Equity-League Health Fund Benefit Changes Effective January 1, 2021

Important information: Please read

Dear Participant:

With most members unable to work since March, the past six months have been among the most difficult any of us has ever faced. We recognize the emotional and financial burdens you are facing.

The sudden changes caused by the COVID-19 pandemic have drastically affected the Fund's financial position. Eighty-eight percent of the Equity-League Health Fund is financed by employer contributions. Although most employer contributions to the Fund stopped when the work did, the Trustees are looking for ways to continue meaningful coverage to as many participants as possible. The Trustees have been working with the Fund's professional advisors to determine how to accomplish that goal.

After looking at many different approaches, the Trustees have developed a solution that balances meaningful coverage with the long-term sustainability of the Fund.

Important changes take effect January 1

In the past, you worked 11 weeks for six months or 19 weeks for 12 months of Health Fund coverage. Beginning January 1, 2021, the plans offered by the Health Fund and the rules for how you earn eligibility are changing.

The Fund now offers three coverage levels, and eligibility is earned for six months at a time. The level of coverage for which you qualify is related to the number of weeks you work in covered employment, as shown in the chart below:

If you work in covered employment…	You qualify for six months of coverage in…
16 weeks or more	Tier 1
At least 14 weeks	Tier 2
At least 12 weeks	Tier 3 In-Network Only

What has not changed

As in the past, eligibility is reviewed monthly. There is still a two-month lag between the eligibility period and the start of coverage, and you have the option to defer your coverage start date, subject to whether the required weeks are available in the subsequent lookback period. The cost to participate in the coverage level for which you qualify is the same as the current cost: **$300 per quarter**.

What coverage levels do the new plans provide?

Tier 1 is similar to the current Health Fund plan. It covers the same services, both in- and out-of-network, but has slightly higher deductibles, copays, and out-of-pocket maximums. That means the amounts you pay when you receive care may be a little higher than under the current plan.

Tier 2 offers in-network and out-of-network coverage but with higher out-of-pocket costs than Tier 1.

Tier 3 In-Network Only is similar to Tier 2 but only covers services received from in-network providers and has higher out-of-pocket costs.

All three plans use Cigna's nationwide provider network and cover the same kinds of services. Visit **equityleague.org** to see a comparison of the three plans' deductibles, copays, out-of-pocket maximums, and a few common expenses.

Choice, flexibility, and control

The new three-tier approach was designed with our members in mind. Since not everyone may have the opportunity to earn enough weeks to attain Tier 1 eligibility, those with fewer weeks of work can still get protection from health care expenses. What's more, buy-up and buy-down options provide you with a greater degree of choice, flexibility, and control. You decide which coverage level meets your needs.

How those options work

When you have 14 weeks of work in covered employment, you qualify for Tier 2 coverage. In that case, you have two ways to buy down to the Tier 3 In-Network Only plan:

- *Use your 14 weeks, but save on premiums.* With this option, you'll pay **$15 per quarter** in premiums (a savings of $285 per quarter). That might be the right choice for you if you don't use the plan frequently or if the doctors you see are all in the Cigna network.
- *Use only 12 of your weeks to enroll in Tier 3 In-Network Only,* and apply the two additional weeks to future eligibility, provided these weeks remain available in the subsequent lookback period. For this option, the premium cost remains **$300 per quarter**. This may be a good choice if you think you may need those extra weeks to qualify for your next six months of coverage.

On the other hand, if you have worked 12 weeks in covered employment and qualify for Tier 3 In-Network Only coverage, you can buy up to Tier 2 coverage at a premium cost of $**585 per quarter** (an additional premium of $285 per quarter). You might choose this option if you use the plan often and you see doctors not in the Cigna network.

There are no buy-up or buy-down options if you qualify for Tier 1 coverage.

Making the transition

If you are a current, active participant in the Health Fund and your coverage continues into 2021, you will transition from the legacy health plan into Tier 1 coverage on January 1, 2021.

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

Looking to the future

The Trustees worked to create a plan that is flexible and maintains the Fund so that it will be available to members into the future.

As part of that focus on flexibility, the number of weeks required for eligibility may be revised in the future based on various factors, including employment levels, participation, and Fund assets. As those factors change, future eligibility requirements can change with them. That means, for example, future eligibility may require fewer weeks of work than are currently needed if employer contributions pick back up.

For more information

You can find more detailed information about the new plans and frequently asked questions at **equityleague.org**.

If you have any questions, please call the Fund Office at **(212) 869-9380**, or toll free **(800) 344-5220**, Monday–Friday from 9:30 a.m. to 5:30 p.m. ET, or email us at **health@equityleague.org**.

Sincerely,

Board of Trustees
Equity-League Benefit Funds

The Board believes that the Health Fund's Tier 1 plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator during normal business hours at: 1-212-869-8530 or 1-800-344-5220 (outside New York City). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.