equipment, when medically necessary	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Medical Supplies, when medically necessary	Out of network benefit only	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required
<b><u>Hospital and Other Facility Based Services</u></b>		
Inpatient Hospital Services	\$100 copayment per in-patient hospitalization.	Covered, subject to the applicable deductible and 30% coinsurance per continuous confinement. Precertification is required.
Outpatient Hospital Services and Ambulatory Surgical Center Services	\$50 copayment	Coverage, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Skilled Nursing Facility Services	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Hospice Care (210 days)		
Inpatient	\$100 per continuous confinement (waived if transferred from a Hospital or Skilled Nursing Facility)	Covered, subject to the applicable deductible and 30% coinsurance for each continuous confinement. Precertification is required.
Outpatient	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
Home Hospice	\$25 copayment per visit	Covered, subject to 30% coinsurance. Not subject to deductible. Precertification is required.
Skilled Nursing Facility Services	No charge	Covered, subject to the applicable deductible and 30% coinsurance. Precertification is required.
<b><u>Alcohol and Substance Abuse Services</u></b>		
Inpatient Rehabilitation	\$100 per continuous confinement	Deductible & 30% Coinsurance
Outpatient Rehabilitation	\$25 copay per visit	Deductible & 30% Coinsurance
Office Visits	\$25 copay per visit	Deductible & 30% Coinsurance
<b><u>Medical Emergency Services</u></b>		

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**[a. OPTION A (continued)]**

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Emergency Room Services	\$100 per visit (waived if the covered person becomes confined in a hospital immediately following Emergency Room visit). When proper notice is given, Out-of-Network Providers will be covered as In-Network Providers.	When proper notice is not given, Medical Emergencies are covered subject to 50% coinsurance and the applicable deductible.
Urgent Care Facility Services	When proper notice is given the services of In-Network and Out-of-Network Providers are covered, subject to a \$25 copayment per visit (Waived if the Covered Person becomes confined in a hospital).	Covered, subject to the applicable deductible and 30% coinsurance.
Ambulance Services	No charge	All covered Ambulance Services will be covered as an In-Network benefit.
<b><u>Mental Health Care</u></b>		
Inpatient Care	\$100 co-payment per continuous confinement	Covered, subject to deductible and 30% coinsurance
Outpatient Care and Office Visits	\$25 co-payment per visit	Covered, subject to deductible and 30% coinsurance.
<b><u>Prescription Drugs</u></b>		
	\$15 per Tier 1 prescription \$25 per Tier 2 prescription \$50 per Tier 3 prescription A \$100 deductible per individual per calendar year will apply for prescriptions. (For a current version of Oxford's 3-tier plan, with an extensive choice of generic equivalents for brand name drugs, log on to <a href="http://www.oxhp.com">www.oxhp.com</a> .)	Covered In-Network only

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**MAXIMUMS AND LIMITATIONS**

**Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits. All reimbursements for Out-of-Network benefits are subject to Usual, Customary, and Reasonable (UCR) charges.**

Benefits & Services	Maximum Coverage
Out-of-Network Benefits	Out-of-Network benefits are unlimited during the period in which you are covered under the Plan.
Diabetic Supplies	Diabetic supplies will only be supplied in amounts consistent with the covered person's treatment plan, as developed by the covered person's physician. Only basic models of blood glucose monitors are covered unless the covered person has special needs relating to poor vision or blindness.
Elective termination of Pregnancy	One procedure per covered person, per Plan Year, up to a maximum of \$350 per procedure.
Treatment of Infertility	One cycle of Advanced Infertility Treatment. This includes one egg harvesting and one transfer during a two-year period. The maximum benefit is \$10,000 per covered person, per lifetime. This benefit is available only In-Network. No treatment of infertility coverage is available Out-of-Network.
Rehabilitative Therapy Services (physical, speech, and occupational therapy)	Inpatient Rehabilitation: One consecutive 60-day period per condition, per lifetime.  Outpatient Rehabilitation: 90 visits per condition, per lifetime.
Transplants	In-Network coverage is available only at facilities specially approved and designated by Oxford Health Plans (NY), Inc. to perform these procedures.
Home Health Services	60 visits per Plan Year.
Chiropractic Services	In-Network benefits are unlimited. Out-of-Network benefits are subject to a \$1500 per calendar year maximum.
Exercise Facility Reimbursement	Reimbursement of \$200 per six-month period. Oxford will Reimburse for benefits for your spouse \$50 per 6-month period. You must complete 50 visits within the 6-month period.
Skilled Nursing Facility Services	30 days per calendar year.
Hospice Services	210 days.
Bereavement Counseling for the Member's family	5 sessions either before or after your death.

[a. OPTION A (continued)]

Benefits & Services	Maximum Coverage

**PRECERTIFICATION**

Oxford must pre-certify all admissions to Oxford-affiliated health care facilities and certain diagnostic tests and therapeutic procedures before you are admitted or receive treatment. Precertification starts with a call to Oxford’s Medical Management Department by your PCP, provider of OB/GYN care or the Network Specialist involved. One of Oxford’s Medical Management professionals will examine the case, consult with your Provider and discuss the clinical findings. If all agree the requested admission, test or procedure is appropriate, the precertification is provided. This evaluation ensures that the treatment you receive is appropriate for your needs and is delivered in the most cost-effective setting.

For In-Network services, your Network Provider is responsible for obtaining any required precertification and is aware of when precertification is required. However, if you wish to double-check that your Network Provider has contacted Oxford about your case, please call Customer Service and inquire.

For Out-of-Network services, if you fail to properly obtain precertification when required to do so, you will be subject to a reduction in benefits.

**Please remember:** Any precertification you receive will not be valid if your coverage under the Plan terminates. This means that covered services received after your coverage has terminated will not be covered even if they were precertified.

**[a. OPTION A (continued)]**

**DEDUCTIBLE**

The applicable Deductibles for this Plan are:

Individual:	\$2,000
Family:	\$4,000

**OUT-OF-POCKET LIMITS**

The maximum amount you must pay in any calendar year for Out-of-Network Covered Services is:

Individual:	\$3,500
Family:	\$7,000

[a. **OPTION A (continued)**]

**COPAYMENT LIMITS**

You are required to pay a copayment in connection with certain benefits and services covered under the Plan. Generally, you must pay the copayment to the service provider at the time you receive benefits or services.

Total copayments paid by or on behalf of a Member during a calendar year shall not exceed 200% of the total annual premium rate for individual or family coverage, whichever is applicable for services provided under the HMO Certificate in any calendar year, provided application is made to the HMO by a Member within 45 days of the end of the calendar year to which such limitation applies. Any excess in the amount of payments will be refunded to the Member.

**COINSURANCE**

You are required to pay a certain percentage (usually 30%) of the total cost of certain benefits or services that you receive and that are covered under the Plan. This is called "Coinsurance." Generally, the service provider or Oxford will bill you for such amount.

**b. OPTION A (Dental Benefits)**

Dental Benefits are provided for Oxford participants through the Oxford Premium Dental Plan. Members select a primary care dentist from Oxford's Roster of Participating Dentists to provide routine dental care. If specialty care is needed, you may seek treatment directly from any of the Oxford dental specialists listed in the Roster. Unlike Oxford's medical plans, no written referral is required in order to visit a specialist. The Oxford Premium Dental Plan requires no deductibles or claim forms. You pay only the appropriate discounted fees for services. Payment must be rendered to the dentist at the time services are provided or in accordance with the payment terms of the dentist's office. For a complete schedule of dental benefits please refer to your Certificate of Coverage or call the Fund Office for details.

Dental Benefits are provided for Kaiser Permanente participants through P.M.I. Delta-Care. For information on this coverage, please refer to your Certificate of Coverage or call the Fund Office for details.

**c. OPTION B (\$2,200 Semi-Annual Medical Spending Account)**

Option B provides for a \$2,200 semi-annual (\$4,400 annual maximum, provided eligibility continues for the year) Medical Spending Account. 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 I.R.S. publication 502 and may be obtained from the I.R.S. or by calling the Fund Office.

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 eligibility 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 family members or Domestic Partners). Whenever possible, an explanation of benefits from your primary insurance carrier should be submitted along with your claim form.

Categories of reimbursement under Option B include:

1. Dental
2. Optical
3. Chiropractic
4. Mental Health (services must be performed by a psychiatrist, licensed psychologist, or licensed social worker)
5. Wellness (preventive exams and procedures and vaccinations)
6. Other Health Expenses (those which qualify as deductible expenses on your personal income taxes, as outlined in I.R.S. publication 502, available from the Fund Office or the I.R.S.). 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).
7. 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.

## 7. CLAIMS AND CLAIMS REVIEW

The effective date of the following procedures is September 1, 2002 and supersedes any prior version. 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.

### **a. How to File a Claim with Oxford 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 Oxford Health Plans or Kaiser Permanente, the Board of Trustees has delegated to Oxford 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 Oxford or Kaiser Permanente plan materials for further details.

### **b. How to File a Claim for the Option B Medical Spending Account**

Medical Spending Account claims are administered directly through the Fund. Please note that Medical Spending Account claims are available to the participant only, not to dependents, spouses or domestic partners. 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.

- Your name, address, and phone number(s)
- Your Social Security 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
- Explanations of benefits, paid receipts, or other evidence of payment
- Participant's signature

Whenever possible, an explanation of benefits from your primary insurance carrier should 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.

#### **i. When Claims Must Be Filed**

Claims should be filed within six months following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim 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.

#### **ii. 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  
1501 Broadway, Suite 1701  
New York, NY 10036  
Phone: 212-869-8129  
Fax: 212-302-6195  
E-mail: Health@sdcweb.org

#### **iii. 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.

#### **iv. 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.

#### **v. Notice of Decision**

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
- If an internal rule, guideline or protocol was relied upon in deciding your claim, 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 the absence of 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

#### **vi. 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.

#### **vii. Review Process**

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; if it was submitted, considered or generated (regardless of whether it was relied upon); if it demonstrates compliance with the Plan's administrative processes for ensuring consistent decisionmaking; or if it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. This person will be a professional who is neither the individual consulted in connection with the initial adverse benefit determination nor a subordinate to that person.

#### **viii. 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.

#### **ix. 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
- 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
- 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

#### **x. 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. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

#### **c. General**

If you have any questions about these procedures, please contact the Fund Office at 212-869-8129 or 800-317-9373 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 booklet, 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 booklet, 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.***

## **8. DUPLICATE COVERAGE OF HOSPITAL, MEDICAL AND DENTAL EXPENSES**

### **a. 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 Oxford 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 Oxford.

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.

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

**When and How Coordination of Benefits Applies**

For the purposes of Coordination of Benefits (or COB, as it is usually called), the word "plan" refers to any group hospital, medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of hospital, medical or dental services incurred by the Covered Person or that provides hospital, medical or dental services to the Covered Person. A "group plan" provides its benefits or services to employees, retirees or members of any group who are eligible for and have elected coverage as a group.

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.

**Which Plan Pays First: Order of Benefit Determination Rules**

Group plans determine which plan pays first by applying order of benefit determination rules in a specific sequence. This Fund uses the order of benefit determination rules described below. Any group plan that does not have COB rules or does not use these same rules as the Fund's 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 that are the same as the Fund's 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 either 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.

### **How Much This Fund Pays When It Is Secondary**

When this Fund pays second, it will pay, with respect to the total benefits under each claim submitted for payment, no more than 100% of the "Allowable Expenses," less whatever payments were actually made by the plan (or plans) that paid first.

An "Allowable Expense" is the necessary, reasonable and customary item of expense for health care, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans

covering the person, except as provided below or where a statute applicable to this Fund requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

- The difference between the cost of a semi-private room in a hospital or other health care facility and a private room, unless the patient's stay in a private hospital room is medically necessary.
- Amounts charged by a health care provider that exceed the highest of the "usual and customary charges" allowed by any of the plans. This means that, among the plans, the highest of the "usual and customary charges" is the amount that all plans will use for COB purposes as such term may be defined under the plans in question.
- Amounts charged by a health care provider that exceed the price, charge, or fee set by agreement with the Fund, if the health care provider has contracted with the Fund (directly or indirectly) to provide the service for the covered person for a specific fee or payment.
- Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered through this Fund.

When benefits are reduced by a primary plan because a covered person did not comply with the primary plan's provisions, such as the provisions related to pre-certification under the Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Fund when it pays second.

### **c. Medicare and Other Government Plans**

#### **Medicare**

Generally, anyone age 65 or older is eligible for Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefit is also eligible for Medicare coverage after a waiting period. If you, your covered Dependant, or your covered Domestic Partner becomes covered by Medicare, either because of age or disability, you may either retain or cancel your coverage through this Fund (see the Section of this booklet entitled "When Your Active Coverage Terminates — Medicare Coverage").

If you, your Dependent or Domestic Partner are covered by this Fund and by Medicare, as long as you remain actively employed and enrolled in the Plan, this Fund pays first and Medicare pays second.

However, if you become eligible for Medicare because of your disability, you may no longer be considered to have current employment status and you may, therefore, no longer be a participant in the Plan. Under these circumstances, Medicare will pay first and this Fund will

pay second. Nevertheless, the Fund continues to pay first if your Dependent or Domestic Partner is entitled to Medicare because of their disability, as long as you maintain current employment status and the disabled individual remains enrolled in the Plan.

If, while you are actively employed, you or any of your covered Dependents becomes entitled to Medicare because of end-stage renal disease (ESRD), this Fund pays first and Medicare pays second for a limited period of time.

**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.

**d. 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.

**e. 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.

**f. Third Party Liability**

**Subrogation**

Under this Plan, a Covered Person may accept payments of plan benefits that arise from or are related to an illness, injury, or medical condition that was caused by a third party. By accepting any such payment of Plan benefits, all Covered Persons agree that the Fund will be subrogated to any Covered Person's right of recovery and entitled to reimbursement of any Plan benefits paid. The Fund's subrogation and/or reimbursement rights will include all claims, demands, actions and rights of recovery of all Covered Persons against any third party or insurer, including any workers' compensation insurer or governmental agency, and will apply to the extent of any and all payments of Plan benefits made or to be made by the Fund.

As used in this SPD "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 a third party who negligently or wrongfully caused the Covered Person's injury or illness that resulted in a payment of benefits by the Fund. The third party which negligently or wrongfully caused the Covered Person's injury or illness is called the "Tortfeasor."

**Subrogation and/or Reimbursement Agreement**

All Covered Persons must execute and deliver any and all instruments and papers requested by or on behalf of the Fund, and must do whatever is necessary to protect all of the Fund's subrogation and/or reimbursement rights. As a condition precedent to the payment of benefits by the Fund, all Covered Persons will, upon written request from the Fund, execute a subrogation and/or reimbursement agreement in a form to be provided by or on behalf of the Fund. However, failure by any Covered Person to execute any such subrogation and/or reimbursement agreement will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's subrogation and/or reimbursement rights. No Covered Person will do anything, either before or after any illness or injury, to waive, compromise, diminish, release, or otherwise prejudice the Fund's subrogation and/or reimbursement rights.

**Cooperation with the Fund by the Covered Persons**

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 Plan 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 Plan 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 Reimbursement of the Fund**

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.

If the Covered Persons fail to reimburse the Fund, the Fund may apply any future Plan 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. If a Covered Person does not receive any recovery from a third party, the Covered Person, is not obligated to reimburse the Fund for benefits that are applied for and appropriately received.

## 9. ADMINISTRATIVE INFORMATION

### a. 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.

### b. 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 plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- obtain copies of all plan documents and other plan information upon written request to the Fund Administrator. The administrator may make a reasonable charge for the copies; and

- 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 in whole or in part you are entitled to receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in 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 plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.

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, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your

telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

**c. 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), or require that a provider obtain authorization from the plan for prescribing a length of stay that is no longer than these periods.

**d. 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 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 benefits under the Plan.

**e. HIPAA Privacy Rights**

Effective April 14, 2004, the Plan is subject to the requirements of the Health Insurance Portability and Accountability Act's regulations concerning the privacy of individually identifiable health information (commonly referred to as the "Privacy Rule"). The Privacy Rule requires the Plan to provide participants with a notice containing a description of the Plan's potential uses and disclosures of protected health information, their rights and the Plan's legal duties with respect to such information, as well as other specific information. The notice must also be provided upon request, and within 60 days of a material revision to the notice. If you wish to request a copy of the notice or if you have any questions regarding the Privacy Rule, please contact the Fund Administrator.

**f. General Administrative Information**

**Name of Fund**

The SDC-League Health Fund

**Type of Plan**

The SDC-League Health Fund provides hospital, medical, and dental benefits.

**Plan Administrator**

The Board of Trustees

**The Board of Trustees**

**Union Trustees:**

Ms. Pamela Berlin  
SDC  
1501 Broadway, Ste. 1701  
New York, NY 10036  
212-391-1070

Mr. Sue Lawless  
SDC  
1501 Broadway, Ste. 1701  
New York, NY 10036  
212-391-1070

Ms. Laura Penn  
SDC  
1501 Broadway, Ste. 1701  
New York, NY 10036  
212-391-1070

Mr. Stephen Rothman  
SDC  
1501 Broadway, Ste. 1701  
New York, NY 10036  
212-391-1070

**Employer Trustees:**

Mr. Christopher Brockmeyer  
The Broadway League  
226 West 47<sup>th</sup> Street  
New York, NY 10036  
212-764-1122

Mr. Harry Weintraub, Esq.  
1501 Broadway, Ste. 2401  
New York, NY 10036  
(212) 944-1501

Mr. Allan Williams  
1650 Broadway, Ste. 800  
New York, NY 10019  
212-307-0800

**Union Alternate Trustees:**

Ms. Karen Azenberg  
 SDC  
 1501 Broadway, Ste. 1701  
 New York, NY 10036  
 212-391-1070

Ms. Edie Cowan  
 SDC  
 1501 Broadway, Ste. 1701  
 New York, NY 10036  
 212-391-1070

Mr. Mauro Melleno  
 SDC  
 1501 Broadway, Ste. 1701  
 New York, NY 10036  
 212-391-1070

**Employer Alternate Trustees:**

Mr. David Anderson  
 Broadway Across America  
 220 W. 42<sup>nd</sup> Street, 14<sup>th</sup> Floor  
 New York, NY 10036  
 917-421-5427

Ms. Alecia Parker  
 National Artists Management Company  
 165 W. 46<sup>th</sup> Street, Ste. 1202  
 New York NY 10036  
 212-575-1044

Mr. Stuart Thompson  
 1501 Broadway, Ste. 1614  
 New York, NY 10036  
 212-768-4610

**Type of Administration**

Although the Board of Trustees is legally designated as the Plan Administrator of the Fund, the Board has delegated certain administrative services to Oxford and Kaiser (with respect to the hospital, medical and dental coverage under the Plan). The Board of Trustees has also delegated many of the day-to-day administrative functions to the Fund's Administrator and the Fund Office staff. To contact the Fund Administrator, call or write the Fund Office at:

Mr. John Everson  
 Fund Administrator  
 The SDC-League Health Fund  
 1501 Broadway, Suite 1701  
 New York, New York 10036  
 212-869-8129  
 JEverson@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 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](http://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 booklet. Not all benefits described in this booklet 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 and Dental Benefits:

Participants residing in the New York, New Jersey and Connecticut metropolitan areas:  
Oxford Health Plans

48 Monroe Turnpike  
Trumbull, CT 06611  
Participants residing in Southern California and the San Francisco area:  
Kaiser Permanente  
393 E. Walnut Street, 5<sup>th</sup> 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 address listed in this booklet. The business telephone number of the Board of Trustees is (212) 869-8129.

**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, certain numbers are used to identify the SDC-League Health Fund:

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

## 10. DEFINITIONS

**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" 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) of the same sex, 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 than 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 Administrator 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.

**Employer:** an Employer that, pursuant to a collective bargaining agreement or other written agreement, is required to contribute to the Fund.

**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.

**Medical Emergency:** a 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 set forth in this booklet reviews the types of benefits.

**Urgent Care:** Urgent Care is 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:** A licensed facility (except Hospitals) which provides Urgent Care.

**Usual, Customary and Reasonable (UCR) Charge:** The amount charged or the amount determined by your insurer to be the reasonable charge, whichever is less, for a particular Covered Service in the geographical area where it is performed. Effective January 1, 2006, the Fund will use the amount which is at the 80<sup>th</sup> percentile of charges for the involved service in determining what is a UCR Charge under the Option A Oxford Freedom Plan (and you will be required to pay for any amount over the amount determined using this 80<sup>th</sup> percentile standard).