NOW PLAYING

EQUITY–LEAGUE

If It's News, It's In This Issue

FALL 2011

Welcome to Our Fall 2011 Issue of *Now Playing*

Happy 50th Birthday to the Pension and Health Funds — 10th Birthday to the 401(k) Fund

On June 1, 2011, the Pension and Health Funds reached a major milestone — 50 years in existence! On July 1, the 401(k) reached its own milestone — 10 years in existence.

In this issue of *Now Playing*, we'll tell you a little about the beginning of the Pension and Health Funds, talk about a Trustee who just retired after serving the Funds for very nearly their entire history, report on some important changes that are taking place on the Health and 401(k) Funds, and provide some important reminders regarding your benefits. More specifically, this issue includes:

A Note on the 10th Anniversary of the 401(k) Fund

While the 401(k) Fund has only been in existence a little more than 10 years, it has grown dramatically as well, reaching assets of more than $100 million and serving more than 12,000 participants as of June 30, 2011. What amazing growth in 10 short years!

A Brief History of the Pension and Health Funds

The Equity-League Pension and Health Funds were formally created through an agreement executed by AEA and League representatives, on March 23, 1961. The Fund Office was first established on May 15, 1961 with a Fund Manager and two employees. There were eight Trustees for the Funds when it began, four representing the AEA (Ralph Bellamy, Angus Duncan, John Effrat and Eddie Weston) and four trustees representing the League (Irving Cheskin , Jay Julien, John Shubert and Herman Shumlin). Mr. Cheskin went on to become the longest serving Trustee in the history of the Funds, remaining with the Funds until shortly before his death, in the fall of 2008. The longest serving trustee representing the AEA was Jeanna Belkin, who began as a Trustee in 1965 and retired in July of 2011. Collectively, the two Trustees served the Funds for a staggering 93 years!

The first health benefit coverage was provided beginning on June 1, 1961. At that time, only those working under a Production Contract were eligible to be covered under the Equity-League Health Fund (those working under Off Broadway, Industrial and Stock contracts were covered for health insurance by the Actors' Equity Association Insurance Fund at that time). Today the Fund covers employees all across the nation and working under virtually all of Actors Equity's contracts. Health coverage was earned almost as soon as work began and lasted for 6 months (those who worked at least 6 months received 9 months of coverage after they terminated employment). However, coverage was solely for life insurance, hospital and certain doctor's services. There was no coverage for prescription drugs or dental services and there was no supplemental workers' compensation coverage.

Health benefits were initially insured with Blue Cross and/or through GHI. In 2005, the Fund had grown large enough to become self-insured (for other than HMO, dental and vision care benefits), saving money for the Fund and enabling a greater percentage of contributions to be passed through to participants in the form of benefits. Today approximately 90% of every contribution dollar received by the Fund and applied to the self-insured part of the plan is used to provide benefits for plan participants. Health Fund revenues could be expressed in the tens of thousands of dollars per year in 1961, as compared with more than $60 million in the plan year that ended in 2011. As of 2011, the Fund had paid out, since its inception, substantially more than half a billion dollars in benefits to its participants.

In its first year, the Pension Fund collected more than $100,000 in contributions, but no benefits were actually paid out until several years later, when the Fund had accumulated enough assets to operate on a stable basis. Today, the Pension Fund has more than a billion dollars under management, has more than 40,000 participants (those for whom some contribution has been made), and is making monthly pension payments to more than 6,000 pensioners.

Jeanna Belkin Announces Her Retirement as a Trustee on the Pension and Health Funds

Jeanna Belkin is well known to AEA members for her past, and continuing, service to the AEA membership. But she has also had a "second career" — serving as a Trustee on the Pension and Health Funds since 1965. To the surprise to the Pension and Health Trustees and professionals, Jeanna announced her retirement as a Trustee at their July 2011 meeting.

While no one can be expected to serve forever, that fact seemed to be ignored by at least the conscious minds of the Trustees and professionals who serve the Funds, people who saw the continued energy, dedication and profound wisdom that Jeanna showed up to and including the day of her surprise resignation.

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Retirement

After what seemed to be several minutes of shocked and awed silence that followed her announcement, the Trustees and professionals produced a spontaneous standing ovation, for Jeanna's having completed one of the most powerful and long running performances of her amazing career. Later, individual expressions of thanks, congratulations and best wishes abounded, as Jeanna's many "fans" crowded around her after the meeting.

It is hard to imagine the Funds without Jeanna, and she can never be replaced, but her teachings will undoubtedly affect the Funds for many years to come, and her skill and dedication will be an inspiration to all who have had and will have the honor of serving the Funds.

November is Open Enrollment Month for the Health Fund

The Health Fund has its Annual Open Enrollment Period in November of 2011. During that period, you can change your benefit options, such as dependent and dental coverage and switch from an available HMO to the CIGNA plan or vice versa. If you do not wish to make any changes to your present coverage, you needn't do anything during the open enrollment period, but if you want to make a change, your enrollment form(s), and payment in full for the coverage(s) being elected, must be received by the Fund Office by November 30th, otherwise you generally lose your opportunity to make a change until the following November (all changes actually take effect on January 1, 2012).

An important caveat applies to dental coverage. Since this coverage is offered on a fully self-pay basis to participants who qualify for medical coverage, premiums for this coverage are based on the claims and administrative expenses incurred during a full year and are calculated on the assumption that all of those who are enrolled in the program will pay their premiums for the full year.

It has come to our attention that a small number of participants stop paying dental premiums at some point during the year (e.g., when they believe they will not have any more dental work done that year) and then enroll in the dental plan again the following year. If such a pattern were to occur regularly, it would affect the premium levels for the entire plan, because premiums would fall short of estimates (which were based on the assumption that everyone would pay for a full year) and would have to be increased, hurting everyone else in the program, even those who paid their premiums for the full year.

Consequently, anyone who applies for dental coverage during open enrollment will have their prior dental premium payment history reviewed. If they had coverage at any time during the prior calendar year and stopped paying for the coverage at some point during the year, they will be required to pay the premiums that were due for the balance of that year, before coverage for the new year is activated.

For example, if someone paid for coverage from January 1, 2011 through June 30, 2011 and then stopped paying premiums, that person would not be permitted to enroll in the dental plan again on January 1, 2012, unless dental premiums for the July 1, 2011 through December 31, 2011 period were paid.

Finally, in an effort to be green, the Fund Office no longer automatically mails paper enrollment packages to eligible participants. All of the forms necessary to make any changes are available online, at: *http://www.equityleague.org/health/index.html*. If you prefer, you can call the Fund Office and request a paper kit, at 212.869.9380 or 800.344.5220.

Your enrollment form(s), and payments for the coverage(s) elected, must be received by November 30th, otherwise you generally lose your opportunity to make a change until the following November.

If you had dental coverage at any time during the prior calendar year and stopped paying for it at some point during the year, you will be required to pay the premiums that were due for the balance of that year.

The Fund Office no longer automatically mails paper open enrollment packages to eligible participants. All of the forms necessary to make any changes are available online.

Expansion of the Health Fund's Mandatory Generic Drug Program Effective January 1, 2012

Effective January 1, 2012, the Health Fund will be adding three categories of drugs to its mandatory generic drug program: drugs that treat sleep disorders, nasal sprays that treat allergies and topical drugs that treat eczema and psoriasis.

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Under the mandatory generics program, the Fund will only pay for the generic form of drugs in these categories (unless your doctor secures prior approval from CIGNA to use a brand name drug instead, or there is no viable generic drug available for your situation).

You may recall that in July of 2009, the Health Fund implemented a mandatory generic drug program which required that those using drugs to treat high blood pressure, high cholesterol and acid reflux try generic drugs first, before using a brand name drug in the same category. This was done in part because the participants of the Fund had a significantly lower use of generic drugs in these categories than the average health plan. That change was generally well accepted by the plan participants who were using these kinds of drugs, and the Fund has saved hundreds of thousands of dollars as a result of the program, which has helped to restrain the seemingly inexorable rising costs experienced by the Health Fund. Now we are hoping for the same result with respect to these new categories of drugs.

Critical Due Dates — Don't Jeopardize Your Health Coverage Critical Premium Due Dates

Every month, quarter and year, plan participants lose coverage for which they are eligible because they fail to pay their premiums when they are due. There are two critical dates to remember…

Health insurance coverage is critical, yet **every month**, quarter and year, plan **participants lose coverage** for which they are eligible **because they fail to pay their premiums when they are due.** There are two critical dates to remember in this connection. **Remember that all the dates shown below are due dates for actual receipt of payment.** It does not matter when your payment is mailed or otherwise transmitted to the Fund Office or the Fund's lockbox. It must reach us by the due dates shown.

Due Dates for the $100 Quarterly Premium for Employee Coverage

The table below shows the annual premium contribution schedule.

Quarter Beginning On	Due Date for Your Contribution	Last Date to Assure Timely Coverage	Last Date for Penalty Avoidance	Last Date for Coverage to be Activated with a Major Penalty
January 1	December 1 of the prior year	December 15 of the prior year	December 31 of the prior year	January 31
April 1	March 1	March 15	March 31	May 1
July 1	June 1	June 15	June 30	July 31
October 1	September 1	September 15	September 30	October 31

For more complete information on the above premium due dates please see page?

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Premium Due Dates for All Other Coverage

For COBRA, COBRA-like Benefits for Those with 10 Years of Vested Service, Medicare Supplemental Coverage, Dental Coverage and Dependent Coverage **premiums are due the first of the month** for that month's/quarter's coverage and **if the premium is not paid within 31 days of its due date, coverage will be irrevocably lost** (until and unless it is re-earned through covered employment.).

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Help Us Remind You that Your $100 Payment is Due, Have the Credit Union Pay Your $100, or Pay in Advance to Avoid Losing Coverage

Remember that, in addition to mailing a bill and reminder notice to your mailing address, **we can remind you** of your $100 payment **via e-mail and text message if we have your up-to-date contact information** (in the case of text messages you must give us permission because such messages can have a cost from your wireless carrier — there is no charge from the Fund Office). To activate text message notices, just send an e-mail authorizing us to contact you via text message to *textme@equityleague.org* and include your cell phone number (we'll then send a secure e-mail back to you requesting you to verify your identity and once you respond you will be all set to receive text reminders). Please note that these reminders are generic in nature, so they will be sent whether or not you have already paid your premium due).

You can also authorize the Actors Federal Credit Union (AFCU) to make a payment on your behalf for any health coverage you are eligible for under the Health Fund (you'll need to complete a form with the AFCA in order to activate this service).

Other Critical Due Dates that Can Result in Loss of Coverage

There are a number of critical due dates that, if ignored, can lead to a loss of coverage or a severe financial penalty. The table that follows summarized a number of the most important ones.

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Nature of Deadline (wherever a deadline begins with "CIGNA" it applies only to those enrolled in the CIGNA medical, prescription drug or dental plans – if you are covered for medical care and prescription drugs by an HMO, the HMO's rules apply to you)	Date/Time of Deadline	Penalty for Missing Deadline
CIGNA Pre-admission Certification: Pertains to all non-emergency admissions to medical treatment facilities, such as hospitals and substance abuse treatment (CIGNA must be notified of emergency admissions within 48 hours of the admission)	Prior to admission (non-emergencies) or within 48 hours of admission (for emergency admissions)	$250 additional deductible is assessed in addition to any regular plan deductible – an inappropriate admission may not be covered at all
Refund of an Overpayment: If you overpay the Fund, you may be able to recover the overpayment for a strictly limited period	12 months from the date of the overpayment	Any overpayment, regardless of its size, will not be refunded

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You must elect the first health coverage for which you become eligible as an employee or a dependent. If you were eligible for other coverage before you became eligible for coverage by the Fund, whether you elected it or not, the Fund will function as the secondary insurer.

An election form for these optional coverages, and payment for them, must be received by the Fund Office by November 30th, otherwise you (your dependents as applicable) will have to wait until the next open enrollment period (if you are still eligible), or, when you earn coverage again.

Other Critical Due Dates

Nature of Deadline (wherever a deadline begins with "CIGNA" it applies only to those enrolled in the CIGNA medical, prescription drug or dental plans – if you are covered for medical care and prescription drugs by an HMO, the HMO's rules apply to you)	Date/Time of Deadline	Penalty for Missing Deadline
Refund of a Pre-Payment: If you have already paid for coverage and wish to cancel that coverage and receive a refund	The day before that coverage period was to begin (e.g., December 31 for coverage that is to begin on January 1 of the following year)	Any pre-payment will not be refunded
Coordination of Benefits Penalty: You must elect the first health coverage for which you become eligible as an employee (or, if you are a dependent, the first health coverage for which you become eligible as a dependent), even if that coverage is more expensive and/or has poorer benefits than those provided by the Fund. If you were eligible for other coverage before you became eligible for coverage by the Fund, the Fund will function as the secondary insurer (pay only the benefits the primary insurer did pay, or would have paid had you actually taken the primary coverage).	As soon you as you become eligible for employee coverage (dependent coverage if you are not eligible for coverage through employment).	Fund benefits are "secondary"(e.g., we might pay 20% of the cost, if the plan you were eligible for would have paid 80% if you were covered, even though you don't actually have that coverage)
Dependent Enrollment: Your existing dependents will become eligible for self-pay dependent coverage as soon as you become eligible (if they are not your dependents at that time, within 31 days of when they become your dependents)	The day before your coverage begins (for current dependents), within 31 days of when they become eligible dependents if that is later.	Your dependents will have to wait for coverage until at least January of the following year (if you remain eligible at that time) or when you next become eligible
CIGNA Dental Enrollment: You will be offered self-pay dental coverage for you and any dependents you may have when you first become eligible for medical coverage	The day before your coverage begins	You and any dependents will have to wait at least until January of the following year (if you are eligible at that time).
Open Enrollment Deadline: If you declined dental coverage for yourself and/or your dependents, or you declined medical coverage for your dependent(s), you have an opportunity to enroll for such coverage in November of each year (if you are still eligible for such coverage)	An election form for these optional coverages, and payment for them, must be received by the Fund Office by November 30th	You (your dependents as applicable) will have to wait until the next open enrollment period (if you are still eligible), or, when you earn coverage again.
Special Enrollment: When you/your dependents declined coverage because you/they had coverage elsewhere and that coverage is lost, and you are eligible for coverage by the Fund by accumulating the requisite work weeks.	Application and payment for coverage must be made within 31 days of the loss of other coverage (60 days for those covered under a CHIP or Medicaid program)	You/your dependent(s) will have to wait for the later of: the next open enrollment period, or, your next period of eligibility
COBRA Deadline for Notice of a Loss of a Dependent: You/your eligible dependent(s) are responsible for notifying the Fund Office of a divorce, a child's losing dependent status under the Fund, the occurrence of a second qualifying event that entitles a dependent to additional COBRA coverage, if a dependent is determined eligible by the SSA, or one who has been disabled under SSA receives notice he/she is no longer considered disabled	Within 60 days of the later of: a) the date of the qualifying event, or, b) the date of the loss of coverage due to the qualifying event	Eligibility for COBRA coverage for your dependents will be lost

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Other Critical Due Dates

Nature of Deadline (wherever a deadline begins with "CIGNA" it applies only to those enrolled in the CIGNA medical, prescription drug or dental plans – if you are covered for medical care and prescription drugs by an HMO, the HMO's rules apply to you)	Date/Time of Deadline	Penalty for Missing Deadline
COBRA Election Deadline: You/your dependents, must elect COBRA coverage on a timely basis and pay the initial premium due on a timely basis	Your election must be made within 60 days from the later of: the date when the Fund Office mails your COBRA eligibility notice, or the date you lose coverage (your iniitial premium must be paid within 45 days of your election)	Loss of COBRA eligibility
Special Fund Self-Pay Program After COBRA: If you have 10 years of vesting service under the Equity-League Pension Fund (subject to any break in service rules) you can continue your health coverage immediately after your COBRA coverage ends (your dependents can continue their coverage as well, until the end of the month of your death)	Premium payments must be kept up to date as per the premium due date schedule presented earlier in this article	Loss of coverage occurs as soon as any premium is not paid timely (coverage is available again only if you earn such coverage through employment)
Creditable Coverage Deadline: If you lose coverage by the Fund, the Fund will provide you with a Certificate of Creditable Coverage, which proves that you had such coverage and documents the date such coverage was lost	You have 63 days from the loss of coverage to obtain coverage elsewhere	If you do not obtain such coverage elsewhere, you may be subject to pre-existing coverage limitations by any new insurer
Submitting Claims: You must submit claims for out-of-network services and Supplemental Workers Compensation (SWC) benefits on a timely basis	Within 12 months of the date charges were incurred (in the case of SWC, 12 months from the date of your Workers Compensation award)	Any CIGNA claim will not be reimbursed (unless you show written proof the claim was submitted as soon as was reasonably possible) — late SWC claims will not be reimbursed
CIGNA Appeals of Claim Denials must be submitted on a timely basis (first and second level appeals)	365 days from the date you receive a denial notice	Your appeal will not be granted
Appeals to the Trustees (for Vision and SWC claims, eligibility claims and third level appeals of CIGNA/HMO denials).	Within 180 days of the initial claims determination	Your appeal will not be heard by the Trustees
Dependent Disability: If your dependent child becomes disabled and is incapable of self-sustaining employment before reaching the age of 19, that child can qualify for coverage under the Fund for as long as yours lasts (if the disability occurred after 19, he/she can still qualify under the Fund for health coverage until the last month of his/her 26th birthday)	Written evidence of the child's disability must be sent to the Fund Office within 31 days of the age when coverage would usually end (and as requested by the Fund Office thereafter)	The opportunity for this special coverage will be forfeited

Your election must be made within 60 days from the later of: the date when the Fund Office mails your COBRA eligibility notice, or the date you lose coverage (your iniitial premium must be paid within 45 days of your election).

You must submit claims for out-of-network services and Supplemental Workers Compensation (SWC) benefits on a timely basis — within 12 months of the date charges were incurred (in the case of SWC, 12 months from the date of your Workers Compensation award).

Security of Your Personal Information is a Main Concern for Us and Should be for You

Standard e-mail is not a secure way of transmitting information. Therefore, you should never include such items as your credit card information or Social Security number in an e-mail.

Most of us have all gotten into the habit of e-mailing information for convenience sake. But standard e-mail is not a secure way of transmitting information. Therefore, you should never include such items as your credit card information or Social Security number in an e-mail.

We recommend that if such information is requested or required by the Fund Office, you: a) transmit it to a live person (in person or over the phone), b) fax it, c) send it via mail in a sealed envelope marked confidential, or d) send it in an encrypted form of e-mail.

Effective immediately, if the Fund Office requests confidential information from you via e-mail, we will send you a secure e-mail that you can respond securely to. The first time you receive such an e-mail from us, you will be asked to create a username and password to access the secure e-mail. You can use this username and password for future secure e-mails as well.

The Federal ARRA Subsidy Goes Away — But the Fund's Policy With Respect to NY State COBRA Subsidies is Liberalized

Those who are covered by the New York subsidy will no longer need to pay their COBRA premiums in full by the end of the month for which they are due, but rather 50% of those premiums (new applicants will still need to pay premiums in full until their subsidy application has been approved by the State).

The Federal ARRA subsidy for COBRA benefits has come to an end (in terms of new eligibility being earned) in September of 2011. You may not apply for the ARRA subsidy for COBRA coverage beginning on or after October 1, 2011.

In contrast, New York State has renewed its commitment to its COBRA subsidy, albeit with more limited benefits (a lifetime limit of 12 months has been placed on the subsidy), and remittances to the Health Fund have become more prompt and regular.

Consequently, the Trustees of the Health Fund have decided that those who are covered by the New York subsidy will no longer need to pay their COBRA premiums in full by the end of the month for which they are due, but rather 50% of those premiums, with the Fund waiting to receive the balance from the State (new applicants will still need to pay premiums in full until their subsidy application has been approved by the State).

The Trustees hope that this new policy will make COBRA more accessible for some of our most needy plan participants. And they are pleased to help. However, we will be monitoring the State's payments to us and if they fall behind, or the State otherwise reduces its COBRA subsidy commitment, the Fund may need to require pre-payment once again.

"But I Didn't Get A Bill" — Why Bills Are Sent For Some Health Premiums But Not Others

The Health Fund's current administration system (which is expected to be replaced in early 2012) can only issue quarterly bills. That means the Health Fund can produce a bill for your $100 quarterly health premium, and other premiums that are payable on a quarterly basis. However, bills for premiums that can be paid monthly, such as COBRA premiums, cannot be produced. Therefore, please do not expect to the billed on a monthly basis for any premiums that may be due the Health Fund. Getting such premiums to the Fund Office or lockbox on a timely basis is solely your responsibility, and if you miss any of the deadlines outlined above, you will lose your health coverage.

New 401 K Investment Options

The Trustees of the 401(k) Fund, in consultation with the Fund's investment advisors, decided to add three new investment options to the Fund, while eliminating one other option (Small Cap Core — Main Street Small & Mid Cap (OFI) managed by the Oppenheimer Funds). These changes will be effective October 4, 2011. Below we provide brief summaries of the new investments. More information regarding them is available at the MassMutual website: *www. Massmutual.com/retire/participants.*

INTERMEDIATE TERM BOND

New **BlackRock Inflation Protected Bond Portfolio**
Portfolio managed by: BlackRock Financial Management, Inc.
Objective: To seek to maximize real return, consistent with preservation of real capital and prudent investment management.
Portfolio: Under normal circumstances, the investment option invests at least 80% of its assets in inflation-indexed bonds of varying maturities issued by the U.S. and non-U.S. governments, their agencies or instrumentalities, and U.S. and non-U.S. corporations.

SMALL CAP VALUE

New **Goldman Sachs Small Cap Value Fund**
Portfolio managed by: Goldman Sachs Asset Management, L.P.
Objective: Seeks long-term capital appreciation.
Portfolio: Invests, under normal circumstances, at least 80% of its Net Assets in a diversified portfolio of equity investments in small-cap issuers with public stock market capitalizations (based upon shares available for trading on an unrestricted basis) within the range of the market capitalization of companies constituting the Russell 2000® Value Index at the time of investment.

REITS

New **Morgan Stanley Institutional Fund U.S Real Estate Portfolio Fund**
Portfolio managed by: Morgan Stanley Investment Management Inc.
Objective: Seeks to provide above average current income and long-term capital appreciation by investing primarily in equity securities of companies in the U.S. real estate industry, including REITs.
Portfolio: Under normal circumstances, at least 80%of the Portfolio's assets will be invested in equity securities of companies in the U.S. real estate industry. The equity securities in which the Portfolio may invest include common stock, preferred stock, convertible securities, depositary receipts and rights and warrants. The Adviser seeks a combination of above average current income and long-term capital appreciation by investing primarily in equity securities of companies in the U.S. real estate industry,

For more information on these and other investment options in the 401(k) please visit the MassMutual website: *www.massmutual.com,* where you can also find a number of other useful tips on retirement planning and investments.

Three new investment options have been added to the Fund, while one other option (Small Cap Core — Main Street Small & Mid Cap [OFI] managed by the Oppenheimer Funds) has been eliminated.

For more information on these and other investment options in the 401(k) Fund please visit the MassMutual website: *www. massmutual.com*, where you can also find a number of other useful tips on retirement planning and investments.

Important Reminder About Your Right to Request a Pension Benefit Statement

If you would like to receive a detailed statement of the pension credit you've earned under the Equity-League Pension Plan, and whether you are vested, please contact the Retirement Services Department at the Fund Office, 165 West 46th Street, 14th Floor, New York, NY 10036 at 212-869-9380 (toll free outside of NYC (800) 344-5220), or via e-mail, *pension@equityleague.org.* You must make this request in writing. You are entitled to receive a pension benefit statement, upon request, only once every 12 months.

A New Health Fund Summary Plan Description (SPD) is Expected to Be in Your Hands By the End of this Year

If you are covered by the Health Fund, you should receive the new SPD before the end of 2011. The new version will also be posted online.

We are currently putting the finishing touches on a new Health Fund SPD. If you are covered by the Health Fund, you should receive the new SPD before the end of 2011. The new version will also be posted online, and we have changed the format so that any subsequent changes to the SPD can be reflected within the online version of the SPD itself (so you won't have to look anywhere else for the most up-to-date description of plan benefits).

We have tried to make it much easier to navigate the new SPD, which has an enhanced table of contents and a more extensive index than the current SPD. In addition, there are a greater number of definitions of terms used in the SPD and they are all grouped into one section, as are the descriptions of things that are not covered. Deadlines are more prominent (with a new clock graphic that appears in areas where deadlines (not just premium deadlines) are important. Finally, there is a section on the many "Life Events" that can (sometimes in surprising ways) affect your health benefits, and a consolidated section on premiums and other deadlines that you should be mindful of.

We hope this new SPD will help you to better understand your many important benefits available through the Health Fund.

Important Reminder About the Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act is a federal law that provides protection for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

The Women's Health and Cancer Rights Act is a federal law that provides protection for breast cancer patients who elect breast reconstruction in connection with a mastectomy. All group health plans, including HMOs, that provide medical and surgical benefits in connection with a mastectomy must also provide for reconstructive surgery, in a manner determined in consultation with the patient and attending physician. If you or an enrolled dependent are a breast cancer patient, you should know that in addition to providing medical and surgical benefits in connection with a mastectomy, your Equity-League Health Fund coverage also includes the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

This coverage is subject to applicable co-pays, referral requirements, annual deductibles and coinsurance provisions. You should review the provision of your plan regarding any such restrictions that may apply. If you have any questions about this coverage, please contact the Fund Office.

HIPAA Privacy Notice

If you would like to see the plan's HIPAA Notice of Privacy Practices, or even get your own copy, please visit *www.equityleague.org/health/health_privacy.html,* or contact: Privacy Officer, Equity League Health Trust Fund, 165 W. 46th Street, 14th Floor, New York, NY, 10036 or call 212.869.9380, or the toll-free number, 800.344.5220. The Notice describes how the plan uses and discloses protected health information, and it also discusses important federal rights that you have with respect to your protected health information.

Contacting the Equity-League Fund Office

The Fund Office strives to be as accessible to plan participants as possible. You can contact us by e-mail, phone, fax, regular mail or dropping by for a visit. We have recently updated our e-mail contact information and provide that below, as well as reminders about other contact methods.

Benefit Related Questions or Suggestions regarding

401(k) Fund: *401k@equityleague.org*
Health Fund: *health@equityleague.org*
Pension Fund: *pension@equityleague.org*

General questions or suggestions not specific to a particular Fund or benefit:

ELFoffice@equityleague.org

Employer Contributions and Collections

Accountsreceivable@equityleague.org

Problems or Suggestions Regarding Our Website:

Webmaster@equityleague.org

Privacy Issues or Concerns

Privacyofficer@equityleague.org

Complaints and Appeals

appeals@equityleague.org

Arranging for text message reminders regarding $100 quarterly premiums due

textme@equityleague.org

According to HIPAA (Health Insurance Portability and Accountability Act), the Fund may not transmit or access PHI (Protected Health Information) insecurely. Due to Federal Privacy Regulations, we cannot respond to a request via email if it contains a member's PHI. An example of a request involving PHI would be a question like, "I will have the required number of weeks by the last week of July. What Benefit Period will I be able to use my health insurance?" If you have such a question (one involving your personal information, such as your work history or Social Security number), you should call the Fund Office directly in order for Equity-League to provide you this information. If you have a general question that does not involve personal PHI, and pertains to the overall requirements under the health plan, such as "Is there a deductible that must be satisfied for the prescription drug plan?", we can answer those via email.

If you have a request that involves your personal PHI, please feel free to call, write, stop in at our office, or send us a fax.

We are located at:

165 W. 46th Street – 14th Floor
New York, NY 10036

Phone 212.869.9380
Toll Free (Outside NYC) 800.344.5220
Fax: Accounts Receivable 212.398.2826;
Health 212.869.3323;
Retirement 212.869.1824

Office Hours (Eastern Time – Mondays through Fridays, except Holidays)

9:30 AM to 5:30 PM for walk-in service (live telephone support available until 7 PM)

The Fund Office has recently updated its e-mail contact information, as well as reminders about other contact methods.

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This newsletter is a publication of the Board of Trustees of the Equity-League Trust Funds. Additional copies are available upon request, or online at our website (www.equityleague.org). For any questions about the newsletter or your benefits, contact The Fund Office, Equity-League Pension, Health and 401(k) Funds, 165 West 46th Street, 14th Floor, New York, NY 10036-2582. To call the Fund Office from the NYC area, phone 1-212-869-9380; if you're calling from outside the NYC area, call the Fund Office toll-free at 1-800-344-5220.

Important Note:

To the extent that any of the information contained in this newsletter is inconsistent with the official Plan documents (which, of course, includes the Trustees' rights to amend or modify the Plans at any time), the Plan documents will govern in all cases. No official (other than the Trustees) has any authority to interpret the Plans, or other official Plan documents, or to make any promises to you about them.