Benefits Spotlight

Equity-League Benefit Funds Newsletter

Fall 2021

Choosing Your Health Plan

Last fall, the Equity-League Health Fund announced changes that were effective January 1, 2021.

Specifically, we changed how you earn eligibility and introduced three new health plans: Tier 1, Tier 2, and Tier 3 In-Network Only. These changes were necessary to provide meaningful health coverage for as many participants as possible now, while preserving the Health Fund for the future.

Although you received communication about these changes last year, the impact of the change is just beginning for most people. Because of the industry-wide shutdown, most members were not actively earning weeks toward Health Fund eligibility. As we return to work, it's important to understand how the changes will affect you and your family.

We are committed to providing the support needed to make the best decisions for you about your health coverage.

Please read this special mailing carefully to better understand:

- How you earn eligibility
- Important similarities and differences between the health plans
- Eligibility requirements for each health plan, and
- Things to consider when choosing your health plan.

In addition, we provide information about COBRA, other important changes made to your benefits and required legal notices.

Earning Eligibility

You earn eligibility for coverage based on the number of weeks you work. Employers report weeks worked to the Fund Office. Each month, the Fund Office reviews the totals to determine who has earned eligibility for health coverage.

Under the new rules:

- You must work at least 12 weeks in a 12-month period to be eligible for any level of health coverage.
- You earn coverage for 6 months at a time.

Once it's determined that you are eligible, there is a two-month lag period between earning eligibility and the start of your coverage. During this time, you'll receive communication from the Fund Office alerting you of your eligibility. **You must take action by the deadline stated on the letter or you will lose the opportunity to enroll in coverage for this benefit period.** You will need to wait until you qualify for coverage at the start of a future coverage period.

Equity-League Benefit Funds

Understanding the Health Plans

The Fund offers three coverage levels: Tier 1, Tier 2, and Tier 3 In-Network Only.

Your eligibility for each health plan is determined by the number of weeks you work in covered employment (as shown on page 3). However, because you may have the opportunity to buy up or buy down to another plan, it's important for everyone to understand how the plans differ.

No matter which health plan you choose, you get protection from health care expenses.

All three plans:

- Use the same nationwide Cigna network
- Cover the same medical services (although the out-of-pocket expenses may be different as shown in the table below)
- Include vision coverage and prescription drug coverage
- Cost you $300 per quarter (unless you choose to buy up or buy down to another tier as shown on page 3)
- Give you the option to self-pay for dental coverage

In Tiers 1 and 2, you pay less when you use a provider who is in-network. In Tier 3 In-Network Only, you will have to pay the full cost for any services received from an out-of-network provider.

The other differences have to do with how you and the Fund share the cost when you receive health care services. See a summary below.

	Tier 1		Tier 2		Tier 3 In-Network Only
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible (Single/ Family)	None	$500/$1,000	$2,000/$4,000	$4,000/$8,000	$2,200/$4,400
Preventive visit	$35 copay	30% coinsurance	Fully covered	30% coinsurance	Fully covered
Office visit	$35 copay	30% coinsurance	$25 copay*	30% coinsurance	25% coinsurance
Specialist visit	$35 copay	30% coinsurance	$50 copay*	30% coinsurance	25% coinsurance
Acupuncture, physical therapy, and chiropractic office visit	$20 copay	30% coinsurance	$50 copay*	30% coinsurance	25% coinsurance
Emergency Room visit	$70 copay	30% coinsurance	$100 copay*	30% coinsurance	25% coinsurance
Out-of-Pocket Maximum (Single/Family)	None	$7,000/$14,000	$4,550/$9,100	$8,000/$16,000	$4,550/$9,100

*You do not have to meet the deductible

There are also differences in how prescription drugs are covered. See a summary below.

	Tier 1		Tier 2 and Tier 3 In-Network Only	
	Retail Pharmacy	Mail or Retail 90	Retail Pharmacy	Mail or Retail 90
Non-Specialty and Specialty Generic	20% coinsurance, $10 minimum	20% coinsurance, $20 minimum	20% coinsurance, $10 minimum	20% coinsurance, $20 minimum
Non-Specialty Preferred Brand	25% coinsurance, $20 minimum	25% coinsurance, $40 minimum	25% coinsurance, $40 minimum	25% coinsurance, $80 minimum
Non-Specialty Non-Preferred Brand	30% coinsurance, $25 minimum	30% coinsurance, $50 minimum	30% coinsurance, $60 minimum	30% coinsurance, $120 minimum
Specialty Brand	25% coinsurance, No maximum	25% coinsurance, No maximum	25% coinsurance, No maximum	25% coinsurance, No maximum

In all three plans, the annual out-of-pocket maximum for covered prescription drugs is $4,000 per individual and $8,000 per family. This out-of-pocket maximum is separate from the medical out-of-pocket maximum.

It's important to make sure you understand what the terms mean.

Deductible is the amount that you must pay before the Fund helps pay for the cost of your health care expenses. The deductible is different depending on whether you are covering just yourself or other dependents as well.

Copays are fixed amounts you pay when you receive health care services.

Coinsurance is the percentage of the health care cost you pay. The Fund pays the rest up to the allowable charge.

You pay coinsurance for prescription drugs in all three health plans. However, each handles coinsurance for medical/hospital services differently.

- **Tier 1:** Coinsurance applies after reaching the deductible only if you use an out-of-network provider.
- **Tier 2:** There are separate deductibles for in- and out-of-network services. Coinsurance applies after reaching the deductible for all out-of-network services.
- **Tier 3:** Coinsurance applies after reaching the deductible for all in-network services.

Out-of-pocket maximum is the most that you could pay for covered expenses in a calendar year before the Fund covers the rest of your health care costs up to the allowable charge. The out-of-pocket maximum is different depending on whether you are covering just yourself or other dependents as well. There is a separate out-of-pocket maximum for prescription drug costs.

Find more details about the Health Plans.

Visit our website at **equityleague.org/benefits-explained**. In addition to the Summary Plan Description (SPD), you can find the Summary of Benefits and Coverage (SBC) and Cigna and OptumRx Summaries for each Tier.

Eligibility Required for Each Health Plan

The level of coverage for which you qualify is based on the number of weeks you work in covered employment in the applicable Accumulation Period as shown in the table below.

By offering three plans, the Fund gives you improved choice and control.

- Once you earn eligibility, you may have a choice to delay the start of coverage. This allows you to save your weeks and apply them to your next accrual period. However, it's important to understand that your weeks worked expire after one year.
- Or, you may choose to pay extra each month for another Plan with lower out-of-pocket costs.

Examples are shown on the next few pages.

Tier 1	Tier 2	Tier 3 In-Network Only
16 weeks or more worked in a 12-month period	**14 weeks or more** worked in a 12-month period	**12 weeks or more** worked in a 12-month period

Things to Consider When Choosing a Health Plan

To help you make the best choice for you, we've developed the table outlining your options.

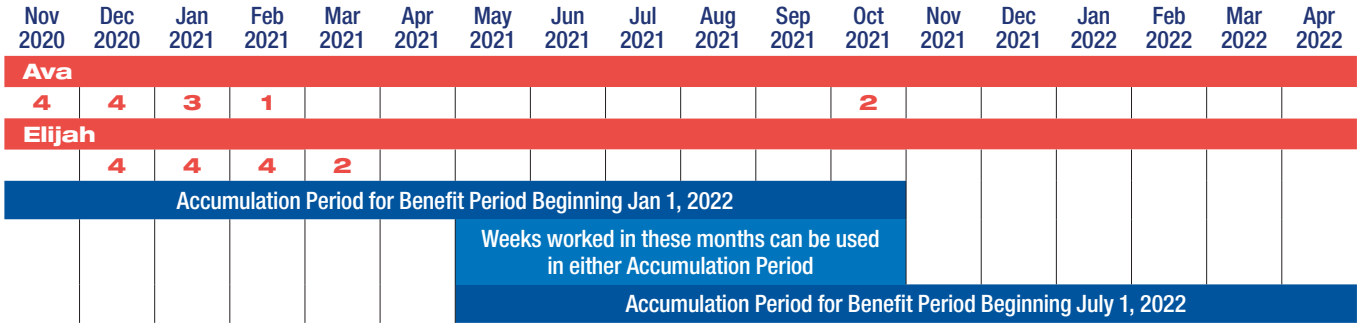
Weeks Worked	Your Choices (and things to consider)
12–13 weeks	Use 12 of your weeks to enroll in the Tier 3 In-Network Only Plan. ➡ You will pay $300 per quarter for coverage. ➡ This plan does not cover out-of-network care. Buy up to the Tier 2 Plan. ➡ You will pay $300 plus an additional $285 for a total of $585 per quarter for coverage. ➡ This plan allows you to use out-of-network doctors and hospitals.
14–15 weeks	Use 14 of your weeks to enroll in the Tier 2 Plan. ➡ You will pay $300 per quarter for coverage. Buy down to the Tier 3 In-Network Only Plan ➡ You still use 14 of your weeks. ➡ You will pay only $15 per quarter for coverage. ➡ This plan does not cover out-of-network care. Save the weeks above 12, and choose the Tier 3 In-Network Only Plan. ➡ You will pay $300 per quarter for coverage. ➡ This plan does not cover out-of-network care. ➡ Weeks that you save can be applied to your next Accumulation period ONLY if they fall within that period. See examples on page 4.
16 weeks	Use 16 of your weeks to enroll in the Tier 1 Plan. ➡ You will pay $300 per quarter for coverage. Save the weeks above 14, and choose the Tier 2 Plan. ➡ You will pay $300 per quarter for coverage. ➡ Weeks that you save can be applied to your next Accumulation period ONLY if they fall within that period. See examples on page 4. Save the weeks above 12, and choose the Tier 3 In-Network Only Plan. ➡ You will pay $300 per quarter for coverage. ➡ This plan does not cover out-of-network care. ➡ Weeks that you save can be applied to your next Accumulation Period ONLY if they fall within that period. See examples on page 4.

Saving Weeks: Understanding Accumulation Periods

Before deciding to save weeks for the future (by electing another Tier), you must remember that you can only use those weeks that fall within the applicable Accumulation Period. Take a look at some examples:

Both Ava and Elijah earned 14 weeks.

Their next possible Benefit Period begins January 1, 2022. This means their Accumulation Period looks at the weeks earned between November 2020 and October 2021. If they want to save their weeks for the next Accumulation Period, the weeks must have been earned May – October 2021. These dates are for illustrative purposes only.



Example: Ava

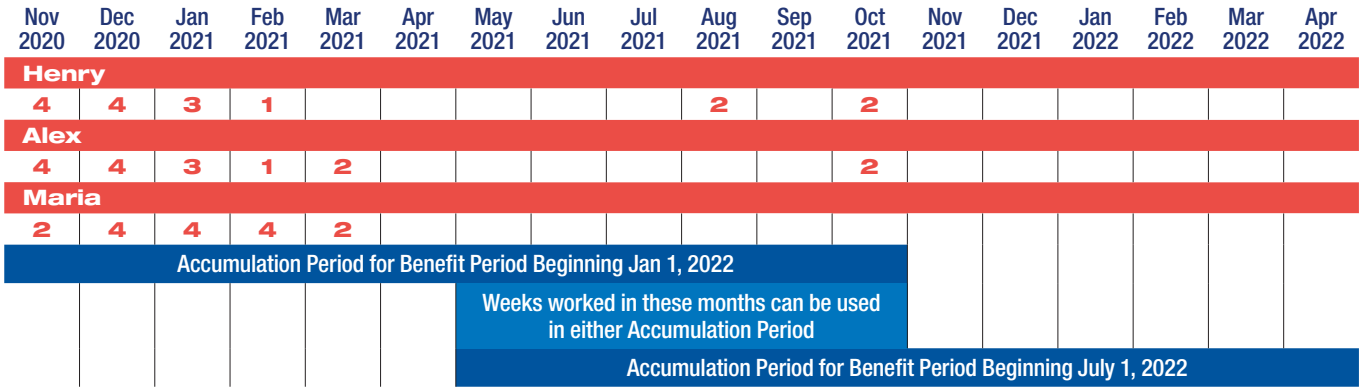
- Because two of Ava's weeks were earned in October 2021, she is able to save them for the next Accumulation Period.
- Before Ava makes this decision, she should be confident that she will be able to earn additional weeks between now and April 30, 2022.

Example: Elijah

- Because all of Elijah's weeks were earned before May 2021, he is not able to save them for the next Accumulation Period.

Henry, Alex, and Maria earned 16 weeks.

Their next possible Benefit Period begins January 1, 2022. This means their Accumulation Period looks at the weeks earned between November 2020 and October 2021. If they want to save their weeks for the next Accumulation Period, the weeks must have been earned May – October 2021. These dates are for illustrative purposes only.



Example: Henry

- Because two of Henry's weeks were earned in August 2021 and two were earned in October 2021, he is able to save up to four weeks for the next Accumulation Period.
- Henry has two options. He can choose to save two weeks and enroll in the Tier 2 Plan or save four weeks and enroll in the Tier 3 In-Network Only Plan.
- Before Henry makes this decision, he should be confident that he will be able to earn additional weeks between now and April 30, 2022.

Example: Alex

- Because two of Alex's weeks were earned in October 2021, they are able to save these two weeks for the next Accumulation Period but not the weeks from before May 2021.
- Alex can choose to save these two weeks and enroll in the Tier 2 Plan.
- Before Alex makes this decision, they should be confident that they will be able to earn additional weeks between now and April 2022.

Example: Maria

- Because all of Maria's weeks were earned before May 2021, she is not able to save them for the next Accumulation Period.

Understanding COBRA: What Happens If You Lose Coverage

If you lose coverage and are offered COBRA, it is essential that you take action by the deadline provided on the notice you receive.

You will be offered COBRA for the same Tier you were enrolled in when you lost coverage due to not working enough weeks. However, you have the same options to change Tiers as an active participant who is eligible for that Tier. The table below shows your options.

If you lost your active coverage with:

Tier 1

You will be offered Tier 1, but can elect down to either Tier 2 or Tier 3 In-Network Only which have a lower premium.

Tier 2

You will be offered Tier 2, but can elect down to Tier 3 In-Network Only, which has a lower premium.

Tier 3 In-Network Only

You will be offered Tier 3 In-Network Only, but can elect up to Tier 2 which has a higher premium.

HMO

You are only able to continue COBRA with that HMO plan. You can only change coverage at open enrollment.

Additionally, you have the option to change Tiers (based on the table above) every six months, beginning with the date your COBRA coverage starts. You will continue in the same Tier, unless you notify the Fund in writing that you wish to make a change before the next six months of COBRA coverage begins. For example, if you elect COBRA for Tier 1 starting on March 1, 2022, you have the ability to switch to Tier 2 as of September 1, 2022, for the next six months. However, you must notify the Fund in writing before September 1, 2022.

Important things to understand about COBRA:

- **If you requalify for continuous coverage at the same Tier and choose voluntarily to elect a lower Tier,** you are not experiencing a COBRA event because it is not due to a reduction or loss of work.
- **If you requalify for continuous coverage at a lower Tier,** you will be offered COBRA for the higher Tier you lost. In this case, you have the choice to elect and pay for COBRA at the higher Tier or enroll in the lower Tier that you earned through employment. For example, if you had the Tier 1 Plan through October 2021 and requalified for the Tier 3 In-Network Only Plan beginning November 2021, you have a choice. You can enroll in the Tier 3 In-Network Only Plan or elect COBRA for Tier 1 and self-pay the Tier 1 COBRA rate.

Questions?

The Fund Office is happy to help! In NYC, call (212) 869-9380 or toll-free outside of NYC call (800) 344-5220. We are available Monday – Friday, 9:30 a.m. – 5:30 p.m. ET.

Additional information, including the Summary Plan Description (SPD) is available on our website at **equityleague.org**.

Parental Benefit

Our new parental benefit recognizes that earning coverage for six months at a time raises unique challenges for growing families.

The Fund will subsidize the cost for three months of COBRA, reducing your cost for single coverage to $250 per month, if:

- You have a child (either by birth or adoption) while you are covered by active employment and you lose coverage through employment 3 months or less after you have the child, and elect COBRA by your deadline, the subsidy will apply for your first three months of COBRA, or
- You have a child (either by birth or adoption) 3 months or less after losing coverage through active employment and you elect COBRA by your deadline, the subsidy will apply for the first three months of COBRA after you have the child.

Only the cost for single coverage is subsidized; if you elect family coverage, you will need to pay the full additional cost for family coverage.

Other Important Benefit News

Additional Self-Pay Option Gives You Added Flexibility

If you previously qualified for Tier 2 or Tier 3 and requalify at the same Tier, you have the option to defer restarting coverage at that Tier in order to qualify later for a higher Tier later. In this instance, you will be offered the right to self-pay at the COBRA rates for up to three months (despite the fact that you are not actually entitled to COBRA because you were offered the same level of coverage).

Take a look at an example:

- You were enrolled in Tier 2 from March – August 2021.
- You requalify for Tier 2 on September 1, 2021, but would qualify for Tier 1 on October 1, 2021.
- You may pay for one month of Tier 2 at the COBRA rate.

COVID-19 and Your 401(k)

While your 401(k) Plan is intended to help you save for retirement, there are times when the need for extra cash now outweighs the desire to save for the future. When life leaves you in need—for example with unreimbursed medical or funeral expenses—you may be eligible to request a Hardship withdrawal.

In addition, many of our members are suffering financially because of the current public health crisis. The Fund has implemented special rules that can help you through this uniquely difficult time.

Understanding the COVID-19 Hardship Withdrawal Distribution Rule

On March 16, 2020, the Equity-League 401(k) Plan added a provision that allows you to make a withdrawal if you have a hardship caused by the COVID-19 pandemic. The rule permits a distribution to be taken for your expenses and losses related to the COVID-19 virus, including loss of income due to closures and layoffs. The rule applies regardless of whether you were infected, quarantined, or otherwise isolated.

Continuing into 2021, COVID-19 hardship withdrawal distributions are still permitted as long as documentation supporting the expense is provided. However, you won't need to provide additional documentation if the Fund Office can verify from its records that you:

- stopped working in covered employment when the COVID-19 pandemic first shut down live theater,
- have not worked since that time, and
- the amount you are requesting does not exceed your lost income for that period.

If the Fund Office cannot verify that those conditions are met, you will need to provide documentation to support your request.

You are not eligible for a hardship distribution if you are eligible for a distribution under any other provision of the Plan, such as for termination of service.

Required start date for 401(k) and Pension Plans increasing from age 70½ to 72

For participants who turned 70½ after December 31, 2019, distributions will not be required until the April 1 after the participant turns 72 (or retires, if later for the 401(k) Plan). **This change does not prevent someone who wishes to start their pension as of the April 1 after they turn age 70½ from doing so.** The new law also changes age 70½ to age 72 for spouses as beneficiaries and 5% owners. This provision applies only to those participants who reach age 70½ after December 31, 2019.

Changes to HIV PrEP Drug Coverage

If you or a covered dependent take HIV drugs used for Pre-Exposure Prophylaxis (PrEP), there have been changes to how these drugs are paid for by the Plan.

The changes are a result of two things: 1) the introduction of a generic equivalent for Truvada; and 2) the Plan's implementation of Optum Rx's comprehensive utilization management program, including step therapy, to help manage prescription drug costs.

Because a generic equivalent of Truvada is now available, both Truvada and Descovy (a newer medication prescribed for PrEP) have been removed from the OptumRx formulary. This means you can obtain Truvada or Descovy ONLY in cases of medical necessity. To do so, your physician must state that you have a history of intolerance or contraindication to Truvada (or its generic equivalent).

Many of the participants who used brand-name Truvada or Descovy in the past had no copay because of a copay assistance card offered by Gilead Sciences, the drugs' manufacturer. These cards periodically expire and renew. As these cards are not affiliated with our Plan, the Health Fund does not have any control over the copay assistance programs. In the past, Teva Pharmaceuticals, the manufacturer of generic Truvada, offered a similar copay assistance card. However, that program has since expired.

As the Plan will cover Truvada or Descovy only when medically necessary, most participants will now receive generic Truvada. Because generic utilization benefits both the participants and the Fund, **the Fund covers the full cost of generic Truvada (at the emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg tablet dose) under Tier 1, Tier 2 and Tier 3 In-Network Only.** For Tiers 2 and 3 In-Network Only, there is no copay if used for HIV PrEP. If your prescription for that same dose is not for HIV PrEP use and you are enrolled in Tier 2 or Tier 3 In-Network Only, you are responsible for the applicable copay.

Effective January 1, 2022, we are pleased to report that, regardless of whether or not the prescription written by your doctor is for HIV PrEP use, the Plan will cover the full cost for generic Truvada (at the emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg tablet dose only) in all three Tiers.

If you have questions about this change, please call the Fund Office.

Legal Notices

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act is a federal law that provides protection for breast cancer patients who choose breast reconstruction in connection with a mastectomy. All group health plans, including HMOs that provide medical and surgical benefits in connection with a mastectomy, must also provide for reconstructive surgery in a manner determined in consultation with the patient and attending physician. If you or an enrolled dependent are a breast cancer patient, you should know that in addition to providing medical and surgical benefits in connection with a mastectomy, the Equity-League Health Plan also includes coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas

This coverage is subject to applicable copayments, referral requirements, annual deductibles, and coinsurance provisions. Review the applicable provisions of the Health Plan about any restrictions that may apply to you. If you have any questions about this coverage, please contact the Fund Office at (212) 869-9380 (New York City area) or toll-free nationwide at (800) 344-5220.

HIPAA Privacy Notice

If you would like to see the Health Plan's HIPAA Notice of Privacy Practices, which was last revised in September 2013, please visit equityleague.org, click on the Health tab, and select HIPAA Privacy Notice. Or, to request your own printed copy of the notice, contact us as directed below:

Email: health@equityleague.org

Mail: Privacy Officer, Equity-League Health Benefit Fund, 165 West 46th Street, Suite 812, New York, NY 10036

Phone: Call (212) 869-9380 (New York City area) or toll-free nationwide at (800) 344-5220

The HIPAA Notice of Privacy Practices describes how the Health Plan uses and discloses protected health information, and it also discusses important federal rights that you have with respect to your protected health information.

Your Right to Request a Pension Benefit Statement

If you would like to receive a detailed statement of the pension credit you've earned under the Equity-League Pension Plan, and whether you are vested, you must make the request in writing. Send your request to Equity-League's Benefit Services Department as directed below:

Email: pension@equityleague.org

Mail: Equity League Benefit Services Department 165 West 46th Street, Suite 812 New York, NY 10036

You are entitled to receive a pension benefit statement, upon request, once every 12-month period. If you have questions, call the Benefit Services Department at (212) 869-9380 (New York City area) or at (800) 344-5220 (toll free nationwide).

Notice of grandfathered status for the Health Fund

The Equity-League Health Fund believes the Cigna Tier 1 Health 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 (ACA), 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 ACA 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 ACA, for example, the elimination of lifetime dollar 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 at (212) 869-9380 or toll-free nationwide at (800) 344-5220. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

In contrast to the Fund's self-insured Tier 1 coverage administered by Cigna and OptumRx, coverage provided through the Fund by an HMO is not grandfathered and will have to satisfy all the minimum coverage requirements of the ACA (which is the HMO's responsibility).

Equity-League
Benefit Funds

Equity League Benefit Services Department
165 West 46th Street, Suite 812
New York, NY 10036

Open Immediately! Important Benefit News

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