Frequently Asked Questions

1) What are the Equity-League Benefits Funds? What is your relationship with Actors' Equity?

The Equity-League Benefit Funds provide benefits to actors and stage managers who are Actors' Equity members. There are three Funds:

- **Health** (medical, dental, vision and supplemental workers' compensation)
- **Pension** (lifetime monthly income), and
- **401(k)** (accounts which accumulate tax deferred income).

For over 60 years, the Equity-League Benefits Funds have represented a partnership between the union—Actors' Equity Association—and employers throughout the industry, including Broadway, touring companies, stock theatres, LORT theatres, and Small Professional Theatres across the country.

We are an independent organization. The Equity-League Benefit Funds exist and operate solely to provide benefits for eligible participants.

2) Who decided to make these changes?

The Equity-League Benefit Funds are jointly managed by a Board of Trustees made up of working theatrical professionals appointed in equal numbers by Actors' Equity and The Broadway League.

The Trustees are not paid by the Funds for their service. Over the last six months, they've spent countless hours working closely with benefit professionals considering the best way to balance providing meaningful coverage for as many participants as possible, while preserving the Plan for the future.

3) Why are you making these changes now?

88% of the Equity-League Health Fund is financed by employer contributions. The remainder comes from investment income and premiums paid by participants. Most of the employer contributions stopped when the work stopped.

In other words, COVID-19 and the resulting theater closures means there is almost no revenue coming in to pay expenses. Without changes, the Health Fund will run out of money.

4) When do these changes take effect?

These changes take effect on January 1, 2021.

5) Where can I get coverage now that I'm not eligible?

Participants who lose coverage are eligible for COBRA through the Equity-League Health Fund. COBRA provides temporary continuation of health coverage at group rates.

However, COBRA premiums are expensive. This is because they are based on the actual cost of benefits, so you may want to look for an alternative option that offers lower monthly premiums and out-of-pocket costs.

— **Another group health plan**
Losing coverage under the Equity-League Health Fund creates a special enrollment period. If you, your spouse, or parent (if you are under age 26) have health coverage offered by an employer, **call the employer's health plan or HR department to see what your options are**.

— **Marketplace plans**
Depending on your household income, **you may be able to enroll in a Marketplace plan with no premium**. **In the Marketplace, you may be eligible for a tax credit that lowers your monthly premiums right away.**

You can also find out about other coverage options by joining the Actors Fund for *Every Artist Insured! Getting & Keeping Affordable Coverage During COVID-19*. This weekly webinar provides clear, step-by-step guidance to the health insurance options currently available to you. To attend, select a session and RSVP using the Eventbrite link.

6) Couldn't you have made changes that allowed more people to keep their coverage?

While designing the new plan, the Trustees balanced three guiding principles. Changes to the Health Fund must:

1) Ensure meaningful benefits,
2) Be accessible to as many participants as possible today, and
3) Remain viable in the future.

They reviewed many options, including increasing the annual deductible and coinsurance of the current plan. While that might have allowed more people to keep their coverage, the plan would no longer provide meaningful protection for participants against health care costs. In other words, the cost required from participants when receiving care would be prohibitively high. In fact, depending on the level of reductions, the plan might not have met the standard for minimum value under the ACA.

The Trustees sought a balance between cost (premiums), coverage (plan design), and accessibility (eligibility rules). The three-tier plan structure with varying eligibility requirements represents the best balance given the Fund's current financial situation.

7) After COVID, will eligibility go back to what it is today?

Beginning in 2022, the eligibility requirements will be reviewed annually. The Trustees have established a method for calculating the number of weeks that will have to be accumulated for future coverage. The method considers a number of variables, including the level of employer contributions, the number of participants, benefit costs, and several other factors. It is hoped that as the industry returns to full employment, the required weeks for coverage may decrease.

8) Will these changes protect the Health Fund for the future?

Yes. The COVID shutdown has severely depleted the Fund. The model that worked before the crisis will not be sustainable when the crisis ends. The new plan design and eligibility rules allow the Fund to be more flexible and dynamic in the face of a less certain future. This will preserve the Fund so that it can be there to provide benefits in the future.

9) If I have the option of "buying up" or "buying down," how will I decide what to do?

When you qualify for coverage, there's no requirement for you to buy up or buy down. The Trustees have provided these options so that you have greater choice, flexibility, and control in matching the plan offerings to your individual needs.

For example, if you qualify for Tier 2 but always see in-network providers, you may want to save on premium costs or required eligibility weeks by buying down to Tier 3 In-Network Only. On the other hand, if you qualify for Tier 3 In-Network Only but need frequent care or use out-of-network providers, you may find it makes sense to buy up to Tier 2.

When you've qualified for coverage, review your plan options and decide which one works best for you.

10) Are you still offering dental and vision coverage?

Vision coverage is automatically included with all three coverage Tiers. Dental coverage remains available as a self-pay option, as it was in the legacy health plan.

11) I have exactly 11 weeks worked and have assumed that I will have coverage. How are you helping me?

For benefit coverage periods beginning January 1 through June 1, 2021, if you have earned the 11 weeks that were previously required for 6 months of health coverage, you will be eligible for Tier 3 In-Network Only coverage for 6 months.

12) Will I pay more in premiums for the new plans?

No. Unless you qualify for Tier 3 In-Network Only and choose to buy up to Tier 2, your premium cost will remain the same as under the legacy health plan: $300 per quarter.

- However, if you take advantage of the option to buy up from Tier 3 In-Network Only to Tier 2, your quarterly premium will be $585 per quarter (a premium increase of $285 per quarter).
- On the other hand, if you buy down from Tier 2 to Tier 3 In-Network Only, your premiums will be lower: $15 per quarter (a premium *decrease* of $285 per quarter).

13) Will I pay more out-of-pocket when I get health care?

The Tier 1 plan has slightly higher deductibles, copays, and out-of-pocket maximums than the legacy health plan. Therefore, in most cases, you will pay slightly more when you receive care. The Tier 2 and Tier 3 In-Network Only plans have higher out-of-pocket costs than the Tier 1 plan. You can see the details on our website.

14) Can I continue to see my doctor and have it covered by the Plan?

It depends. If your doctor participates in Cigna's nationwide provider network, you will be able to see your doctor at the plan's in-network rates, regardless of your plan. If your doctor is not in Cigna's network, the Tier 1 and Tier 2 plans will pay coinsurance at the out-of-network rate after you have met your deductible. If you are enrolled in Tier 3 In-Network Only, the plan will not pay for any out-of-network expenses, so your doctor visit would not be covered.

15) Why does the Tier 3 In-Network Only Plan require using in-network providers?

The Tier 3 In-Network Only plan is a way to offer members a level of protection against health care expenses while keeping costs under control. In-network providers have contracted with Cigna to accept discounted rates for care, so the plan is better able to manage costs. Out-of-network providers do not limit the amount they charge for services.

16) Are the same services covered under the new plans?

All three plans cover the same broad range of services as the legacy health plan. However, there are some minor differences. The details will be available online before Open Enrollment.

17) What happens if I switch between plans during the year?

If you switch between plans during the year, any visit limits or amounts you have paid toward the deductible and out-of-pocket maximum carry over to the new plan. (Deductibles, out-of-pocket maximums, and visit limits reset each calendar year on January 1.) If you have met your deductible or out-of-pocket maximum under one plan but then switch to a plan with a higher deductible or out-of-pocket maximum, the amounts you have already paid will apply toward meeting the new requirements.

18) If my current coverage continues into 2021, what plan am I in?

If you are currently enrolled in the legacy Health Fund plan, you will transition to Tier 1 coverage on January 1, 2021. Your deductible, out-of-pocket maximum, and visit limits reset on January 1, just as they would under the legacy plan.

19) Will I get a new ID card?

Yes. Regardless of your plan, you will receive a new ID card.

20) If my coverage crosses from one calendar year to the next, does the money I spent on health care in the last calendar year carry over to the next?

Your deductible does not carry over from one calendar year to the next. The deductible and visit limits reset every calendar year on January 1. Just as in the legacy plan, there are limits to the number of times you can receive a specific service.

21) Can I cover my dependents on these plans?

You may cover your legal spouse, domestic partner, and dependent children under the plan. You must provide proof—such as a marriage certificate, certificate of registration, or birth certificate—to cover your dependent. However, the cost of dependent coverage is not subsidized, so you will pay the full premium cost for their coverage.

22) Is there any discussion of delaying these changes to eligibility until after the pandemic?

We discussed this but are unable to delay. COVID-19 and the resulting theater closures mean there is almost no revenue coming in to pay expenses. In order for the Fund to survive this difficult period, changes must be made now. Changes to the Health Fund will provide meaningful coverage for as many participants as possible today, while preserving the Plan for the future.

23 Do the three new plans have the same network as the current plan?

Yes! All of the new plans (Tier 1, Tier 2, and Tier 3 In-Network Only) use the same Cigna nationwide network as the current legacy Health Fund plan.

24) How do I find a network provider?

Visit mycigna.com or download the myCigna mobile app to find a Cigna network provider.

25) Why can’t you use our dues to help support the Health Fund?

Union dues do NOT pay for your benefits. Your benefits are paid for primarily by employer contributions, which are negotiated by the union and the contributing employers.

26) Why didn’t the union negotiate higher employer contributions to keep this from happening?

The union does not unilaterally decide the level of employer contributions. The level of contributions are bargained between the union and the contributing employers. Furthermore, employer contributions are generated by the work performed by our participants. The sudden and unprecedented cessation of theatre work means that there are no employer contributions -- regardless of what was negotiated by the union.

27) Why don’t we use those millions in reserves now – in this worst crisis ever – rather than save them for the future?

We are using the bulk of our reserves now.

Before COVID, the Fund typically maintained a very healthy $120 million in reserves. This is nearly 140% of annual expenses.

Because we are still paying claims for the health needs of currently enrolled participants and there is no money coming in, the reserves have already declined to approximately $90 million since the pandemic began.

And it is expected that, if work does not return to near normal levels by the middle of 2021, our reserves will have fallen to less than $30 million by that time. Specifically, we estimate that claims for benefits through mid-2021 will be roughly $60 million, and payments for claims incurred but not yet paid will be in the neighborhood of $10 million.

We cannot drain all of the reserves for several reasons. First, the money must be there to pay for the health care costs of those who are already in coverage. Second, if we don’t maintain some level of reserves, the Health Fund will not be positioned to survive future crises, such as rising medical treatment and prescription drug costs or an unexpected rise in claims from participants.

28) What can we do to stop these terrible changes before they are implemented?

We simply cannot afford to keep the current rules in place. If no changes are made, we will be unable to meet our obligations to participants who have or will qualify for coverage.

We understand that, without the availability of work, many participants will not qualify for coverage under the new plan. But we cannot financially sustain the legacy plan and eligibility rules. Sadly, there is nothing the Health Fund can do to affect the course of the pandemic or to accelerate the safe reopening of live theatre. However, there is something that our federal leaders can do to help our participants maintain their vital healthcare coverage. Join us in strongly urging Congress and the White House to act swiftly and urgently to pass COVID-19 relief legislation that includes a 100% COBRA subsidy for workers who have been laid off or furloughed because of the pandemic.

Visit our website at https://equityleague.org/advocate-to-congress/ to quickly and easily reach out to your elected leaders.

29) Is the Health Fund going to go bankrupt?

The new plan design and eligibility rules allow the Fund to be more flexible and dynamic in the face of a less certain future. This will preserve the Fund so that it will be there to provide benefits in the future.

30) These changes do not address systemic racism in the theater industry. Why didn't you take into account the concerns of the BIPOC community?

We recognize the concerns of BIPOC theatre artists about employment patterns in the industry. This is an important issue for all stakeholders involved in employment policy decisions to examine.

As a benefits fund, we only collect data that is directly relevant to providing benefits, so we have never collected information on participants' racial identity, and we aren't aware of any multiemployer benefits fund that does collect such data. Recognizing the importance of addressing these real concerns, we have begun working with Actors' Equity to gather the type of demographic data that we hope will allow us to assess whether or to what extent these issues impact eligibility for the Fund's healthcare coverage.

What is clear right now is that immediate action is needed to respond to the disastrous impact that the COVID-19 pandemic is having on our Health Fund. If we don't make these benefit changes now, there won't be a Fund in the future.

31) These changes seem elitist. Why do you care more about Broadway stage managers and actors?

Based on Fund experience, the Tier 1 plan will be accessible to participants who live and work throughout the nation. Looking at Fund data from 2019, 65% of participants who would have qualified for Tier 1 did so without any work on Broadway or touring productions, whereas just 23% would have qualified for Tier 1 with only this type of work.

The Fund's new three-tier approach was designed to address participants' needs in a financially responsible way, considering the uncertainties related to the COVID pandemic. And, the three tiers take into account the varying levels of work across our participant population.

32) SAG-AFTRA offered a COBRA subsidy to those losing eligibility. Why isn't ELBF doing the same thing?

As Trustees we decided to offer immediate help to those losing coverage in 2020 by offering the Silver Plan, a reduced plan subsidized by the Fund's reserves. Unfortunately the rapidly dwindling reserves do not allow us to continue to offer a subsidy beyond 2020. We are committed to preserving the viability of the Fund so that it can provide benefits in the future.

33) Is ELBF doing anything to advocate for our needs in Washington, DC?

Yes. In response to historic levels of unemployment, countless healthcare advocates, labor unions, businesses and citizens have been urging Congress and the White House to swiftly pass COVID-19 relief legislation that includes **a 100% COBRA subsidy for workers who have been laid off or furloughed because of the pandemic**. We have been among those advocates, as has Actors' Equity.

While a COBRA subsidy may not address the Fund's pressing financial issues, it would be extraordinarily helpful for our participants who will otherwise lose coverage, by keeping many insured until you can return to full employment and regain eligibility. The Health Fund -- and Actors' Equity -- have advocating for this desperately needed assistance from our elected leaders.

In addition, we've supported the Actors' Fund work to restore COBRA subsidies on the state level.

We encourage you to join us in making your voice heard. Visit our website at https://equityleague.org/advocate-to-congress/

34) I heard that the Fund is self-insured. What does that mean? Why does it matter?

Self-insured means that the Health Fund, not an insurance company, assumes the risk of the costs of coverage. The Fund saves a great deal of money by being self-insured, which keeps costs lower for participants too.

By being self-insured, the Fund is able to maintain greater flexibility with respect to benefit design. Because we are self-insured we are:

- NOT subject to state "premium" taxes that are imposed on insurers in most states,
- NOT forced to pay insurers premiums that are priced to include a profit for the insurer,
- Able to invest the monies that are held in reserves for future liabilities and use the full returns of those investments to pay for health care claims,
- Able to avoid situations where insurers significantly and unexpectedly raise their premiums because they believe health care costs will rise in the future, and
- Able to exercise control over how benefits are used by participants.

35) Is out-of-network emergency care covered?

Yes. In the event of an emergency, out-of-network care is covered. This is true for all three of the plans.