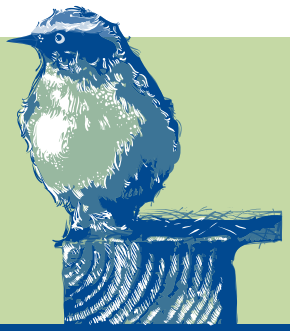
NOW PLAYING

EQUITY – LEAGUE

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

FALL 2013



Welcome to Our Fall 2013 Issue of *Now Playing*

We have important news about all three Funds in this issue of *Now Playing*, but by far the most exciting news is about a reduction in the waiting period for health insurance coverage from its current 6-9 months to 5-6 months. We'll also provide what we hope will be useful information on Patient Protection and Affordable Care Act of 2010 (PPACA), also known as "Obamacare" and the "Affordable Care Act (ACA). We'll use this latter (ACA) term from this point forward in this newsletter. Many of that law's key provisions will take effect in January of 2014 and we want to help you prepare for the changes that will be coming.

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New Health Plan Eligibility Rules

The Health Fund's Trustees have authorized two major changes in the Fund's eligibility rules for health coverage.

What we've heard from you over the years is that you would like to be eligible for health insurance sooner rather than later. But certain provisions of the Patient Protection and Affordable Care Act (PPACA or ACA) that take effect on January 1 of 2014, will add a new reason to want health coverage sooner — Federal tax penalties for individuals who do not have health coverage. In order to help you secure health coverage more quickly, the Health Fund's Trustees have authorized two major changes in the Fund's eligibility rules for health coverage:

1) The Waiting Period for coverage will be reduced to two months.
2) Eligibility for health coverage will be measured monthly —Your work weeks for the past 12 months will be counted at the end of every calendar month, instead of only at the end of every calendar quarter.

What do these changes mean for you and how will they work?

The New Two Month Waiting Period

The waiting period for coverage will be reduced to 2 months.

Beginning with the 12 month Accumulation Period ending on October 31, 2013, you will be able to begin coverage only two months after you have earned the required weeks (in this case on January 1, 2014), instead of having to wait for three months as you do under the current rules.

Transition Rules That Enable You to Have a 13 Month Accumulation Period When You Switch to a Two Month Waiting Period

...during a transition period you'll be able to accumulate the weeks you worked across a full 13 months, instead of 12 months, the first time you use the 2 month waiting period.

In addition to the improved accumulation and waiting period rules, you'll be able to accumulate the weeks you worked across a full 13 months, instead of 12 months the first time you use the two month waiting period. This will be permitted during an accumulation "transition period" that will run from October of 2012 through September of 2013 for newly earned coverage commencing between January and December of 2014.

For example, if you use a two month waiting period to earn coverage on January 1, 2014, you'll be able to use weeks earned from October 1, 2012 through October 31, 2013 — a full 13 months to qualify for the coverage beginning on January 1. So you'll be able to use this 13 month "transition rule" for coverage beginning in any month through December of 2014. However, for coverage that commences January 1, 2015 or later, only the two month waiting period and 12 month accumulation period will apply.

Testing for Eligibility Every Month Instead of Only Once Each Calendar Year

Beginning early in 2014, the Health Fund will define an "accumulation Period" as any 12 month period ending on the last Sunday of a calendar month (instead of only 12 month periods ending in calendar quarters). For instance, in June of 2014, we'd look at the weeks worked between June of 2013 and May of 2014, to see if you accumulated enough work weeks to qualify for health coverage beginning in August of 2014. During July of 2014, we'll look at the Accumulation Perioid beginning in July of 2013 and ending in June of 2014 to see if you qualify for health coverage beginning on September 1, 2014, and so on. This change alone can result in your earning coverage up to two months earlier than under the current quarterly eligibility testing approach (and make it less likely that you'll lose credit for weeks because of pure timing).

How Will Split Weeks Be Handled Under the New Monthly Accumulation Period?

Weeks that fall at the end of any calendar month but have at least one day in the next month can be used in the month in which the week began, or the month in which the week ends. If you don't elect one method or the other, we'll automatically put any week at the end of an accumulation period that spans two months in the month in which the week ends. For example, if your work week runs from Monday, July 29 to Sunday, August 4, it will be applied to the 12 month Accumulation Period ending on August 31, unless you tell us that you want it applied to the Accumulation Period that ends on July 31.

Your work weeks will be counted at the end of every calendar month instead of only at the end of every calendar quarter.

The 12/20 Week Rules for Earning 6/12 Months of Coverage Remain in Place and You'll Still Be Able to Postpone Coverage

While you'll be able to begin coverage sooner under the Fund's new rules, the existing "12 weeks for 6 months of coverage" and "20 weeks for 12 months of coverage" rules will remain in effect. Similarly as is the case today, you will not be required to take coverage when it is offered. You may instead defer your election of coverage (by not paying the $100 premium). But the important difference under the monthly testing approach is that if you decline coverage one month you don't have to wait an entire quarter to qualify again. You can qualify the very next month, as long as you have enough weeks of covered employment during the 12 month Accumulation Period that next month. Remember however, that each time you postpone coverage you will lose access to the weeks you accumulated in the earliest month of the most recent Accumulation Period, so if you don't earn the additional weeks you expect to earn by waiting, you could forfeit your eligibility for coverage until you accumulate the requisite weeks once again. And remember that any period without coverage that you may have beginning on January 1, 2014 may make you subject to a penalty at tax time.

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...the 12/20 week rules remain in place to earn 6/12 months of health coverage.

The 12/20 Week Rules

On a combined basis, the new monthly eligibility testing and 2 month waiting period make coverage available in 5–6 months instead of the current 6–9 months.

How Much Can These Changes Speed Up Your Coverage Eligibility?

The net effect of switching to the monthly Accumulation Periods and the two month Waiting Period will be to make coverage available to you as early as five months from the day you commence Covered Employment and no later than six months after continuous Covered Employment commences. This is a very significant improvement over the current rules, which require you to wait for your health coverage for a minimum of six months (and possibly as long as nine months), even if you work continuously.

Monthly Eligibility Testing Has a Downside — No More Quarterly Paper Bills for Self-Pay Coverage

A downside to the switchover to monthly eligibility testing is that we will no longer be able to generate paper bills that will reflect a quarter of premium, for self-pay coverage (e.g., dental only, or COBRA). Such bills will only display the premiums for one month of coverage (although you will still be able to pay for three months of coverage at one time).

And There is Still More Good News! A Faster, Greener and Monthly Electronic Billing Option is Available — But Your Consent and Up-to-Date Email Address and/or Cell Phone Number is Required

If you opt for electronic billing notices, you can receive them monthly.

The Fund has for many years been mailing quarterly paper bills to those who are eligible for new or continuing health coverage. That option will continue to be available going forward. However, mailing bills on a monthly basis, to reflect the new monthly eligibility rules, would be prohibitively expensive for the Fund, and cause us to kill three times as many trees as we do today, with quarterly paper bills. So even though, under the new rules, you could be eligible for coverage in any given month, you will only be notified by regular mail of the option to take coverage on a quarterly basis.

For example, if you first qualify for coverage starting January 1, 2014 but do not elect it, the earliest coverage period for which you would receive another paper bill would not be until April 1, 2014. That bill would be generated as it is today, in late January or early February (assuming you were eligible for coverage beginning at that time). So you would not receive a paper bill for coverage you might be eligible for beginning in February or March.

But if you want to be notified of your eligibility on a monthly basis instead of quarterly, we have a solution!

You can elect a new electronic billing option that will optimize billing for the new monthly eligibility testing process. If you opt to use this new billing approach, we will dispense with paper bills altogether and you will be notified electronically, each month, of your eligibility for coverage. In addition, if you choose electronic billing, you will be sent monthly electronic reminders of any amounts that may be due for any of the following coverages that you may have through the Fund:

1) Your medical coverage earned through employment (a payment for which would only be due quarterly),
2) Dental coverage for you and any of your eligible dependents, and/or,
3) Dependent medical and vision care coverage.
4) Self-pay (e.g., COBRA) coverage

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Monthly Bills

You can choose to receive the new electronic notices via e-mail, or text messages to your cell phone, or both. So going forward you will have a choice of continuing with the old paper quarterly bills, or, receiving monthly electronic notices of both your eligibility for coverage and premiums due for the coverages listed above. And remember that if you choose the electronic notices, you'll be helping the Fund to save trees and postage! Both the email and text message services are available free of any charge by us (although charges for text messages may be made by your cell phone provider, depending on the rules of the plan you have with them).

In order for this new electronic eligibility notice and payment reminder approach to work optimally, it is very important for you to **ensure that you have a current e-mail address on file with the Equity-League Fund Office. Remember** that because **the Fund Office and AEA have totally separate computer systems,** your Fund Office contact information is maintained in a completely separate database from the contact information that you supply to your Union (AEA), **so telling one entity of a change will NOT inform the other.** To ensure that e-mails from the Fund Office get to you promptly, please add either the following email *health@equityleague.org* to your email "white list" or, add the domain @equityleague.org to your Address Book or Contacts, so that you will receive your email notices in your inbox without delay. **If you want to receive text message** notices from the Fund Office, simply send an email to *textme@equityleague.org.* **Include your cell phone number. We'll send a secure email back to you requesting you to verify your identity. That's it!**

You can choose to receive the new electronic notices via e-mail, or text messages, or both…

Checking Your Contact Information, Eligibility and Health Payment Status Online

By the late fall of this year, you'll be able to check the mailing address, e-mail address and any text message (cell phone) number you have on file with the Fund Office through the Fund Office website (*www.equityleague.org*). In addition, you will be able to check on your monthly eligibility status. Finally, you'll be able to see any payments received from you by the Fund Office, so you'll be able to see if your payment status is current, no matter whether you are at home or on the road.

You will be able to check and modify your contact information online.

Open Enrollment for the Equity-League Health Fund

We want to remind everyone that the Health Fund's Annual Open Enrollment Period takes place in the month of November. This period represents your once a year opportunity to make/change your decisions regarding dependent coverage and dental coverage. So if you want to add a dependent to the Equity-League Health Plan, or add dental coverage, November is the time to do it (with coverage to be effective on January 1, 2014). If you miss this opportunity, it will not come up again until January of 2015 (you can add a dependent at other times of the year if that dependent is new — e.g., you just got married, or had a child, but only if you fit one of the Fund's special enrollment criteria). So if you wish to add a dependent or dental insurance, please don't miss the November 30th deadline for doing so.

If you miss the November 30th deadline for sending in your forms and payments, you will still have an opportunity to change coverage as late as December 31, 2013, with the payment of a $100 penalty. So those who enroll later than November 30th, but before January 1, will be required to pay a $100 late payment penalty, but will still be able to enroll. No changes in coverage will be permitted if we receive payments/forms after December 31, 2013.

Open enrollment runs through the full month of November (December with a $100 penalty payment).

Same-sex Spousal Benefits

Special Announcement Regarding Legal Recognition of Same-sex Spouses by the Equity-League Health, Pension and 401(k) Funds

Same-sex spouses will be treated as all other spouses by all 3 Equity-League Funds.

We recommend you update your spousal records with the Funds.

On June 26, 2013, the U.S. Supreme Court repealed Section 3 of the federal Defense of Marriage Act ("DOMA"), which had prohibited same-sex married couples from being recognized as "spouses" for purposes of federal laws.

In light of the Supreme Court's decision, the Trustees of the Funds have authorized the following changes to Fund benefits and/or policies.

The Funds will now recognize any same-sex marriage entered into in a jurisdiction where such marriage is legal. Note that a participant's same-sex partner in a domestic partnership or a civil union will not be recognized by the Funds as a spouse, but the partner may be eligible for Health Fund coverage as a domestic partner.

Health Fund

Same-sex spouses will now be considered spouses under the Fund and entitled to all of the rights and obligations applicable to spouses under the Fund's rules (such as COBRA and HIPAA special enrollment rights).

Pension Fund

The Pension Fund will now recognize same-sex spouses as spouses under the Pension Plan and they will be entitled to the same rights (such as survivor benefits) and obligations as an opposite-sex spouse. If you have a same-sex spouse but have not provided a copy of your marriage certificate to the Fund Office, we recommend that you do so as soon as possible so that we may update our records accordingly. You may also wish to update any beneficiary designations that you have on file. Note that under the Plan's rules, if you are married, any prior beneficiary designation of someone other than your spouse will not be effective unless your spouse executes the required consent.

401(k) Fund

The 401(k) Fund will now recognize same-sex spouses as spouses under the 401(k) Plan and they will be entitled to the same rights (such as survivor benefits) and obligations as an opposite-sex spouse. If you have a same-sex spouse but have not provided a copy of your marriage certificate to the Fund Office, we recommend that you do so as soon as possible so that we may update our records accordingly. You may also wish to update any beneficiary designations that you have on file at the Fund. Note that under the Plan's rules, if you are married, any prior beneficiary designation of someone other than your spouse will not be effective unless your spouse executes the required consent.

For more information on the Plans, to provide the Fund Office with a copy of your marriage certificate, or to request a copy of the Domestic Partner Policy for the Health Fund, please contact the Fund Office at (212) 869-9380 or (800) 344-5220. Information on the Plans is also available on the Fund's website, *www.equityleague.org*.

We've summarized important plan rules, but we don't intend for this information to replace or amend the official plan documents of each of the plans. We will follow the rules of the official plan documents if those rules differ from the summary information provided.

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 email, *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.

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. 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, which was last revised in September 2013, or get your own copy, please visit *www.equityleague.org/health/health_privacy.html*, or contact: Privacy Officer, Equity-League Health Trust Fund, 165 West 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.

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.

In addition to providing medical and surgical benefits in connection with a mastectomy, your Equity-League Health Fund coverage also includes prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Affordable Care Act (ACA)

…most of you who qualify for Fund health coverage will want to rely on it instead of going to an exchange.

If you are not eligible for health insurance coverage through the Fund or other employment, you may qualify for premium assistance on an exchange.

Despite all of the media discussion, political maneuvering and judicial deliberating generated by ACA since it was enacted, many of you have not yet been materially affected by the law in any way. But as we move toward 2014, many of you will be affected by the law, and some will be affected very profoundly. This is true because some of the most far reaching provisions of ACA will take affect beginning in January of 2014. Among these important changes are:

1) The emergence of **state insurance "exchanges," aka the "marketplaces," where virtually anyone** who is not covered by Medicare/Medicaid will be **eligible to purchase insurance coverage.** You'll be able access this coverage regardless of any pre-existing medical conditions. Enrollment in these exchanges will begin by October 1 of 2013, for coverage starting on January 1 of 2014 (although, as we explain shortly, most of you who qualify for Fund health coverage will want to rely on it instead),

2) The assessment of **penalties on all individuals who fail to maintain health insurance coverage** throughout a calendar year, and,

3) The availability of **premium assistance tax credits (subsidies) to some** who purchase insurance through an exchange (and a more limited number of people will be eligible for certain out-of-pocket medical cost caps). The "list" price (non-subsidized price of health insurance coverage on the exchanges) will be substantial, so those with lower income levels may find such coverage difficult to afford unless they receive a subsidy.

As you have probably heard many times, ACA is an extremely complex and far reaching law. The good news is that, in terms of ACA's effects on your health insurance and finances, we believe that you can learn what you need to know relatively quickly — if you focus on the three major factors that will influence the cost of health coverage for you and your family: 1) your eligibility for health insurance through employment, 2) your (family) income, and 3) your age. Here is why.

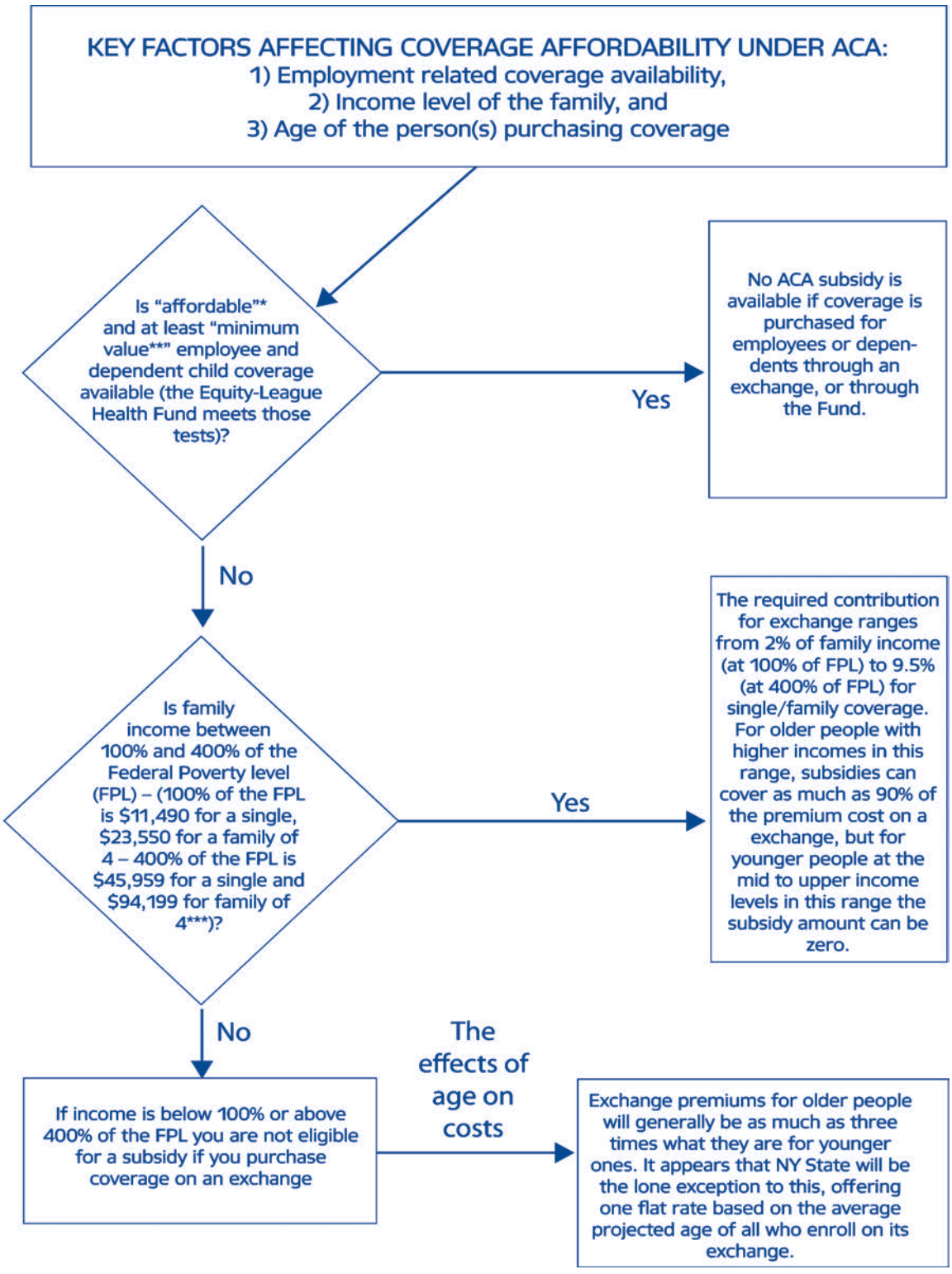
The Equity-League Health Plan exceeds the ACA minimum standards for coverage through employment by providing "affordable" health coverage, and benefits of at least "minimum value." Therefore, if you qualify for the Equity-League health plan, or any other coverage from another employer sponsored plan that meets ACA's minimum standards, but decide not to take that coverage, you will not be eligible for any premium subsidies if you decide to purchase coverage through an exchange.

If you are not eligible for health insurance coverage through the Fund or other employment, you may qualify for premium assistance for insurance you purchase on an exchange, **if your income is below a certain threshold. The lower your income, the higher the subsidy** for which you will be eligible.

Under ACA, your income also determines your penalty for not having coverage. There is a flat minimum amount of penalty regardless of your income, but above that level, the penalty that applies is determined as a percentage of your income, so the higher your income the larger your penalty.

Finally, **in almost all states, (with** the important **exception of NY**) insurance **premium costs on the exchanges will vary significantly in cost by age.** Older individuals will pay up to three times as much as younger ones, so age is another important factor that can affect the attractiveness of exchange coverage, especially for these at the middle to higher income levels (those not eligible for subsidies).

We have prepared the following summary chart to illustrate how the availability of employment based health insurance coverage, your income and your age will determine how ACA will affect you and your family. More details regarding each item summarized in the table will be provided later on in this newsletter.



*"Affordable" is defined as costing an employee no more than 9.5% of the employee's household income for employee only coverage (there is no comparable test for dependent coverage cost).

** "Minimum Value" means that the benefits offered under the plan meet certain ACA guidelines, which the Equity-League Health Fund's plan does.

***These Federal Poverty Level (FPL) numbers represent the latest ones available as this is being written (2013). They apply to the 48 contiguous states and Washington DC and are subject to annual adjustment, so may be different in 2014 (Alaska and Hawaii have separate FPL numbers).

If You Are Eligible for Fund Health Coverage — You Have Something to Truly Celebrate!

If you are eligible for Fund health coverage through employment, you'll see little in the way of change on January 1, 2014.

If you are eligible for Fund health coverage through employment, you will see little in the way of change to your coverage in 2014, other than the eligibility improvements that have been discussed earlier in this newsletter.

We want to point out that retaining your right to Fund health coverage was the result of a huge effort on the part of multiemployer plans (such as the Equity-League Health Fund) throughout the country. For those who may not be aware of it, multiemployer plans are very special kinds of benefit plans. Under these plans, multiple employers contribute to a Trust Fund created for the sole benefit of its participants and managed by a Board of Trustees. It has been estimated that more than 25 million Americans receive health insurance through multiemployer plans.

ACA, as enacted, did not give special consideration to multiemployer health funds, resulting in many ambiguous and conflicting scenarios during the implementation of the law that could have jeopardized the very existence of multiemployer plans.

As a result, representatives of multiemployer plans in many industries throughout the country lobbied intensely for regulations that, among other things, would deem employers compliant with ACA in 2014, if they contribute to a qualified multiemployer plan (such as the Equity-League Health Fund). The multiemployer community is working to assure that this important rule is made permanent. Why?

The Fund's CIGNA network is one of the largest in the country…many insurers participating in the exchanges will have smaller networks.

The long term preservation of multiemployer health plans is important to you because, regardless of your age or income, the health insurance coverage provided to working actors through the Fund will almost certainly be less costly to you than any comparable coverage purchased on an exchange (if such comparable coverage is available there). But there is much more to consider beyond premium costs.

Tax Leveraged Benefits – Fund Health coverage through employment is paid for in pre-tax dollars but exchange coverage is paid for on an after tax basis, so employment based coverage saves both employees and employers money.

Benefit Levels – The health benefits provided by the Fund are comparatively generous. Those who use network providers generally pay only a modest ($25) copay when they receive most services from providers in CIGNA's vast network. But they also have the option to go out-of-network at any time. In such a scenario, they are responsible for the relatively low (by today's standards) $350 annual individual medical, and $100 annual prescription drug, deductible and have separate out-of-pocket maximums of $5000 for covered medical and prescription charges. In combination, these benefits make the Fund's benefit plan more generous than even the "platinum" (highest benefit) plans available on the exchanges.

Network Size and Quality – The Fund's CIGNA network is very large and extends nationwide — it's one of the largest networks in the nation. Many insurers participating in the exchanges may have much smaller networks.

Low Administrative Costs – Relative to some insurance companies who will participate on the exchanges, many Fund offices, including ours, have lower administrative costs.

Community Rates and Guaranteed Issue (No Pre-existing Conditions Limitations) –The Fund charges the same rates to all of those in the same class (e.g., employees and family) regardless of their age or health, and no eligible employee has ever been turned away from the Fund because of his/her health history.

Equity-League is a Not-for-Profit Organization and Its Trustees Serve Without Compensation from the Fund – The monies received by the Fund are used exclusively for the benefit of plan participants.

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Fund Health Coverage

If we have a surplus, that surplus will be applied to future benefits. There are no profits to distribute to shareholders.

And the Fund's Trustees, representatives of Actors Equity Association or The Broadway League, are familiar with the kinds of challenges faced by those who work in live theater. They work hard, and with no compensation from the Fund, to deliver benefits that meet the unique needs of those who work in the industry.

Fund Office Staff and Professionals – The Health Fund is administered by a staff that is dedicated solely to serving the plan participants, as are the professionals the Fund hires (e.g., attorneys, actuaries and auditors), who are all specialists in multiemployer plans.

For these and many other reasons, we expect that plan participants will find Fund coverage to be a terrific value relative to the coverage available through an exchange.

However, should you choose to decline or terminate Fund coverage and enroll in an exchange, you must re-qualify should you wish to be covered by the Fund again in the future.

Whatever your decision regarding your source of coverage, remember that if you decline all health coverage, you will be subject to ACA's penalties for not maintaining coverage.

The Situation for Your Dependents is Quite Different

In January of 2014, your dependents will find themselves in much the same situation that they are in today with regard to Fund coverage. They can purchase coverage through the Fund, but at the full cost of that coverage.

The new option open to dependents is coverage through an exchange. But you should be aware that your dependents will not be eligible for any premium assistance subsidies if they purchase exchange coverage, no matter what your family income level may be.

That is because ACA says that if you (as an employee) and your dependent children under 26 qualify for health coverage through your employer (or a Fund), you are not eligible for a subsidy if you decide to purchase coverage on an exchange.

You might ask, "Why doesn't the Fund just abandon dependent coverage so that my dependent is no longer offered coverage and, therefore, becomes eligible for subsidies?" Elimination of Fund dependent coverage is not a viable option for several reasons.

First, if the plan stopped offering coverage to dependent children, the entire plan (for purposes of employees and dependents) may no longer be compliant with the ACA, causing both employees and employers to pay penalties.

Second, in many cases, the exchange coverage may cost more, offer less coverage and have more limited networks than the Fund.

So eliminating Fund dependent coverage could leave many currently covered dependents worse off than they are today, even though they are paying the full cost of the coverage to the Fund.

Monies received by the Health Fund are used exclusively for the benefit of plan participants.

Because dependents of those employees offered coverage by the Health Fund are also offered such coverage, they are not eligible for premium subsidies on the exchanges.

The Insurance Exchanges — An Option Open To All

...many people who have incomes between 100% and 400% if the FPL will qualify for subsidized coverage through the exchanges.

Almost everyone who is not covered by Medicare will be eligible to obtain coverage through a state insurance exchange. Each exchange is expected to have at least two insurers participating (in some cases it will be more than a dozen) and each is expected to have between two and five plans, a special high deductible limited scope of services plan for those under 30, and at least two of the following plans:

Overall Plan Benefit Level	Minimum Percentage of Eligible Expenses Covered	Out-of-Pocket Limit for Individual/ Family*
Platinum	90%	
Gold	80%	$6,350/$12,700
Silver	70%	
Bronze	60%	

*These limits are the maximum permitted, but some states may have lower limits for richer plans.

Once you know your premium subsidy (if any) you will be able to select from among the plans offered on the exchanges in your state.

"Guaranteed Issue" policies will be required of insurers participating in the exchanges (coverage cannot be denied because someone already has a serious health condition, or for any other reason, as long as a person is otherwise qualified for coverage and follows the appropriate enrollment rules). In addition, pre-existing conditions clauses (which in the past could delay or limit coverage for a certain condition for a limited period of time) are also forbidden. And, as was already mentioned, many people who have incomes between 100% and 400% of the FPL will qualify for subsidized coverage through the exchanges.

Enrolling in an Exchange

If you wish to purchase coverage on an exchange, you will need to go to the exchange in your state (online, via the phone or mail, or by visiting a local office, or perhaps a retail outlet near to you). Using your Social Security number and other personal information, you will set up an account. Upon verification of your personal information, the IRS will calculate your subsidy (if any) and create a tax credit for your account reflecting any subsidy. With this information, you will then have the opportunity to select from among the plans offered by the exchange in your state. For those who are leaving other forms of health coverage with at least minimum value, the opportunity to enroll in exchanges is also expected to be available at the beginning of any month. Enrollment for all others will be restricted to the open enrollment periods (e.g., the period beginning October 1, 2013 for coverage commencing on January 1, 2014).

An Example of What Real Exchange Benefits, Rates and Networks Look Like

The table below summarizes some premium, benefits and network features recently announced for a typical plan on the exchange that will be available in Los Angeles and New York, compared with coverage offered by the Fund (through CIGNA and the Kaiser-CA and HIP/EmblemHealth-NYC HMOs). You can set up a similar table for your state to help you evaluate the options that are available to you or your dependents.

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Insurance Exchanges

Insurer	Monthly Premium*	Medical Benefits	Prescription Drug Benefits*	Exchange Reduced Cost sharing	Network in the Applicable State
Equity-League Fund - CIGNA	$100 per quarter if you are eligible through employment or $755 per month if you self pay (e.g., you have COBRA Coverage) thru the end of 2013	In network copay $25 Coinsuracne - None Out of network (OON) the plan pays 70% after a $350 annual deductible	A $100 annual deductible plus the greater of**: $10/20% Gen $20/25% Pref $25/30% Brnd	NA	67,000+ doctors and 386 hospitals in CA 50+ hospitals in NYC
Fund – HMO (Kaiser-CA)	$100 per quarter if you are eligible through employment or $600 per month if you self-pay thru the end of 2013	$5 copay No OON coverage	$5 copay all prescription drugs	NA	14,000 doctors and 35 hospitals
Anthem EPO Silver-CA on the Exchange	$299 for an individual who is 40 years of age	Average of $55 copay for doc visits, an annual deductible of $2000 for treatments such as outpatient surgery and hospitalizations then 20% coinsurance to an OOP max of $6,350	$25 generic copay, $250 annual deductible then $50 copay for brand drugs	Applies	30,000 doctors and 300 hospitals
Anthem EPO Platinum-CA on the Exchange	$420 (age 40)	Average $30 copay/visit 90% reimbursement for outpatient surgery or hospital stays Max OOP $4,000	$5 generic $15 brand	Applies	30,000 doctors and 300 hospitals
Fund - HIP/ EmblemHealth HMO	Approximately $730 per month for self-pay coverage ($100 if eligible through employment)	$0 copay No OON coverage	$10 generic copay $30 copay preferred brands (non-preferred brands not covered)	NA	51 hospitals No services Out-of-Network (OON)
HIP/EmblemHealth HMO Silver on the Exchange	$420 per month estimated coverage	Approximate $40 copay for doctor visits after an annual deductible of $2,000 on non-preventive services (additional $1,500 deductible for facility admissions after annual deductible) out of pocket maximum $5,500	$10 copay Tier 1 $35 copay Tier 2 $70 copay Tier 3	Applies	No services OON Network size not available
HIP/EmblemHealth HMO Platinum on the Exchange	$600 per month estimated coverage	No annual deductible Average $25 copay (additional $500 deductible for facility admissions)	$10 copay Tier 1 $30 copay Tier 2 $60 copay Tier 3	Applies	No services OON Network size not available

*If you are eligible for premium assistance through the exchange, for purposes of comparison, the premium listed here should be the premium after it has been reduced by the amount of the assistance.

**Non-mail order

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Insurance Exchanges

…the Silver Plan in California will have average copays of approximately $50…there will also be a $2,000 annual deductible on major outpatient procedures and hospitalizations.

…there may also be large differences among insurers with regard to how they cover prescription drugs.

A Few Exchange Features That You Should Be Mindful Of

There are a number of things that you should be very careful about when you consider purchasing coverage through an exchange, as these issues are serious and can be surprising.

First, the benefits offered on the exchanges in at least some states offer features very different from those of the Fund.

For instance, as can be seen in the above chart, a silver plan in CA will have average copays for physician visits of about $50 and brand name drug copays of $90, copays which are much higher than what most HMO, EPO (no-out-of-network coverage available) and PPO plans offered today. And there will be a full $2,000 annual deductible on major outpatient procedures and hospitalizations.

Similarly, in NY, there is a $2,000 annual individual deductible on silver plans. In addition, there is a separate deductible of $1,500 for facility (e.g., hospital) admissions.

In other States, benefits may be richer, but premiums can be expected to be higher as well. However, in some cases your out of pocket costs may be capped and so you will not have to pay further copays or coinsurance.

Second, many of the insurance companies who participate on the exchanges offer narrower networks than they have in the past, sometimes much narrower. So don't assume that the network offered by an insurer through an exchange is the same network that it offered in 2013 (or will offer outside of the exchange in 2014). Instead, make sure the selection of providers offered by the exchange insurer you choose will meet your needs.

Third, there may also be large differences between insurers with regard to how they cover particular prescription drugs, so if you regularly use certain drugs, you should check to see how they will be covered by any plan you may be considering.

For instance, one insurer may cover a certain brand name prescription drug after a copay, while another insurer may not cover that same drug at all.

Fourth, any subsidies you receive to purchase exchange coverage are conditional on your income remaining as you projected at the beginning of the year. If your actual income is higher than you projected, your subsidy will be lower, and you may be responsible for returning some or all of your subsidy dollars at tax time.

Please remember that eligibility for subsidies throughout the year is contingent on your remaining ineligible for employment related benefits. Subsidies only apply for the part of the year in which employment based coverage was unavailable to you.

Premium Assistance Tax Credits (Subsidies) Available through the Exchanges

All of the premium rates offered through the exchanges are, in effect, the "list" prices for coverage. The actual cost of coverage to an individual or family will vary considerably from person to person, as a function of their income level. Subsidies will be very substantial at the lower income levels and will drop off rapidly as ones income rises. The chart below demonstrates this phenomenon using rates that are approximately equal to the rates announced silver plans in Los Angeles, CA.

				Premium Payable After Crediting Any Premium Assistance					
A	B Annual Income	C	D	Silver Plan for Age 40 Insured		Silver Plan for Age 25 Insured		Silver Plan for Age 60 Insured	
Income As a % of FPL	Single	Family of 4	Responsibility for Premium Costs as % of Family Income	E Single	F Family of 4	G Single	H Family of 4	I Single	J Family of 4
100	$11,490	$23,550	2.00	$230	$417	$230	$417	$230	$417
150	$17,235	$35,325	4.00	$689	$1,413	$689	$1,413	$689	$1,413
200	$22,980	$47,100	6.30	$1,448	$2,967	$1,448	$2,967	$1,448	$2,967
250	$28,725	$58,875	8.05	$2,312	$4,739	$2,312	$4,739	$2,312	$4,739
300	$34,470	$70,650	9.50	$3,275	$6,712	$2,830	$6,712	$3,275	$6,712
400	$45,960	$94,200	9.50	$3,600	$8,949	$2,830	$8,489	$4,366	$8,949
400+	$45,961	$94,201	NA	$3,600	$10,800	$2,830	$8,489	$8,568	$20,736

As can be seen from the table, a 40 year old with an income at 100% of the FPL will have his/her exchange insurance cost capped to 2% of family income (about $230 annually for a single and $417 for a family of 4). If that same person had an income equal to 300% of the FPL the caps would be more than $3,000 and $6,000, respectively.

ACA Limits on Out-Of-Pocket Medical Spending and Premium Cost Limits in Relation to Income

Premium subsidies may make the Fund's self-pay coverage (e.g., COBRA) less attractive than it was before.

In addition to the premium assistance subsidies already discussed, you may qualify for out of pocket medical expense caps for such items as copays, coinsurance and deductibles (though not premiums or bills from non-network providers). You may also qualify for caps on your premium costs, if you purchase at least a silver level insurance plan on your state's insurance exchange.

Self-Pay Coverage Through the Fund May Be Less Attractive Than Before

Under ACA, employers and plans like the Equity-League Health Fund must still offer COBRA coverage on the same basis as they have in the past and may still offer extended coverage. However, with the advent of the exchanges, extended Self-Pay coverage may not be as desirable ast it once was, since participants will be able to access coverage through the exchanges, regardless of their health condition. In addition, for those at lower income levels, coverage through the exchanges may be much more affordable than the Self-Pay coverage offered by the Fund. This is because subsidies do not apply to Fund coverage, but they do apply to coverage offered through the exchanges.

Therefore, anyone who is presently on Self-Pay coverage should take a look at what is available at the exchanges versus the Fund.

Medicaid

In some states people in certain income ranges will be able to choose between Medicaid coverage and subsidized exchange coverage. Medicaid eligibility and coverage is very complex and well beyond the scope of this newsletter. Therefore, if you may be eligible for Medicaid we suggest that you consult with the Actors' Fund or another entity/expert that is knowledgeable about Medicaid and ACA (contact information for the Actors' Fund is provided later in this newsletter).

Medicare

ACA has enhanced Medicare Part D drug coverage. It has also materially increased the premiums charged to higher income Medicare participants and ACA is expected to change reimbursements to providers in a number of ways. However, in 2014, most Medicare participants will see little change in their Medicare programs.

Individual Penalties

Individual penalties for not having coverage will start at the greater of $95 and 1% of income for individuals in 2014, but become $695/2.5%, respectively, by 2016.

Beginning in 2014, all individuals will be required to have health insurance or pay a penalty. The penalty begins in 2014 at the greater of: $95 per person (up to a maximum of 3 individuals) or 1% of income. The penalty quickly escalates over the next two years, so that by 2016, it becomes the greater of: $695 per person, or 2.5% of income (the dollar amount of the penalty will be adjusted by an inflation factor after 2016).

As the table below indicates, the percentage of income penalty becomes larger than the flat dollar amount relatively quickly, as income rises (the dollar amounts are all illustrated for a full year, partial years of no coverage would generate prorated penalties).

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ACA Personal Annual Penalties for Not Securing Health Insurance

YEAR		2014		2015		2016	
		Annual Penalty		Annual Penalty		Annual Penalty	
Family Unit -->		Single	Family 4	Single	Family 4	Single	Family 4
Minimum Penalty		$95	$285	$325	$975	$695	$2,085
Annual Income		Maximum Annual Penalty*					
Single	Family 4	Single	Family 4	Single	Family 4	Single	Family 4
$11,490	$23,550	$115	$285	$325	$975	$695	$2,085
$25,000	$50,000	$250	$500	$500	$1,000	$695	$2,085
$50,000	$100,000	$500	$1,000	$1,000	$2,000	$1,250	$2,500
$100,000	$200,000	$1,000	$2,000	$2,000	$4,000	$2,500	$5,000

*The maximum penalty is the greater of the minimum penalty and 1% of annual household income in 2014, 2% of income in 2015 and 2.5% of annual income in 2016.

...the percentage of income penalty becomes larger than the flat dollar amount relatively quickly as income rises.

Equity-League Health Plan is Grandfathered but HMOs Offered by the Fund May Not Be

We have already mentioned that the health insurance plans offered on the exchanges will be categorized as bronze, silver, gold and platinum. We wanted you to know that the Equity-League Health Fund's coverage would likely qualify for platinum status, as in-network benefits pay for well more than 90% of covered medical expenses in network. However, there are some things that insurers must cover under the new law, but that the Equity-League Health Fund is not planning to cover in 2014, as a result of its grandfathered status under ACA. A "grandfathered" plan is a plan that pre-dated the law and provided benefits that, overall, met or exceeded the requirements of the law. As long as the Fund remains grandfathered the Trustees have more flexibility than insurers to manage the overall plan in the best interests of its participants.

In contrast, to the Fund's self-insured coverage administered by CIGNA, coverage provided through the Fund through an HMO is not grandfathered and will have to satisfy all the minimum coverage requirements of ACA.

The Equity-League Fund's coverage would likely qualify for "platinum" status... however, there are some benefits that must be provided by insurers, but not the Fund, because the Fund's plan is "grandfathered."

The Actors' Fund In An Official "Navigator" for ACA

The Actors' Fund has stepped into a more leading role as an official ACA navigator.

The Actors' Fund has played a major role in helping employees in the entertainment industry maintain their health insurance coverage over the years. Now they have stepped into an even more leading role as an official ACA "Navigator," which authorizes the Actors' Fund to help people navigate their way through the complexities of ACA. Please call on them if you have non-Health Fund related questions concerning ACA.

Actors' Fund
729 Seventh Avenue, 10th floor
New York, NY 10019
(212) 221-7300
info@actorsfund.org
(800) 221-7303 – NYC

For More Information On ACA

This above information is being provided as a courtesy based on our understanding of the Affordable Care Act. For more information about the ACA, the federal government has a website dedicated to ACA information — *www.healthcare.gov*. In addition, each state will have information on its own exchange (e.g., NY State uses the website *www.nystateofhealth.ny.gov*) .

This article provides general information, but the Fund Office cannot give you individual advice about Marketplace coverage or the availability of subsidies. When making decisions regarding your health care coverage, we encourage you to consult with your advisors. The Fund cannot provide legal, tax or other advice to Fund participants.

Health Care Quality and Cost Incentive Pilot Plan (QCIP)

QCIP is available to all participants in the CIGNA plan.

You may recall that this program commenced at the beginning of this year. It is available to all participants in the CIGNA plan and provides financial incentives for you to use higher quality and lower cost healthcare providers. These incentives are in the form of a credit issued by the Fund to a Health Care Reimbursement Account in the name of the participant who selects a provider who meets certain requirements. There are several categories of credits in the pilot program.

Certain Orthopedic Procedures Are Included in the QCIP

First, there will be a $400 credit issued to participants who have disc surgery, spinal surgery, total hip replacements and total knee replacements the credit is available only if you use one of CIGNA's three-star doctor CCN physicians (CIGNA's highest designation) and a CIGNA Center of Excellence (COE) facility for the surgery. You may recall from prior issues of Now Playing that CCN physicians and COEs are selected on the basis of widely accepted quality indicators generated by respected resources (e.g., Medicare outcome data).

Colonoscopies Are Included in the QCIP

Second, there is a $100 credit for participants who receive colonoscopies using one of CIGNA's three star doctor CCN physicians. An additional $200 credit is available to those participants who use a non-hospital setting for the procedure (e.g., have it performed in a physician's office). So a participant who receives a colonoscopy from a three star CCN doctor in a non-hospital setting receives a $300 credit.

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How the QCIP Credit Can Be Used

The amounts credited to a participant's Health Care Reimbursement Account can be used for a wide variety of purposes, such as paying for health care premiums, meeting deductible or coinsurance requirements, or paying for costs not covered by the Fund, such as certain chiropractic care or home care expenses not reimbursed by the Health Fund. A complete list of items for which the incentive can be used appears on the Fund Office's website: *www.equityleague.org.* Participants will be able to use amounts in their accounts for up to four years. So how does one go about finding a CIGNA three star CCN Provider or a Center of Excellence?

How to Locate a CIGNA Three-Star CCN Provider or Center of Excellence

CIGNA's three-star CCN providers can be located through a simple three step process:

1) CIGNA's CIGNA Care Network (CCN) providers can be found on the CIGNA website, *www.CIGNA.com.* Once you are there, place your cursor over the "Welcome" tab and click on "Find a Doctor."

2) Then, under the "What Type of Health Care Provider Are You Looking For" heading, check the "Physician" button, enter your Zip code below and click on "Next."

3) Finally, under the "What you're looking for" heading, click the down arrow and select a specialty that is one of the 19 that are part of the CCN program (e.g., "Knee Replacement") then click "Search."

A list of physicians will appear, with the third column on the list indicating the physician's CIGNA Care designation (a "Yes" means the physician is a CCN provider). Similarly, CIGNA's Center of excellence (COE) program has identified 29 inpatient procedures for which they have evaluated quality (e. g, using mortality complications and Medicare's quality measures for such conditions as heart attacks and infection protection). These procedures include the aforementioned spinal surgery and joint replacement procedures, but also procedures such as angioplasty and heart and gastric bypass procedures (although these latter three procedures are not currently part of the QCIP program).

CIGNA has created a three star system to rate hospitals for the 29 aforementioned inpatient procedures. Three stars indicate a hospital with the highest quality rating for a given procedure (a hospital can have three stars for one procedure but not earn that distinction for other procedures). To find a hospital that is considered a COE for at least one of the aforementioned 29 procedures, you can go to: *www.myCigna.com* (you have to set up a user name and password to access this site). Once you have set up an account (which takes minutes) you can find a COE for a procedure you are considering by going to the *myCigna.com* website and clicking on "Find a Doctor or Service."

Let's suppose you are considering getting a knee replacement.

1) Under the heading "Find a Person, Place or Procedure," click on the drop down menu and select "Procedure"

2) Then enter in the box to the right "knee replacement" and in the box to the right of that, enter your zip code.

3) Then click on "Search." Any COE facilities in your area will come up at the top of the page that appears. Now click on "Doctors" at the upper left of the screen and you will see a list of doctors and their hospital affiliations.

An indication of whether the physician is affiliated with a COE will appear in the second to the last column on the right.

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CCN providers can be found at *cigna.com*

To find CIGNA's Centers of Excellence go to *myCigna.com*

QCIP

Early Results in the QCIP Program

Scores of plan participants have already earned a credit under the QCIP program, saving money for themselves and the Fund. So if you find yourself in the position of needing one of the procedures that are included in the QCIP program, please consider whether you may be able to have that procedure done by a CIGNA CCN/COE provider.

Scores of plan participants have already earned a credit under the QCIP program.

For Additional Information on the QCIP Program

If you are interested in participating in the QCIP program, please do not hesitate to contact the Fund Office at (212) 869-9380, (800) 344-5220, or *www.equityleague.org* and we will be happy to provide further information regarding the program and how to access it. The new QCIP pilot program is an experimental program, which is subject to change and/or termination.

Equity-League Pension, Health and 401(k) Funds
165 West 46th Street, 14th Floor
New York, NY 10036

Changes in CIGNA Lab and Prescription Drug Provider Networks

As part of a continual effort to improve quality and manage costs, CIGNA has recently negotiated special contracts with two national labs and a pharmacy management organization.

CIGNA has recently negotiated special contracts with two national labs and a pharmacy management organization…

CIGNAs Nationwide Lab Providers

The labs are two of the largest in the nation — Quest Diagnostics and Lab Corp (aka Laboratory Corporation of America). CIGNA has negotiated very large discounts with both of these lab services vendors, as well as contracting with other vendors for in-network lab services. Network physicians should automatically order any lab tests they prescribe from a network lab, but when you are using an out of network provider, that might not be the case. Therefore, in order to save you and the Fund money, it is always a good idea to specify that you wish to have your testing done through Quest or LabCorp (most physicians deal with both of these organizations on a regular basis). In the unlikely event that your physician does not want to use Quest or LabCorp, you can always look for another network lab in your area at *www.myCIGNA.com*.

…the labs are two of the largest in the nation—Quest Diagnostics and Lab Corp.

A Larger Prescription Drug Network

When it comes to prescription drugs, CIGNA is now collaborating with Catamaran, one of the largest pharmacy benefit managers in the nation. For the vast majority of plan participants, this collaboration means that more pharmacies will be available through the CIGNA network, giving you more choices about retail pharmacies. In the very small number of instances in which a pharmacy that was in CIGNA's old network but will not be in the new one, participants will be notified by CIGNA, who will provide a list a local pharmacies that are in the new CIGNA/Catamaran network.

CIGNA is now collaborating with Catamaran, one of the largest pharmacy benefit managers in the nation.

Meningitis Threat

Recent news reports have heightened attention on a new and especially lethal strain of bacterial meningitis. It kills approximately one third of those who are infected with it. A growing number of patients are being diagnosed with this disease, so Public Health officials have become concerned that if steps are not taken to control the disease's spread, there could be a major outbreak.

Thus far, this new variant of meningitis has appeared largely among gay men, but health experts are not sure why this is the case or if it will remain the case. This form of meningitis is carried in the nose and mouth, so it can be transmitted by kissing, cuddling, sneezing, or sharing a spoon or cigarettes, as well as through sexual contact.

Fortunately, there is an effective vaccine for the disease. It reportedly takes 7-10 days to become protective and affords up to five years of immunity. The vaccine is covered by the Equity-League Health Plan.

In New York City, those who are uninsured can obtain the vaccine at a Department of Health Clinic (a list is available at *www.nyc.gov/html/doh/html/living/std-clinics.shtml).*

This form of meningitis is carried in the nose and mouth so can be transmitted by kissing or sneezing.

Some Tips on Getting a Better Price for Medical Care

Despite the push to provide health care coverage for a greater number of people through initiatives such as ACA, some may find themselves in situations in which they still do not have health coverage, or that coverage reimburses them for a particular treatment at a level that requires them to pay a considerable portion of the charges made for a particular treatment. What are they to do?

In a recent article in the Wall Street Journal, a physician reported that when a patient's insurance company's allowances for a procedure he was about to have were much lower than what the patient's health care providers planned to charge, the hospital demanded a very large pre-payment of the amount the insurer was not covering. At this point, the surgeon suggested that the patient cancel the surgery and start the scheduling process all over again, with one difference.

This time the patient classified himself as a "self-pay" patient. The surgeon in this particular case then agreed to charge the patient a reasonable flat amount for the surgery, as did the associated anesthesiologist. The hospital quoted a price less than half of what they wanted when the patient was considered insured. Overall, the patient saved more 50% on the procedure, compared with what he would have paid by having the same procedure done while classified as an "insured" patient.

It is certainly not the case that every patient, or even most, may be able to enjoy the kind of savings reported in the article, but a similar approach may be worth exploring if you find yourself in a similar situation.

It is certainly not the case that every patient, or even most, may be able to enjoy the kind of savings reported in the article…

A New Secret to Weight Control?

Two recent studies done at the University of California suggest a new approach to reducing urges to eat high calorie foods may be effective

Two recent studies done at the University of California suggest a new approach to reducing urges to eat high calorie foods may be effective. Dr. Kerry Boutelle, who conducted the studies, calls her technique "cue exposure". The studies' subjects were 40 8-12 year old obese children (who participated in a four month study) and 36 overweight children (who participated in a 8 week study).

The participants in both studies were handed a favorite food, such as a cookie, and asked to rate their desire for it on a scale of 1-5. A rating of 1 meant they could comfortably resist the urge to eat the cookie and a rating of 5 meant they were "dying for it". They were then asked to put the item down, to wait 30 seconds and to again rate their desire for it. Another rating was recorded after they sniffed the food and still another after they took a small bite and stared at the food for 5 minutes. Finally, the children were instructed to throw the food away.

These tests were performed on children who were not hungry at the time. The intention was to teach them to refrain from eating when they were not hungry.

A specific individual case mentioned in the report of the study involved an 8 year old who initially rated a food as an absolute 5. After going through the protocol, his numbers dropped into the 1-2 range and he finally said "Oh, I don't need it."

Boutelle's technique turns much conventional willpower control wisdom on its head by suggesting that instead of avoiding any contact with fattening foods, one builds resistance to temptations by confronting such temptations with a structured approach. According to Boutelle, she tracked children exposed to her technique for a year and found that resistance to tempting foods persisted an average of six months after the completion of the study. She is now involved in a longer term study to see if, through longer training, even more permanent results can be achieved.

So the next time that bag of chips is staring you down, consider trying the "cue exposure" technique to see if it can bring your urges under better control.

Davis Vision Is Now VISION WORKS

Davis Vision is now known as Vision Works, but their benefits remain the same.

Davis Vision has changed its name to Vision Works. The benefits provided and contact information remains the same.

SUMMARY ANNUAL REPORT
FOR EQUITY-LEAGUE HEALTH TRUST FUND

This is a summary of the annual report of the EQUITY-LEAGUE HEALTH TRUST FUND, EIN 13-6092981, Plan No. 501, for period June 01, 2011 through May 31, 2012.The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Kaiser Foundation Health Plans Inc., Hip Health Plan Of New York, Medica, Connecticut General Life Insurance Company and Affiliates, and Kaiser Foundation Health Plan Mid-Atlantic to pay health, dental, stop loss, HMO, indemnity and NON-HMO claims incurred under the terms of the plan.The total premiums paid for the plan year ending May 31, 2012 were $4,719,281.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $102,086,938 as of May 31, 2012, compared to $94,350,296 as of June 01, 2011. During the plan year the plan experienced an increase in its net assets of $7,736,642.This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $66,229,919, including employer contributions of $45,551,099, employee contributions of $15,124,692, realized losses of ($69,828) from the sale of assets, earnings from investments of $2,298,956, and other income of $3,325,000.

Plan expenses were $58,493,277.These expenses included $3,623,421 in administrative expenses, and $54,869,856 in benefits paid to participants and beneficiaries.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request.The items listed below are included in that report:

- an accountant's report;
- financial information;
- information on payments to service providers;
- assets held for investment;
- transactions in excess of 5% of the plan assets;
- insurance information, including sales commissions paid by insurance carriers;
- information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates;

To obtain a copy of the full annual report, or any part thereof, write or call the office of BOARD OF TRUSTEES OF THE EQUITY-LEAGUE HEALTH TRUST FUND at 165 WEST 46TH STREET 14TH FLOOR, NEW YORK, NY 10036-2501, or by telephone at (212) 869-9380.The charge to cover copying costs will be $0.00 for the full annual report, or $0.00 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (BOARD OF TRUSTEES OF THE EQUITY-LEAGUE HEALTH TRUST FUND, 165 WEST 46TH STREET 14TH FLOOR, NEW YORK, NY 10036-2501) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The Equity-League Funds (Pension, Health and 401K) Systems *Are Separate From AEA and We Now Have Separate Systems and Databases As Well*

Changing your contact information with AEA will no longer do so with the Fund Office (or vice versa).

You need to inform both the Fund Office and AEA of any changes in your contact information.

Although we have mentioned it a number of times in the past, there still seems to be some confusion regarding the status of the Equity-League Funds relative to AEA. The Equity-League Funds are a completely separate entity from AEA. We are distinct organizations in terms of our legal status, governance and corporate purposes themselves. The Funds are separate not-for-profit entities that are each governed by Trustees, half of which are appointed by AEA and the other half of which are appointed by The Broadway League. The Funds are not the AEA nor are they subsidiaries of AEA.

The purpose of the Funds is solely and exclusively to provide benefits to participants of the three Funds, the vast majority of whom are AEA members (the staff members of the Fund Office, the AEA, the Actors' Federal Credit Union and the Broadway League are also participating in one or more of the Funds but they collectively represent a small share of participants).

We sometimes hear from plan participants who blame the AEA for any Fund Office policies or decisions that they do not favor, but if the policies or procedures followed by the Funds are found to be wanting, the responsibility for that rests with the Fund Office staff and/or Trustees of the Funds, not AEA.

In the past, the Funds and AEA used to use the same vendor to provide their computer systems, but each organization has gone its separate way with regard to systems in recent years, as there was no single vendor who could meet the needs of both organizations. A consequence of these completely separate systems is that we can no longer share data with respect to member demographics, such as phone numbers and addresses. **Therefore, if you have a change in your personal information, you must let both the Fund Office and AEA know, separately, of such changes. Notifying one organization will no longer suffice.** We know that this will cause and inconvenience for some but there were often errors in the past, when both organizations used the same data even though members would have preferred the two organizations to have different information. So please remember that if you need to change your home address, email or phone number, you need to let both the Fund Office and AEA know of any changes.

Retirement Benefits (Combined PENSION Plan and 401K) SPDs Coming Soon

A number of you have suggested that having all information on the Pension Fund's and 401(K) Fund's benefits all in one place would be helpful. Therefore, we are happy to announce that we expect a combined retirement benefits "book" which will contain the Summary Plan Descriptions of both the Equity-League Pension and Equity-League 401(K) Fund, will be released soon.

401(K) Plan Investment Information

Default investment. You may invest your 401(k) account(s) (your "directed account(s)") in any of the investment choices offered in the Plan. If you do not make an election as to how the Plan should invest any of your future directed account(s) (e.g. rollover contribution, employee or employer contribution) by returning the election form to the Plan Administrator, by electronically making your election via logging on to the participant website at *www.retiresmart.com* or by calling (800-) 43-5274, the Plan Trustee will invest your future directed account(s) in the "default" investment that the Plan officials have selected. The default investment is the Manning & Napier Investment Series:

Manning & Napier Target Income
Manning & Napier Target 2010
Manning & Napier Target 2020
Manning & Napier Target 2030
Manning & Napier Target 2040
Manning & Napier Target 2050

Generally target retirement date (lifecycle) investment options are designed to be held beyond the presumed retirement date to offer a continuing investment option for the investor in retirement. The year in the investment option name refers to the approximate year an investor in the option would plan to retire and likely would stop making new contributions to the investment option. However, investors may choose a date other than their presumed retirement date to be more conservative or aggressive depending on their own risk tolerance.

Target retirement date (lifecycle) investment options are designed for participants who plan to withdraw the value of their accounts gradually after retirement. Each of these options follows its own asset allocation path ("glide path") to progressively reduce its equity exposure and become more conservative over time. Options may not reach their most conservative allocation until after their target date. Others may reach their most conservative allocation in their target date year. Investors should consider their own personal risk tolerance, circumstances and financial situation. These options should not be selected solely on a single factor such as age or retirement date. Please consult the prospectus (if applicable) pertaining to the options to determine if their glide path is consistent with your long-term financial plan. Target retirement date investment options' stated asset allocation may be subject to change. Investments in these options are not guaranteed and you may experience losses, including losses near, at, or after the target date. Additionally, there is no guarantee that the options will provide adequate income at and through retirement.

If you do not make an election as to how the Plan should invest any of your future directed account(s)... the Plan Trustee will invest your future directed account(s) in the "default" investment that the Plan officials have selected.

Plan: Equity-League 401(k) Plan
Subscription: Equity-League
Created: 06/25/2013

Account Number: 51505-1-1

You are a participant or beneficiary in an individual account plan that allows you to direct the investment of your account balance. This disclosure statement is designed to provide you with information that will allow you to make informed decisions when selecting and managing your investments. This disclosure statement advises you of information regarding fees and expenses associated with your participation in the Plan. The General Plan Information section provides information regarding the operation of the Plan. The Comparative Chart section provides information about the Plan's designated investment alternatives including investment performance, operating expenses, fees, trade restrictions, and an industry benchmark relative to each non-fixed interest investment to help you make investment decisions. If the Plan has target date or life cycle investment allocation alternatives, this disclosure statement will include a Target Date Asset Allocation Investment Alternatives section providing information on how the investment allocation will change over time, when it will reach its most conservative asset allocation, the relevance of any dates used to describe the investment and the participant age groups for whom the investment alternative is designed. If your Plan's administrative expenses could be deducted from your account balance, this disclosure statement will include an Administrative Expenses section. The Administrative Expenses section provides information regarding charges for administrative expenses incurred on a Plan-wide basis that may be deducted from your account. An Individual Expenses section regarding individual expenses that may be deducted from your account, will also be included in this disclosure statement if the Plan charges participants and beneficiaries for the expenses associated with individual transactions.

- An investment's past performance is no guarantee of future results.
- To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio.
- Fees are only one of several factors you should consider when making investment decisions. For more information and an example demonstrating the long-term effect of fees and expenses, please visit: http://www.dol.gov/ebsa/publications/401kemployee.html and http://www.dol.gov/ebsa/publications/undrstndgrtrmnt.html.

Investment Instructions: In order to direct your Plan investments, you must make your election at www.retiresmart.com or contact the MassMutual Participant Information Center at 1-888-606-7343. If you are currently not participating in the Plan and have questions concerning plan provisions, including eligibility requirements, contact Equity-League 401(k) Trust at (212) 869-9380 or 165 West 46th St., New York NY 10036.

Limitations on Instructions:

- You may give investment instructions on any day the New York Stock Exchange is open for business.
- Any trade restrictions specific to an individual investment alternative will be listed in the Comparative Chart.
- If the Plan offers publicly traded employer securities as a designated investment alternative, certain discretionary transactions requested by participants who are officers, directors, or principal stockholders that involve employer securities will have trading restrictions imposed as additional reporting of those transactions is required.

Designated Investment Alternatives (DIA): The Plan provides designated investment alternatives into which you can direct the investment of your Plan funds. The Comparative Chart below identifies these designated investment alternatives and provides information regarding the alternatives.

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Investment Manager: For information regarding the designated investment manager for the Plan (if any), please contact your

Glossary of Terms: Please visit http://www.massmutual.com/glossary for a glossary of investment terms relevant to the investment options under this Plan. This glossary is intended to help you better understand your options.

This section includes important information to help you compare the investment alternatives offered under your Plan. If you want additional information about your investment options, you can go to the specific Internet web site addresses shown below or you can contact the MassMutual Participant Information Center at 1-888-606-7343. If you are currently not participating in the Plan, contact Equity-League 401(k) Trust at (212) 869-9380 or 165 West 46th St., New York NY 10036-. To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform very well often cause another asset category, or another particular security, to perform poorly. If you invest more than 20% of your retirement savings in any one company, industry or class of investment, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk. In deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of the Plan. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk. It is also important to periodically review your investment portfolio, your investment objectives, and the investment alternatives under the Plan to help ensure that your retirement savings will meet your retirement goals.

Document Summary

This section focuses on the performance of investment alternatives that have a fixed or stated rate of return. The chart shows the annual rate of return of each such alternative, the term or length of time that you will earn this rate of return and other information relevant to performance.

Fixed Return Investments			
Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	**Annual Rate of Return**	**Term**	**Shareholder-Type Fees, Restrictions and Other**
CASH			
SF Guaranteed STABLE VALUE MassMutual www.MassMutual.com/FF/RM3500.PDF	3.00%	Semi-annually	The rate of return listed was effective beginning on 01/01/2013, is reset Semi-annually, and is calculated net of certain contract expenses. Under the terms of your group annuity contract, there is a guaranteed minimum gross interest rate of 3.00%. Although the gross rate of return provided under the contract will never fall below 3.00%, the net rate of return may, in some instances, be less than 3.00% after applicable expenses are deducted from the contract. Current rate of return information is available by contacting the MassMutual Participant Information Center at 1-888-606-7343. If you are currently not participating in the Plan, contact Equity-League 401(k) Trust at (212) 869-9380 or 165 West 46th St., New York NY 10036-.

This section focuses on the performance of investment alternatives that do not have a fixed or stated rate of return. The chart shows how these alternatives have performed over time and allows you to compare them with an appropriate benchmark for the same time periods. ***Past performance does not guarantee how the investment alternative will perform in the future. Your investment in these alternatives could lose money.***

Information about an investment alternative's principal risks is available on the Investment Profile. You can obtain a specific Investment Profile using the web site address provided for the specific investment alternative in the Comparative Chart.

This chart also shows fee and expense information for the investment alternatives under your Plan. It shows the Total Annual Operating Expense which are expenses that reduce the rate of return of the investment alternative. Any shareholder-type fees are also disclosed. These fees are in addition to Total Annual Operating Expenses. Expense information is reflected as of the date of this report and may change over time. Please note that expense information for each investment alternative reflected on the Investment Profile is updated from time to time. Please see the Investment Profile which includes current expense information as well as the date the expenses were most recently updated.

	Variable Return Investments						Fees and Expense Information				
Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	**Average Annual Total Return as of 05/31/2013**			**Benchmark**			**Gross Total Annual Operating Expenses**		**Net Total Annual Operating Expenses****		**Shareholder-Type Fees, Restrictions and Other**
	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	As a %	Per $1000	As a %	Per $1000	
CASH											
Government Money Mrkt (Babson) STABLE VALUE 11/01/1991 MassMutual www.MassMutual.com/FF/RM3506.PDF	N/A	0.20%	1.45%	0.11%	0.25%	1.64% CitiTreasury Bill 3Mon	0.50%	$5.00	0.50%	$5.00	Transfers In are not allowed
BOND											
BlackRock Inflation Protected INTERMEDIATE TERM BOND 08/01/2004 BlackRock www.MassMutual.com/FF/bprax.PD	-1.41%	5.21%	5.76%	-1.79%	5.49%	5.77% Barclays US TIPS Treasury Idx	0.99%	$9.90	0.86%	$8.60	
Select PIMCO Total Return INTERMEDIATE TERM BOND 02/01/1997 MassMutual Select www.MassMutual.com/FF/l9395.PDF	3.75%	6.72%	5.55%	0.93%	5.51%	4.67% Barclays US Agg Bond	0.86%	$8.60	0.86%	$8.60	

Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	Variable Return Investments						Fees and Expense Information				
	Average Annual Total Return as of 05/31/2013			Benchmark			Gross Total Annual Operating Expenses		Net Total Annual Operating Expenses**		Shareholder-Type Fees, Restrictions and Other
	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	As a %	Per $1000	As a %	Per $1000	
ASSET ALLOCATION											
Total Return (MFS) ASSET ALLOCATION/LIFESTYLE 01/01/1993 MFS Investment Management www.MassMutual.com/FF/msfrx.lw.pdf	18.40%	5.03%	6.32%	27.27%	5.42%	7.57% S&P 500® Index	0.77%	$7.70	0.77%	$7.70	This investment is closing as of 09/17/2013
Balanced-Risk Alloc (Invesco) ASSET ALLOCATION/LIFESTYLE 08/01/2009 Invesco www.MassMutual.com/FF/abrix.PDF	8.97%	N/A	11.35%	27.27%	5.42%	16.43% S&P 500® Index	0.92%	$9.20	0.92%	$9.20	This investment will be available as of 09/17/2013
Trg Incm Srs (Manning&Napier) ASSET ALLOCATION/LIFECYCLE 04/01/2008 Manning & Napier www.MassMutual.com/FF/mtdkx.pdf	10.07%	5.91%	5.69%	3.04%	4.93%	4.85% DJ Target Today Index	1.18%	$11.80	0.98%	$9.80	
Trg 2010 Srs (Manning&Napier) ASSET ALLOCATION/LIFECYCLE 04/01/2008 Manning & Napier www.MassMutual.com/FF/mthkx.pdf	12.24%	3.44%	4.03%	4.82%	4.23%	4.47% DJ Target 2010 Index	1.34%	$13.40	1.07%	$10.70	

	Variable Return Investments						Fees and Expense Information				
Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	**Average Annual Total Return as of 05/31/2013**			**Benchmark**			**Gross Total Annual Operating Expenses**		**Net Total Annual Operating Expenses****		**Shareholder-Type Fees, Restrictions and Other**
	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	As a %	Per $1000	As a %	Per $1000	
Trg 2020 Srs (Manning&Napier) ASSET ALLOCATION/LIFECYCLE 04/01/2008 Manning & Napier www.MassMutual.com/FF/mtnkx.pdf	16.58%	4.79%	5.35%	10.83%	4.02%	4.74% DJ Target 2020 Index	1.20%	$12.00	1.12%	$11.20	
Trg 2030 Srs (Manning&Napier) ASSET ALLOCATION/LIFECYCLE 04/01/2008 Manning & Napier www.MassMutual.com/FF/mtpkx.pdf	21.58%	4.85%	5.58%	17.74%	4.13%	5.26% DJ Target 2030 Index	1.22%	$12.20	1.13%	$11.30	
Trg 2040 Srs (Manning&Napier) ASSET ALLOCATION/LIFECYCLE 04/01/2008 Manning & Napier www.MassMutual.com/FF/mttkx.pdf	26.21%	4.59%	5.46%	22.96%	4.31%	5.65% DJ Target 2040 Index	1.28%	$12.80	1.14%	$11.40	
Trg 2050 Srs (Manning&Napier) ASSET ALLOCATION/LIFECYCLE 04/01/2008 Manning & Napier www.MassMutual.com/FF/mtykx.pdf	27.10%	5.12%	5.98%	24.17%	4.46%	5.82% DJ Target 2050 Index	1.57%	$15.70	1.14%	$11.40	

Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	Variable Return Investments						Fees and Expense Information				
	Average Annual Total Return as of 05/31/2013			Benchmark			Gross Total Annual Operating Expenses		Net Total Annual Operating Expenses**		Shareholder-Type Fees, Restrictions and Other
	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	As a %	Per $1000	As a %	Per $1000	
STOCK											
BlackRock Equity Dividend Fund LARGE CAP VALUE 01/01/2000 BlackRock www.MassMutual.com/FF/mddvx.lw.pd	21.75%	4.25%	9.67%	32.71%	4.73%	8.01% Russell 1000® Value Idx	0.99%	$9.90	0.99%	$9.90	
MM S&P 500 Index(Northrn Trst) LARGE CAP CORE 07/01/1993 MassMutual Select www.MassMutual.com/FF/RM3535ZR.PDF	27.04%	5.22%	7.37%	27.27%	5.42%	7.57% S&P 500® Index	0.26%	$2.60	0.21%	$2.10	
Sel Gr Opprts (Sands/Delaware) LARGE CAP GROWTH 05/01/2000 MassMutual Select www.MassMutual.com/FF/RM3590LR.PDF	20.10%	8.01%	8.97%	27.27%	5.42%	7.57% S&P 500® Index	1.25%	$12.50	1.10%	$11.00	
Levd Co Stck(Fidelity Advisor) MID CAP CORE 01/01/2001 Fidelity Advisor www.MassMutual.com/FF/flstx.pdf	41.01%	2.79%	13.05%	30.49%	6.74%	10.89% Russell Mid Cap® Idx	1.35%	$13.50	1.35%	$13.50	

Variable Return Investments							Fees and Expense Information				
Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	Average Annual Total Return as of 05/31/2013			Benchmark			Gross Total Annual Operating Expenses		Net Total Annual Operating Expenses**		Shareholder-Type Fees, Restrictions and Other
	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	As a %	Per $1000	As a %	Per $1000	
Sel Md Cp Gr II (TRP/Frontier) MID CAP GROWTH 03/01/1998 MassMutual Select www.MassMutual.com/FF/RM3559L.PDF	24.52%	7.00%	10.81%	26.78%	6.25%	10.23% Russell Mid Cap® Growth Index	1.20%	$12.00	1.10%	$11.00	
Goldman Sachs Small Cap Value SMALL CAP VALUE 02/01/2002 Goldman Sachs www.MassMutual.com/FF/gssix.pdf	30.83%	9.37%	11.04%	31.30%	6.51%	9.53% Russell 2000® Value Idx	1.04%	$10.40	0.96%	$9.60	
New Horizons (T. Rowe Price) SMALL CAP GROWTH 01/01/1962 T. Rowe Price www.MassMutual.com/FF/prnhx.pdf	27.42%	12.57%	12.83%	30.85%	7.69%	9.90% Russell 2000® Growth Index	0.81%	$8.10	0.81%	$8.10	
EuroPacific Growth (American) INTL/GLOBAL LARGE CORE 01/01/1994 American Funds www.MassMutual.com/FF/rercx.pdf	25.09%	0.06%	9.97%	25.82%	-1.61%	9.40% MSCI® AC World ex-USA	1.14%	$11.40	1.14%	$11.40	Transfers not allowed between 2:30 p.m. and 4 p.m. ET each day

Name of Investment Type of Investment Investment Inception Date Investment Manager Investment Profile	Variable Return Investments: Average Annual Total Return as of 05/31/2013			Benchmark			Fees and Expense Information: Gross Total Annual Operating Expenses		Net Total Annual Operating Expenses**		Shareholder-Type Fees, Restrictions and Other
	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	1 Year	5 Year	10 Year or *Since Fund Inception if less than 10 years	As a %	Per $1000	As a %	Per $1000	
Premier Global (OFI) INTL/GLOBAL LARGE GROWTH 03/01/1998 MassMutual Premier www.MassMutual.com/FF/rm3536s.PDF	33.84%	4.26%	6.35%	26.02%	1.16%	5.28% MSCI® AC World Index NR	1.05%	$10.50	0.89%	$8.90	
Morgan Stanley Inst U.S Real REITS 02/01/2002 Morgan Stanley www.MassMutual.com/FF/musdx.PDF	13.72%	4.53%	11.77%	19.41%	5.74%	11.45% FTSE NAREIT Equity REIT Index	1.28%	$12.80	1.25%	$12.50	

*The benchmark since inception return is calculated from the month-end of the investment's inception.

**The Net Total Annual Operating Expenses include any investment expense waiver/reimbursement arrangements documented in the investment's prospectus and may be lower than the Gross Total Annual Operating Expenses due to the indicated expense waivers or reimbursements, which may be subject to expiration. Additional information regarding investment expense waivers specific to each investment is included in this document, if available, including whether the waiver is contractual or voluntary and its date of expiration. All available information about investment expense waivers is current and complete as of the date of this report. If information regarding the waivers is incomplete, it is because our third-party data provider was unable to make the information available. For some investments, the Net Total Annual Operating Expense ratio figure reflects the subtraction of interest expense, which results from an investment's use of certain other investments. This expense is required to be treated as an investment expense for accounting purposes, but is not payable to the investment adviser or subadviser (if applicable). For more information, please see the investment profile or the prospectus that corresponds to the investment, which are both available from MassMutual. Contact the MassMutual Participant Information Center at 1-888-606-7343. If you are currently not participating in the Plan, contact Equity-League 401(k) Trust at (212) 869-9380 or 165 West 46th St., New York NY 10036-.

Other share classes of an investment or its underlying investment (depending upon the investment) may have existed longer, which may account for any pre-inception performance shown. If pre-inception performance is shown, it is generally the performance of an older share class of the investment itself or its underlying investment (depending upon the investment) adjusted for fees and expenses of the newer share class. However, if using the expenses of the newer share class rather than the expenses of the older share class (due to lower expenses of the newer share class) would result in better performance, then pre-inception performance represents that of the older share class without any expense adjustment.

The cumulative effect of fees and expenses can substantially reduce the growth of your retirement savings. Visit the U.S. Department of Labor's Website for an example showing the long-term effect of fees and expenses at http://www.dol.gov/ebsa/publications/401k_employee.html. Fees and expenses are only one of many factors to consider when you decide to invest in an alternative. You may also want to think about whether an investment in a particular option, along with your other investments, will help you achieve your financial goals.

To obtain additional information about the Plan's designated investment alternatives, please obtain the Investment Profiles for the specific investment alternatives you are interested in using the web site addresses provided in the Comparative Chart or go to www.retiresmart.com.

You have the right to request the following information relating to the Plan's investment alternatives: copies of prospectuses or any short-form or summary prospectus or similar documents, financial statements or reports, a statement of the value of each investment available under the Plan as well as the valuation date, and a list of the assets that make up the portfolio of each investment under the Plan that constitute "plan assets" within the meaning of U.S. Department of Labor regulations and the value of each of these assets. In addition, you may request a free paper copy of the information available on the web site(s) listed on the Comparative Charts above and the Glossary of Investment Terms. This information can be obtained by contacting Equity-League 401(k) Trust at (212) 869-9380 or 165 West 46th St., New York NY 10036- or MassMutual Participant Information Center, P.O. Box 219062, Kansas City, MO 64121-9062, 1-888-606-7343.

Target Date Asset Allocation Investment Alternatives offer professional management and monitoring as well as diversification - potentially, an all in one investment. Each Target Date Asset Allocation Investment Alternative is generally intended to be comprised of more conservative investments as retirement nears. A group of target date (or lifecycle) investments from one investment family constitutes a series.

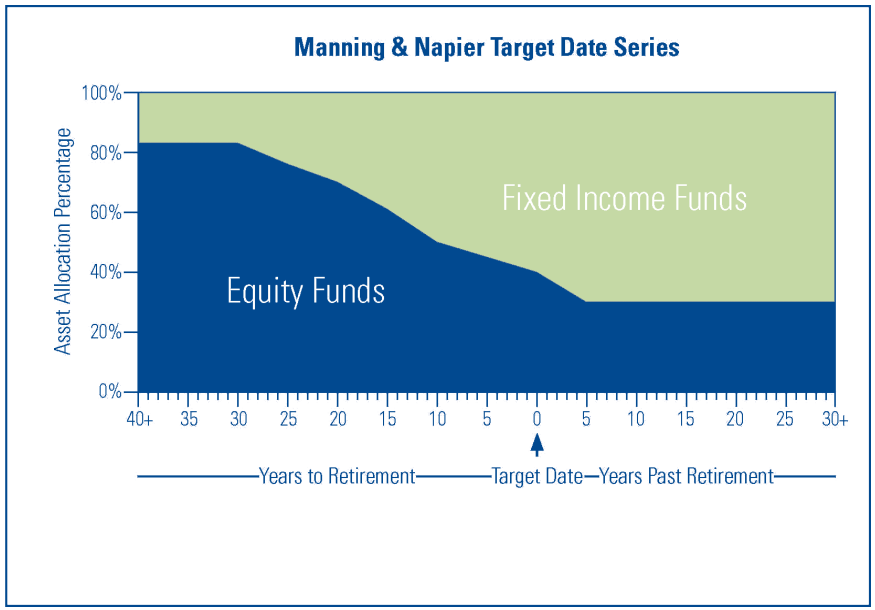
Target date investment alternatives are generally mutual funds or similar investments which hold a diversified portfolio of stocks, bonds, and other investments. Typically, target date investment portfolios shift over time from a mix primarily focused on stock investments earlier in the lifecycle of each portfolio to a mix weighted more toward bond investments (commonly referred to as the "glide path").

The investment manager periodically reviews the target asset allocation and underlying investment options and may, at any time, in its discretion, change the target asset allocation or deviate from the target asset allocation. Under normal circumstances, the Funds' asset allocation among equity, fixed income and certain other asset classes is generally expected to vary by no more than plus or minus ten percentage points from the target asset allocation at that time.

The below target date series included in your Plan consists of the investments listed below. These investments are named for the approximate year when an investor plans to retire, will likely stop making new contributions, and will withdraw or begin taking withdrawals ("target year").

Trg Incm Srs (Manning&Napier) - 76% in Fixed Income & Short Term/Money Market and 24% in Equity and similar funds.
Trg 2010 Srs (Manning&Napier) - 62% in Fixed Income & Short Term/Money Market and 38% in Equity and similar funds.
Trg 2020 Srs (Manning&Napier) - 46% in Fixed Income & Short Term/Money Market and 54% in Equity and similar funds.
Trg 2030 Srs (Manning&Napier) - 39% in Fixed Income & Short Term/Money Market and 61% in Equity and similar funds.
Trg 2040 Srs (Manning&Napier) - 14% in Fixed Income & Short Term/Money Market and 86% in Equity and similar funds.
Trg 2050 Srs (Manning&Napier) - 14% in Fixed Income & Short Term/Money Market and 86% in Equity and similar funds.

The following chart illustrates the Funds' target asset allocations among equity, fixed income and certain other asset classes as of the date of this disclosure statement and how their asset allocations are expected to change over time. The number of years until retirement, target retirement date and number of years past retirement are depicted on the bottom axis. The corresponding asset allocation percentage is reflected on the left hand axis of the chart. To find the target allocation relevant to the number of years until you may retire, find the number of years on the bottom axis and follow it up to see where on the left hand axis it intersects with each asset class reflected in the chart. As time passes and the target date approaches (and then is passed), the asset allocation will move along the "glide path" until the most conservative asset allocation is reached. Each of the Funds' target asset allocation may differ from this illustration.



Target date investment alternatives do not guarantee that you will have adequate retirement income. You can lose money at any time, including near and following retirement. Target date asset allocation investment alternatives do not eliminate the need for you to decide, before investing and from time to time thereafter, whether the investment alternative fits your financial situation. Even if you plan to retire in 2030, you may decide, based on your investment objectives, tolerance for risk, and other assets, that the investment strategy and risks of a 2020, 2040, or other target date fund would be more appropriate for you. Or you may decide that you don't want to invest in a target date asset allocation investment alternative and would rather actively manage your investments by selecting different investment alternative(s).

If fees/expenses are incurred for plan administration, such fees/expenses may be charged to the Plan. As an individual account Plan, these Administrative Fees may be charged against your account balance to the extent they are not charged against forfeitures or paid by the Plan Sponsor. As a result, your account balance may be reduced for your share of any Plan Administrative fees charged against your account. These fees may be charged on a pro rata basis (i.e., based on the relative size of each participant and beneficiary's account) and/or a per capita basis (i.e., each participant and beneficiary is charged the same fee). If Plan Administrative fees are charged to your account balance, the actual dollar amount will be reported to you in the calendar quarter following the quarter in which the charge occurs. Please refer to your quarterly account statement for information on any fees actually charged to your account.

Please note that the Plan Administrative fees which appear below are not reflected in the total annual operating expenses of any of the Plan's investment options. However, in addition to the Plan Administrative fee amounts listed in this section, some of the Plan's Administrative fees may have been paid through revenue sharing arrangements maintained with one or more of the Plan's investment options in which you may be invested.

Pro Rata Fees

Plan administration fees/expenses that may be charged pro rata include, but are not limited to, fees/expenses for legal, accounting, audit, compliance, intermediary/advisor, investment, recordkeeping, and trustee services (collectively "Plan Administration Fees").

Per Capita Fees

If the Plan's Sponsor normally pays the fees for administrative services performed by MassMutual, and the payment is overdue in accordance with the Plan Sponsor's Administrative Services Agreement with MassMutual, the Plan Sponsor is authorizing that the outstanding expenses will be deducted from participants' account balances on a pro rata basis to the extent allowed by the Plan's Administrative Services Agreement. Your share of the overdue expense will be determined by multiplying the fee by a ratio that is equal to the value of your account balance divided by the value of all account balances under the plan.

Consulting Services

Certain consulting services may be performed during the next 12 months if applicable to the provisions in your Plan and if requested by the Plan Sponsor. The fee for any of the services that are performed will only be paid from plan assets if directed by the Plan Sponsor. Consulting services include the following.

Employer contribution calculation and allocation service is an optional service that a Plan Sponsor can elect to have MassMutual perform on their behalf. The fee for employer contribution calculation and allocation services is $500. An additional fee of $200 per hour will be charged if more than three hours are required to complete the service. If the Plan has a matching contribution provision that requires a true-up calculation to be performed at the end of a plan year, there is a $250 fee if the true-up contribution has to be revised.

If the Plan Sponsor requests MassMutual to perform research, (such as documenting regulatory compliance, e.g. providing historical participant transaction forms, supporting financial reports, past Forms 5500 filings, prior years nondiscrimination tests, etc.) a $75 per hour fee may be charged.

If a plan amendment is required for a MassMutual plan document due to a change in a regulation, law, or to comply with Title I of ERISA, there will be a charge of $100. If the Volume Submitter plan document is amended and requires customization of provisions, an additional hourly fee of $200 will be charged.

If an amendment to the investment contract is required, the amendment preparation fee is $300.

If the Plan has a participant loan provision and the Loan Policy needs to be amended, the loan Policy amendment fee is $100.

If the Plan has a qualified default investment arrangement, a safe harbor plan design, an automatic enrollment feature or other plan provision for which a participant disclosure notice must be provided annually, the Plan Sponsor may request MassMutual to prepare the applicable notices. The fee for preparation of participant disclosure notices may be paid from participant accounts if directed by the Plan Sponsor. The fees for mailing participant notices and disclosures may be paid from participant accounts if directed by the Plan Sponsor. The fee for mailing certain required notices is calculated based on producing, packaging and mailing the materials.

If any of these consulting services are performed and the Plan's Sponsor directs MassMutual to deduct the fees for these services from participants' account balances, the fees will be deducted on a pro rata basis. Your share of the expense will be determined by multiplying the fee by a ratio that is equal to the value of your account balance divided by the value of all participants' account balances under the plan.

Regulatory Testing

Nondiscrimination testing is required to be performed each year. Basic nondiscrimination testing services are included as part of the Plan's administrative services expenses. However, in certain situations additional fees for nondiscrimination testing may be charged.

If the Plan Sponsor maintains two or more retirement plans and those plans must be combined to perform the annual nondiscrimination testing, a fee will be charged to aggregate the plans data and perform the testing on a combined basis. The fee for aggregating the retirement plan data is $2,000 per plan. If a completed nondiscrimination test needs to be revised at a later time, a $500 fee will be charged for each revised test. This revision fee applies to ADP and ACP tests, 415 limitation tests, and the 416 top-heavy tests. Specialized nondiscrimination testing may be required due to the complexity of certain plan provisions. The fee for specialized testing is $1250. An additional fee of $200 per hour will be charged if more than three hours are required to complete the testing service. In addition, the Plan's definition of compensation used for the annual nondiscrimination testing purposes may itself require a nondiscrimination test. If the compensation ratio test is required to be performed the fee is $500. If any additional regulatory testing services are performed and the Plan's Sponsor directs MassMutual to deduct the fees for these services from participants' account balances, the fees will be deducted on a pro rata basis. Your share of the expense will be determined by multiplying the fee by a ratio that is equal to the value of your account balance divided by the value of all participants' account balances under the plan.

Reporting Services

The retirement plan is required to file Form 5500 Annual Return/Report of Employee Benefit with the U.S. Department of Labor each plan year. Preparation of the Form 5500 Annual Return/Report is part of the Plan's administrative services expenses. However, in certain situations, additional fees for preparation or amendment of the Form 5500 filing may be charged. If this Plan has investments with more than one investment provider, a fee will be charged to prepare a consolidated Form 5500 filing. The fee for preparation of a consolidated Form 5500 Annual Return for a plan that has plan assets with multiple investment providers will be $500 per investment provider.

If MassMutual prepares an amended Form 5500 Annual Return/Report filing for the Plan's Sponsor, a fee will be charged. The fee to prepare an amended Form 5500 Annual Return/Report is $250 for plan years beginning in 2009 and later and $500 for plan years that began prior to 2009.

If the Plan's Sponsor directs MassMutual to deduct the fees for this service from participants' account balances, the fees will be deducted on a pro rata basis. Your share of the expense will be determined by multiplying the fee by a ratio that is equal to the value of your account balance divided by the value of all participants' account balances under the plan.

Contract Discontinuance and Termination Services

If at some point in the future the Plan discontinues the investment provider relationship with MassMutual either by transitioning the Plan to a new record keeper or because of the complete termination of the Plan, additional fees may be charged depending on the terms of the investment contract/agreement in effect at that time and certain administrative services performed in conjunction with the event.

When investment contracts are discontinued, the participants' accounts could be assessed contract surrender charges, termination asset charges, or market value adjustments. Your Plan's specific investment contract/agreement will identify which of these discontinuance fees in effect. The discontinuance fees may also be dependent on the conditions of the market at the point in time of the investment contract/agreement is discontinued. If any special reports are requested during the transition of the plan to a new record keeper, a $300 fee may be charged for each report.

Adjustment Fees

On occasion, the Plan Sponsor may request that certain calculations be performed to make adjustments to specific participants' accounts or to calculate and allocate earnings. The fee for such a service is $75 per hour. If the Plan's Sponsor directs MassMutual to deduct the adjustment fee from participants' account balances, the fee will be deducted on a pro rata basis. Your share of the expense will be determined by multiplying the fee by a ratio that is equal to the value of your account balance divided by the value of all participants' account balances under the plan. In addition, there may be other administrative services performed by service providers outside of MassMutual during the next 12 months. However, it is unknown at this time if any services by other service providers will be required, what fees may be charged and whether those fees will be paid from plan assets. Examples of other administrative services that may occur outside of MassMutual and that may be paid by plan assets if not paid by the Plan Sponsor include but are not limited to: legal services; third party administrator services; accounting services; plan audits; and intermediary/advisor services. If any fees for services performed outside of MassMutual are to be deducted from participant accounts, they may be deducted on a pro rata or a per capita basis. The Plan Sponsor will direct which allocation method will be used when the fee for the service is submitted for payment to the service provider or reimbursement to the Plan Sponsor.

The Plan may impose certain charges against individual participants' accounts rather than charge them against the Plan as a whole. These charges may arise based on your use of a feature available under the Plan (e.g., participant loans), or based on the application of applicable law (e.g., processing a qualified domestic relations order in case of a divorce). Any fee or expense charged against your account will be reported to you in your quarterly account statement in the calendar quarter following the quarter in which the charge occurs (and/or, as applicable, in any transaction statement).

Activity Type	Current Fees
Annuity Purchase	$175
Reprocessing (adjustment)	$75
Special Mailing	$20

ANNUAL FUNDING NOTICE

For

EQUITY - LEAGUE PENSION TRUST FUND

Introduction

This notice includes important information about the funding status of your pension plan ("the Plan") and general information about the benefit payments guaranteed by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. All traditional pension plans (called "defined benefit pension plans") must provide this notice every year regardless of their funding status. This notice does not mean that the Plan is terminating. It is provided for informational purposes and you are not required to respond in any way. This notice is for the plan year beginning June 1, 2012 and ending May 31, 2013 ("Plan Year").

How Well Funded Is Your Plan

Under federal law, the plan must report how well it is funded by using a measure called the "funded percentage." This percentage is obtained by dividing the Plan's assets by its liabilities on the Valuation Date for the plan year. In general, the higher the percentage, the better funded the plan. Your Plan's funded percentage for the Plan Year and each of the two preceding plan years is set forth in the chart below, along with a statement of the value of the Plan's assets and liabilities for the same period.

Funded Percentage			
	2012 Plan Year	2011 Plan Year	2010 Plan Year
Valuation Date	June 1, 2012	June 1, 2011	June 1, 2010
Funded percentage	120.5%	126.1%	124.8%
Value of Assets	$1,408,326,714	$1,378,294,048	$1,310,875,082
Value of Liabilities	$1,169,045,970	$1,092,845,422	$1,050,709,904

Year-End Fair Market Value of Assets

The asset values in the chart above are measured as of the Valuation Date for the plan year and are actuarial values. Because market values can fluctuate daily based on factors in the marketplace, such as changes in the stock market, pension law allows plans to use actuarial values that are designed to smooth out those fluctuations for funding purposes. The asset values below are market values and are measured as of the last day of the plan year, rather than as of the Valuation Date. Substituting the market value of assets for the actuarial value used in the above chart would show a clearer picture of a plan's funded status as of the Valuation Date. The fair market value of the Plan's assets as of the last day of the Plan Year and each of the two preceding plan years is shown in the following table:

	May 31, 2013	May 31, 2012	May 31, 2011
Fair Market Value of Assets	$1,375,970,889	$1,224,601,682	$1,272,365,857

Critical or Endangered Status

Under federal pension law a plan generally will be considered to be in "endangered" status if, at the beginning of the plan year, the funded percentage of the plan is less than 80 percent or in "critical" status if the percentage is less than 65 percent (other factors may also apply). If a pension plan enters endangered status, the trustees of the plan are required to adopt a funding improvement plan. Similarly, if a pension plan enters critical status, the trustees of the plan are required to adopt a rehabilitation plan. Rehabilitation and funding improvement plans establish steps and benchmarks for pension plans to improve their funding status over a specified period of time.

The Plan was not in endangered or critical status in the Plan Year.

Participant Information

The total number of participants in the plan as of the Plan's valuation date was 41,865. Of this number, 6,426 were active participants, were retired or separated from service and receiving benefits, and 10,741 were retired or separated from service and entitled to future benefits.

Funding & Investment Policies

Every pension plan must have a procedure for establishing a funding policy to carry out plan objectives. A funding policy relates to the level of assets needed to pay for benefits promised under the plan currently and over the years.

The Plan is funded by contributions made by employers pursuant to collective bargaining or other written participation agreements.

Once money is contributed to the Plan, the money is invested by Plan officials called fiduciaries. Specific investments are made in accordance with the Plan's investment policy. Generally speaking, an investment policy is a written statement that provides the fiduciaries who are responsible for Plan investments with guidelines or general instructions concerning various types or categories of investment management decisions. The investment policy of the Plan is to invest in a diversified group of asset classes with target allocations that have a minimum and maximum allowed weighting as follows:

Asset allocation	Ranges	Asset Class Target
Domestic Equity	25 - 35%	30.0%
International Equity	12.5 - 17.5%	15.0%
Real Estate	7.5 - 12.5%	10.0%
Hedge Fund of Funds	2.5 - 7.5%	5.0%
Private Markets	0 - 7.5%	5.0%
Infrastructure		2.5%
Private Equity		2.5%

Fixed Income	22.5 - 32.5%	27.5%
Inflation Hedging	5 - 10%	7.5%
Real Return		5.0%
Commodities		2.5%

Investment Objectives:

Assets of the Plan are invested in a manner consistent with the fiduciary standards of the Employee Retirement Income Security Act of 1974 ("ERISA") and supporting regulations. Through its investment portfolio, the Plan desires to preserve its capital base while generating income necessary to meet the costs of providing pension benefits to the Plan's participants and beneficiaries in a timely fashion. Consistent with the provisions of the Plan and applicable law, the Plan's intent is to obtain a favorable net rate of return on investments at a prudent level of risk and protect assets that will be used for the payment of pension benefits. Sufficient liquidity is maintained to meet benefit payment obligations and other Plan expenses.

Investment Guidelines:

To assist the Trustees in their responsibility to invest the Plan's assets, the Trustees have the authority to appoint and delegate responsibility for the investment of all or any portion of the Plan's assets to Investment Managers. Each Investment Manager is a bank (trust company), insurance company, or a registered investment advisor. Each Investment Manager shall at all times be registered in good standing as an investment advisor under the Investment Advisers Act of 1940. Full discretion is granted to each Investment Manager with regard to the sector and security selection and the timing of any transactions.

Standards of Investment Performance:

Each Investment Manager is reviewed regularly regarding performance, personnel, strategy, research capabilities, organizational and business matters and other qualitative factors that may affect its ability to achieve the desired investment results. Consideration will be given to the extent to which performance results are consistent with the goals and objectives set forth in the Investment Policy and/or individual guidelines provided to an Investment Manager. The Plan's investment policy outlines prohibited investments as well as limits regarding the percentage of the Plan that may be invested in any one company and industry. Minimum credit quality guidelines are established and provided to investment managers. No investment may be made which violates the provisions of ERISA or the Internal Revenue Code.

The Trustees review the Plan's investment policy on a regular basis and make periodic changes when, based on all available information, it is prudent to do so.

Under the Plan's investment policy, the Plan's assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

Asset Allocations	Percentage
1. Cash (Interest bearing and non-interest bearing)	0.97%
2. U.S. government securities	19.68%
3. Corporate debt instruments (other than employer securities):	
Preferred	5.78%
All other	7.06%
4. Corporate stocks (other than employer securities):	
Preferred	0%
Common	29.11%
5. Partnership/joint venture interests	14.63%
6. Real estate (other than employer real property)	0%
7. Loans (other than to participants)	0%
8. Participant loans	0%
9. Value of interest in common/collective trusts	16.46%
10. Value of interest in pooled separate accounts	0%
11. Value of interest in master trust investment accounts	0%
12. Value of interest in 103-12 investment entities	0%
13. Value of interest in registered investment companies (e.g., mutual funds)	3.60%
14. Value of funds held in insurance co. general account (unallocated contracts)	0%
15. Employer-related investments:	
Employer Securities	0%
Employer real property	0%
16. Buildings and other property used in plan operation	
17. Other	2.71%

For information about the plan's investment in any of the following types of investments as described in the chart above – common/collective trusts, pooled separate accounts, master trust investment accounts, or 103-12 investment entities – contact Mr. Arthur Drechsler, Executive Director, Equity-

League Pension Trust Fund, 165 West 46th St, 14th Floor, New York, NY 10036, (212) 869-9380, or (800) 344-5220 toll free outside NYC, or pension@equityleague.org.

Right to Request a Copy of the Annual Report

A pension plan is required to file with the US Department of Labor an annual report called the Form 5500 that contains financial and other information about the plan. Copies of the annual report are available from the US Department of Labor, Employee Benefits Security Administration's Public Disclosure Room at 200 Constitution Avenue, NW, Room N-1513, Washington, DC 20210, or by calling 202.693.8673. For 2009 and subsequent plan years, you may obtain an electronic copy of the plan's annual report by going to www.efast.dol.gov and using the Form 5500 search function. Or you may obtain a copy of the Plan's annual report by making a written request to the plan administrator. Individual information, such as the amount of your accrued benefit under the plan, is not contained in the annual report. If you are seeking information regarding your benefits under the plan, contact the plan administrator identified below under "Where To Get More Information."

Summary of Rules Governing Plans in Reorganization and Insolvent Plans

Federal law has a number of special rules that apply to financially troubled multiemployer plans. The plan administrator is required by law to include a summary of these rules in the annual funding notice. Under so-called "plan reorganization rules," a plan with adverse financial experience may need to increase required contributions and may, under certain circumstances, reduce benefits that are not eligible for the PBGC's guarantee (generally, benefits that have been in effect for less than 60 months). If a plan is in reorganization status, it must provide notification that the plan is in reorganization status and that, if contributions are not increased, accrued benefits under the plan may be reduced or an excise tax may be imposed (or both). The plan is required to furnish this notification to each contributing employer and the labor organization.

Despite the special plan reorganization rules, a plan in reorganization could become insolvent. A plan is insolvent for a plan year if its available financial resources are not sufficient to pay benefits when due for the plan year. An insolvent plan must reduce benefit payments to the highest level that can be paid from the plan's available financial resources. If such resources are not enough to pay benefits at a level specified by law (see Benefit Payments Guaranteed by the PBGC, below), the plan must apply to the PBGC for financial assistance. The PBGC will loan the plan the amount necessary to pay benefits at the guaranteed level. Reduced benefits may be restored if the plan's financial condition improves.

A plan that becomes insolvent must provide prompt notification of its status to participants and beneficiaries, contributing employers, labor unions representing participants, and PBGC. In addition, participants and beneficiaries also must receive information regarding whether, and how, their benefits will be reduced or affected, including loss of a lump sum option. This information will be provided for each year the plan is insolvent.

Benefit Payments Guaranteed by the PBGC

The maximum benefit that the PBGC guarantees is set by law. Only benefits that you have earned a right to receive and that cannot be forfeited (called vested benefits) are guaranteed. Specifically, the PBGC guarantees a monthly benefit payment equal to 100 percent of the first $11 of the Plan's monthly benefit accrual rate, plus 75 percent of the next $33 of the accrual rate, times each year of credited service. The PBGC's maximum guarantee, therefore, is $35.75 per month times a participant's years of credited service.

Example 1: If a participant with 10 years of credited service has an accrued monthly benefit of $500, the accrual rate for purposes of determining the PBGC guarantee would be determined by dividing the monthly benefit by the participant's years of service ($500/10), which equals $50. The guaranteed amount for a $50 monthly accrual rate is equal to the sum of $11 plus $24.75 (.75 x $33), or $35.75. Thus, the participant's guaranteed monthly benefit is $357.50 ($35.75 x 10).

Example 2: If the participant in Example 1 has an accrued monthly benefit of $200, the accrual rate for purposes of determining the guarantee would be $20 (or $200/10). The guaranteed amount for a $20 monthly accrual rate is equal to the sum of $11 plus $6.75 (.75 x $9), or $17.75. Thus, the participant's guaranteed monthly benefit would be $177.50 ($17.75 x 10).

The PBGC guarantees pension benefits payable at normal retirement age and some early retirement benefits. In calculating a person's monthly payment, the PBGC will disregard any benefit increases that were made under the plan within 60 months before the earlier of the plan's termination or insolvency (or benefits that were in effect for less than 60 months at the time of termination or insolvency). Similarly, the PBGC does not guarantee pre-retirement death benefits to a spouse or beneficiary (e.g., a qualified pre-retirement survivor annuity) if the participant dies after the plan terminates, benefits above the normal retirement benefit, disability benefits not in pay status, or non-pension benefits, such as health insurance, life insurance, death benefits, vacation pay, or severance pay.

Where to Get More Information

For more information about this notice, you may contact Mr. Arthur Drechsler, Executive Director, Equity-League Pension Trust Fund, 165 West 46th St, 14th Floor, New York, NY 10036, (212) 869-9380, or (800) 344-5220 toll free outside NYC, or pension@equityleague.org. For identification purposes, the official plan number is 001 and the Plan sponsor's employer identification number or "EIN" is 13-6696817. For more information about the PBGC and benefit guarantees, go to PBGC's website, www.pbgc.gov, or call PBGC toll-free at 1-800-400-7242 (TTY/TDD users may call the Federal relay service toll free at 1-800-877-8339 and ask to be connected to 1-800-400-7242).

Equity-League Pension, Health and 401(k) Funds
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NOW PLAYING

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.