NOW PLAYING

EQUITY – LEAGUE

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

SUMMER 2014

Welcome to Our Summer 2014 Issue of *Now Playing*

This Summer 2014 issue of *Now Playing* focuses mainly on the new self-service website modules that we are asking you to help us test. We also have quite a bit of news about a number of changes that are being made in the Health Fund.

Now you can do your own pension estimates, health eligibility checks and more—online…

Now You Can Do Your Own Pension Estimates, Health Eligibility Checks and More—Online, Anytime, Anywhere!

We'd Like to Ask for Your Help in Testing Our New Self-Service Modules

Our new self-service website modules are finally available online. We are still testing these modules and working out some of their kinks. Consequently, we would really appreciate your help in this connection. We urge you to try these modules and let us know about your experiences with them, by sending an email to us at *website@equityleague.org*.

Our initial efforts in this area have focused on three major functions: health eligibility checks, health premium payment status and pension estimates, because the Fund Office receives more inquires about these subjects than any others.

In addition, you now have the option of changing the contact information you have on file with the Fund Office online. Pensioners can also change their direct deposit information and federal tax withholding elections. In order to do this, you'll need to set up an ID and password, which you'll be able to use to access your account, even after the testing process has been completed.

Health Eligibility and Payment Status

Among the questions we hear most often from Fund participants are questions about health eligibility. Participants want to know "Will I qualify for 12 months of coverage on January 1? What about March 1? How many weeks did I earn in a given 12-month accumulation period and how many have I used?"

These questions and others are answered with text and graphics on the new Health Eligibility module on our website. You can use that function to look at eligibility for any 12-calendar-month accumulation period you like. You can pull up a screen that will show, by month and by week, your weeks earned. Your weeks earned but not used appear in green. Weeks earned but already used for coverage appear in red, and weeks for which no health contributions were received appear in black. Since you can specify the accumulation period of your choice, you'll be able to look at the most recent 12 months, or at future accumulation periods. For example, you'll be able to see how many weeks you've earned toward eligibility for coverage to be effective January 1, 2015. You can also view your weekly work history, by employer, within the past two years.

Finally, you'll be able to see the coverage period for which the Fund has received and processed your health premiums, by coverage type (e.g., medical vs. dental).

Pension Benefit Estimates

Participants often ask, "Based on my earnings to date, what would my pension be like if I were to retire at age 65 (or some other age)", or, "If I earn X dollars per year over the next 20 years, what would my pension be?"

Our self-service pension estimator will allow you to answer these questions and others, 24 hours a day, seven days a week, projecting as many different scenarios as you wish. The answers are based on the salary information and contribution information that we have on file for you as of the date you request the calculation. You'll also be able to create future pension scenarios assuming different average annual earnings between now and your retirement date.

Changing Contact Information and Pension Payments Options

You can now change the contact information you have on file with the Funds at any time. Just be aware that changing your contact information in our system does not change it in the Actors' Equity Association's ("AEA") separate system (and making a change to your information with AEA does not pass through to our system—they are completely separate systems).

In addition to changing your contact information, you can elect or change your direct deposit information, or your tax withholding elections (e.g., withhold estimated federal income tax from your payments, or stop doing so).

Activating Self-Service Is Easy, But It's Not Automatic

Activating Self-Service access is easy, but it's not automatic.

In order to access all of the self-service modules that are available to you as of any given date you only need to register once. After you have registered (registration only takes a few minutes) you will have access to all of the above modules. You can register at: *http://portal.equityleague.org/*.

The New "Retirement Benefit Book"

Your new "Retirement Benefit Book" will include both the Pension and 401(k) Summary Plan Descriptions…

The long promised "Retirement Benefit Book," which includes new Summary Plan Descriptions (SPD) for the Pension Fund and the 401(k) Fund, is finally at the printer. It will be mailed to you in the next few weeks. We trust that, as a result of having had many more laypeople (including participants) review the drafts of the book than ever before, the text will be easier to understand than previous editions of either SPD. And an added bonus will be having all of your retirement benefits explained in one place.

Updated Heath Fund SPD

We are also updating our Health Fund SPD. While the changes are not substantial enough to warrant a complete reprint, future printed versions of our SPD will include these changes, as will the version of the SPD soon to be posted on our website.

The Quality and Cost Incentive Plan (QCIP) is Enhanced Once Again

More than 100 plan participants have already qualified for a QCIP credit…

You may recall that the QCIP was introduced in 2013 as a vehicle for enhancing benefits for those who used high quality yet less costly providers to serve their medical care needs. Those who use physicians who have received CIGNA's "CCN" designation, and hospitals who are considered to be Centers of Excellence by CIGNA for certain major orthopedic procedures, such as hip replacements and certain spinal surgeries, can receive a credit of up to $400.

Those who have colonoscopies in a physician's office, instead of an inpatient or outpatient hospital facilities (whether with a CCN physician or not) can receive a $300 credit.

In addition, beginning on July 1, 2014, if you have a colonoscopy under light instead of deep sedation, you can earn another $200 credit—a total of a $500 credit for one colonoscopy procedure.

What is light sedation and why might you prefer it? When you undergo deep sedation, you are completely unconscious. When you have light sedation, you typically feel drowsy, but are not unconscious. Light and heavy sedation are generally equally pain-free. Light sedation was the method of choice for colonoscopies for many years. However, in recent years, many of these procedures have been done with deep sedation administered by an anesthesiologist. Often, the cost of the anesthesiologist for such procedures is greater than the cost of the physician who is performing the colonoscopy. Yet there appears to be no evidence that colonoscopies performed under deep sedation are more comfortable than those done with lighter sedation. In contrast, at least one study suggests that the risk of complications, while very low with either form of sedation, is significantly higher under deep versus light sedation.

To summarize, whether you have your colonoscopy in a physician's office or a separate facility, using deep or mild sedation, you will receive the full regular benefits available from the Fund for colonoscopies of any type. However, if you have the procedure in a doctor's office and/or, have mild sedation, you can earn a credit of between $200 and $500.

The credits earned under the QCIP can be used to pay for you or your dependent's medical premiums, any necessary medical procedures that are not normally covered by the Fund, dental care, or a number of other health-related needs (a full list of expenses that QCIP monies can be used for is available on our website).

More than 100 plan participants have already qualified for a QCIP credit. We suggest that if you need one of the covered procedures, you consider planning your treatments so that you too earn QCIP credit. Remember that by doing so you'll be saving money for both yourself and the Fund.

Changes in the Health Fund's Self-Pay Program After COBRA

Today, the very substantial premiums paid by those covered under this extended self-pay program do not even cover 50% of the costs…

If the "general viability" test is not satisfied, the participant may continue on the Self-Pay program…

The passage of the Affordable Care Act (ACA) in 2010 has had a profound effect on the US health insurance landscape. For instance, before ACA, insurance companies in certain states were permitted to restrict or deny coverage to individuals with pre-existing medical conditions and to have annual and/or lifetime dollar limits on their medical and/or drug benefits. Under ACA, all individuals, regardless of their medical conditions, are able to obtain comprehensive coverage, subsidized by the federal government if certain income requirements are met.

At the same time, ACA has profoundly influenced the environment in which the Equity-League Health Fund operates. In recent years the Fund has been required by ACA, and other laws or regulations, to extend its eligibility rules and benefits. For example, the Fund was required to reduce its waiting period for coverage from three to two months, to make dependent children eligible up to the age of 26 and to remove limitations on mental health and substance abuse benefits.

Partially as a result of these changes, and due to other factors driving health care costs, the Health Fund's claims costs have begun to climb once again, particularly in the Self-Pay Program after COBRA. Today, the very substantial premiums paid by those covered under this extended self-pay program do not even cover 50% of the claims costs of that program, and our actuaries project that the cost of self-pay benefits, and of the Health Fund benefits in general, will continue to rise. Therefore, the Trustees need to address these costs in order to protect the long-term stability of the Fund.

With costs for the Self-Pay Program at a very high level, and likely to continue to increase, and guaranteed comprehensive and affordable coverage generally available in the Marketplaces, the Trustees have decided to redesign Fund coverage for those whose COBRA eligibility has run out. Going forward, the nature of this coverage will be somewhat different for those who are currently covered by the existing Self-Pay Program, or who qualify for that Program by April 1, 2015, as compared with those who were not covered by COBRA benefits as of January 1, 2014.

Future Extended Coverage for Those Who Are Currently Covered Under the Self-Pay Program After COBRA

If you are covered under the Self-Pay Program today or begin such coverage on or before April 1, 2015, and you live in an area where viable Marketplace or Medicaid coverage will be available to you, Fund self-pay coverage will cease on December 31, 2014, or after you have self-paid after COBRA for a total of 18 months, if later. However, if you have Medicare as your primary coverage, you may continue to self-pay without any change to the rules after December 31, 2014.

If viable coverage is not available, Fund coverage will be available after December 31, 2014 (or if later, 18 months after your post-COBRA coverage began). What is "viable" coverage? The Fund has adopted two viability tests.

The General Viability Test

The general viability test says that if, in a given state, the Marketplace does not meet all four of the following criteria, anyone residing in that state will not be required to exit the Self-Pay Program at this time. The general viability criteria are:

1) There are three or more participating insurers available on the Marketplace,
2) There are two or more silver and two or more bronze plans available,
3) The Marketplace has achieved at least 2/3 of its enrollment target for 2014, and
4) The state where the Market place operates has expanded Medicaid eligibility coverage as per standards set forth under ACA.

If a Self-Pay participant resides in a state where any one of these four criteria are not met, the general viability test is not satisfied and the participant may continue on the Self-Pay Program after December 31, 2014.

Based on these four criteria, the following states have met the general viability test:

continued on next page

- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Illinois
- Iowa
- Michigan
- Minnesota
- New Hampshire
- New Jersey
- New York
- North Dakota
- Ohio
- Rhode Island

Additional Individual Viability Tests For Special Situations

Even if you live in an area that meets the general viability test, you may not be required to exit the Self-Pay Program if any of the conditions listed below exist (i.e., the plans available in your area do not meet the "individual" viability test):

1) If you only have access to plans with very narrow networks or some other feature that limits access to needed care for a condition you currently have, including not having reasonable access to specific health care providers or prescription drugs needed to treat specific conditions or illnesses (this kind of exception would only be considered after you participated in a review process with the Actors Fund to determine what coverage options you have—Actors Fund assistance will be explained more fully later in this document), or,

2) If you worked at least one week under an AEA contract in 2013 or 2014, in a geographic area to which you could not reasonably commute from your permanent residence (or you can demonstrate that you will have such work later in 2014 or 2015), and, the Marketplace in your state of residence offers only in-network (e.g., HMO) coverage that does not cover you in the area to which you are travelling (or will travel), or,

3) If the second lowest rate silver plan available in your area exceeds the Fund's self-pay rates, or,

4) If you live in a state that satisfies all four of the viability criteria of the General Viability test, but your county does not.

In order to assist you in determining whether your own situation meets the individual viability test related to your medical condition(s) referenced in Test 1 above, the Fund has contracted with the Actors Fund (AF). The AF will assist you in evaluating your non-Fund options under the ACA Marketplaces, Medicaid and other sources of health insurance coverage that may be available to you in your area (see further details in the section on the Actors Fund program below).

AF is very skilled at identifying coverage options for everyone they service, but if they are unable to find viable coverage for you, they will submit a report to the Fund that explains your case confidentially, but in detail. And the Fund will promptly (well before any other options you have expire) make a determination as to whether you are eligible to continue in the Fund's Self-Pay Program.

If you wish to request continued coverage based on the individual viability test 1, you must have had the Actors Fund analyze your options for coverage outside the Fund no later than September 30, 2014.

If your self-pay coverage will end after January 1, 2015 because you did not have at least 18 months of such coverage as of December 31, 2014, and you believe you qualify for continued self-pay coverage after 18 months based on one of the special circumstances discussed above, you should contact the Fund Office at least two months before you would otherwise lose coverage (or the Actors' Fund at least three months before you would otherwise lose such coverage, if your special circumstance is related to a medical condition). Such requests for continued coverage must be based on current medical conditions being treated. Requests for exceptions on the basis that the networks on the Marketplace are too narrow, that your provider(s) is not in those networks (if another provider qualified to treat your condition as available), that you are in an area where only HMOs or EPOs are available (there is no out-of-area coverage), or that you might develop a condition that current network providers may not be able to treat, would not be

continued on next page

Even if you live in an area that meets the general viability test, you may not be required to exit the Self-Pay program…

In order to satisfy the more straightforward tests 2 and 3, you need to submit evidence to the Fund Office by November 1, 2014…

…The Actors Fund has added to its credentials by becoming an official "navigator" for the ACA Marketplaces…

Actors Fund will dedicate a staff member to provide priority service to Fund participants covered under the Self-Pay beyond COBRA program, but you must contact them soon…

considered a basis for eligibility for the Self-Pay Program after December 31, 2014.

In order to satisfy the more straightforward individual viability tests 2, 3 or 4, you need to submit satisfactory evidence to the Fund Office by November 1, 2014. If the Fund does not receive such evidence by November 1, or it deems your evidence insufficient, and you live in an area that meets the general viability tests, you will not be eligible to self-pay after December 31, 2014 and should expect to secure health coverage outside the Fund beginning on January 1, 2015.

More About the Special Counseling From the Actors Fund to Determine if You Meet the Individual Viability Test

For decades, members of the theater community have relied on the Actors Fund (AF) to provide counseling regarding their insurance needs when they are not covered through employment. Recently, the AF has added to its expertise and credentials by becoming "navigators" recognized by ACA Marketplaces as counselors who can assist people seeking health insurance coverage through the Marketplaces.

Both the AF services offered prior to ACA and the new services AF offers in connection with ACA will continue to be available to everyone the AF currently serves. However, the Fund has contracted with the AF to provide special counseling services to those who are losing eligibility for the Self-Pay Program After COBRA and must secure coverage through the Marketplaces, Medicaid, Medicare or other health insurance providers.

AF will dedicate a staff member who is familiar with the Equity-League Health Fund to provide priority service to any participant whose extended self-pay coverage might cease at year-end 2014 (or soon thereafter). This special service is being offered by the Fund in order to assist current self-pay participants in obtaining alternative coverage. As was mentioned above, in addition to helping all of those currently self-paying navigate their non-Fund insurance options, the AF will assist participants who request continued self-pay coverage under the Fund if the options outside the Fund are not viable for them for medical reasons.

For additional information and/or assistance please call 212.221.7300 x280, or e-mail ***ahirc@actorsfund.org.***

Coverage for Those Who Exhaust COBRA Coverage That Began or Begins After December 31, 2013

For those who began COBRA benefits after December 31, 2013, or begin COBRA in the future, a new COBRA Extension (CE) benefit will be available. This extended self-pay coverage will be available after the regular COBRA coverage period has been exhausted.

As was the case under the original Self-Pay Program After COBRA, the CE benefit will be available to all Health Plan participants who have earned the equivalent of at least 10 years of Vesting Service under the Pension Plan, except that the Pension Plan's two-for-one rule does not apply to this extension.

Under the CE program, the Fund will establish an extended health coverage "bank" for a participant who accumulates at least 10 separate years of Vesting Service under the Pension Fund across his/her career. Such participants will have 18 months of extended self-pay health coverage eligibility placed in their "bank" accounts.

In addition, for each additional year of Vesting Service that such participants accumulate across their careers, beyond the 10 years required to qualify for the initial 18-month extension, they will have one additional month of extended self-pay health coverage eligibility added to their "bank" accounts.

These eligibility months can be used as of the first of the month following the completion of a participant's 18-month COBRA coverage period, but no more than 18 of the bank's months can be used after any single period of COBRA coverage ends (unused months can be used to extend any subsequent periods of COBRA coverage). Months placed in an account can be used only one time, and of course the coverage must be paid for on a timely basis. Once the total number of additional months is exhausted, there are no additional months beyond the 18-month COBRA coverage period.

The table below provides examples of bank account accumulations based on years of service:

continued on next page

Years of Vesting Service	Extended Coverage Months
10	18
15	23
20	28
25	33
30	38

Some Background on the Self-Pay Program That Is Being Replaced

When the Health Fund was created in 1961, coverage was limited to those working on Broadway, but the Fund soon expanded to cover a much wider group of participants. In the early years of the Fund, only a few weeks of work were required to earn coverage, and participants were covered at no additional cost for a period after their covered employment ceased. When that extended coverage ended, participants were able to continue their coverage on a self-pay basis indefinitely. But, in those years, the national average daily hospital room and board costs were under $15 per day and high tech equipment like MRIs and expensive prescription drugs did not exist. Consequently, in the early years of the Fund, the cost of health insurance was many times less, in dollars and in comparison to wages, than current costs.

Health care costs grew steeply during the 1970s and 1980s, but in the late 1980s health costs virtually exploded on the Health Fund, driven largely by enormous annual increases in overall claims costs and by the costs generated by those infected with HIV in particular, as the theater community was ravaged by that dreaded disease. Claims costs exceeded income to the Fund by a significant margin, and the Health Fund's Trustees came face to face with the possibility of Plan insolvency if action was not taken.

An analysis of the Fund's claims costs at the time revealed that fully half of those costs were generated by less than 10% of those insured by the Fund — those who were continuing coverage on a self-pay basis. The Trustees agonized over the bad and worse alternatives that they faced in rescuing the Fund. After much deliberation, they decided to change the Fund's eligibility rules, both for those covered by employment and those who were covered on a self-pay basis.

To address the need for extended coverage after employment-based coverage ended, the Self-Pay Program was established for those who were vested in the Pension Fund (which then required 10 years of vesting service), a requirement that was designed to demonstrate significant attachment to the industry. Even with this more stringent requirement for earning eligibility to self-pay, the costs of the self-pay program would still be very large. However, the Trustees were deeply concerned that without such a program, the lack of individual insurance alternatives for those who had pre-existing conditions, such as HIV infection, could cause many to be without coverage. In certain states (states with high-risk pools and similar programs) coverage was available to all, but in some other states this was not the case. And this remained true for many years after the formation of the Self-Pay program. However, in view of the universal coverage available today under ACA, the Self-Pay program is no longer the only available coverage option for the vast majority who are currently enrolled in, or would have otherwise been eligible for, the Fund's Self-Pay coverage under the current plan, had that program not been changed.

In the late 1980s, claims costs far exceeded the Health Fund's income…

Conclusion

The Trustees regret the need to modify the Health Fund's Self-Pay after COBRA Program at this time, but believe that all of the aforementioned steps combined will help to assure the long-term viability of the Health Fund, while at the same time continuing to provide extended coverage where it is most needed — to help participants through periods when they are not working in covered employment and where viable Marketplace coverage is not available.

Changes in CIGNA's Drug ID Cards

CIGNA will be making changes in the ID cards you use for your prescription drug benefit later this year and in recognition of that you'll be receiving a new ID card from CIGNA. This card contains critical information for the pharmacy that processes your prescription drug claims. As soon as you receive the new card, please begin using it and discard your old card. If you have any questions regarding your new card, please contact CIGNA at 1.800.Cigna24 (1.800.244.6224).

As soon as you receive your new prescription drug ID card from CIGNA, please discard your old card…

Equity-League Pension, Health and 401(k) Funds
165 West 46th Street
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New York, NY 10036-2582

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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.