NOW PLAYING

EQUITY–LEAGUE

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

SPRING 2011

Welcome to Our Spring 2011 Issue of *Now Playing*

The early part of 2011 saw some major changes in the Equity-League Funds and you'll learn about them in this issue of *Now Playing*. There are also some old issues that continue to be of concern, so we want to address them again. Here is a preview of what we'll cover in this issue.

Taking the Annual Dollar Limits Off Chiropractic Care, Physical Therapy and Nutritional Forumulas

Effective April 1, 2011, the annual maximum for those benefits has been removed.

You may recall that on January 1, 2010 the Health Fund placed an annual maximum of $4000 on Chiropractic and Physical Therapy treatments. This was done primarily because the Fund was experiencing very high costs in these areas, and our health benefit administrative services provider (CIGNA) did not have any significant ability to manage chiropractic and physical therapy care. However, that has changed. CIGNA has developed a utilization management capability in both of these areas, so the Trustees are comfortable that with CIGNA and their affiliated organizations overseeing the utilization of these benefits, dollar maximums are no longer needed. Therefore, effective April 1, 2011, the annual maximum for those benefits has been removed.

The existing annual maximum on nutritional formulas of $2500 has also been removed. While these formulas are only available to those with very special nutritional needs, to the extent they are medically necessary, they will be covered with no annual dollar limits effective June 1, 2011.

"I Want and Have a Right to Appeal!"

Indeed you do have a right to appeal decisions made about your benefits.

Indeed you do have a right to appeal decisions made about your benefits under the Equity-League Pension, Health and 401(k) Trust Funds (respectively the "Pension Fund," the "Health Fund" and the "401(k) Fund" and collectively referred to as the "Fund(s)"). However, that process may sometimes seem to be confusing. We thought we'd try to give you a reasonably simple explanation of the appeals process for each of the Funds, and its general purposes through a series of frequenrtly asked questions (FAQs). We hope that once you have read those you will be better able to assess whether an appeal makes sense for your case. Of course, in the end, you have a right to appeal in accordance with the applicable appeal procedures for the Funds, and the final determination of whether to take that avenue is ultimately yours.

What is an Appeal?

An appeal is essentially a challenge to a decision that has been made regarding your benefits.

Pension Fund Appeals: For the Pension Fund, this generally means you have requested a pension benefit, your request has been denied by the Fund Office and you wish to challenge that decision. Decisions on Pension Fund appeals are made by the Administrative Committee of the Pension and Health Funds ("Administrative Committee").

401(k) Fund Appeals: For the 401(k) Fund, this generally means you have requested the distribution of some or all of the funds in your 401(k) account, that request has been denied by the Fund Office, and you wish to challenge that decision. Decisions regarding these appeals are made by the Board of Trustees ("Trustees") of the 401(k) Fund.

Health Fund Appeals: For the Health Fund, appeals fall into one of two categories, depending on the benefit that is involved. The first category of appeal arises when your appeal concerns a hospital, medical, dental or prescription drug treatment for which you are seeking advance approval (all non-emergency hospital stays must be approved in advance of admission, and CIGNA or your HMO does not approve the admission), or , you have presented a claim for one of these kinds of treatments you have already received, and CIGNA (or your HMO) has denied that claim. Appeals of such decisions must be made to CIGNA or your HMO. Each of these entities permits appeals at two levels. Your first appeal is termed

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Right to Appeal

"level one" and is considered by an appeals committee at CIGNA, or your HMO. If that appeal is denied, you have the right to a second level appeal (which is heard by a different committee at CIGNA or your HMO). The details of how to submit appeals of this kind are explained in the Summary Plan Description ("SPD") of the Health Fund, which is available on request, or online at: *www.equityleague.org* (click on Health).

The second category of health appeal occurs when either: a) a Vision or Supplemental Workers Compensation claim has been denied, b) you have been denied health benefits because of lack of eligibility, or c) CIGNA or your HMO has denied a second level appeal that you have made to them. Appeals in this category are presented to the Administrative Committee for their consideration and determination.

FAQs Regarding Appeals Made to the Administrative Committee or the Trustees of the 401(k) Fund

How can I appeal?

You must first make a written request to the Executive Director. You may send it to the Executive Director at Fund Office by traditional mail, e-mail or fax. Please remember there may be limits on your time to make such a request; please consult the SPD for the applicable Fund as to the deadline to make a claim. We also recommend that you keep proof of the date that you submitted your request. For example, you should retain a copy of the email or fax confirmation page, or certified mail receipt with regard to the delivery of such a request. Upon receipt of your request, the Executive Director will review it to determine whether it can be approved by him, based on the merits, and any proof attached to your request in relation to the applicable plan rules and policies of the Fund at issue. If the Executive Director decides to approve your request, there is nothing further you need to do. However, the Fund Office is required to strictly enforce the existing benefits, rules and procedures of the Funds, so the Executive Director will not typically be permitted to grant your request if it requires the waiver of existing benefits, policies or procedures of the Funds.

If your request is denied, you will be offered the right to appeal to the Trustees of the applicable Fund. Again, there are deadlines to request an appeal. ou should consult the Summary Plan Description of the applicable Fund and retain proof of the date you request an appeal. You must appeal in writing and should include any information you wish the Trustees to consider. You may also ask (in writing) that your initial request to the Executive Director be forwarded to the Trustees as your appeal. The Executive Director will forward your appeal to the Administrative Committee/401(k) Fund Trustees.

An appeal of a second level appeal that has been denied by CIGNA or an HMO will go directly to the Administrative Committee; you do not have to first make a request to the Executive Director and await his decision. You should mail, fax or email your appeal to the Fund Office.

When will my appeal be heard?

The Administrative Committee (and the Trustees of the 401(k) Fund) typically meet once per calendar quarter. If your appeal is received at least 30 days in advance of a scheduled meeting, it will be heard at that upcoming meeting. If it is received less than 30 days before an upcoming meeting, it will be heard at the next regularly scheduled meeting. The reason for this requirement is that your appeal may need to be researched by the Fund Office and reviewed by Fund Counsel before it is presented to the Administrative Committee/ Trustees of the 401(k) Fund. In addition, the respective appeals are sent to the Administrative Committee (or the Trustees of the 401(k)

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You must first make a written request to the Executive Director.

If your request is denied, you will be offered the right to appeal to the Trustees.

Right to Appeal

All appeals are presented…without any identifying information.

Fund) well ahead of the meeting for which such appeals are scheduled to be heard, so that they can review the appeal prior to the meeting, and pose questions to the Fund Office and/or Fund Counsel, as they see fit, in order to give the appeal full consideration.

Urgent Medical Appeals

Naturally, whenever you face a life threatening health situation, you should seek medical attention immediately. If payment for your emergency treatment is denied by CIGNA/HMO that decision can always be appealed. There may be occasions in which you may need medical treatment on a non-emergency but urgent basis, such that a delay in a benefit determination could jeopardize your life or health. In such a case, you may be eligible for an Urgent Care Appeal. These kinds of appeals fall into one of two categories with respect to timing.

When your appeal involves an immediate threat to your life, health, or maintaining or recovering your ability to function, and advance approval of the service is required, the Administrative Committee, or its designee, will review any voluntary appeal from a denial by CIGNA within 72 hours after receipt of your initial appeal. When you are appealing directly to the Administrative Committee (Vision and Eligibility) and pre-approval is required, the Administrative Committee's, or its designee's, review will be completed and you will be notified of its decision within 15 days after receipt of your request for review. A more detailed description of the foregoing rules is explained in the Health Fund's SPD; please refer to this SPD for questions that you may have with regard to claims of this nature.

It is impossible to predict the outcome of an appeal. But certain kinds of appeals are more likely to be granted than others.

Can I present my appeal in person?

All appeals are presented to the Administrative Committee (or the Trustees of the 401(k) Fund, as the case may be) without any identifying information as to the appellant/participant who is the subject of the appeal. This redaction procedure ensures that each appeal is considered solely on its merits; and affords the surest way of providing for an impartial decision with respect to the appeal. For the same reason, appellants are not permitted to appear or argue their appeal before the Administrative Committee (or the Trustees of the 401(k) Fund, as the case may be). Instead, as part of the appeal process, appellants are encouraged to present their cases in a written format with supporting documents for consideration (there are no limitations placed on the length of written submissions).

How likely is it that my appeal will be granted?

Each appeal is considered on its own merits, and in the context of applicable Plan rules, prior appeals and benefit interpretations. Consequently, it is impossible to predict the outcome of an appeal. But certain kinds of appeals are more likely to be granted than others, such as appeals that relate to extenuating circumstances versus appeals based upon overturning an existing or longstanding plan rule or policy.

For instance, proof (such as receipt of mailing) that the required copayment to the Health Fund was made well in advance of the applicable deadline could be a basis for granting coverage, even though the Fund Office's records did not reflect that actual payment was received on a timely basis.

In contrast, appellants who have argued they are "on the road" and, as a result, did not receive their bill for premium payments to the Health Fund, have not been successful with their appeals for the acceptance of late premium payments. The Administrative Committee regards being on the road as very much a part of an actor's life and, therefore, does not view it as an extenuating circumstance. Instead, the expectation is that actors who are travel-

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ing will make the necessary arrangements to receive their mail and to pay their Health Fund premiums on a timely basis. Please remember that Health Fund premiums may be paid automatically by the Actors Federal Credit Union, subject to your authorization. Also, if you provide the Fund Office with your up-to-date contact information, it can send email and text message reminders of the premium payment.

As mentioned above, appeals that would require a change in plan benefits cannot be granted. Although the Trustees may occasionally change Plan benefits, they would first need to consider the cost and feasibility of any change. For example, an appellant requested that 2 unused weeks of work from a prior year be used, in combination with 10 weeks from the current year, to earn coverage under the Health Fund, which requires at least 12 weeks of work for six (6) months of coverage (20 weeks for a full year of coverage). The appeal was denied because the appellant had clearly not earned the requisite work weeks during any of the defined accumulation periods set forth under the SPD to the Health Fund.

The Trustees did not agree to change the eligibility rules of Health Fund at that time. Generally speaking, the Health Fund operates on the basis of stable rules that permit financial projections to be made and financial security to be assured. If an appellant was permitted to secure coverage with less than the requisite weeks of work, then all others who were similarly situated could have the expectation of receiving a similar benefit improvement. For obvious reasons, such an improvement was not contemplated by the Health Fund and could significantly impact its financial stability—particularly without corresponding contribution increases or benefit reductions or changes in some other area. For these reasons, appeals of this nature are routinely not granted by the Administrative Committee.

When and how will I find out whether my appeal was granted?

A letter providing the results of your appeal will be mailed to you within five (5) calendar days of the meeting of the Administrative Committee/Trustees of the 401(k) Fund, at which a final determination on the appeal was made. This letter inform you of such decision, the reason(s) for that decision and describe any additional steps that you make take with respect to this matter including, but not limited to, your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

A letter providing the results of your appeal will be mailed to you within five (5) calendar days.

What happens if my appeal is successful?

If your appeal is granted, generally speaking, every effort will be made to put you in the position you would have been in had your claim not been denied in the first instance. For example, if you were denied health coverage on January 1, 2011, and your appeal was granted on April 1, 2011, coverage would typically be backdated to January 1st. Similarly, if the pension you wished to have started on January 1, 2011 was denied, but your pension was subsequently approved under an appeal decided in March 2011, the Pension Fund would typically commence your pension benefits effective as of January 1st of 2011, so that you would receive pension payments as of that date.

What if my Appeal was denied?

Generally speaking, a decision by the Administrative Committee/ Trustees of the 401(k) Fund regarding an appeal is final. There are no additional appeals that can be made after such determination. If material new facts not available at the time of the appeal was considered by the Administrative Committee (or the Trustees of the 401(k) Fund) are subsequently discovered by you, a new appeal may be made. In the absence of any new material informa-

Generally speaking, a decision by the Administrative Committee/ Trustees of the 401(k) Fund regarding an appeal is final.

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Right to Appeal

By law, half the Trustees for each of the Funds are appointed by the Union (Actors' Equity Association) and the other half are appointed by the employers who make contributions to the Funds.

The Funds will not impose fees or costs on you (or your representative) should you choose to invoke the optional appeals process.

tion, an appeal will not be heard again. After you have completely exhausted your rights under the Fund's appeal procedures, as mentioned above, you have the right to bring a civil action under Section 502(a) of the ERISA. Please consult the SPD of the applicable Fund for more information about your rights under ERISA.

Should I buy other health coverage if I'm waiting for my appeal for health coverage to be heard?

Everyone's circumstances are different and it is impossible to give general advice in this area, but you should be aware of the risks of going uncovered for an extended period. Apart from the obvious risk of not having coverage when you need it, there are several other risks that you are exposed to if you let coverage lapse. First, if you are offered COBRA coverage and do not take that coverage within the time limits described in your enrollment offer, you will irrevocably lose the right to that coverage, unless you first earn coverage through employment again. Second, if you are not covered for at least 63 days, after losing health coverage you may be subject to pre-existing condition limitations if you do subsequently secure coverage elsewhere. Consequently, allowing coverage to lapse is a very serious decision.

Who are the Trustees?

By law, half the Trustees for each of the Funds are appointed by the Union (Actors' Equity Association) and the other half are appointed by the employers who make contributions to the Funds. Therefore, if an appeal is denied, it is not because "your Union did not support you" but rather because the Trustees, who agree to serve only with the overall benefit of all plan participants in mind, have made a decision on the basis of the law and the nature, policies and procedures of the Fund in question. The Funds are separate legal entities from the Union. The Trustees receive no compensation from the Funds for their services as Trustees.

Is there any charge to me for making an appeal?

The Funds will not impose fees or costs on you (or your representative) should you choose to invoke the optional appeals process.

Do You Have Any Further Questions?

If you have any questions, please call the Fund Office. To request an appeal, (except a first or second level appeal of a decision by CIGNA or your HMO),contact the Trustees at:

Board of Trustees
c/o Executive Director
Equity-League Pension, Health and 401(k) Trust Funds
165 West 46th Street, 14th Floor
New York, NY 10036-2582

In NYC: 1-212-869-9380
Outside NYC: 1-800-344-5220

Important Note: The above FAQs are intended as an easy-to-understand brief description of certain features of the appeal procedures for each of the Funds. While every effort has been made to make the foregoing descriptions as accurate as possible, these FAQs cannot contain a full restatement of the respective plan terms and provisions of the Funds. If any conflict should arise between these FAQs and the plan documents to the Funds, the terms of the plan documents for each of the Funds will control. In addition, a fuller description of the foregoing rules is explained in the applicable SPD to the Funds, a copy of which is available free of charge from the Fund Office during normal business hours, or at the following website: *www.equityleague.org.*

Dramatically Improved Flexibility in Timing Your 401(k) Distributions

Those of you who are participating in the 401(k) Plan know that you may withdraw your funds for a limited number of reasons without penalty. The two most common examples of this are withdrawals when you reach normal retirement age (59 ½ or older as defined by our plan) or become eligible for disability benefits. Up until now, you had to withdraw your monies from the 401(K) Fund either by taking all of your money and closing your account, or making periodic applications to withdraw funds.

Now, if you become eligible to withdraw funds as a result of reaching normal retirement age, or becoming disabled, you have two new options that enable you to activate automatic periodic payments to you: arrange for Installment Payments, or, purchase an Annuity from Mass Mutual. You could have always withdrawn your money and purchased an individual annuity from Mass Mutual, or another insurer, and can still do that. But individual annuities can be hard to understand and may require a significant "additional cost" (e.g., commissions) paid to the entity that sells you the annuity. You can avoid some of those problems by purchasing an immediate annuity from Mass Mutual.

Installment Options for All Participants and Beneficiaries

Effective immediately, you (your Beneficiary if you are no longer living) may elect the following installment options (scheduled payments for 401(k) normal retirement/disability distributions):

Fixed Amount Installment - A Fixed Amount Installment is an amount fixed by you (or your Beneficiary) and payable every month, calendar quarter, semi-annually, or annually. A Fixed Amount Installment Option provides for payment in that fixed amount until the Account Balance is exhausted.

Fixed Period Installment - A Fixed Period Installment is an amount paid every month, calendar quarter, semi-annually, or annually, as elected by you (or your Beneficiary). The amount of each payment shall be the Account Balance divided by the number of remaining payments for the period elected and shall be paid until the Account Balance is exhausted.

Lifetime Installment - A Lifetime Installment is paid over the period estimated to be your (or your Beneficiary's) life expectancy, as determined by your (or your Beneficiary's) Single Life Expectancy factor under the IRS table ("Life Expectancy"). Such payments will be paid every month, calendar quarter, semi-annually, or annually, as elected. The amount of each payment shall be recalculated each time by dividing your (or your Beneficiary's) Account Balance by your (your Beneficiary is) Life Expectancy at the time of the payment and shall continue until the Account Balance is exhausted.

Installment options are a convenient way to establish periodic payments, but neither the amount or length of payments are guaranteed over the long run. When your money runs out, it runs out. In contrast, annuities can provide guaranteed income for a specified period, for a price.

The Annuity Option

Effective immediately, you have an annuity option as well. An annuity offers a second option for those who wish to receive periodic payments. The advantage of an annuity is that the payments made under the annuity are guaranteed. When the annuity is purchased, you are assured a period certain for a specific amount (the guarantee period ranges from five years, to your life and that of your beneficiary, depending on the specific type of annuity you choose).

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Now, if you become eligible to withdraw funds as a result of reaching normal retirement age, or becoming disabled, you have two new options that enable you to activate automatic periodic payments.

The advantage of an annuity is that the payments made under the annuity are guaranteed.

Timing Your 401(k) Distributions

We want to be clear from the outset that an annuity through Mass Mutual is only one option.

The biggest downside of purchasing an annuity under the Fund's 401(k) plan (apart from having to pay a fee of $175 to Mass Mutual to purchase it) is that you no longer have control of the lump sum that you used to purchase the annuity. That now belongs to the insurance company.

We want to be clear from the outset that an annuity through Mass Mutual is only one option. You should consider other annuity options and other approaches to handling your 401(k) distribution before you decide to purchase an annuity from Mass Mutual or any other insurer.

Annuity Options for Unmarried Participants, Beneficiaries and Married Participants with Spousal Consent

If you are married, the only annuity option available is what is known as a Joint and Survivor Annuity.

Single Life Annuity with a 5 Year Guarantee – You may elect a Single Life Annuity with a 5 Year Guarantee if you are not married, or if you are married and have your spouse's consent. The Single Life Annuity is the option that provides you with the highest monthly payments during your lifetime.

A Single Life Annuity with a 5 Year Guarantee means an annuity payable over your lifetime, but with a guarantee of a minimum of 60 monthly payments. If you die before receiving at least 60 payments, your Beneficiary will receive the remaining monthly payments until 60 have been made by the annuity. The Single Life Annuity with a 5 Year Guarantee benefit will be the amount of monthly benefits that can be purchased in that form from an insurance company (currently Mass Mutual) with your Account Balance at the time payment is due. You may also choose to elect to purchase an Annuity with only part of your Account Balance.

Joint and Survivor Annuity with Non-Spouse Beneficiary – If you are single (or you are married and your spouse consents), you may also chose a Joint and Survivor Annuity with a non-spouse beneficiary, described in the next section.

Annuity Options for All Participants

If you are married, the only annuity option available is what is known as a Joint and Survivor Annuity (an annuity that pays a monthly amount to you for your life, and then to your spouse for his or her lifetime upon your death, (if he or she survives you). You may elect a different annuity option (either the Single Life Annuity, or a survivor annuity with a non-spouse beneficiary) only if your spouse consents in accordance with the Plan's rules. You may not revoke a Joint and Survivor election once payments have begun, nor will your benefits increase if you divorce or your spouse (or non-spouse beneficiary) dies.

50% Joint and Survivor Annuity – A 50% Joint and Survivor Annuity means a monthly annuity payment to you for the life, with a monthly payment of 50% of that amount to your spouse (or non-spouse beneficiary) upon your death if he or she survives you. The 50% Joint and Survivor Annuity benefit will be the amount of monthly benefits that can be purchased in that form from an insurance company (currently Mass Mutual) with your Account Balance at the time payment is due. You may also choose to elect to purchase an Annuity with only part of your Account Balance.

75% Joint and Survivor Annuity – A 75% Joint and Survivor Annuity means a monthly annuity payment to you for your life, with a monthly payment to your spouse (or non-spouse beneficiary) equal to 75% of that amount upon your death (if he or she survives you) The 75% Joint and Survivor Annuity benefit will be the amount of monthly benefits that can be purchased in that form from an insurance company (currently Mass Mutual) with your Account Balance at the time payment is

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Timing Your 401(k) Distributions

due. You may also choose to elect to purchase an Annuity with only part of your Account Balance.

100% Joint and Survivor Annuity – A 100% Joint and Survivor Annuity means a monthly annuity payment to you for life, with a payment of 100% of that amount to your spouse (or non-spouse beneficiary) upon your death if he or she survives you. The 100% Joint and Survivor Annuity benefit will be the amount of monthly benefits that can be purchased in that form from an insurance company (currently Mass Mutual) with your Account Balance at the time payment is due. You may also choose to elect to purchase an Annuity with only part of your Account Balance.

The Penalty for Permitting Dental Coverage to Lapse

Dental coverage is offered to all participants who qualify for Health Fund coverage through employment. However, dental coverage is different from medical and vision coverage in two important ways. First, there is the bad news – participants must pay the full cost of dental coverage, for themselves and their dependents. Second, there is the good news - dental coverage may be continued indefinitely, even after eligibility for medical coverage and COBRA benefits are exhausted, as long as dental premiums are fully paid on a timely basis. However, if you stop paying your dental premiums and lose coverage as a result, no COBRA coverage is available and, when you decide to resume your dental coverage, there is a penalty applicable for failure to maintain your enrollment.

Because dental coverage is fully paid for by the participant, it is subject to what's referred to, in insurance lingo, as "adverse selection". That means people who expect to use the coverage tend to buy it more often than do people who have no particular plans to access dental care. It also means that people who have exhausted their annual maximum, or completed their expected treatments, have a greater tendency to drop the coverage. This presents a problem for other participants who remain in the plan continuously. To the extent that some plan participants exhibit adverse selection against the plan, those remaining members must pay more, and this has been occurring.

Therefore, to combat this phenomena, the Trustees decided that, beginning with the Open Enrollment Period of 2011, anyone who had discontinued dental coverage before or during 2010 would be required to pay a penalty equal to the premiums that would have been paid had coverage continued throughout 2010.

This practice has now been extended to all periods of re-enrollment in the dental program after coverage has been lapsed for lack of premium payment. For instance, if you qualify for coverage on July 1, 2011 and had prior eligibility for dental coverage but dropped it, you will be required to make a penalty payment equal to the premiums that would have been paid had you continued coverage (to a maximum of 12 months). So in this example, if you had prior dental coverage but let it lapse on June 30, 2010, you will be required make a penalty payment equal to 12 months of dental premiums before dental coverage can commence on July 1, 2011. In contrast, if you lapsed coverage in April of 2011 and wanted to start coverage again on July 1, you would only be required to pay for three months of missed coverage.

Given this new penalty, those who have dental coverage may want to think twice before letting it lapse.

Dental coverage is different from medical and vision coverage in two important ways.

Given this new penalty, those who have dental coverage may want to think twice before letting it lapse.

Elimination of the Set-Aside Fund

Over time, the use of this benefit has declined to the point where the Fund has not seen a claim of this type in more than 10 years.

Several decades ago, when the Health Fund added HMOs as an option, many had trepidations about selecting an HMO and then going on the road. HMOs typically cover only emergency care when one is outside of the geographical "service area" covered by the HMO. The set-aside fund was established to cover some very limited expenses when one is outside his or her HMO's service area. Specifically, the set aside Fund covered one office visit to a physician. Over time, the use of this benefit has declined to the point where the Fund has not seen a claim of this type in more than 10 years. Consequently, this benefit has been eliminated by the Trustees.

A Reminder About Critical Premium Due Dates – Don't Lose Your Health Coverage

We have seen many instances in which employees believed they would earn additional weeks but that did not come to pass.

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

Due Dates for the $100 Quarterly Prtemium for Employee Coverage

Eligibility Does Not Constitute Coverage — You Must Also Make a Timely $100 Contribution

When you first become eligible for medical/vision coverage, we'll notify you by mail. While you may have worked the weeks needed to become eligible for employee coverage, **you will not actually be covered unless you make a $100 quarterly contribution to the Fund on a timely basis.** The Fund does not require that you complete complicated forms in order to obtain the coverage

that you are eligible for, but it does require that you make a $100 contribution on a timely basis in order for your coverage to begin (and continue). The chart below shows annual contribution due dates for the $100 quarterly contribution.

While the $100 payment helps to keep the Fund financially sound, it constitutes only a very small portion of what coverage actually costs the Fund. But the payment also constitutes a way for you to signify that you wish to enact and maintain the coverage for which you have become eligible. Why is this important? Because you may not wish to activate or maintain coverage for a number of reasons. For example, you may want to forgo coverage altogether because you have secured it through another source, such as your spouse's employer-sponsored coverage. Or you may want to defer coverage, so that you can use your weeks at a later date when some other coverage you may have is no longer available. Or you may want to forgo six (6) months of coverage because you expect you'll earn 12 months of coverage by the end of the next quarter. While we do not encourage this, because we have seen many instances in which employees believed they would earn additional weeks but that did not come to pass (e.g., an illness or injury prevented work for a time, or a show closed earlier than expected), you nonetheless have a right to make such a choice.

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Critical Premium Due Dates

If the Fund does not receive your $100 contribution on a timely basis for the first quarter in which you qualify (or re-qualify for coverage), the plan will assume that you do not wish to have coverage for the entire Benefit Period in question. Therefore, the decision you make regarding your payment can have far reaching implications. For instance, you may not change your mind and begin paying for coverage the next quarter, unless you earned coverage eligibility for that quarter on the basis of the following accumulation period, or satisfy one of the special eligibility rules discussed in the Plan's Summary Plan Description (such as losing coverage elsewhere).

For example, if you earned 12 months of coverage eligibility beginning on July 1, 2011, and you do not pay your premium by June 30, 2011 for at least the first quarter of the 12 months of coverage you were offered, beginning on July 1, 2011, you will be forfeiting an entire year's coverage, unless you re-qualify in a succeeding accumulation period. To continue the example, let us assume you worked for 12 weeks in the second quarter of 2010, six (6) weeks in the third quarter of 2010 and had no covered employment during the last quarter of 2010 or the first quarter of 2011. If you decline coverage on July 1, 2011, you will not be permitted to pay for coverage beginning on October 1, because you declined the offer to pay for the first quarter for which you earned eligibility and you will not qualify for coverage again when your weeks are tested after June of 2011 has finished, because the 12 weeks you worked in the second quarter of 2010 will no longer be available when the accumulation periods that ended on June 30 of 2011 and later are examined. Even if you work 12 consecutive weeks in the third quarter of 2011, you will not be offered coverage again until January 1, 2012, because that accumulation period will not be considered until the test for coverage beginning on January 1, 2012 is performed. Therefore, it is very important that you make your coverage decision carefully.

The table below shows the $100 quarterly premium contribution schedule — **please note the premium due dates as they are critical to assuring that you do not lose coverage.**

The decision you make regarding your payment can have far reaching implications.

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

The table (left) shows the $100 quarterly premium contribution schedule…critical to assuring that you do not lose coverage.

* Very Important Note: All of the above **due dates are for actual receipt of a valid payment (e.g. not a "bad check").** Therefore, if you have any doubt about whether there are sufficient funds in your account to cover your check, you may want to consider paying via a credit card, through the Fund's website, www.equityleague.org. If you decide to send your payment, please use a method that guarantees delivery and/or provides proof of mailing.

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Critical Premium Due Dates

Any payment received more than 31 days after the coverage period begins will not be accepted under any circumstances.

The Fund Office is not able to produce monthly bills, so no written notice of these premiums due will be sent.

The reason for an initial "Due Date" (shown in Column Two above) being one month before coverage begins is to assure that coverage is in place in our records well before the start of coverage.

The "Last Date to Assure Timely Coverage" means that if we receive your payment by that date we assure that CIGNA's records (or those of any HMO you may be eligible for coverage with) will reflect coverage accurately when you present your ID card at the doctor's office, pharmacy or hospital. If your payment is received after that date, we cannot assure that your ID card will not be rejected by a provider as of the first day coverage begins (e.g., if you pay after December 15 and present your card to your physician an January 1, the doctor may well say that you have no coverage - this will eventually be rectified if payment is received before the last date by which coverage may be activated (with a major penalty) for the quarter at issue, but you may well be turned away from treatment until the records are corrected).

The "Last Date to Pay and Avoid a Penalty" is the last date that payment can be received without your incurring a late penalty. A payment made at this late date will still mean that your coverage will not be reflected in CIGNA's records when you present your ID card to a health care provider (CIGNA's records will not be accurate until about two (2) weeks after we received payment), but coverage will be secured.

Finally, The "Last Date That Coverage Can Be Activated With a Major Penalty" is the last date on which you can secure coverage at all, but with two major penalties. First, you will be required to pay an extra $100. In addition, your coverage will not begin until the day payment is received, so you will have lost some coverage to which you had been eligible. In addition, it will still take about two (2) weeks for coverage to be reflected in CIGNA's records, though it will be backdated to the date that payment was received. Any payment received more than 31 days after the coverage period begins will not be accepted under any circumstances. Your opportunity for coverage will be irrevocably lost. You will not be offered coverage again unless your work weeks earn you eligibility once again.

Due Dates for All Other Premiums

Please remember that the above applies only to the $100 contribution for health coverage that is earned through employment (which covers only medical care and vision care). **All other premiums** (i.e., for Dental coverage, for Dependent coverage, for COBRA coverage, for Vested Beyond COBRA — for those with 10 Years of Vested Pension Service — and for Medicare Supplemental Coverage) **are due no later than the end of the month for which coverage is being provided.** For instance, premiums for dental and dependent coverage, as well as for COBRA coverage, are due no later than January 31 for January coverage. However, if you do pay that late, your records will show that you have no coverage for the month of January, at least until two weeks into February (the time it takes to record your payment in our system and notify CIGNA or the HMO that you are in fact covered). If you want to assure that your records always show that your coverage is in place, you need to assure that the Fund Office receives your payment at least two weeks before the month begins (in this example, by December 15). The Fund Office is not able to produce monthly bills, **so no written notice of these premiums due will be sent**. It is your responsibility to assure that your payments are kept up-to-date. Remember that **if you miss a payment for any of the voluntary coverages, your coverage will be irrevocably lost**, unless you earn eligibility through employment once again.

Help Us Remind You that Your Premium is Due, Have the Credit Union Pay Automatically for You, or Pay in Advance to Avoid Losing Coverage

Quarterly $100 Payments for Health Coverage

Remember that, with regard to any health coverage you become eligible for as a result of working in covered employment, you must make a $100 quarterly payment before the beginning of each calendar quarter (i.e., by March 31, June 30, September 30 and December 31) in order for you to actually receive health coverage for that following quarter. The Fund Office will mail a bill and a separate reminder notice to the mailing address we have on file for you. If we have an e-mail address for you, we will also remind you of the payment due via e-mail. We can even remind you of your $100 payment via a text message, if we have your current mobile phone number. But in this latter case, you must give us permission to send you text messages, because such messages can have a cost from your wireless carrier (there is no charge from the Fund Office for such messages).

Reminder of Monthly Premiums, Such as for COBRA Coverage

While health coverage earned through employment must be paid for on a quarterly basis, certain other coverages offered by the Health Fund can be paid for on a monthly basis. However, the Fund Office does not currently have the capability to bill monthly for these coverages.

However, you can now elect to receive text message reminders that health care premiums are due. Send an email to *textme@equityleague.org* and include your cell phone number and Actors' Equity member number to sign up for text message reminders.

Please be aware that while it does not cost you anything to sign up for text messages, your carrier's standard text message rates apply. If you sign up, reminders will be scheduled for texting to you, both for your $100 premium due and any monthly premium due. However, we cannot be responsible for messages not transmitted or received (though we will make every reasonable effort to assure that does not happen). Please note that some text messages may be generated even if you have paid, so please ignore them if you are sure we received your payment.1

Automated Premium Payments Via the AFCU

Many are not aware that the Health Fund has agreed to accept direct payments from members' Actors Federal Credit Union (AFCU) accounts for the following:

- $100 quarterly health care premiums
- COBRA premiums
- Premiums for all self-pay coverage.

You can also authorize the AFCU to make a payment for you, or pay for the full number of quarters for which you have already earned eligibility at any time.

If you have an AFCU account, you can't beat direct payment for convenience. But what's even better is that you get overdraft protection up to $750. That is, if you don't have enough in your account to make the required payment(s), AFCU will make up the difference through their Courtesy Pay Program. To join the Credit Union, or to get a direct payment authorization form, stop by the Credit Union's New York or Los Angeles offices or go to *www.actorsfcu.com* and click on "Services," then "Special Offers." You can also reach Actors FCU by phone at 1-800-2-ACTORS.

You can now elect to receive text message reminders that health care premiums are due.

The Health Fund has agreed to accept direct payments from members' Actors Federal Credit Union (AFCU)

Reminder – Health Premiums Are Not Refundable Once Coverage Commences

If a month has begun, you cannot receive a refund of that premium for that month, even if you make a mistake or have made no claims.

We often get request for refunds of health premiums. Such refunds, including refunds for partial periods, are not available once coverage begins. For instance, you cannot receive a refund of your $100 contribution for quarterly health insurance once a quarter has begun. Similarly, if a month has begun, you cannot receive a refund of that premium for that month, even if you make a mistake or have made no claims.

Apart from the administrative cost of making refunds, the primary reason for this policy is that if it were not in place, some people would regularly wait until a coverage period was over, and request a refund if they made no claims. Such behavior could have a catastrophic financial impact on the Health Fund, since funds received and already counted on by the Fund for long term financial stability would be subject to return. Any insurance program relies on the fact that some people will have lower costs than others, that everyone pays a premium without knowing exactly how much in terms of claims they will incur. Some will pay premiums and have few or no claims, while others will have claims that are much larger than their payments. This sharing of risk is the essence of insurance, and permitting refunds to those who have low or no claims, undermines the entire practice.

The one exception to this rule occurs when someone has paid for several quarters (or in this case of monthly premiums, several months) in advance, and requests a refund before those future quarters (or months) begin. In such a case, a refund is available for periods that have not yet commenced.

Equity-League Funds and Actors' Equity Association (AEA) are Separate Entities

The Funds themselves are Tax-Exempt Trust Funds that are managed by Boards of Trustees; they are NOT departments of the union.

The AEA is of course the labor union representing actors and stage managers in collective bargaining with theatre producers and other employers. The AEA negotiates agreements with producers that require those producers to contribute to the Equity-League Funds to provide health, pension and 401(k) benefits to AEA members.

The Funds themselves are Tax-Exempt Trust Funds that are managed by Boards of Trustees; they are **NOT** departments of the union. Each Fund's Board of Trustees consists of Union Trustees and Employer Trustees with equal voting power. Day-to-day operations of the Equity-League Funds are performed by the Fund Office (that's us). The Funds are each not-for-profit organizations whose sole purpose is to provide benefits for participants. The Trustees, who serve without compensation from the Fund, have a fiduciary duty to act solely in the best interests of plan participants (that's you). While they're wearing their Trustee hats, the Trustees are required to put aside any partisan, Union/Management considerations and concern themselves only with the financial well-being and smooth operation of the Funds. Similarly, the one-and-only purpose of the Fund Office is to serve you by executing the decisions made by the Trustees.

The Trustees and the Fund Office work together to put contributions to the best possible use: providing benefits, paying claims and improving participants' lives. For more information about the Fund Office and how we work, contact the Fund Office directly.

CIGNA Health Status Tool

As we mentioned in the last issue of *Now Playing,* CIGNA offers many benefits to our members. One of the most useful benefits CIGNA provides for purposes of preventing illness and accidents, is CIGNA's Health Assessment™, which they offer in collaboration with the University of Michigan. It is important to note that any information you provide via the Health Assessment will be handled securely and confidentially.

The Health Assessment process is completed in three steps. First, you log into my CIGNA.com. If you have not registered in the past, you must do so in order to take the Health Assessment. Second, you must register for the My Health and Wellness Center within my CIGNA.com (you will be prompted to do so after clicking the "Take My Health Assessment Now" link on the right side of the page). These steps take only a few minutes, once registered for the My Health and Wellness Center, you may begin taking the Health Assessment.

The Health Assessment begins with a number of demographic questions, such as your age, gender and whether you are pregnant. It asks about your height, weight, waist size and various other health markers, such as your blood pressure, cholesterol level, smoking habits and the amount and kind of time you spend in a motor vehicle. This tool also has questions about your dietary and exercise habits.

There are subjective questions about your overall health, and mental and physical status. There are also specific questions about health conditions you may have and whether you are currently taking medications, or receiving other forms of care for these conditions. Questions are asked about the screening tests you've taken and then there are some gender-based questions. For example, women are asked about their menstrual cycles and whether they have been pregnant. Both men and women are asked about any plans they may have to improve their health, such as adopting an exercise program, or cutting down on smoking. Those who are currently employed are asked about the characteristics of their employment.

Upon completing the Health Assessment, which takes approximately 20 minutes, a health profile is created on the spot. You're given a wellness score, told about what you're doing that is good, and what you can do better. It then talks about your health conditions, where you are now with respect to those conditions, and what some appropriate goals might be in dealing with them. There's a section on body weight and nutrition, stress, your cholesterol level, your level of physical well being, your smoking habits, your blood pressure, your alcohol consumption, and your use of safety belts. In each case, there is a clear indicator that helps you to understand where you are and what your target should be. Finally, there is a general section on managing your health and improving your life satisfaction, which includes recommendations about tests, or vaccinations that you want to receive and various health promotion resources.

All in all, taking the Health Assessment is a very worthwhile exercise that could very well add years and better health to your life.

Any information you provide via the Health Assessment will be handled securely and confidentially.

Is Tai Chi for You?

Tai Chi is the ancient Chinese exercise and meditation program that began as a martial art. It focuses on moving the body slowly through a series of postures seamlessly, in a steady flow. A number of studies suggest that this art can improve ones general fitness and is particularly helpful in improving ones balance. The latter is critical in preventing falls as one gets older. Because Tai Chi movements are done slowly and have low impact, they are accessible to most people, regardless of their fitness level and physical limitations. Many also find the practice of Tai Chi a very useful way to reduce stress. There are many printed and video guides to this exercise regimen, as well as classes that are available across the country in places like Y's, Senior Centers and Wellness Facilities. Please take a look at this ancient but still very useful activity.

Because Tai Chi movements are done slowly and have low impact, they are accessible to most people.

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