



EQUITY-LEAGUE BENEFIT FUNDS
PENSION, HEALTH & 401(K)

HEALTH PLAN BENEFIT BOOK:
SUMMARY PLAN DESCRIPTION (SPD)
MAY 2018

This SPD will be updated from time to time. The most up-to-date version of this document can always be found on the “Health” page of the Fund’s website: equityleague.org.

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Important Note: The Equity-League Health Trust Fund and the Actors' Equity Association Are Separate Entities

ALL BENEFITS DESCRIBED IN THIS SUMMARY PLAN DESCRIPTION ARE PROVIDED BY: The Equity-League Health Trust Fund (the Fund) (not Actors' Equity Association, AFL-CIO [AEA or the Union], which is a separate entity).

Accordingly, if you have a question regarding your benefits under the Fund, please do not contact Actors' Equity Association. Instead, all questions concerning the Fund should be directed to the Fund Office.

The Fund is what the law calls a "health and welfare" benefits program that is established and maintained in accordance with the applicable provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Fund covers employees of the various employers who are required to contribute to the Fund pursuant to the terms of a collective bargaining or other written agreement with AEA as well as eligible employees of the Equity-League Pension, Health, and 401(k) Trust Funds and certain other employers who have agreements with the Fund. The Fund is a not-for-profit entity, created and administered for the sole purpose of providing benefits to AEA-represented employees working under collective bargaining agreements with **contributing employers** and other Fund **participants**. The Fund makes no profits of any kind, and all assets are used for the sole and exclusive benefit of Fund **participants**. The Trust Fund is governed by a Joint Board of Trustees that is made up of an equal number of Union and Employer Trustees who have equal voting power. Therefore, neither the Union nor the Employers may unilaterally determine the policies of the Trust Fund. The Trustees receive no compensation from the Fund for their service to the Fund.

History of the Health Fund

The Equity-League Health Fund was formally created through an agreement executed by the AEA and the Broadway League (then the League) representatives on March 23, 1961. The Fund Office was first established on May 15, 1961, with one Fund Manager and two employees, and the first health benefit coverage was provided commencing on June 1, 1961. At that time, only those working under a production contract were eligible to be covered under the Fund (those working under Off Broadway, Industrial, and Stock contracts were covered by Actors' Equity Insurance Fund). Today the Fund covers employees all across the nation and working under virtually all Actors' Equity Association contracts.

There were eight Trustees for the Health Fund when it began: four representing AEA (Ralph Bellamy, Angus Duncan, Eddie Weston, and John Effrat) and four representing the League (Jay Julien, Herman Shumlin, John Shubert, and Irving Cheskin). These same trustees served on the Equity-League Pension Fund as well, as Trustees for the Health Fund do today. Mr. Cheskin went on to become the longest serving Trustee in the history of the Funds, remaining with the Funds until shortly before his death, in the fall of 2008. The longest serving trustee representing AEA is Jeanna Belkin, who began as a Trustee in 1965 and retired in 2011.

When the Fund commenced, health coverage was earned almost as soon as work began and lasted for six months (those who worked at least six months received nine months of coverage after they terminated employment). However, coverage consisted only of life insurance and reimbursement of **hospital** and certain doctor's services. There was no coverage for prescription drugs or dental care, and there was no supplemental workers' compensation coverage. Health benefits were initially insured with Blue Cross and/or through Group Health Incorporated or Health Plan of New York. In 2005, the Fund had grown large enough to become self-insured (for other than HMO and dental benefits), saving money for the Fund and enabling a greater percentage of contributions to be passed through to **participants** in the form of benefits.

Today more than 90% of every contribution dollar received by the Fund and applied to the self-insured part of the plan is used to provide benefits for plan **participants**. Fund revenues were in the thousands of dollars per year in 1961, compared with more than \$60 million in the plan year that ended in 2016. As of 2016, the Fund has paid out, since its inception, substantially more than half a billion dollars in benefits to its **participants**.

Contacting the Fund Office

The Equity-League Fund Office is located at: 165 West 46th Street, 14th Floor, New York, NY 10036-2582

Business hours are: 9:30 a.m. to 5:30 p.m. Eastern Time, Monday-Friday

Phone: 1-212-869-9380 or 1-800-344-5220 (Outside NYC only) Fax: 1-212-869-3323

Website: equityleague.org; Health Department e-mail: health@equityleague.org

For a complete listing of Fund Office contact information, see page 81.

May 2018

Dear Equity-League Health Trust Fund Participant:

We are pleased to provide this updated Summary Plan Description (SPD), which describes the benefits and eligibility rules under the Equity-League Health Trust Fund (the Fund) that are in effect as of January 1, 2018 (unless otherwise specified herein). The SPD summarizes the Fund's benefits, which include these plans:

- Comprehensive Medical Plan, which includes **hospital**, medical, and prescription drug coverage (in some geographic areas, an HMO is available as an alternative),
- Vision Care Plan,
- Supplemental Workers' Compensation Plan, and
- Dental Plan (optional on a fully self-pay basis).

This SPD (including any modifications) along with certificates of insurance for any insured benefits constitutes the Plan Document.

We urge you to become familiar with these benefits and to keep this SPD handy for future reference. Although this SPD provides essential information about your benefits, it is intended only as a summary of the terms under which they are provided. Because only a minority of Plan **participants** elects dental coverage, that voluntary dental coverage is not fully described in this book. For more information on dental coverage, please contact the Fund Office. Additional information concerning your benefits under the Fund is included in related documents, such as Cigna's certificates of dental insurance and other governing documents. These documents, along with any applicable administrative rules and regulations, are available from the Fund Office and/or the Fund's website.

We have made every effort to ensure that the SPD provides an accurate explanation of all Plan rules, including any insured benefits. Nonetheless, in the event of any conflict between this document and any insurance contract, the insurance contract will govern. As always, your rights to benefits can only be determined by the Fund, as interpreted by the official action of the Fund's Board of Trustees (Trustees or Board). In addition, the Board reserves the right, in its sole discretion, to amend, modify, or terminate any benefits provided under the Fund at any time. Please see the "Other Important Information You Should Know" section for more details.

Note Regarding Special Eligibility Rules: Special eligibility rules may apply for staff — e.g., employees of the Union, Fund, and Broadway League — and certain foreign actors employed under agreements with Actors' Equity Association. Contact the Fund Office for more information.

Special Note About Health Care Reform: The Equity-League Health Plan is grandfathered under the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). (See the Important Government Notice Regarding the Plan's Grandfathered Plan Status on page 54.) The Fund will notify you of any future benefit changes and will post any updates on its website, equityleague.org.


If you have any questions regarding the information in this book, you are encouraged to contact the Fund Office or visit our website at equityleague.org. The most up-to-date version of this document is always available there.

Sincerely,

The Board of Trustees

Notes Regarding the Style Conventions Used in this SPD

Throughout this SPD, when a word or term appears in **bold** type, it means it is a defined term for Fund purposes. See the "Key Medical Benefit Terms, Definitions and Benefit Elaborations" section on page 12 for the definition.

Each time the clock symbol  appears, it means there is a time-sensitive item being discussed.

EQUITY-LEAGUE HEALTH FUND (the Fund) ELIGIBILITY SUMMARY CHART (AS OF 5/01/18)

INITIAL PARTICIPANT MEDICAL/VISION COVERAGE begins 2 months after you work at least 11 weeks of **covered employment** (earn 11 health credits) in a 12-month period ending on the last day of a month and pay \$100 (which buys 3 months of coverage) to the Health Fund. You are eligible for 6 months of coverage if you work 11–18 weeks in the aforementioned period, and 12 months of coverage if you work at least 19 weeks. **Supplemental Workers' Compensation (SWC)** eligibility begins as soon as you commence **covered employment**.

Your opportunities for continuing coverage after that are explained in the boxes presented from left to right below. If you don't qualify for continued coverage, the Fund will continue to examine your work history after each calendar month to see if you newly qualify.

SUBSEQUENT COVERAGE

Already Earned Employment-Based Coverage

Once you have earned 6 or 12 months of coverage **and have paid** for the first quarter of coverage of that period, you will be billed each quarter for any remaining coverage you have earned, and you may choose to pay or not each quarter (you may elect at the outset to pay for the full 12-month period for which you have earned coverage).

Newly Earned Employment-Based Coverage

If you did not pay for (elect) coverage in the first month of a period for which you qualified (or your previously earned coverage is running out), at the end of each month, your unused work weeks earned in the past 12 months are counted to see if you have earned coverage eligibility for the next benefit period beginning 2 months later (weeks earned more than 12 months ago, or used to earn prior coverage, are never counted). If so, you are again offered coverage. If not, coverage eligibility will be determined once again at the end of the next month.

COBRA Coverage

If your coverage through employment runs out, you will be offered 18 months of COBRA coverage (29 months if you were recognized as being totally and permanently disabled by the Social Security Administration [SSA]).

Extended Self Pay After COBRA

If you elected COBRA coverage and your coverage runs out, you are eligible to continue your coverage up to an additional 18 months – if you have earned 10 years of vesting service under the Equity-League Pension Plan. If you become Medicare eligible within this 18-month period, you can continue your coverage, but it will become secondary to your Medicare coverage unless you requalify based on weeks of **covered employment**.

DEPENDENT AND DENTAL COVERAGE ELIGIBILITY

You will be offered self-pay dental coverage for you and your dependents, and medical coverage for your dependents, when:

- you first become eligible for health coverage,
- you become eligible for health coverage again after a gap in coverage,
- you inform us within 31 days of the acquisition of a dependent through birth, adoption, a Qualified Medical **Child** Support Order (QMCSO), marriage, or the creation of a domestic partnership or within 31 days of having a dependent in one of these categories lose coverage they previously had (your dependent(s) will only be offered dental if you elected it), and/or
- you elect dependent and/or dental coverage during the Fund's annual open enrollment period in November of each year (offered to members who will be eligible for coverage in January of the following year). Whatever choices you make at this time (when you newly enroll) will last until the next annual open enrollment.

Once you have dental coverage, you can continue it for as long as you continuously pay the premium, regardless of your continuing medical eligibility.

SPECIAL ELIGIBILITY RULES FOR DEPENDENTS

In almost all cases, dependent eligibility is tied to **participant** eligibility: If the employee is not eligible, neither is the dependent. For instance, if the **participant** is not qualified for health coverage through employment, neither is the dependent. In addition, if the **participant** does not elect dependent coverage for a dependent when it is offered, the dependent will generally not become eligible for coverage again unless the **participant** becomes newly eligible for coverage through employment after a gap in coverage or through an open enrollment opportunity.

Eligibility for dependent coverage is based on the dependent's relationship to the **participant**. In the case of a spouse or **domestic partner**, the dissolution of the relationship dissolves coverage eligibility for the dependent spouse or **domestic partner**. **Children** may be protected from the loss of coverage by QMCSOs, which require continued coverage of dependent **children** in the event of divorce or separation. Generally, in the case of **children**, the relationship that qualifies the child is being a dependent of the **participant**. **Children** under the age of 26 are automatically considered dependents, as are permanently **disabled children** of any age (if the **child** became disabled while covered by the Fund as your dependent and before reaching age 19).

The exception to the above rules relates to COBRA coverage. Under the COBRA rules, if the **participant** dies, divorces from a spouse, or dissolves a domestic partnership; if dependent **children** no longer qualify as dependents; or if the member becomes entitled to Medicare coverage less than 18 months prior to a qualifying event, the dependent is eligible for 36 months of COBRA coverage. Dependents or **participants** who lose coverage because of employment termination or a reduction of hours, are entitled to 18 months of COBRA coverage (those who become disabled by the 60th day from the start of COBRA coverage and were eligible for 18 months of coverage become eligible for an additional 11 months of COBRA coverage if you notify the Fund Office before the end of the initial 18 months and within 60 days of the latest of: a) SSA disability determination, b) initial qualifying event, or c) date of loss of coverage from the initial qualifying event).

EQUITY-LEAGUE HEALTH FUND (the Fund) BENEFITS SUMMARY CHART

(As of 5/01/18)

BASIC HEALTH BENEFIT RULES: The Fund's benefits structure is summarized below, but remember that the following overarching rules apply to those benefits:

1. Before any benefits can be paid to you/your health care provider, the following criteria must be met: a) you must be covered by the Fund during the time period when any treatment was rendered (see the page on "Eligibility"), and b) the treatment rendered must be **medically necessary** (both these words are important). You might need an aide to cook for you due to a disability, but that is generally considered a custodial service, not a medical treatment. Similarly, a spinal manipulation may be a medical treatment, but it may not be considered **medically necessary** to treat your particular condition. You can always contact the Fund Office to confirm that you are covered. When you are in doubt about whether a treatment is considered **medically necessary**, please contact Cigna, which makes these determinations on behalf of the Fund (or your HMO if you have HMO coverage).
2. When you use out-of-network providers, covered treatments are reimbursed only up to the **maximum reimbursable charge (MRC)** level as determined by Cigna (providers can charge well in excess of the **MRC**, so check with Cigna in advance if you are having an expensive procedure out-of-network), and claims must be filed within 12 months of the date charges were incurred.
3. Non-emergency inpatient and certain outpatient treatments must be precertified by Cigna. Failure to precertify for inpatient treatment can result in the application of an extra \$250 deductible and/or the **hospital stay** may not be covered.
4. Some charges are excluded from coverage (such as on-the-job injuries, experimental treatments, and/or custodial care), so when in doubt review the plan documents and/or contact Cigna).

Cigna/ProAct TWO BASIC MEDICAL COVERAGE CHOICES: CIGNA/PROACT or HMO (see next page)

MEDICAL BENEFITS THROUGH THE FUND'S SELF-INSURED OPEN ACCESS PLAN (OAP) ADMINISTERED BY CIGNA

In-Network: Go to an in-network health care provider and pay only a \$25 copay for most treatments; no referral is necessary. Preventative/Wellness benefits are paid at 100% (with no **copayment** required).

Out-of-Network: All out-of-network care is subject to a \$350 (\$700 per family) calendar year deductible against covered charges, after which benefits are paid at 70% of allowable charges (you pay the balance of 30%, or more if the charges are higher than allowable), with an annual out-of-pocket maximum of \$5,000 (\$10,000 per family).

Precertification: Any non-emergency admission to a health care facility must be precertified by Cigna (if the precertification for an inpatient admission does not take place, the admission is subject to a \$250 deductible). You have 48 hours to inform Cigna of an emergency admission; beyond that, the \$250 penalty applies.

Skilled Nursing Care Facility: Covered if those days are in lieu of **hospital** days.

Home Health Care: Covered up to 200 days per year, 16 hours per day, in lieu of **hospital** or skilled nursing home care, with a separate \$50 deductible per year (coverage is 75% of reasonable and customary charges out-of-network).

Chiropractic, Acupuncture, and Rehabilitation Therapy: A \$15 **copay** applies to in-network chiropractic, **acupuncture**, and physical therapy treatments; rehabilitation therapy (physical, occupational, and speech therapy), with a maximum of 60 days per calendar year for all three rehabilitation therapies combined.

Hospice: Covered in a Cigna-approved program.

Mental Health & Substance Abuse: Includes inpatient and outpatient visits for mental health and substance abuse.

PRESCRIPTION DRUG BENEFITS THROUGH PROACT

Prescription Drug Benefits: Through the Fund's Pharmacy Benefit Manager – ProAct – prescription drug benefits vary with the category of drug, whether you use generic, specialty, preferred, or non-preferred brand name drugs, and whether you purchase drugs at a local pharmacy, or through ProAct's mail order drug/90 Day retail programs. The use of mail order and certain ProAct 90 Day retail pharmacy locations is mandatory after the initial prescription and refill of "maintenance" drugs for up to 30 days that are typically used at the same dosage level on a long-term basis. A \$100 annual calendar year deductible per person (limit of \$200 per family) applies before any benefits are available except for generic drugs, for which there is no annual deductible. After that, there are varying **copays** for different classes of drugs and at in-network versus out-of-network pharmacies, as shown below. However, only generic versions of drugs that treat high blood pressure, high cholesterol, acid reflux, eczema and psoriasis, sleep disorders, and allergies (nasal sprays) are paid for by the Fund, unless your **physician** has secured an exception to the generic requirement from ProAct:

Generic Drugs at In-Network Pharmacies (30-day supply): You pay 20% of cost but no less than \$10.

Specialty Drugs at In-Network Pharmacies (30-day supply): You pay 25% of cost of the cost of the drug. However, if a specialty drug is also a generic drug you pay even less – because the generic copay described above applies. Specialty drugs are high-cost medications that often have special handling or administration requirements. Specialty drugs are typically prescribed to treat rare, chronic, and/or complex medical conditions.

Preferred Brand Name Drugs at In-Network Pharmacies (30-day supply): You pay 25% of cost but no less than \$20.

Note: If the overall cost of a drug is less than the minimum copay required, you will **only be charged the actual cost of the drug.**

Certain Preventative Medications: Covered prescriptions are paid at 100%, where no **copay** is required.

Non-Preferred Brand Name Drugs at In-Network Pharmacies (30-day supply): You pay 30% but no less than \$25.

ProAct 90 Day Retail Pharmacies or Mail Order Program (90-day supply): Standard supply is 90 days for retail pharmacies that are in the ProAct 90 day network as well as ProAct's mail order program (compared to 30 days at a regular retail pharmacy; hence, the higher flat dollar **copay**). The use of one of these programs is required after the first refill of a 30-day supply for a drug at a regular retail pharmacy (i.e., the 30-day standard retail pharmacy cannot be used after the first 60 days that you have used a particular prescription drug at the same potency). Same percentages as indicated above, but flat dollar minimums are doubled (e.g., generic 20% but no less than \$20).

Out-of-Network Pharmacies: For all drugs, 30% and you must fully pay for the drugs at the pharmacy, then file a claim for reimbursement with ProAct.

Out-of-Pocket Drug Cost Cap: Covered prescription drugs are reimbursed at 100% after you have paid \$4,000 out of pocket for drugs in a calendar year.

DENTAL

Dental Coverage:
Dental HMO (DHMO)
or Dental PPO (DPPO)

The DHMO has no annual maximum benefit and covers many preventive and basic dental services in full. The premium required to purchase DHMO coverage is much lower than what it is for the DPPO plan. However, the choice of providers is narrower than under the DPPO, and there is no out-of-network benefit except for emergencies (which have a \$50 reimbursement limit). Finally, coverage for major services can actually be lower than under the DPPO.

Under the DPPO, in-network reimbursement for preventive services is 100% and out-of-network is 70%; basic services are 80% in-network and 60% out-of-network; and major restorative and orthodontic services are 50% in-network and 40% out-of-network. The annual maximum under the DPPO is \$2,000. There is a \$1,500 lifetime maximum on orthodontic procedures.

Choose Either of Two Dental Options OR No Dental

EQUITY-LEAGUE HEALTH FUND (the Fund) BENEFITS SUMMARY CHART

(As of 5/01/18)

Cigna/ProAct con't.

VISION CARE: Eye exams are covered every 12 months. Basic lenses and select frames are also covered in full (contacts have a \$25 copay) every 24 months with the Davis Vision network. A \$100 credit, plus a 20% discount in excess of the \$100, will be available for any frames selected outside of the Davis Vision frame collection within a **network provider's** office. Amounts exceeding the \$100 will be the **participant's** responsibility. If contact lenses outside of the Davis Vision collection are selected, a \$115 credit, plus a 15% discount in excess of the \$115, will be applied toward the purchase, in addition to the evaluation, fitting, and follow-up care. The network credit allowance will also apply at participating retail locations. Amounts exceeding the \$115 will be the participant's responsibility. For out-of-network, the same kinds of products and services are covered, but the Fund only pays up to the comparable amount it would reimburse a **network provider** in the same geographic area for the same service. Out-of-network contact lenses that are considered **medically necessary**, the maximum reimbursement is \$225.

SPECIAL RULES FOR COORDINATION WITH MEDICARE AND SAG-AFTRA HEALTH PLANS

MEDICARE: If you are covered by the Fund based on employment and are also covered by Medicare, any health benefits you receive from the Fund are primary (the Fund pays your health benefits first) and Medicare is secondary. If you are covered on COBRA or any other form of self-pay and you become Medicare eligible, Medicare becomes primary and the Fund's benefits are secondary (which means Medicare pays its benefits and the Fund pays the balance up to 100% of the amount billed). In this latter case, the Fund pays as if you have Medicare, even if you have not secured Medicare coverage.

SAG-AFTRA: If you are eligible for SAG-AFTRA health benefits and those of the Fund, special rules determine which plan is primary (pays first) and which is secondary (pays up to 100% of remaining charges after the primary plan has paid). For instance, if you qualified for SAG-AFTRA coverage before Fund coverage, SAG-AFTRA is primary. In such a case, the Fund will pay as if it were secondary, even if you do not elect the SAG-AFTRA coverage. SAG-AFTRA will do the same in the reverse situation, so it is very important that you elect and retain the coverage you are first eligible for if you expect to receive primary coverage from one of the two plans. If you have not elected six months of Fund coverage because you are waiting to qualify for 12 months, and qualify for SAG-AFTRA coverage before qualifying for 12 months of coverage with the Fund, SAG-AFTRA is primary.

HMO

HMOs – Alternative Medical and Drug Coverage

HMOs are offered as an alternative to the Open Access Plan (OAP) in certain major metropolitan areas. In those areas, eligible members may choose between the OAP and HMO when they are newly eligible for medical coverage or during the annual open enrollment period. If you are going on the road for 9 months or more, you can switch to the OAP during the year. The benefits provided vary with the HMO but tend to be similar to what is provided under the in-network benefit under the OAP plan, though **copays** are often lower. Please see HMO marketing materials for the details of these benefits (available online at equityleague.org). However, remember that HMOs do not offer out-of-network benefits of any kind (except for **emergency care**). Since HMO networks are local in nature, members who travel outside their area of residence will generally not have access to HMO benefits. In addition, HMOs generally require that you use a primary care **physician** for most of your care and require that you secure a referral from the primary care **physician** before you can see a **specialist** (except in emergency situations). Such a referral is not required under the OAP.

Prescription Drug Benefits

Drug benefits are included in an HMO's medical benefits and vary by HMO, and generally have no annual deductible of the kind that is in effect in the OAP. See any HMO offering that may be available in your area for the details of their specific plan.

Vision Care

The same vision care benefit provided under the Cigna Plan is also provided to those who elect HMO coverage.

Supplemental Workers Compensation (SWC)

SWC benefits replace part of your income if you become sick/injured while performing, are unable to continue working, and qualify for Workers' Compensation (WC) benefits (any SWC benefits are reduced by amounts payable under WC). The standard weekly SWC benefit is the lesser of: a) 100% of your weekly salary or b) 75% of the production contract weekly minimum. Generally, SWC benefits are paid up to a total of 104 weeks – as long as you are still getting paid by WC. During those 104 weeks, you will be considered disabled if you are unable to perform your usual occupation (e.g., acting, singing or dancing). Your benefits can be extended beyond 104 weeks, if you both (1) continue to receive Workers' Compensation benefits after the 104 weeks and (2) Workers' Compensation determines that you are totally disabled and unable to work in any occupation for which you are reasonably qualified. In addition, no benefits will be paid for any period after your Workers' Compensation benefits end.

VERY IMPORTANT NOTICE: We've summarized many important plan rules in this chart, but we don't intend for this chart to replace or amend the official plan document. We will follow the rules of the official plan document if those rules differ from this chart in any way. The Summary Plan Description is available at the website equityleague.org or from the Fund Office.

DENTAL

Dental Coverage: Dental HMO (DHMO) or Dental PPO (DPPO)

The DHMO has no annual maximum benefit and covers many preventive and basic dental services in full. The premium required to purchase DHMO coverage is much lower than what it is for the DPPO plan. However, the choice of providers is narrower than under the DPPO, and there is no out-of-network benefit except for emergencies (which have a \$50 reimbursement limit). Finally, coverage for major services can actually be lower than under the DPPO.

Under the DPPO, in-network reimbursement for preventive services is 100% and out-of-network is 70%; basic services are 80% in-network and 60% out-of-network; and major restorative and orthodontic services are 50% in-network and 40% out-of-network. The annual maximum under the DPPO is \$2,000. There is a \$1,500 lifetime maximum on orthodontic procedures.

Choose Either of Two Dental Options OR No Dental

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EQUITY-LEAGUE OPEN ACCESS MEDICAL PLAN (OAP) ADMINISTERED BY CIGNA THE “CIGNA PLAN”

The Equity-League Medical Plan administered by Cigna is self-insured. That means all claims are paid out of the Health Trust Fund. Any surpluses of revenues received relative to claims and administrative costs contribute to the reserves of the Fund, which in turn are used only for the benefit of the plan participants by the Fund. The Fund has contracted with Cigna solely to administer medical claims, and ProAct solely to administer prescription drug claims, provide access to their respective medical and pharmacy networks to plan participants, and otherwise manage the care provided through the Plan. The prescription drug benefit of the medical plan administered by ProAct is described separately, beginning on page 21. From this point forward, this medical plan will be referred to as the “Cigna Plan.”

HOSPITAL, SURGICAL, AND GENERAL MEDICAL EXPENSES UNDER THE CIGNA PLAN

Under the Cigna Plan, participants may choose to use health care providers who are part of Cigna’s nationwide Open Access Plus Network (i.e., network or “participating providers”) or go to licensed providers who are not in Cigna’s network (out-of-network or non-participating providers). The network and out-of-network benefits available under the Cigna plan differ significantly.

NETWORK SERVICES (PROVIDED BY CIGNA’S OPEN ACCESS PLUS NETWORK) — USE THESE TO MINIMIZE YOUR OUT-OF-POCKET COSTS

Services received through Cigna’s network generally are subject only to a \$25 copay (some services have a lower or no copay). No deductible or coinsurance generally applies to such services. Network providers agree by contract with Cigna not to charge plan participants any amount in excess of what Cigna pays them for services and supplies covered under the Cigna Plan. Consequently, you pay the least out-of-pocket (and have little or no paperwork to worry about) when you use network providers. More information on network benefits is provided beginning on page 2.

OUT-OF-NETWORK SERVICES — USE THESE AND YOU WILL LIKELY PAY MORE — PERHAPS MUCH MORE

Services provided by out-of-network providers are generally subject to a \$350 per person/\$700 per family annual deductible before being eligible for reimbursement. Covered out-of-network expenses are reimbursed at 70% of the maximum

reimbursable charge, leaving you responsible for the remaining 30% of the maximum reimbursable charge, plus 100% of any amount above the maximum reimbursable charge. This extra amount above the maximum reimbursable charge is commonly referred to as “balance billing.” After you have satisfied the annual deductible and paid \$5,000 in coinsurance (\$5,350 combined, \$10,700 for a family) in a given year, any remaining eligible expenses are reimbursed at 100% of the maximum reimbursable charge for the remainder of that year. Because out-of-network providers can balance bill you (charge any amount they wish above Cigna’s Plan maximum reimbursable charge (MRC)), any such excess amount is your responsibility even after you have satisfied the \$5,350 (single) or \$10,700 (family) amount. More information on out-of-network coverage is provided beginning on page 6.

MANAGING YOUR MEDICAL CARE AND PENALTIES FOR FAILURE TO PRECERTIFY CERTAIN CIGNA PLAN CARE

Certain benefits provided under the Cigna Plan must be precertified or they will be subject to penalties as follows. For in-network care you receive from network providers, the health care providers are responsible for obtaining the necessary precertification prior to the service being rendered. You (the patient) are responsible for precertifying care from non-network providers prior to services being rendered. You must contact Cigna to obtain precertification by calling the number found on the back of your ID card.

Pre-admission Certification Penalty for Failing to Precertify Non-Emergency Inpatient Care: Any non-emergency inpatient admission to a health care facility (e.g., hospitals, mental health, and substance abuse facilities) must be precertified by Cigna (if the precertification does not take place, the admission is subject to a \$250 deductible and one or more of the days you stay in the hospital may not be covered under the Cigna Plan). You have 48 hours from the time you are admitted to inform Cigna of an emergency admission; beyond that, the \$250 penalty applies, whether the days you are in the hospital are approved by Cigna or not. In addition, if you fail to precertify services, the claim will be subject to clinical review once it is received. If Cigna determines that clinical criteria is not met, it will deny the claim due to clinical criteria not being met, and you will be responsible for the entire claim. Cigna considers the following services to be inpatient, so they should be precertified:



- Hospital stays
- Inpatient services at other health care facilities (non-acute care hospitals), including skilled nursing care rehabilitation hospitals, other sub-acute facilities, and residential treatment centers for mental health and substance abuse
- Hospice care
- Transfer between inpatient facilities
- Maternity stays of longer than 48 hours (longer than 96 hours when there has been a C-section)

PRECERTIFICATION REQUIREMENT FOR NON-EMERGENCY OUTPATIENT SERVICES

Precertification allows participants to know what care will be covered in advance and at what level. For outpatient care, Cigna will determine whether and at what level a procedure will be covered. If you fail to precertify services, the claim will be subject to clinical review once it is received. If Cigna determines that clinical criteria are not met, it may deny the claim due to clinical criteria not being met, and you might be responsible for the entire claim. **The following patient services must be precertified to make sure that the services are covered and at what level in advance:**

- Outpatient surgery
- High tech radiology (MRIs, CAT Scans, PET Scans, nuclear cardiology)
- Injectable drugs (other than self-injectables)
- Home health care/home infusion therapy
- Dialysis
- Durable medical equipment
- External prosthetic appliances
- Biofeedback
- Speech therapy
- Cosmetic or reconstructive procedures
- Infertility treatment
- Radiation therapy
- Sleep management
- Musculoskeletal services (major joint surgery and pain management)
- Transplants
- Requests for services provided by a non-participating provider to be covered at the in-network level
- Intensive outpatient and partial hospitalization treatment for mental health and substance use disorders

OVERVIEW OF SPECIFIC CIGNA PLAN LIMITATIONS

Skilled Nursing Facility Care: Room and board at a skilled nursing facility are covered for up to 60 days per calendar year, as long as the attending physician certifies that the admission to the facility is medically necessary as a substitute for hospital confinement. Note that benefits are not payable for custodial care, care received in a non-approved facility, or care that is not medically necessary.

Home Health Care: Covered up to 200 days per year, 16 hours per day, only if in lieu of hospital or skilled nursing home care, with a separate \$50 deductible per year (out-of-network coverage is reimbursed at 75% of the maximum reimbursable charge).

Hospice: Covered only in a Cigna-approved program.

Rehabilitation Therapy: Rehabilitation therapy (physical, occupational, and speech therapy) — maximum of 60 days per calendar year for all therapies combined for inpatient and outpatient care.

A MORE DETAILED LOOK AT THE CIGNA PLAN

This section provides more details regarding hospital and medical coverage offered under the Cigna Plan. You'll find the following information in this section:

1. A side-by-side comparison of how benefits are paid in both network and out-of-network under the Cigna Plan. The chart starts on page 3.
2. Definitions of terms and covered medical expenses, starting on page 12.
3. Special Plan features that help you manage your care, starting on page 7.
4. An explanation of ineligible medical expenses, starting on page 8.

You will get additional information and updates from the Fund Office on the Cigna Plan, including limitations that apply to certain benefits, and important procedures you need to follow in order to qualify for benefits. Any additional information you get about the Plan should be considered part of, and kept with, this SPD. The most up-to-date information regarding the Plan is posted on the Fund's website, equityleague.org.

The Cigna Plan covers a wide range of health care services — from office visits, to lab tests and x-rays, major surgery and hospital care, and prescription drugs. Most eligible medical expenses are covered, both when they are received from Cigna's network providers and when they are received from out-of-network providers. Prescription drug benefits are also available on both a network basis (through a participating Cigna pharmacy and through Cigna's nationwide Tel-Drug Mail Order Program) and out-of-network basis. More details regarding the prescription drug benefits are available beginning on page 21.

THE NETWORK ADVANTAGE

Cigna offers a nationwide network of more than one million network providers. Through the Cigna Plan network, you have the option to choose a primary care physician (PCP) to serve as your personal physician and help you coordinate your health care needs. However, no referrals are necessary to see specialists in the network — just choose the participating doctor and make an appointment. You have the option to see any licensed physician chosen within or outside of the provider network, though your out-of-pocket expenses are typically lower when care is received from a provider in the network. Additionally, emergency care is covered 24 hours a day.

While you have the option of going out-of-network for your medical care, you pay the least out of your own pocket when you use providers in Cigna's network. In fact, your only out-of-pocket cost is the \$25 copay that applies to some services (certain types of care require a lesser copay or no copay at all).

Here are some other advantages of using network providers:

1. There is no deductible or coinsurance to pay, only a \$25 per visit copay for most outpatient treatments (chiropractic care, physical therapy, and acupuncture)

are subject to only a \$15 copay) and a \$50 copay for Emergency Room visits; there are no claims to file for outpatient care.

2. The credentials of medical care providers are prescreened by Cigna.
3. You are free to see a **specialist** without a referral from your PCP.
4. No “balance billing” — **network providers** have agreed not to charge anything beyond the **copay** for services covered under the Cigna Plan.

Cigna also conducts an extensive “credentialing” process for purposes of selecting and retaining providers as part of its network of **physicians** and **hospitals**. (Cigna does not perform credentialing of **hospital-based physicians**.) Where applicable, this process includes:

1. Verifying education, training, and any Board Certification (or completion of the training requirements) with the American Board of Medical Specialties/the American Osteopathic Association,
2. Verifying that MDs and DOs have unrestricted state medical licenses with the appropriate agency and DEA and CDS certificates,
3. Identifying any prior sanctioning by regulatory bodies or the Centers for Medicare and Medicaid Services (CMS),
4. Ensuring that appropriate levels of malpractice insurance are in place and checking malpractice claims history and disciplinary history, and
5. Verifying appropriate professional licensure.

In addition, Cigna also verifies that **physicians** have clinical privileges at Cigna-participating **hospitals** in states where this is required in order to practice at that **hospital**. Finally, on-site **office visits** are made to primary care **physicians**, OB/GYNs, and high volume behavioral health **specialists**.

THE CIGNA OPEN ACCESS PLUS NETWORK OR “PARTICIPATING PROVIDERS”

The Cigna Open Access Plus network is a network of doctors, **hospitals**, and other health care facilities selected by Cigna to provide care to Cigna Plan **participants**. These health care providers are referred to as “network” or “participating” **providers**.

FINDING A NETWORK PROVIDER

Here’s how to find a participating doctor, **hospital**, lab, or other network facility near you.

1. **Call Cigna:** You can talk to a Cigna Member Services Representative, who can assist you with locating a **network provider** by calling the toll-free number on your ID card. Don’t forget to specify that your network is the Open Access Plus network. Cigna is available 24 hours a day, 7 days a week, and 365 days a year. A provider network directory for your area is available without charge from Cigna.
2. **Browse Cigna’s Online Directory:** To locate a network doctor, pharmacy, **hospital**, or other provider in the Cigna Open Access Plus network, log on to *Cigna.com* and browse the online provider directory. (There’s also a link to the Cigna site on our website, *equityleague.org*.)
3. **Contact the Fund Office:** The Fund Office can help you find a **network provider**; please call during normal business hours of operation, which are from 9:30 am to 5:30 pm Eastern time Monday through Friday.

Key Terms and Definitions. We’ve tried to explain the Cigna Plan in everyday and non-technical language. If you come across terms you don’t understand, you can look them up in the “Key Terms and Definitions” section, which starts on page 12.

HOW YOUR ELIGIBLE MEDICAL EXPENSES ARE REIMBURSED

The following chart briefly illustrates how the Cigna Plan works, as well as how eligible expenses are covered in both network and out-of-network. As you will see, your out-of-pocket expenses are typically less when you utilize a **network provider** (as opposed to an out-of-network provider) for your care.

| Cigna Plan Benefits Summary | | |
|--|------------------|--|
| Site and Type of Care Plan Feature | How It’s Covered | |
| | Network | Out-of-Network |
| Lifetime Maximum | No Maximum | No Maximum |
| Annual Deductible (There is a separate annual deductible for prescription drugs [see page 21]). | None | \$350 individual \$700 family |
| Coinsurance | None | Generally 70% of maximum reimbursable charge (MRC) , after the deductible |
| Annual out-of-pocket maximum for coinsurance (There is a separate annual out-of-pocket maximum for prescription drugs [see page 21]). | Not Applicable | \$5,000 individual \$10,000 family |

| Site and Type of Care | How It's Covered | | |
|---|------------------|--|--|
| | Plan Feature | Network | Out-of-Network |
| Copay Per Visit | | \$25 most services | Not Applicable Other costs may apply—see below |
| Emergency Room Copay Per Visit | | \$50 | \$50 |
| Physician's Office – Certain Preventive Care - Pap tests, PSA tests, mammograms, maternity care (after 1 st visit to confirm pregnancy), allergy serum (dispensed by the physician in the office) | | 100% | 70% of MRC , after the deductible |
| Physician's Office – Regular Care (office visits including 2 nd opinions, urgent/ emergency care , family planning, infertility treatments, pre-admission testing , initial maternity visit to confirm pregnancy, adult and child immunizations, and allergy treatments/injections) | | 100% after \$25 copay (allergy treatment/injections the lesser of \$25 and the contracted amount) | 70% of MRC , after the deductible |
| Physician's Office – Outpatient Surgery (including abortions , sterilizations via vasectomy/tubal ligation but excluding reversals, procedures for correction of infertility, artificial insemination, excluding in vitro insemination, GIFT (gamete intrafallopian transfer) and ZIFT (zygote intrafallopian transfer), and similar procedures) | | 100% | 70% of MRC , after the deductible |
| Outpatient Department of a Hospital or a Freestanding Surgical Facility (including use of operating, recovery, procedure, and treatment rooms; services of anesthesiologists, radiologists, pathologists, surgeons, assistant and co-surgeons, and other licensed physicians) | | 100% | 70% of MRC , after the deductible |
| Hospital Inpatient (including private and semi-private room and board , professional services such as anesthesiology, radiology, pathology, surgery , and physician visits, Intensive Care Unit (ICU), Critical Care Unit (CCU), delivery of a baby in a birthing center, family planning)—precertification is required for all inpatient hospital stays* | | 100% of negotiated rate (semi-private room rate for room and board , whether room is private or semi-private) | 70% of MRC , after the deductible (up to the facility's most common semi-private rate for room and board , CCU, and ICU) |
| Inpatient Services at Other Health Care Facilities (including skilled nursing, rehabilitation hospital, and other inpatient sub-acute facilities) – Skilled nursing facility is covered up to 60 days per calendar year, as long as the attending physician certifies that admission to the facility is medically necessary as a substitute for hospital confinement | | 100% of negotiated semi-private room rate | 70% of MRC , after the deductible for most common semi-private room rate |
| Outpatient Short-Term Rehabilitation Therapy (including physical, occupational, speech, cardiac, cognitive, pulmonary) — limited to a total of 60 days per calendar year for all treatments, network and out-of-network combined. This limit includes both inpatient and outpatient treatment. | | 100% after \$25 copay per visit (except chiropractic care and physical therapy —see below) | 70% of MRC , after the deductible |
| Chiropractic Care and Physical Therapy | | 100% after \$15 Copay per visit | 70% of MRC , after the deductible |
| Acupuncture – subject to medical review for necessity | | 100% after \$15 copay per visit | 70% of MRC , after the deductible |
| Home Health Care (200 days per calendar year, 16 hours per day, for network and out-of-network services combined) | | 100% | 75% of MRC , after separate \$50 annual home health deductible |
| Organ Transplant (network providers are facilities in the Cigna LIFESOURCE network) | | 100% (travel to and from limited to \$10,000 lifetime) | 70% of MRC , after the deductible (travel services not covered) |

| Site and Type of Care | How It's Covered | |
|---|---|---|
| | Plan Feature | Network |
| Emergency Room (ER) of Hospital (the ER copay is waived if you are admitted within 24 hours of an ER visit for the same condition) | 100% after \$50 ER copay | 70% of MRC after the deductible and \$50 ER copay |
| Emergency Treatment in Urgent Care or Other Outpatient Facility | 100% | 100% of MRC |
| Ambulance | 100% | 70% of MRC , after the deductible |
| Certain Other Services: <ul style="list-style-type: none"> ● Abortions ● Durable Medical Equipment ● Infertility Services of Certain Kinds (see pages 11 and 15 for more detail). ● Outpatient Private Duty Nursing ● Prosthesis of Some Kinds ● Wigs (one per lifetime) | 100% | 70% of MRC , after the deductible |
| Hospice (room and board and outpatient services) Unlimited bereavement services as part of a covered hospice care program | 100% of negotiated room rate (home visits same as home health care) | 70% of MRC , after the deductible (room and board up to facilities' most common semi-private rate) |
| Dental Care limited to charges made for an injury to sound, natural, teeth, and temporomandibular joint disorder (TMJ) <ul style="list-style-type: none"> ● Office Visit/Physician services ● Inpatient/Outpatient facility <p>Note: Other dental care is not covered under the Cigna Medical Plan.</p> | 100% after \$25 copay | 70% of MRC , after the deductible |
| Most Other Covered Expenses (e.g., radiology and laboratory) | 100% | 70% of MRC , after the deductible |
| Mental Health Services | | |
| ● Inpatient* | 100% | 70% of MRC , after the deductible |
| ● Outpatient | Office Visits: \$25 copay per visit, then 100% for other outpatient/facilities (including intensive outpatient programs and partial hospitalization) | 70% of MRC , after the deductible |
| Substance Use Disorders including alcohol and drug abuse | | |
| ● Inpatient* | 100% | 70% of MRC , after the deductible |
| ● Outpatient | Office Visits: \$25 copay per visit, then 100% for other outpatient/facilities (including intensive outpatient programs and partial hospitalization) | 70% of MRC , after the deductible |

*Pre-admission certification is required for all inpatient treatments, including hospitalizations of any kind and inpatient services at other health care facilities, including treatment for mental health and substance abuse disorders in residential treatment facilities. Failure to precertify may result in a \$250 special, per incident, penalty payment and exclusion of some or all of the days from coverage under the Cigna Plan.

MORE INFORMATION ON HOW OUT-OF-NETWORK CARE IS COVERED

Here are some key facts you need to know if you choose to go out-of-network for your medical care.

1. **There's a deductible.** You must meet a \$350 annual deductible (\$700 for a family) before being reimbursed a portion of your eligible expenses. It's important to understand that the following expenses do not count toward meeting the annual deductible: **copays** for network care; charges in excess of the **maximum reimbursable charge (MRC)** established by Cigna for a covered expense; anything you pay because you did not meet the Cigna Plan's precertification requirements (explained on page 7); and any charges excluded or limited by the Plan (see "Ineligible Medical Expenses" starting on page 8). Also note that while the deductible will not be more than \$50 for charges made for home health care, any expenses incurred in excess of \$50 for these charges will not apply toward the annual deductible.
2. **Expenses are reimbursed at 70% of the MRC.** Once you've met the annual deductible, the Fund will reimburse 70% of the MRC for a covered expense. The 30% you are responsible for paying is your coinsurance. **You are also responsible for anything over the MRC.**
3. There's a cap on what you have to pay in coinsurance. Your 30% coinsurance is capped at \$5,000 a year (\$10,000 for a family), after which your remaining eligible expenses are reimbursed at 100% of MRCs **for the rest of that year.** However, note that the following expenses do not count toward the annual coinsurance limit: expenses over the MRC; anything you pay because you did not meet the Cigna Plan's coinsurance limit; anything you pay because you did not meet the Cigna Plan precertification requirements (see page 7); and any charges excluded or limited by the Plan (see "Ineligible Medical Expenses" starting on page 8). **Any amount over MRC is not capped. That is, you are responsible for 100% of any amount charged in excess of the MRC even after you have met the cap.**
4. **You must file a claim.** In most cases, you have to pay the provider when the service is rendered, then submit a claim for reimbursement to Cigna.
5. While Cigna's network is extensive and nationwide, if you live in a geographic area in which Cigna has no **network providers**, the out-of-network deductible may be waived.

Please contact the Fund Office if you believe you live in such a geographic area.

IMPORTANT NOTE REGARDING CHARGES MADE BY OUT-OF-NETWORK PROVIDERS

Out-of-network providers may charge patients amounts in excess of the Fund's MRC for a given treatment. Such amounts are the responsibility of the Plan participant and are not reimbursed by the Plan.

Therefore, if you choose to use an out-of-network provider, you should always make sure that you understand whether and how much the provider will charge beyond the MRC. Since these amounts can range from zero to many thousands of dollars, it is critical to understand your responsibility beforehand. You can find out whether the provider's charge is in excess of the Cigna Plan's MRC by asking the provider for its charge for the "CPT code" for that procedure (a five-digit code that uniquely identifies the procedure) and calling Cigna's customer service telephone number (some providers will do this for you). Please have the zip code of the provider ready when you call. (The MRC under the Cigna Plan may vary by geographic area.) Also, make sure you know who all the providers for a given procedure or treatment will be, so that you understand the charges of each (e.g., you should know not only what the surgeon will charge for a giving surgical procedure, but also what the anesthesiologist who will care for you during the surgical procedure will charge). **Out-of-network providers may charge patients amounts in excess of the Fund's MRC for a given treatment. Such amounts are the responsibility of the Plan participant and are not reimbursed by the Plan.**

UNDERSTANDING THE CONCEPT OF MEDICAL NECESSITY

The Cigna Plan covers only those services and supplies Cigna determines to be required for treatment or evaluation of a medical condition, consistent with the diagnosis, and not omitted under generally accepted medical standards or provided in a less intensive setting.

In general, **medically necessary** services and supplies are those determined by Cigna to be:

1. Required for treatment or evaluation of a medical condition;
2. Consistent with the diagnosis;
3. Meeting generally accepted medical standards and consistent in type, frequency, and duration of treatment with scientifically based guidelines as determined by medical research;
4. Required to meet essential health needs and for purposes other than the convenience of the provider or the comfort and convenience of the patient; and
5. Rendered in the least intensive setting that is appropriate for the delivery of health care.

The Cigna Plan covers virtually every **medically necessary** service or supply. If a particular expense was not listed in this section or if you have a question about **medical necessity**, or Cigna’s criteria for determining necessity, you should call Cigna at the toll-free number on your ID card. You can confirm whether or not something is considered an eligible expense by calling Cigna at the toll-free number on your ID card. You may also find it helpful to review the section on “Ineligible Medical Expenses,” which begins on page 8.

MANAGING YOUR MEDICAL CARE

PRE-ADMISSION CERTIFICATION

All non-emergency **hospital** stays must be approved under Cigna’s Pre-admission Certification Program. To do this, you, a family member, or your doctor should call the number on your ID card. In addition to approving the admission itself, Cigna will determine the appropriate length of your **hospital** stay. Should your doctor want you to stay longer than the number of days that have been approved, your additional days in the **hospital** have to be approved by Cigna or they will not be covered by the Fund.

If you bypass the pre-admission certification/continued stay review process, you will be subject to a \$250 per-incident pre-admission certification penalty. In addition, you may be in the **hospital** for days that have not been approved by Cigna as **medically necessary**, which will make the cost of those days your responsibility in their entirety. Therefore, be sure to call Cigna before any non-emergency **hospital** stay.

Pre-admission certification applies whenever you or a covered dependent requires treatment in a **hospital**:

1. As a registered bed patient,
2. For partial **hospitalization** for treatment of mental health,
3. For substance abuse treatment in a substance abuse structured therapy program, and/or
4. For mental health and substance abuse residential treatment services.

In the case of an emergency admission, you should contact Cigna within 48 hours after the admission. For admission due to pregnancy, you should call Cigna by the last day of the third month of pregnancy.

CASE MANAGEMENT ASSISTANCE — AN INVALUABLE FREE BENEFIT

Case management is designed to assist enrolled individuals who need special or extended care for serious illness or injuries. Its primary goal is to ensure that the patient receives appropriate care in the most effective setting (at home, in a **hospital**, or in a specialized facility, for example). Your Cigna Case Manager, whose role is advisory, will help you arrange for treatment and work with you, your family, and your doctor to coordinate the treatment program, arrange for necessary resources, and provide ongoing support for the family in times of medical crisis.

When to Request Case Management. Case management is voluntary and offered at no cost to you. When certain types of specialized care are recommended for certain serious and long-term conditions (home health care, **hospice care**, or a stay in a **skilled nursing facility**, for example), you are encouraged to request case management, which you can do by calling Cigna Member Services at the toll-free number shown on your ID card. (A family member or attending **physician** can also make the call.)

Medical Conditions and Situations That Typically Qualify for Case Management

| | |
|--|---|
| AIDS (HIV) | Kidney failure |
| Alzheimer’s disease | Multiple Sclerosis |
| Cancer | Newborns with high-risk complications or multiple birth defects |
| Child and adolescent mental and nervous disorders | Obstructive Pulmonary Disease (Emphysema) |
| Chiropractic treatment that is expected to be long-term | Rehabilitation therapy following an accident that is expected to be long-term |
| Heart conditions | Stroke |
| Intravenous therapy (IV) therapy that will be long-term | |

HEALTHY BABIES® — SPECIAL HELP DURING AND AFTER PREGNANCY

Cigna's Healthy Babies® Program is designed to help expectant mothers and babies stay well throughout pregnancy. Expectant mothers who participate in the program are provided with educational materials, including a comprehensive handbook on pregnancy and childbirth. Early detection of high-risk pregnancies is another key benefit of the Healthy Babies® Program. In conjunction with her obstetrician or family doctor, an expectant mother completes a risk assessment/screening questionnaire. If a high-risk pregnancy is identified, a Case Manager will be assigned to the mother for the duration of her pregnancy. The Case Manager, a registered nurse trained in obstetrics, works with the patient and her doctor to develop and carry out an appropriate treatment plan that fosters a successful pregnancy and childbirth. To enroll in the Healthy Babies® Program call the toll-free number on your Cigna ID card before the end of the third month of pregnancy (or as soon as your doctor confirms the pregnancy).

SOME ADDITIONAL VALUABLE SERVICES THAT CIGNA OFFERS

In addition to providing claims payment, medical management and network management services to the Fund, Cigna offers Plan participants customer services in a broad number of areas.

The Cigna HealthCare 24/7 Health Information Line connects you to trained nurses and a library of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S. Just call 1-800-870-3470 or visit Cigna's website at myCigna.com. If you register for myCigna.com, their convenient and secure website combines helpful, easy-to-use tools with personalized benefits information to help you make the most of your plan.

1. Cigna Healthy Rewards® includes special offers on programs and services designed to enhance your health and wellness.
2. Cigna Speaks Many LanguagesSM. Cigna offers Language Line Services so that you can talk with Cigna representatives in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.
3. It's Your Health. When you choose Cigna HealthCare, you can take advantage of Cigna's health and wellness programs.
4. Cigna Well Informed provides participants with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor, and Cigna have access to this information.

5. Cigna Well-Aware for Better Health® can help you manage certain chronic conditions.

Please consider these and other services offered by Cigna to help you better utilize your health benefits.

INELIGIBLE MEDICAL EXPENSES

While the Cigna Plan covers most services and supplies you're likely to need, there are certain expenses that are not covered, including those shown in this section. For more information on eligible and ineligible expenses under the Cigna Plan, you can always call Cigna at the toll-free number on your ID card. The Cigna Plan has been designed to cover **medically necessary** treatments for illnesses and injuries that are not job related and are not already covered by another program, while the person is covered by the Plan (expenses incurred before or after coverage was in place are not eligible). Expenses, charges, and treatments that are not covered generally fall into the following broad categories:

EXPERIMENTAL OR NOT MEDICALLY NECESSARY

Any services and supplies for or in connection with experimental, investigational, or unproven services, including medical, surgical, diagnostic, psychiatric, substance abuse, or other health care technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by Cigna to be:

1. Not demonstrated, through existing peer-reviewed, evidence-based scientific literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;
2. Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
3. The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of this book;
4. The subject of an ongoing phase I, II, or III clinical trial, except as provided in the "Clinical Trials" section of this book; or
5. Charging for experimental drugs or substances not approved by the FDA or limited by federal law for investigational use, including drugs labeled "Caution — limited by federal law to investigational use."

The following is a non-exhaustive list of some specific examples of experimental or non-medically necessary medical services or supplies:

1. Eye surgery or treatment mainly to correct refractive errors;
2. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless **medically necessary** to determine the existence of a gender-linked genetic disorder;

3. **Genetic testing** and therapy, including germ line and somatic, unless determined **medically necessary** by Cigna for the purpose of making treatment decisions;
 4. Biologicals that are immunizations or medications for the purpose of travel or to protect against occupational hazards and risks;
 5. Orthognathic treatment/**surgery**, including but not limited to treatment/**surgery** for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, **medically necessary** treatment for temporomandibular joint disorder (TMJ) is covered;
 6. Speech therapy when it is used to improve speech skills that have not fully developed (except when speech is not fully developed in **children** due to underlying disease or malformation that prevented speech development), intended to maintain speech communication, or not restorative in nature;
 7. Cosmetic **surgery** or therapy. Cosmetic **surgery** or therapy is defined as **surgery** or therapy performed to improve appearance or self-esteem. Charges for cosmetic therapy or **surgery** may be covered if the treatment is to repair or correct a severe physical deformity or disfigurement that is accompanied by functional deficit (other than abnormalities of the jaw related to TMJ disorder) and when: a) the **surgery** or therapy restores or improves function; b) reconstruction is required as a result of **medically necessary surgery**; or c) the **surgery** or therapy is performed prior to the patient reaching age 19 and is required as a result of congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant improvement. An exception for **Transgender/Gender Dysphoria and Gender Reassignment Benefits** may apply (see page 19 for more information);
 8. Erectile dysfunction, except for penile implants, which are covered when an established medical condition is the cause of the erectile dysfunction; and/or
 9. Obesity treatment or control of obesity, unless for the treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
1. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the sections of this book on home health services, and breast reconstruction and breast prostheses;
 2. Chiropractic treatment or other therapy or treatment services to improve general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to routine, long-term, or maintenance care that is provided after resolution of the acute medical problem and when significant therapeutic improvement is not expected;
 3. Education, special education, or job training, whether or not given in a facility that also provides medical or psychiatric treatment;
 4. Marriage, family, **child**, career, social adjustment, pastoral, or financial counseling;
 5. Adoption or surrogate's expenses;
 6. Preparation of medical reports, itemized bills or claim forms, or mailing, shipping, or handling expenses;
 7. Transportation, except licensed **ambulance service** covered under the Plan and certain transportation expenses associated with Network **organ transplants** or **transgender genital surgery**;
 8. Speech therapy that is considered custodial or educational;
 9. Non-medical ancillary services, including but not limited to: vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, work hardening, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism, or mental retardation;
 10. Dental or hearing expenses, unless otherwise noted in this book;
 11. Cosmetics, dietary supplements, health and beauty aids, or and **nutritional formulas**. However, **nutritional formulas** are covered when required for: the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism) or enteral feeding for which the **nutritional formulas** under state or federal law can be dispensed only through a **physician's** prescription and are **medically necessary** as the primary source of nutrition;
 12. Routine foot care, including services made for, or in connection with, tired, weak, or strained feet for which treatment consists of routine foot care, including but not limited to the removal of corns or calluses, or the trimming of toenails. However, services for foot care for diabetes and peripheral vascular disease are covered when **medically necessary**;

NON-MEDICAL SERVICES OR CUSTODIAL/ MAINTENANCE CARE

The following are certain examples of non-medical services or custodial/maintenance care not covered:

13. Artificial aids, including but not limited to corrective orthopedic shoes, orthotic shoes, or shoe additions, procedures for foot orthopedic shoes or, shoe modifications and transfers; orthoses primarily used for cosmetic rather than functional reasons, arch supports, elastic stockings, garter belts, corsets, hearing aids and dentures, external **prosthetic** devices, biomechanical external **prosthetic** devices; or external power enhancements or power controls for **prosthetic** limbs and terminal devices;
14. **Custodial and/or maintenance care**, defined as services and supplies furnished to a person mainly to help with the activities of daily life, including room, board, and other institutional care;
15. Personal or comfort items, such as personal care kits provided on admission to a **hospital**, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles that are not for the specific treatment of an injury or **sickness**;
16. Convalescent care, except as described under “**Skilled Nursing Facility**” in the “Key Medical Benefit Terms, Definitions and Benefit Elaborations” section;
17. Membership costs or fees associated with health clubs, weight loss programs, and smoking cessation programs; and/or
18. Vision care services. Most vision care services are not covered under the Cigna Plan including those described below (certain vision care services are covered under a separate vision benefit described in the “Vision Care” section of this SPD that begins on page 33):
 - a. Routine eye examinations;
 - b. Examination for, prescription of, and/or purchase or replacement of eyeglasses or contact lenses, except the charge for the first pair of eyeglasses, lenses, frames, or contact lenses following keratoconus or cataract **surgery**;
 - c. Vision care services related to vision training or orthoptics magnification vision;
 - d. Refractive **surgeries** or procedures that lessen or eliminate the need for glasses or contact lenses, including but not limited to radial keratotomy, astigmatic keratotomy, or photorefractive keratotomy;
 - e. Tinting, anti-reflective coatings, and prescription sunglasses or light-sensitive lenses;
 - f. Eye examinations required as a condition of employment or that an employer is required to provide under a collective bargaining agreement; and/or
 - g. Eye examinations required by law, safety glasses, or lenses required for employment.

Any cosmetic **surgery** or therapy related to **Transgender Benefits** may be considered covered subject to Cigna’s Medical Coverage Policy Guidelines. For more information on **Transgender Benefits/Gender Dysphoria and Gender Reassignment Benefits**, see page 19.

AN INELIGIBLE PERSON OR ENTITY PROVIDES CARE

The following are certain examples of ineligible persons or entities or services provided by such persons or entities that are not covered by the Plan:

1. Services and supplies that do not require the technical skills of a medical, mental health, or dental professional;
2. A medical provider who is a family member;
3. Lab, pharmacy, x-ray, or imaging services referred by a practitioner who has a financial relationship (or whose immediate family member has a financial relationship) with the provider of those services; and/or
4. Services and supplies provided by a person who is not licensed to provide the services that were furnished in the location in which the service was delivered.

THE COST OF THE CARE IS NOT REASONABLE OR EXCEEDS PLAN LIMITS

The following are certain examples of where the cost of care is not reasonable or exceeds the Fund’s limits:

1. Charges beyond what Cigna determines is the contract rate for Network services or the MRC for Out-of-Network services;
2. Expenses in excess of Plan limits; and/or
3. **Home health care services** or supplies that are not a part of an approved home health care program, described in the section called “Home Health Care.”

THE TREATMENT WOULDN’T HAVE BEEN PROVIDED IN THE ABSENCE OF PLAN COVERAGE OR IS ILLEGAL

The following are certain examples of treatments that wouldn’t have been provided in the absence of Fund coverage or are considered to be illegal:

1. Charges that would not have been made if you didn’t have this coverage;
2. Expenses you or your enrolled dependent are not legally obligated to pay; and/or
3. Expenses for treatment, services, and supplies (including prescription drugs) that are unlawful where the person resides when the expenses are incurred.

EXPENSES ARE (OR SHOULD BE) COVERED ELSEWHERE

The following are certain examples of expenses that are (or should be) covered elsewhere:

1. Resident **physician** or intern billed separately from **hospital** services;
2. Services incurred because the patient was or is in the armed forces;
3. Services incurred under any government law (except a plan established by a government for its own employees, and/or their dependents or Medicaid);
4. Reports, evaluations, physical examinations, or **hospitalization** not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered forensic or custodial evaluations;
5. Collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in Cigna's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to **surgery**;
6. Administration of blood for the purpose of general improvement in physical condition;
7. Non-injectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, unless otherwise covered under the Fund; and/or
8. Work-related injuries, illnesses, or medical expenses.

CERTAIN TREATMENTS FOR MENTAL HEALTH AND SUBSTANCE ABUSE

The following are specifically excluded from mental health and substance abuse services:

1. Any court-ordered treatment or therapy, any treatment or therapy ordered as a condition of parole, probation, or custody, or visitation evaluations unless **medically necessary** and otherwise covered under the Fund;
2. Medical disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
3. Developmental disorders, including but not limited to developmental reading disorders, developmental arithmetic disorders, developmental language disorders, or developmental articulation disorders;
4. Counseling for activities of an educational nature;
5. Borderline intellectual functioning, occupational problems, or issues related to consciousness raising;
6. Vocational or religious counseling;
7. IQ testing;

8. Custodial care, including but not limited to geriatric day care;
9. Psychological testing on **children** requested by or for a school system; and/or
10. Occupational/recreational therapy for age-related cognitive decline programs, even if combined with supportive therapy for age-related cognitive decline.

CERTAIN TREATMENTS FOR FERTILITY

The following are specifically excluded **infertility services**:

1. Gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and variations of these procedures;
2. Collection, washing, preparation, or storage of sperm for artificial insemination (including donor fees);
3. A reversal of voluntary sterilization;
4. **Infertility services** when the infertility is caused by or related to voluntary sterilization;
5. Cryopreservation of donor sperm and eggs;
6. Experimental or investigational infertility procedures or therapies;
7. Any expenses you or your covered dependent incurs in connection with attempts at artificial insemination, with or without superovulation drug therapy, more than 12 months after the start of such treatment;
8. Surrogate mothers;
9. Collection, preparation, and storage of sperm or oocyte (egg), including any associated donor fees;
10. **Infertility services** following the reversal of voluntary sterilization;
11. Experimental or investigational procedures as determined by Cigna HealthCare;
12. Infertility diagnostic and treatment supplies available over the counter, regardless of place of issue or place of purchase, including but not limited to LH surge kits (such as an ovulation kit);
13. Cryopreservation of embryos, resulting from the use of assisted reproductive technologies, for more than 12 months beyond the date of retrieval.

Any questions about ineligible medical expenses should be directed to Cigna at the number shown on your ID card.

CIGNA PLAN CHANGES WITH REGARD TO ELIGIBLE EXPENSES

Cigna Plan rules, like many other things in life, sometimes change. To confirm whether a service or procedure is in the Plan's most recent list of covered or ineligible expenses, call Cigna at the number on your ID card, or call the Fund Office.

KEY MEDICAL BENEFIT TERMS, DEFINITIONS, AND BENEFIT ELABORATIONS

There are many terms used in this SPD that you may be unfamiliar with or that may have special meaning in the context of the Fund. Therefore, we provide definitions for, or elaborations of the coverage for, those terms in this section of the book. Please note that terms related to Claims and Appeals are defined in that section, beginning on page 57.

Abortions – elective and therapeutic procedures to terminate a pregnancy are covered for both **participants** and covered dependents under the Plan.

Acupuncture – **acupuncture** treatment when rendered by a trained acupuncturist for the relief of pain and for producing anesthesia is covered subject to medical review for necessity.

Allowable Expense – **allowable expenses** do not include expenses for services received because of an occupational illness or injury, or expenses for services that are excluded or not covered by the Fund. An “**allowable expense**” means a necessary, reasonable, and customary health care service or expense (including deductibles, coinsurance, or **copays**) that is covered in full or in part by the Fund, except as provided. This means that an expense or service (or any portion of an expense or service) not covered by the Fund is not an **allowable expense**. Examples of expenses or services that are not **allowable expenses** include, but are not limited to, the following: a) the difference between the cost of a semi-private room in a **hospital** or other health care facility and a private room, unless the patient’s stay in a private room is **medically necessary**, and, b) amounts charged by a health care provider that exceed the highest of the **MRCs** allowed by the Fund. For those covered by more than one health plan, **allowable expenses**, for the purpose of **Coordination of Benefits (COB)**, will be determined as follows. If you are covered by one plan that provides services or supplies on the basis of **maximum reimbursable charges** and one plan that provides services and supplies on the basis of negotiated fees, the primary plan’s fee arrangement will be the **allowable expense**. When benefits are reduced by a primary plan because a covered person did not comply with its provisions (e.g., provisions related to utilization management), the Fund will not consider the amount of those reductions an **allowable expense** when it pays second.

Ambulance Service – facility transportation in a licensed ambulance to take you to the **hospital** for a medical emergency or urgent situation is covered.

Audiology – hearing tests and any other **audiology** services, whether provided by a **physician** or an audiologist, are covered for both **children** and adults. The Plan will only pay up to a \$400 maximum for out-of-network services.

Bariatric Surgery – medical and surgical services intended primarily for the treatment or control of obesity. These services are generally not covered. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines, is covered if the services are demonstrat-

ed, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

Breast Pumps – are covered after the birth of a **child**, with no requirement to demonstrate **medical necessity**.

Child(ren) – eligible dependent **child(ren)**, including your biological **child**, adopted **child** (including a **child** placed in your home for whom you have begun adoption procedures), stepchild, the **child** of your **domestic partner**, or a **child** living with you for whom you are financially responsible and have been appointed legal guardian by a court.

Chiropractic Care – **chiropractic care** provided by a chiropractor in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body to remove nerve interference and the effects of it. The interference must be the result of or related to distortion misalignments, or subluxation of or in the vertebral column.

Clinical Trials – routine patient services associated with cancer **clinical trials** approved and sponsored by the federal government. In addition, the following criteria must be met:

1. The cancer clinical trial is listed on the National Institutes of Health website *clinicaltrials.gov* as being sponsored by the federal government;
2. The trial investigates a treatment for terminal cancer and: 1) the **participant** has failed standard therapies for the disease; 2) the **participant** cannot tolerate standard therapies for the disease; or 3) no effective non-experimental treatment for the disease exists;
3. The patient meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
4. The trial is approved by the Institutional Review Board of the institution administering the treatment; and
5. Coverage will not be extended to **clinical trials** conducted at non-participating facilities if a **participant** is eligible to participate in a covered **clinical trial** from a **Participating Provider**.

The following are explicitly excluded (are not covered services) under the Clinical Trials benefit:

1. The investigational service or supply itself;
2. Services or supplies that are otherwise explicitly excluded under the plan (e.g., listed herein as Ineligible Medical Expenses);
3. Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs); and/or
4. Services or supplies that, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item, or service supplied by manufacturer but not yet FDA-approved) without charge to the trial **participant**.

COB – see **Coordination of Benefits**

Contributing Employer – an employer obligated to contribute to the Fund pursuant to an agreement with Actors’ Equity, or other written agreement with the Fund.

Coordination of Benefits (COB) – special benefit rules that apply when you are eligible for more than one health benefit plan (see page 26 for an explanation and examples).

Covered Employee or Participant – an employee who has qualified for coverage under the Fund through **covered employment**.

Copay – a dollar amount payable by the **participant** at the time a covered service or supply is delivered by a health care provider.

Covered Employment – each week of work for which your employer is required to contribute to the Fund on your behalf. The two exceptions are work requiring only contributions for Supplemental Workers Compensation benefits, which counts only toward eligibility for Supplemental Workers Compensation and is otherwise not **Covered Employment**, and work that does not require contributions for Supplemental Workers Compensation, which does not count as **Covered Employment** for Supplemental Workers Compensation benefits.

Custodial and/or Maintenance Care – services not intended primarily to treat a specific injury or **sickness** (including mental illness and alcohol or substance abuse). Custodial services include, but are not limited to, services related to watching or protecting a person; services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, and taking medications that can usually be self-administered; and services not required to be performed by trained or skilled medical or paramedical personnel.

Diabetic Services and Supplies – services and supplies in connection with the treatment of diabetes. Such services and supplies include charges made by a **physician**, a member of his or her office staff, a certified diabetes nurse-educator, certified nutritionist, or licensed dietitian for a program that provides instruction for a person with diabetes, for the purpose of instructing the person about the disease and its control. Training is to be provided in group sessions where practicable. If **medically necessary**, training can be provided in the person’s home. Charges for glucometers, blood glucose monitors, monitors for the legally blind, insulin pumps, infusion devices, and related accessories are covered, as are charges for insulin needles and syringes, glucose monitor test strips, visual reading strips, urine test strips, pre-filled insulin cartridges for the legally blind, and injection aids such as lancets and alcohol swabs.

Disabled Child – a **child** of any age who is incapable of self-sustaining employment because of mental illness, developmental disability, mental retardation, or physical handicap. The handicap must have existed before the **child’s** 19th birthday and must have begun while the **child** was covered by the Fund. Written evidence of the handicap must be sent to the

Fund Office within 31 days of the age when coverage would usually end, and when requested by the Fund Office thereafter.

Domestic Partners – two unmarried* adults of the same or opposite sex who:

1. Have lived with each other for at least six months before the application for benefits and who intend to live continuously with each other indefinitely;
2. If living in a state or municipality providing for the registration of domestic partnerships, have registered as **domestic partners**;
3. Are not related by blood closer than the law would permit by marriage;
4. Are financially dependent on each other;
5. Have a close, and committed relationship with each other; and
6. Have not terminated the domestic partnership.

*You are considered married even if you are legally separated.

Durable Medical Equipment – equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose; is generally not useful to a person in the absence of **sickness** or injury; is appropriate for use in the home; and is not disposable. The rental or purchase of durable medical and surgical equipment (such as wheelchairs, crutches, **hospital** beds, and dialysis machines) when prescribed by a **physician** for use outside a **hospital** or health care facility is covered. Coverage for repair, replacement, or duplicate equipment is provided when required due to anatomical change and/or reasonable wear and tear. Equipment that is not covered includes (but is not limited to) the following types of equipment:

1. Bed-related items (such as special trays, tables, pillows, and mattresses);
2. Bath-related items (such as lifts, rails, grab bars, raised toilet seats, and bath benches);
3. Chair lifts and standing devices;
4. Air-quality items (such as humidifiers, vaporizers, and air purifiers);
5. Blood/injection-related items;
6. Pumps (such as back packs for portable pumps); and/or
7. Other equipment (such as heat lamps, cooling pads, heating pads, ultraviolet cabinets, magnetic equipment, stair gliders, elevators, saunas, and exercise equipment).

Be sure to check with Cigna if you aren’t sure whether a particular type of equipment is covered.

Emergency Care or Emergency Service – medical, psychiatric, surgical, **hospital**, and related health care services and testing (including **ambulance service**) required to treat a sudden, unexpected onset of a bodily injury or serious illness that could reasonably be expected by a prudent layperson to result to serious medical complications, loss of life, or permanent

impairment of bodily functions in the absence of immediate medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. If you are admitted to the **hospital** after getting emergency treatment, you (or a family member, a friend, or your doctor) must call Cigna no later than 48 hours after you are admitted.

Family Planning Services – family planning services, including office visits for tests and counseling. Surgical procedures for vasectomies and tubal ligations are covered on an outpatient basis only. (If due to medical complications, these procedures may be covered on an inpatient basis, in which case the **hospital** stay must be certified in advance; see “Pre-admission Certification.”)

Free-Standing Surgical Facility – an institution that: (a) has a medical staff of **physicians**, nurses, and licensed anesthesiologists; (b) maintains at least two operating rooms and one recovery room; (c) has a diagnostic laboratory and x-ray facilities; (d) has equipment for **emergency care**; (e) has a blood supply; (f) maintains medical records; (g) has agreements with **hospitals** for immediate acceptance of patients who need to be confined on an inpatient basis; and (h) is licensed in accordance with the laws of the appropriate legally authorized agency.

Genetic Testing – the Fund covers **genetic testing** that uses a proven testing method for the identification of genetically-linked inheritable disease, but only if:

1. You or a covered dependent has symptoms or signs of a genetically linked inheritable disease.
2. It has been determined that you or a covered dependent is at risk for carrier status, and the determination is supported by existing peer-reviewed, evidence-based, scientific literature for the development of genetically linked inheritable disease when the results will impact clinical outcome.
3. The therapeutic purpose is to identify a specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
4. The Plan covers pre-implantation **genetic testing** (genetic diagnosis prior to embryo transfer) when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.
5. The Plan covers genetic counseling for someone undergoing approved **genetic testing**, or someone who has an inherited disease and is a potential candidate for **genetic testing**. Genetic counseling is limited to three visits per year for both pre- and post-**genetic testing**.
6. No coverage is provided for general population-based genetic screening or pre-implantations genetic screening. (General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.)

Home Health Care Services – the home care and treatment of a covered person who is under the care of a **physician** and the treatment plan covering the home health service is established and approved in writing by that **physician**. Home care will be provided only if **hospitalization** or confinement in a nursing facility would otherwise be required. Home health services do not include non-skilled services (such as bathing, eating, and toileting) and will only be provided during times when there is a family member or caregiver present in the home to meet your non-skilled needs. Physical, occupational, and other **short-term rehabilitative therapy** services provided in the home are not subject to the home health services benefit limitations described above, but they are subject to the benefit limitations described in the section on **short-term rehabilitative therapy**. The Plan covers up to 200 days of “home health services” per calendar year, for up to 16 hours of care per day if you require skilled care that you are unable to obtain as an ambulatory outpatient.

IMPORTANT REMINDER! While precertifying home health care is not required, it's in your best interests to coordinate your care through Cigna's Case Management; see page 7 for more information.

Hospice Care – care on an inpatient and outpatient basis, for counseling and pain relief for **terminally ill** patients (defined as those with a life expectancy of six months or less). The following services are covered: **room & board** at a **hospice facility** (at the semi-private room rate), **physician** services, medical supplies, part-time or intermittent nursing care, psychological and counseling services, pain relief treatment, including medicines, drugs, and medical supplies, home health aide services, physical, occupational, and speech therapy, and bereavement counseling within one year of a person's death. To be covered, these services must be provided under an approved **hospice care program** through a **hospital**, **skilled nursing facility** or similar institution, home health care agency or other licensed agency, or a **hospice facility** or any other licensed facility or agency under a **hospice care program**. The Fund does not cover services or supplies that are not part of a **hospice care program**, funeral arrangements, financial or legal counseling (including estate planning or the drafting of a will), home-maker or caretaker services, or respite care.

Hospice Care Program – a coordinated, interdisciplinary program that meets the physical, psychological, spiritual, and social needs of the **terminally ill** and their families and provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness.

Hospice Facility – an institution or part of it that primarily provides care for **terminally ill** patients; is accredited by the National Hospice Organization; meets standards established by Cigna; and fulfills any licensing requirements of the state or locality in which it operates.

Hospital – an institution that meets one of the following criteria:

1. An institution licensed as a **hospital** that maintains on its premises all facilities necessary for medical and surgical treatment; provides that treatment on an inpatient basis, for compensation, under the supervision of **physicians**; and provides 24-hour services by RNs;
 2. An institution that qualifies as a **hospital**, a psychiatric **hospital**, or a tuberculosis **hospital** and is a provider of services under Medicare, if such institution is accredited as a **hospital** by the Joint Commission;
 3. An institution that specializes in treatment of mental illness, alcohol or drug abuse, or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency; or
 4. A **free-standing surgical facility**.
7. Oxygen and other gas therapy;
 8. Prescribed drugs and medications;
 9. Use of **hospital** equipment (such as incubators, respirators, and hemodialysis machines);
 10. Operating, delivery, and treatment rooms;
 11. Special and intensive care units;
 12. Routine nursery care of a newborn **child** during the mother's **hospital** stay for **maternity care**;
 13. Diagnostic services (x-rays as well as laboratory, pathology, radiology, EKG, EEG, and other diagnostic procedures);
 14. Any additional covered medical services and supplies if Cigna determines they are customarily provided to treat the medical condition that resulted in the **hospitalization**; and/or
 15. In-**hospital** services provided by anesthesiologists, radiologists, pathologists, surgeons, assistant or co-surgeons, and other **physicians** who visit you in the **hospital**.

The term **hospital** does not include an institution that is exclusively a place for rest, a place for the aged, or a nursing home.

Necessary (**hospital**) services and supplies include charges (except those for **room and board**) made by a **hospital** on its own behalf for medical services and supplies actually used during a **hospital confinement**; charges for licensed **ambulance service** to or from the nearest **hospital** where the needed medical care and treatment can be provided; and charges for the administration of anesthetics during a **hospital confinement**. Necessary services and supplies do not include any charges for special nursing fees, dental fees, or medical fees.

Hospital Confinement or Confined in a Hospital – confinement as a registered bed patient in a **hospital** upon the recommendation of a **physician**; receiving treatment for mental health and **substance abuse services** in a partial **hospitalization** program; receiving treatment for substance abuse in a substance abuse intensive therapy program; or receiving treatment in a mental health and **substance abuse residential treatment center**. The Cigna Plan covers **hospital** care on both an inpatient and outpatient basis.


Inpatient **hospital** care and charges – inpatient **room and board** charges, based on the **hospital's** semi-private rate, and services and supplies on an inpatient basis or, when prescribed by the attending **physician**, received in the **hospital's** outpatient department or emergency room, including the following services and supplies:

1. Administration of blood and blood plasma, including the cost of the blood;
2. Licensed **ambulance service** to or from the nearest **hospital** where the needed medical care and treatment can be provided;
3. Anesthesia and its administration;
4. General inpatient nursing services by an on-staff registered graduate **nurse (RN)** or licensed practical **nurse (LPN)**;
5. Staff **physicians'** visits for treatment of a medical condition;
6. Intravenous injections and solutions;

Outpatient Hospital Care – the Cigna Plan also covers services provided by the outpatient department of a **hospital** or a freestanding surgical facility. Covered services in this category include the use of operating, recovery, procedure, and treatment rooms, and/or the services of anesthesiologists, radiologists, pathologists, surgeons, assistant and co-surgeons, and other licensed **physicians**.

Infertility Services – after you pay any required **copayment**, deductible, and/or coinsurance, the Fund provides benefits for you or your covered spouse or **domestic partner** for expenses you incur for the following services and supplies, provided you meet the Plan requirements:

1. Medical history;
2. Physical exams;
3. Medical supervision in accordance with generally accepted medical practice;
4. Diagnostic services to establish cause or reason for infertility; and/or
5. Treatment for infertility, such as any of the following:
 - a. Surgical procedures to correct a medical problem related to infertility except infertility due to voluntary sterilization;



IMPORTANT REMINDER! You must have all non-emergency inpatient stays approved in advance or you will be subject to an additional \$250 deductible (above and beyond any other applicable Plan deductibles) for that stay. In the case of an emergency admission, you should contact Cigna within 48 hours after the admission.

- b. An unlimited number of attempts at artificial insemination, with or without superovulation drug therapy;
- c. Superovulation therapy; and
- d. Assisted reproductive technologies, with or without superovulation drug therapy.

Lab Services – independent **lab services** not provided in connection with an inpatient **hospital** stay are covered. For services in a network **physician's** office, the cost is included in your normal per-visit **copay**. In an effort to better control lab test costs, Cigna has negotiated an exclusive arrangement with a laboratory network that includes two of the largest testing companies in the country: Labcorp and Quest Diagnostics. Therefore, your provider must use one of these laboratories (or another in the Cigna Open Access Plus Network). If you want to enjoy all of the many and important advantages of using the Fund's in-network benefits, it is important that you take steps to ensure that all of the providers you use are currently in Cigna's network. For instance, you shouldn't assume that if you go to a doctor in Cigna's network that the doctor will always refer you to Cigna's network labs or **hospitals**. Therefore, before you receive treatment from any provider, please confirm with Cigna, or the provider, that the provider is in Cigna's network. If you were misled by a provider in this regard, you may make an appeal to the Fund Office and request that the lab charge be paid as if it were an in-network charge the first time this occurs with such a provider.

Maternity Care – a **physician's** charges for total obstetrical care, including the initial visit to confirm pregnancy, all subsequent prenatal and postnatal visits, the services of a certified **nurse/midwife**, elective and therapeutic **abortions**, and delivery in the **hospital** or at a birthing center, are covered. **Hospital** benefits include newborn nursery charges during the covered portion of the mother's confinement. Other conditions of the newborn are covered only if the **child** is enrolled with the Fund within 31 days of birth (including providing proof of birth and payment of any additional premiums). Although the Cigna Plan allows a minimum **hospital** stay of 48 hours for a normal delivery and 96 hours for a cesarean section, shorter or longer lengths of stay may be approved at the request of the attending **physician**. Necessary home care services are available following discharge from the **hospital**. Home care nurses are trained to give a full assessment of both the mother's and the baby's health and any home environment issues, as well as answer any questions. As a **participant** who is covered under the Cigna Plan, you should also know about Cigna's Healthy Babies® Program for expectant mothers; see page 8 for more information.

Maximum Reimbursable Charge (MRC) – the maximum charge that will be reimbursed for a covered treatment. The **MRC** for a particular treatment is established by considering one or more factors, including but not limited to the type of treatment, the nature and severity of the illness or injury being treated, the amount charged by other providers in the geographic area in which the treatment is provided, the amount reimbursed by the Centers for Medicare and Medicaid Services (CMS) under Medicare for that treatment, and/or the amount based upon a methodology similar to that utilized by

CMS to determine the amount reimbursed under Medicare for the same or similar service. You can find out in advance of treatment whether the charge made by your provider exceeds the **MRC** by obtaining that charge from your provider and contacting Cigna to see if the charge exceeds the **MRC**.

Medically Necessary or Medical Necessity – health care services and supplies that are determined by Cigna to be:

1. Required to diagnose or treat an illness, injury, or disease or its symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Clinically appropriate in terms of type, frequency, extent, site, and duration;
4. Not primarily for the convenience of the patient, **physician**, or other health care provider, and
5. Rendered in the least-intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, Cigna may compare the cost-effectiveness of alternative services, settings, or supplies when determining the least-intensive setting.

Mental Health Services – services that are required to treat a disorder that impairs behavior, emotional reaction, or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health. Treatment of mental disorders on both an inpatient and an outpatient basis is covered. Inpatient mental health benefits cover care received at a **hospital** or a **mental health residential treatment center** and are payable for room, board, and other services or supplies necessary for the effective treatment of a mental disorder.

If you are traveling out of town to perform **Covered Employment** (such as with a touring show) and have an existing patient relationship with a mental health provider, you may receive telephonic mental health sessions with your primary mental health provider during this period. Each telephonic mental health session will be treated as an outpatient visit.

Mental Health Residential Treatment center – an institution that:

1. Specializes in the treatment of psychological and social disturbances that are the result of mental health conditions;
2. Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of **physicians**;
3. Provides 24-hour care, in which a person lives in an open setting; and
4. Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Mental Health Outpatient Partial Hospital Treatment – is considered a comprehensive, short-term, and intensive clinical treatment program. Partial **hospitalization** is a step below inpatient **hospitalization**, but more concentrated than tradition-

al outpatient care. Individuals are generally referred to partial programs when they are experiencing acute psychiatric symptoms that are difficult to manage, but do not require 24-hour care. As part of partial **hospitalization** programs, individuals would attend structured programming throughout the day, three to five days a week, and return home in the evenings.

Mental Health Intensive Outpatient Program (IOP) – regularly scheduled sessions of structured treatment related to mental health counseling. IOP is a step-down level of care for individuals who have completed residential treatment, where they can continue to receive the support of treatment programming without the need for 24-hour supervision. IOP is also used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. The typical IOP program offers group and individual services of 10–12 hours a week.

MRC – see **Maximum Reimbursable Charge**.

Network Provider – see **Participating Provider**.

Nurse – a registered graduate nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN).

Nutritional Formulas – enteral formula is covered for home use required for the treatment of:

1. Inherited diseases of amino acid or organic acid metabolism;
2. Crohn's disease;
3. Gastroesophageal reflux with failure to thrive;
4. Disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and/or
5. Multiple, severe food allergies.

The **physician** must issue a written order stating that the enteral formula is **medically necessary** and has been proven effective as a disease-specific treatment regimen for individuals who are or will become malnourished or suffer from disorders that, if left untreated, cause chronic physical disability, mental retardation, or death. The Fund also covers expenses for **medically necessary** modified solid-food products that are low in protein or contain modified protein.

Office Visits – visits to a **physician's** and **specialist's** office, as well as **surgery** performed in the doctor's office, are covered.

Oral and Dental Treatment of a Medical Nature – services and supplies needed to treat cancer of the jaw or mouth, a cleft lip/palate, or temporomandibular joint (TMJ) disease are covered under the Cigna Plan (appliances related to TMJ treatment and orthodontic treatment are not covered). Covered expenses include dental work, **surgery**, or orthodontic treatment needed to remove, repair, replace, restore, or reposition sound natural teeth or other body tissues as a result of an injury. (An "injury" for these purposes does not include damage done in the course of biting or chewing.) Inpatient and outpatient facility charges for covered dental treatment are covered the same way as other services in such facilities.

Organ Transplants – human **organ transplants**. The Cigna Plan covers the full cost of such transplants if they are performed at a facility in the Cigna LIFESOURCE **Organ Transplant Network**, an organization of participating **hospitals** that provide outstanding **organ transplant** services. The Plan also covers up to a lifetime maximum of \$10,000 in travel expenses for the participant and a travel companion/caretaker in connection with the transplant. Call Cigna at the number on your ID card for more information on the Cigna LIFESOURCE Organ Transplant Network. Transplants performed at another facility are covered the same as any other inpatient **hospital** stay, subject to Network and Out-of-Network reimbursement. However, travel expenses related to a facility not in the Cigna LIFESOURCE network are not covered.

Orthotics – are covered if prescribed by a Doctor of Medicine (MD), a Doctor of Osteopathic Medicine (DO), or a Doctor of Podiatric Medicine (DPM).

Outpatient Private Duty Nursing – outpatient care by a registered or licensed practical **nurse** is covered subject to **medical necessity** review.

Participating Provider – an institution, facility, agency, or health care professional with a contractual agreement to provide medical services at a predetermined cost.

Physical Therapy – therapy prescribed by a **physician** and provided by a licensed physical therapist.

Physician – a licensed medical practitioner practicing within the scope of his or her license and licensed to prescribe and administer drugs or perform **surgery**. It also includes any other licensed medical practitioner if he or she is operating within the scope of his or her license and performing a service for which benefits are provided under the Cigna Plan when performed by a **physician**.

Pre-Admission Testing – tests required before a **hospital** admission. These tests are covered in the doctor's office or in an outpatient facility. Also remember to have your **hospital** admission precertified. (See page 7 for details.)

Preventive Care such as checkups – provided for both **children** and adults, and includes immunizations. For enrolled dependent **children** through age 18, routine checkups and immunizations are provided in accordance with current guidelines of the American Academy of Pediatrics. The intervals at which these services are provided are spelled out in the Cigna documents and range from every few months for infants to every three years for **children** ages 12 through 18.

Prosthetics – external **prosthetic** devices such as artificial limbs are covered. The **prosthetic** must be prescribed by a **physician** as a replacement or substitute for a missing body part and be necessary for the alleviation or correction of **sickness**, injury, or congenital defect. The Cigna Plan covers the initial purchase and fitting of the device, as well as replacements and repairs required due to reasonable wear and tear and/or anatomical change that are not otherwise provided under a manufacturer's warranty or purchase agreement. Maintenance and repairs that result from a covered individual's misuse are not covered. The Cigna Plan covers the following types of **prosthetics**:

1. Basic limb **prosthetics**; terminal devices such as hands or hooks; and braces and splints. Only the following types of non-foot orthoses are covered: rigid and semi-rigid custom fabricated orthoses; semi-rigid prefabricated and flexible orthoses; and rigid prefabricated orthoses including preparation, fitting, and basic additions, such as bars and joints; and/or
2. Custom foot **orthotics**, which are covered only in the following cases: when the foot orthotic is an integral part of a leg brace and is necessary for the proper functioning of the brace; when used as a replacement or substitute for a missing part of the foot (e.g., amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and for individuals with a neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

Ineligible prosthetic expenses – see the section called “Ineligible Medical Expenses” for more details on the types of prosthetic devices the Cigna Plan does not cover.

Room and Board – all charges made by a **hospital** on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Reconstructive Surgery – see “Surgery”

Second Surgical Opinions – a second or additional opinion from a surgeon after your doctor recommends elective surgery.

Skilled Nursing Facility – a licensed institution (other than a **hospital**) that specializes in physical rehabilitation on an inpatient basis or skilled nursing and medical care on an inpatient basis, but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of **physicians**; and provides **nurses’** services. **Room and board** at a **skilled nursing facility** is covered for up to 60 days per calendar year, as long as the attending **physician** certifies that admission to the facility is **medically necessary** as a substitute for **hospital confinement**. Note that benefits are not payable for custodial care, care received in a non-approved facility, or care that is not **medically necessary**.

Short-Term Rehabilitation Therapy – physical, speech, occupational, cognitive, cardiac, and pulmonary rehabilitation therapy when provided in the most medically appropriate setting. The following limitations apply to rehabilitation therapy (services considered custodial or educational in nature are not covered): Occupational therapy is provided only for purposes of enabling the patient to perform the activities of daily living. Benefits are limited to 60 days per calendar year (for all types of therapy combined). However, a separate **copay** will apply to the services provided by each provider. Speech therapy can be considered custodial or educational and not be covered under the Plan if the therapy is: a) not restorative in nature, b) used to improve speech skills that have not fully developed, except

when speech is not fully developed in **individuals** (under age of 19) due to an underlying disease or malformation that has prevented speech development, or c) intended to maintain speech communication.

Sickness – a physical or mental illness. It also includes pregnancy. Expenses incurred for routine **hospital** and pediatric care of a newborn **child** prior to discharge from the **hospital** nursery are considered incurred as a result of **sickness**.

Specialist – a **physician** who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology, or pediatrics.

SUBSTANCE ABUSE SERVICES:

Inpatient substance abuse rehabilitation services are services received in a **hospital** when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Note that **inpatient substance abuse services** also include residential, partial **hospitalization**, and substance abuse intensive outpatient therapy programs.

Outpatient Substance Abuse Benefits – There are two types of **outpatient substance abuse benefits**: rehabilitation services and a substance abuse intensive outpatient therapy program.

1. **Substance abuse rehabilitation services** are services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs **while not confined in a hospital** (including outpatient rehabilitation in an individual, group, or structured group).
2. A substance abuse intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. These intensive programs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours a week.

Substance Abuse Residential Treatment Center – an institution that:

1. Specializes in the treatment of psychological and social disturbances that are the result of substance abuse conditions;
2. Provides a subacute, structured, psychotherapeutic treatment program, under the supervision of **physicians**;
3. Provides 24-hour care in which a person lives in an open setting; and
4. Is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Substance Abuse Outpatient Partial Hospitalization – a comprehensive, short-term, and intensive clinical treatment program. **Partial hospitalization** is a step below inpatient **hospitalization**, but more concentrated than traditional outpatient care. Individuals are generally referred to partial programs when they are experiencing acute substance abuse symptoms that are difficult to manage, but do not require 24-hour care. As part of partial **hospitalization** programs,

individuals would attend structured programming throughout the day, three to five days a week, and return home in the evenings.

Substance Abuse Intensive Outpatient Program (IOP) – regularly scheduled sessions of structured treatment related to addiction counseling. The IOP for substance abuse is a middle ground between Residential Treatment and Aftercare. IOP is a step-down level of care for individuals who have completed detox and residential treatment, where they can continue to receive the support of treatment programming without the need for 24-hour supervision. IOP is also used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. The typical IOP program offers group and individual services of 10–12 hours a week.

SURGERY:

Surgical procedures performed on both an inpatient and outpatient basis. These procedures are covered, including pre- and post-operative care. Covered expenses include those incurred in a **hospital, free-standing surgical facility, or doctor’s office.**

Reconstructive Surgery – surgery to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw related to temporomandibular joint [TMJ] disorder). These services are covered if:

1. The **surgery** or therapy restores or improves function;
2. Reconstruction is required as a result of **medically necessary, non-cosmetic surgery**; or
3. The **surgery** or therapy is performed before age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part, including, but not limited to: microtia, amastia, and Poland Syndrome. Repeated or subsequent surgeries for the same condition are covered only when there is a probability of significant additional improvement, as determined by Cigna. **Surgery** necessary to correct deformities due to malignancy is also covered, including reconstruction of either or both breasts to produce symmetry, prostheses, and treatment of physical complications following a mastectomy. (See “Women’s Health and Cancer Rights Act of 1988” on page 53.) **Surgery** performed primarily for cosmetic or beautifying purposes, as determined by Cigna, is not covered.

Terminally Ill – a person has a life expectancy of six months or less, as diagnosed by a **physician.**

Transgender/Gender Dysphoria and Gender Reassignment Benefits – including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to any **surgery.** In addition, enhanced benefits are also available for a number of services related to gender transition, including **medically necessary gender reassignment surgery.** Because there are a limited number of in-network Cigna surgeons who perform the transgender genital surgery, the Plan will cover travel expenses of up to \$5,000 per lifetime for the participant

and a companion/caretaker **incurred in connection with transgender genital surgery by an in-network surgeon.** This travel allowance may be used for transportation, lodging, and meal allowances.

When applicable, covered services also include the following:

- Behavioral counseling
- Hormone therapy
- Genital reconstruction
- Initial mastectomy
- Breast augmentation
- Facial feminization **surgery**
- Thyroid cartilage reduction
- Speech therapy
- Voice feminization **surgery**
- Electrolysis epilation of the face and genitalia.

Gender transition treatments are considered **medically necessary** for individuals 18 or older with gender dysphoria. Patients must participate in a recognized gender identity treatment program to be considered for coverage. Adolescents under the age of 18 covered under the Plan can only receive hormonal treatment for gender dysphoria in accordance with Cigna’s Medical Coverage Policy Guidelines.

For more information and a complete list of these services, please visit our website, equityleague.org, to review Cigna’s Medical Coverage Policy Guidelines.

Urgent Care – medical, surgical, **hospital,** or related health care services and testing that are not **emergency care,** but are determined by Cigna, in accordance with generally accepted medical standards, to be necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services.

Well-Woman Care – includes an annual pelvic exam and Pap test for female **participants** age 18 or older. Mammograms are covered according to the following schedule.

| Mammogram Coverage | |
|---------------------------|---|
| Age | Frequency of Mammogram |
| 35 through 39 | One baseline mammogram |
| 40 through 49 | One mammogram every two years, more frequently if recommended by her physician |
| 50 and over | Annual mammogram |
| Any age | Mammogram at any age if there is a history of cancer for the patient, her mother, or her sister and the test is ordered by a physician |

REFUNDS AND OVERPAYMENTS

Payments for coverage made to the Fund are generally not refundable. This is partly because payments trigger coverage, and being able to cancel coverage retroactively defeats the purpose of insurance, which is to pool the payments of **participants** to protect against the uncertainties of the future. In addition, the regulatory framework in which the Fund operates contains a number of rules that proscribe refunds in most cases.

However, there are three instances in which the Fund will consider refunding part or all of a health premium payment it has received from a **participant**. First, if you overpay for coverage, it may be possible to receive a refund for up to 12 months after the date the payment was made for any given coverage period that has not yet begun. Second, if you wish to cancel coverage for a future period, a refund may also be available after the original payment for that period was made. Third, in instances in which:

- 1) a **participant** induces any insurer to refund the Fund a premium the Fund has paid to that insurer, and
- 2) that insurer is one to which the Fund has transferred the full risk for a specific benefit (e.g., an HMO).

The Fund may then refund to the **participant** the lesser of

- a) the refund received from the insurer, and,
- b) the amount remitted to the Fund for that coverage by the **participant**.

If the Fund provides you (or your dependent or beneficiary) with more than you are entitled to receive for a claim, you (or your dependent or beneficiary) must return the overpayment. The Fund will have the right to recover any excess payments made for any reason (including, without limitation, error, mistake of fact or law, reliance on any false or fraudulent statements, information or proof submitted by a claimant) by deducting the overpayment amount from any future benefits from this Fund that you (or your dependent or beneficiary) would otherwise receive and/or may initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest and cost) against the person who received the overpayment, or such person's estate.



If payment is made on your (or a dependent's or beneficiary's) behalf to a **hospital**, doctor, or other provider of health care and that payment is found to be an overpayment, the Fund will request a refund of the overpayment from the provider. The Fund may hold back and delay payment to you of benefits otherwise due to you pending receipt of such refund from the provider. If the refund is not received, the amount of the overpayment will be deducted from future benefits payable to you (or your dependent or beneficiary), or a lawsuit may be initiated to recover the overpayment.

PRESCRIPTION DRUG BENEFITS UNDER THE PROACT PLAN — A SUMMARY

Prescription drug benefits vary with the category of prescription drug, whether you use generic, specialty, preferred, or non-preferred brand name drugs and whether you purchase prescription drugs at a local pharmacy or through ProAct’s 90 day retail or mail order programs. The use of either the 90 day retail or mail order pharmacies is required after the initial prescription and first refill for “maintenance” prescription drugs that are typically used at the same dosage level on a long-term basis.

A \$100 annual calendar year deductible per person (limit of \$200 per family), which is separate from the deductible under the Medical Plan, applies before any prescription drug benefits are available, with the exception of generic drugs. Meaning, the annual calendar year deductible will only apply to non-generic drugs. After that, there are varying copays for different classes of drugs and at participating versus non-participating pharmacies as follows:

Copays for Prescription Drugs At-A-Glance (After the Annual Deductible, Described Above, Has Been Satisfied)

| | Generic* | Specialty | Preferred* | Non-Preferred* |
|--|---|---|--|--|
| Participating Retail Pharmacy – per 30-day supply | Greater of \$10 or 20% of the actual cost of the prescription drug | 25% of the actual cost of the prescription drug | Greater of \$20 or 25% of the actual cost of the prescription drug | Greater of \$25 or 30% of the actual cost of the prescription drug |
| ProAct 90 Day Retail and Mail Order Programs* – per 90-day supply | Greater of \$20 or 20% of the actual cost of the prescription drug | 25% of the actual cost of the prescription drug | Greater of \$40 or 25% of the actual cost of the prescription drug | Greater of \$50 or 30% of the actual cost of the prescription drug |
| Non-Participating Pharmacy – per 30-day supply | For Generic, Specialty, Preferred and Non-Preferred Drugs, 30% of the actual cost of the drugs (<i>for maintenance drugs, non-participating pharmacies can only be used for the first 60 days*</i> ; after that they must be obtained through either the ProAct’s 90 day retail network or mail order programs). | | | |

Note: If the overall cost of a drug is less than the minimum copay required, you will only be charged the actual cost of the drug.

Mandatory Generic Program – If you are taking prescription drugs to treat high blood pressure, high cholesterol, and/or acid reflux and/or certain drugs for eczema and psoriasis, sleep disorders, and allergies (nasal sprays), the Fund covers only generic drugs (not preferred or non-preferred drugs) unless your **physician** has obtained an exception to the generic requirement from ProAct — see the section “The Use of Generic Drugs is Required For Certain Classes of Drugs” later on in this book.

* **Mandatory ProAct 90 Day Retail or Mail Order Programs** – The standard supply for these programs is 90 days (compared with 30 days at a standard retail pharmacy, hence the higher flat dollar copay). Use of these programs is required after the first refill of a drug at a retail pharmacy (i.e., the standard retail pharmacy cannot be used after the first 60 days that you have used a particular prescription drug at the same potency).

Out-of-Pocket Drug Cost Cap: Covered prescription drugs are reimbursed at 100% after you have paid \$4,000 out of pocket for drugs in a calendar year.

Listed below is some contact information as to how you are able to locate a ProAct participating pharmacy:

- For a Participating ProAct Retail pharmacy, visit equityleague.org/5185-2/, or contact ProAct directly at 1-833-636-1400.
- For a Participating ProAct 90 Day Retail pharmacy, visit, equityleague.org/5185-2/, or contact ProAct directly at 1-833-636-1400. The list that appears online includes a 90-Day indicator as to whether or not a particular pharmacy is in the ProAct 90-Day Retail network.
- For ProAct’s mail order program, visit, secure.proactrx.com/mail-order/, or contact ProAct directly at 1-833-636-1400.

PRESCRIPTION DRUG BENEFITS — IN DETAIL

Prescription drug benefits are provided subject to an annual deductible (which does not apply to generic drugs), per prescription copays or coinsurance as described in the table on page 21. Benefits vary by the provider of the prescription drug (i.e., participating pharmacy — either a 30- or 90-day supply — versus non-participating pharmacy or mail order program) as follows:

At a Participating ProAct Pharmacy: After satisfying the deductible, you pay the copay as shown in the chart on page 21). You can get up to a 30-day supply of medicine for each prescription and your first refill at the participating pharmacy. After your first refill of the same drug at the same potency, further supplies of the drug may be required to be ordered through the ProAct mail order program or at one of the ProAct's 90 Day retail pharmacy locations. Only the generic version of drugs to treat **high blood pressure, high cholesterol, and/or acid reflux and certain drugs for eczema and psoriasis, sleep disorders, and allergies (nasal sprays)** are covered by the Plan. The Plan does not cover preferred or non-preferred drugs for treatment of these conditions unless you have received special approval — see the section “The Use of Generic Drugs is Required for Certain Classes of Drugs” referenced on page 23.

At a Non-Participating Pharmacy: If you have a prescription filled at a pharmacy that is not in ProAct's pharmacy network, your eligible expenses are reimbursed at 70% of the cost of the covered prescription drugs and medication after the deductible. You can get up to a 30-day supply of medicine for each prescription and your first refill at the non-participating pharmacy. After that, refills of the same drug at the same potency must be ordered through ProAct's mail order program or at one of their 90 Day retail pharmacy locations. As noted above, if you are taking prescription drugs to treat **high blood pressure, high cholesterol, and/or acid reflux and/or certain drugs to treat eczema and psoriasis, sleep disorders, and allergies (nasal sprays)**, the Fund covers only generic drugs (not preferred or non-preferred drugs) unless you have received special approval — see the section “The Use of Generic Drugs is Required for Certain Classes of Drugs” referenced on page 23.

Through the ProAct 90 Day Retail or Mail Order Programs: You can get up to a 90-day supply of drugs or medication through ProAct's mail order pharmacy, or at one of their 90 Day retail pharmacy locations. Prescriptions filled or refilled through either program are reimbursed after you pay the greater of the applicable copay. The copay depends on the category of prescription drug (see the chart on page 21 for further details). **The use of either the ProAct 90 Day retail or mail order programs is required after the first refill of a 30-day prescription drug at a retail pharmacy has been received.**

HOW TO LOCATE A PROACT PHARMACY

There are close to 68,000 participating ProAct pharmacies nationwide, including most of the large national pharmacy chains, where you will be able to get a 30-day supply of your covered prescription medications. ProAct also has a slightly smaller retail pharmacy network, known as ProAct 90 Day, which provides you with another option to fill your prescriptions for up to a 90-day supply in the event you do not want to have them filled under the their mail order program. There are over 60,000 retail pharmacies participating in the ProAct's 90 Day network, including national retail chains such as Walgreens, CVS, Target, and Kroger. To locate any of these participating pharmacies in your area, you can call ProAct at the number located on the back of your pharmacy ID card or visit our website at, equityleague.org/5185-2/. The list that appears includes a 90 Day indicator as to whether or not a given pharmacy is in the ProAct 90 Day Retail network.

USE OF PROACT'S 90 DAY RETAIL PHARMACIES OR THEIR MAIL ORDER PROGRAM IS REQUIRED FOR MAINTENANCE DRUGS

The ProAct 90 Day retail pharmacy and mail order programs are designed for those who take maintenance drugs (medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes, and asthma). Use of the 90-day retail or mail order programs is required after your first refill of a new prescription of a 30-day supply at a retail pharmacy. You can get up to a 90-day supply under either program. Just make sure to ask your doctor to write your prescription for a 90-day supply. To activate mail order service:

1. Determine the amount of your share of the cost by calling ProAct at 1-833-636-1400 or by visiting its website, secure.proactrx.com/mail-order/.
2. Complete a mail order claim form and send it with your prescription and your share of the payment to ProAct. (You also have the option of charging your payment to a credit card.)
3. You can use ProAct's online service, secure.proactrx.com/mail-order/, to order a new prescription, refill an existing one, or transfer a prescription from a pharmacy to mail order (certain drugs, such as controlled substances, require a new prescription). Payment may be made only by credit card when you order online.

Your medication will be delivered to whatever address you specify as part of the order, postage-paid. You should allow about 7–10 business days to receive any initial or refills of your prescription as part of ProAct's mail order delivery process. You also have the option of paying for overnight or second-day shipment at an additional cost of such delivery.

If you don't already have one, you can get a “Mail Order Drug Introductory Kit” by contacting ProAct.

PAYMENT ASSISTANCE WITH HIGH MAIL ORDER DRUG COPAYS THROUGH A PERSONAL HOUSE ACCOUNT WITH PROACT

Using mail order prescriptions will nearly always result in lower **copays** for the same quantities of drugs, so using mail order will save you, and the Fund, money. However, mail order prescriptions are generally filled in 90-day supplies, versus the 30-day supply that is typical at retail pharmacies. Consequently, while **copays** will only be due on mail order prescriptions every 90 days, those **copays** will be considerably higher than the **copay** for a 30-day supply in a retail setting. We recognize that some **participants** with high drug costs may find the more uneven mail order **copay** schedule burdensome. In order to address this issue, we are pleased to tell you about a service that is available. Through ProAct, you have the option of setting up a House Account with ProAct Mail Order, which enables you to purchase a 90-day supply through mail order and charge it to this account. This permits you to pay off your **copay** over a period of time.

How Does the House Account Work?

Your **copay** for a 90-day drug supply will be charged to your account, and you will be responsible for making monthly payments. In order to use the House Account option, you will not be allowed to exceed \$750. Please note that failure to comply with making payments could result in a delay of your next orders.

What Do I Need to Do to Activate the House Account Payment Option?

Have a credit card handy when you call ProAct customer service at 1-833-636-1400, and be sure to mention that you are interested in setting up a House Account. You will be able to sign up over the phone and your next mail order will be charged once your medication is shipped. If you have questions or concerns, please feel free to reach out to customer service at 1-833-636-1400 or the Fund office at 1-212-869-9380 or 1-800-344-5220.

THE USE OF GENERIC DRUGS IS REQUIRED FOR CERTAIN CLASSES OF DRUGS

If you are being treated with prescription drugs for **high blood pressure, high cholesterol, and/or acid reflux and/or certain drugs for eczema and psoriasis, sleep disorders, and allergies (nasal sprays)**, the Fund covers only **generic drugs** (not preferred or non-preferred drugs) unless you have received special approval. In order to secure such approval, you have two options. First, your **physician** can prescribe a generic drug to treat your condition. If the generic drug does not work as desired, your **physician** can report that and approval for coverage of a non-generic drug may be given.

If you have tried the generic drug in the past year without success, this could also be the basis for your request for approval. Second, your **physician** can contact ProAct and make the case, before a generic drug is tried, that your case requires the use of something other than a generic drug. For either of these approaches your **physician** can contact ProAct at 1-833-636-1400.

COVERED PRESCRIPTION DRUGS

Prescription drugs and medications are covered when prescribed to treat an injury or disease and dispensed by a provider acting within the scope of his/her license. The Fund covers the following drugs and supplies when prescribed by a **physician**:

1. A drug, biological, or compounded prescription that can be dispensed only by prescription and labeled "Caution: federal law prohibits dispensing without a prescription";
 2. Oral or injectable insulin, dispensed only with a written prescription; *
 3. Insulin needles and syringes; *
- * The Fund will only require a **copay** be charged on all prescriptions for insulins and oral diabetic medications, but not on any of the diabetic supplies typically used by diabetics: insulin pens and cartridges, insulin syringes, needles, pen needles, lancets, alcohol swabs, and blood and glucose test strips. This provision applies to whether items are bundled and filled either on the same or different days.
4. Tretinoin for participants through age 45;
 5. Prenatal vitamins;
 6. Glucose test strips;
 7. Any other drug (including injectable drugs) that, under the applicable state law, may be dispensed only with a written prescription from a physician; and/or
 8. Oral contraceptives or contraceptive devices, regardless of intended use including implantable contraceptive devices.
 9. Nutritional Supplements and Prescription Vitamins
 10. Androgen/Anabolic Steroids **
 11. Narcolepsy Medications **
 12. Anorexiants Medications **
 13. Antifungal Medications **

** Requires a Prior Authorization by ProAct before being covered under the Plan.

14. Smoking Cessation Products – limit of two courses per year and requires a Prior Authorization by ProAct before being covered under the Plan.

The plan also covers certain preventive treatments in the following categories without a copay:

1. Contraceptive drugs and devices
2. Forms of aspirin
3. Bowel preparations for a colonoscopy — limited to one fill per year at \$0 copay
4. Smoking cessation
5. Folic Acid Supplementation
6. Vitamin D
7. Breast Cancer Prevention (Women) – \$0 copay only applies when prior authorization with ProAct has been met and approved in addition to not being used for longer than 5 years.
8. Pediatric Fluoride Supplements for Prevention of Dental Caries

To view the list of these preventative medications that do not require a copay, please visit our website, equityleague.org/druglist/. In the event the medication(s) that you have been prescribed is not on that list, then the standard copay associated with that drug(s) category will be required to be paid.

COVERAGE OF NEW DRUGS

All newly approved prescription drugs (that is, drugs newly approved by the US Food and Drug Administration [FDA]) are designated “non-formulary/non-preferred” until ProAct’s “Pharmacy and Therapeutics Committee” [the Committee] evaluates the drug clinically and considers whether it should be placed on ProAct’s list of formulary drugs. This means the Fund might not cover a prescription for such a drug.

Prescription drugs that represent an advance over available therapy according to the FDA will be reviewed by the Committee within six months after FDA approval. Prescription drugs that appear to have therapeutic qualities similar to those of an already marketed drug, according to the FDA, will not be reviewed by the Committee for at least 12 months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of such prescription drugs.

INELIGIBLE PRESCRIPTION EXPENSES

The ProAct Plan does not cover the following prescription drugs, services, or supplies:

1. Experimental drugs or drugs labeled: “Caution — limited by federal law to investigational use”;
2. Those for indications not approved by the FDA;
3. A refill that is over the number of refills specified by the prescribing **physician**;
4. A refill of a drug dispensed more than one year after the latest prescription or as legally allowed where the drug is dispensed;
5. More than a 30-day supply of prescriptions filled or refilled at any retail pharmacy;
6. More than a 90-day supply of prescriptions dispensed through the mail order program other than a permitted refill;
7. Maintenance medications obtained through a pharmacy other than a ProAct 90 Day retail pharmacy or the mail order program;
8. Drugs consumed where they are dispensed;
9. Immunization agents, biological sera, and blood or blood plasma;
10. Therapeutic devices or appliances, support garments, and other non-medicinal substances;
11. Drugs used for cosmetic purposes;
12. Dietary supplements;
13. Administration of any drug;
14. Prescriptions a **participant** is entitled to receive without charge from any Workers’ Compensation or similar law or any public program other than Medicaid;
15. Oral infertility drugs;
16. Growth hormones;
17. Drugs for the treatment of a work-related injury or illness;
18. Drugs that are not considered essential for the necessary care and treatment of an injury or **sickness**, as determined by ProAct; and/or
19. Non-generic prescription drugs for the treatment of hypertension, hyperlipidemia, and/or acid reflux, unless the use of something other than a generic drug is approved by ProAct for medical reasons.

Non-prescription items such as vitamins and nutritional supplements are never covered.

HEALTH MAINTENANCE ORGANIZATIONS (HMOS) — ALTERNATIVE MEDICAL AND PRESCRIPTION DRUG COVERAGE

SUMMARY OF THE HMO OPTION

HMO plans are separate plans from the Cigna Plan and are available as an alternative to the Cigna Plan in certain geographic areas. HMO benefits are similar to what is provided under the in-network benefit under the Cigna Plan (there are generally no deductibles or coinsurance), though **copays** are sometimes lower than under the Cigna Plan. However, HMOs generally do not offer any out-of-network **physician** or facility benefits (except for **emergency care**), and their networks cover limited (usually metropolitan) geographic areas (as compared with the national Cigna Plan network). In addition, HMOs generally require that you use a primary care **physician (PCP)** for most of your care and require that you secure a “referral” from the PCP before you can see a **specialist**. Such a referral is not required under the Cigna Plan, but such rules vary with the HMO.

If you elect to join an HMO instead of using the Cigna Plan, your coverage is determined solely by your HMO. When you become eligible to enroll in the Fund, the Fund Office will let you know whether an HMO is available in your area. You can also get information on HMOs in your area on our website (equityleague.org) or by calling the Fund Office.

MORE DETAILS REGARDING THE HMO OPTION

ELECTING AN HMO

You may be eligible to elect an HMO as an alternative to coverage under the Cigna Plan. If you live in an HMO area, you can elect an HMO when you first become eligible for Fund coverage, when you move to an area serviced by an HMO, or during the open enrollment period in November of each year for coverage beginning the following January 1.

If you enroll in an HMO, you can switch to the Cigna Plan if you permanently move out of the HMO service area or are on tour for at least nine months outside the HMO service area, or during the open enrollment period.

IF YOU GO ON TOUR WHILE COVERED BY AN HMO

If you’re in an HMO and are going on tour for nine months or more, you can switch to the Cigna Plan. When your tour is over, you can revert back to your HMO coverage (provided, of course, that you are still eligible for it, either through your employment or through self-pay). Contact the Fund Office for the procedure you must follow to make this switch.

HOW AN HMO WORKS

Generally, you must receive all medical services from a doctor or health care provider who works at the HMO’s facilities or is affiliated with the HMO. You will not be covered for any services from a provider who is not affiliated with the HMO, except in a medical emergency. A medical emergency is a condition that could result in death or serious injury unless it is treated immediately. If you have a medical emergency while you are outside the HMO service area, you may be covered for emergency treatment you receive from a local doctor or **hospital**. However, you must notify your HMO of the emergency immediately, if possible, or within the time frame your HMO sets for such situations. The services your HMO covers and the amount of your coverage may differ from what is provided under the Cigna Plan. For more information on the HMOs available to you, visit the Fund’s website (equityleague.org) or call the Fund Office. You can find enrollment forms for the HMOs that the Fund offers by going to the website previously mentioned and clicking on the “Health” tab and then the “Health Forms” link.

WHERE TO FIND FULL DETAILS ON YOUR HMO PARTICIPATION

If you elect HMO coverage, you will receive information from the HMO that supplements this SPD and replaces the information on the Cigna Plan. Your HMO material will provide complete details on the amount of your HMO **copays** and any other cost-sharing provisions, any other limits on benefits, the extent of your HMO benefits (including whether preventive services are covered, the circumstances under which existing and new prescription drugs are covered, and to what extent medical tests, devices, and procedures are covered), procedures to follow to get HMO benefits, any rules applicable to obtaining **emergency care**, and procedures to follow to appeal a denied benefit claim. Your HMO will also provide you with a list of its providers and instructions on how to contact the HMO.

COORDINATION OF BENEFITS (COB) WITH OVERLAPPING MEDICAL PLANS

Employees and/or family members are often covered by more than one group health insurance plan. As a result, two or more plans may provide coverage for the same expense. To determine which plan is the “primary” plan (i.e., pays first), the Equity-League Health Trust Fund follows a series of COB provisions. COB affects the medical, prescription drug (including drugs received through the mail order program), and vision benefits summarized in this SPD. *The rules for determining which plan is primary are described on page 27.* If you are enrolled in an HMO, your HMO will provide information on any applicable COB provisions.

COB operates so that one of the plans (the primary plan) pays benefits first, as if the other plan (called the “secondary plan”) did not exist. The secondary plan may then pay additional benefits.

If you’re covered by two plans and the other plan does not have a COB provision, the other plan will be primary and this plan will pay second. If both plans have COB rules, the rules below will apply.

WHAT THE FUND PAYS (HOW IT PERFORMS COB) WHEN IT IS THE PRIMARY PLAN

When the Fund pays first (is primary), it will pay up to 100% of “allowable expenses,” less any copays, deductibles, coinsurance, and provisions up to any limits.

A COB EXAMPLE WHEN THE FUND IS PRIMARY AND TREATMENT IS RECEIVED FROM A NON-NETWORK PROVIDER

You go to an out-of-network provider and are billed \$6,000 for a procedure for which the Fund has an MRC of \$5,350. You would be reimbursed \$3,500 (\$5,350 minus the \$350 annual deductible, times 70%). Your responsibility would be 30% of \$5,000, or \$1,500, plus the \$350 deductible amount, plus \$650 (the amount by which the physician’s charge exceeded the MRC of \$5,350), for a total of \$2,500. Your secondary insurer would generally (depending on the plan of benefits it provides) pay up to 100% of what was not reimbursed by the Fund.

A NETWORK COB EXAMPLE WHEN THE FUND IS PRIMARY

You go to a network physician for an office visit. You need only to remit your copay to the provider, and the Fund reimburses the provider in accordance with Cigna’s agreement with that provider. Your secondary insurer may reimburse you for your copay.

WHAT THE FUND PAYS WHEN IT IS THE SECONDARY PLAN

When the Fund pays second, it will pay, with respect to the total benefits under each claim submitted for payment, up to 100% of “allowable expenses,” minus whatever payments were actually made by the plan (or plans) that paid first, but never more than the Fund would have paid had it been primary. More information on the definition of an allowable expense is provided in the Key Definitions section of this book that begins on page 12.

AN OUT-OF-NETWORK COB EXAMPLE

For example, let’s assume that you became eligible for the SAG-AFTRA Health Plan, which should have been your primary health care plan, but you did not enroll with that plan and then enrolled with the Fund instead. (See below for the rules as to when another plan would be primary.) You go to an out-of-network provider and are billed \$6,000 for a procedure. Let’s further assume the Fund has an MRC for that procedure of \$5,350. We therefore calculate the amount we would have reimbursed you had we been primary. That amount is \$3,500 (\$5,350 minus the \$350 annual deductible, times 70%). Your responsibility would have been 30% of \$5,000, or \$1,500, plus the \$350 deductible amount, plus \$650 (the amount by which the physician’s charge exceeded the MRC of \$5,350), for a total of \$2,500.

If the SAG-AFTRA Health Plan had the same benefits as the Fund and you actually had enrolled in the SAG-AFTRA Health Plan, your out-of-pocket expenses under the SAG-AFTRA Health Plan would have been the same \$2,500 under that plan (and the SAG-AFTRA Health Plan would have paid \$3,500). In such a case, we, as the secondary provider, would pay the lesser of \$3,500 (our maximum liability had we been the primary plan) and 100% of the actual cost to you, less any amount by which the charges exceeded the MRC and less the deductible. In this example, the amount would be \$1,500 (\$2,500 minus the \$650 by which the physician’s charges exceed the MRC, minus the Equity-League \$350 deductible). If the SAG-AFTRA Health Plan’s MRC is greater than the Fund’s MRC, the Fund will use the SAG-AFTRA Health Plan’s charge in performing our coordination reimbursement calculation (if ours is greater, we will use ours). However, we never pay more than a) what we would have paid had we been the primary insurer, b) 100% of what the other plan paid, or c) your actual out-of-pocket expense.

A NETWORK COB EXAMPLE

If you use a network provider with the Fund, we will perform our COB calculation so that we will pay the lesser of what we would have paid had we been primary, or 100% of the amount paid by the primary plan, but no more than your actual cost. We will reimburse you for any deductible you may have paid under the primary plan (e.g., if you were out-of-network there) up to the amount we would have paid if we were primary.

GENERAL COB DETERMINATION (DETERMINING WHICH PLAN IS PRIMARY)

For those who are covered as employees only or both as employees and dependents (in addition to the entertainment industry rules presented below), certain universally accepted COB rules apply, except for certain governmental benefits (e.g., Medicare and military health benefits — some of which are discussed elsewhere in this SPD).

COB DETERMINATION FOR THOSE COVERED AS EMPLOYEES

When you are covered as an employee under any plan, the following COB rules apply:

1. Employee coverage is primary to coverage as a dependent,
2. Active employee coverage is primary to coverage as a non-active employee (e.g., retiree, COBRA), and
3. The plan that has covered an active employee longer is primary when the employee is active under two plans .

COB DETERMINATION FOR THOSE COVERED ONLY AS DEPENDENTS

If you are covered only as a dependent and are covered by more than one plan, the following rules apply:

1. If all such coverage is attributable to only one employee, whichever plan is primary for the employee is primary for the dependent as well.
2. If a dependent **child's** coverage is attributable to employees who are married (and not legally separated) or **domestic partners**, the following rules apply, in the order shown:
 - a. The plan of the parent whose birthday falls earlier in the year is primary (e.g., February 3 is primary over March 1, the year of birth does not matter), but
 - b. If both parents have the same birth date, the plan of the parent who has had coverage longer is primary.
3. If a dependent **child's** parents are divorced or legally separated and the divorce decree/separation agreement or QMCSO (Qualified Medical **Child** Support Order) specifies a parent who is responsible for health coverage, the plan of the parent who is specified in such a decree, agreement, or order is primary.
4. If the parents of a **child** are divorced/legally separated and responsibility for **child** health coverage is not legally specified in the decree, agreement, or QMCSO:
 - a. The plan of the parent with custody is primary,
 - b. The plan of the spouse of the parent with custody is secondary,

- c. The plan of the non-custodial parent is next, and,
 - d. The plan of the spouse of the non-custodial parent is last.
5. If the parents of a **child** are divorced/legally separated and custody is joint, the plan of the parent whose plan has been in effect longer is primary.



WARNING! SPECIAL COB RULES APPLY FOR INDIVIDUALS WHO ARE ELIGIBLE UNDER OTHER ENTERTAINMENT INDUSTRY HEALTH PLANS

YOU COULD RECEIVE ONLY A FRACTION OF YOUR BENEFITS IF YOU FAIL TO ENROLL IN YOUR "PRIMARY" ENTERTAINMENT INDUSTRY PLAN

Employees in the entertainment industry are often eligible for more than one benefit plan. In order to facilitate benefit coordination among such plans, a number of them, including the Fund, have adopted similar coordination rules. These rules work as follows:

If you would have primary coverage under other entertainment industry health plans (e.g., qualified first for one of those plans such as the SAG-AFTRA Health Plan), but have failed to enroll and/or pay the premium required by the other entertainment industry health plan, the Fund will process your claims as if you were covered under the other entertainment industry health plan and will only pay benefits on a secondary basis. For example, if you qualify for coverage under the SAG-AFTRA Health Plan before you qualify for coverage under the Fund, the SAG-AFTRA Health Plan will be your primary plan, and the Fund will provide you with secondary coverage, regardless of whether you paid the premium and/or enrolled in the SAG-AFTRA Health Plan.

The Fund will determine what would have been paid for primary coverage by calculating what the Fund would have paid as primary payer and will then process the claim as secondary payer. See page 26 for more details on what the Fund pays when it is secondary. You will be responsible for the amount you would have been reimbursed by the primary plan had you enrolled and/or paid the premium.

If you qualify for coverage under both the Fund and another entertainment industry health plan on the same day, the order of coverage will be determined as follows:

1. **Participants** whose birthdays fall in the first half of the year (January through June) will be primary under the other entertainment industry health plan and secondary under the Fund; and
2. **Participants** whose birthdays fall in the second half of the year (July through December) will be primary under the Fund and secondary under the other entertainment industry health plan.

Please call the Fund Office to find out which entertainment industry health plans participate in this COB program.

Those who incur claims abroad are subject to the Fund's COB rules, with the Plan's responsibility determined on the basis of the currency exchange rate at the time the service was rendered.

ADMINISTRATION OF COB

In order to administer the COB provisions, the Fund reserves the right to exchange information with other plans involved in paying claims; require that you or your health care provider furnish any necessary information; reimburse any plan that made payments this Fund should have made; and recover any overpayment from your **hospital, physician, dentist** or other health care provider, other insurance company, and you or your dependent.

If the Fund should have paid benefits that were paid by any other plan, it may pay the party the amount the Board (or its designee) determines to be proper under the COB provision. Any amounts so paid will be considered to be Fund benefits, and the Fund will be fully discharged from any liability it may have to the extent of such payment.

Please note that the coordination of medical benefits is determined and administered by Cigna, not the Fund.

HEALTH COVERAGE FOR PARTICIPANTS WITH MEDICARE

MEDICARE ELIGIBILITY

Medicare consists of three parts: Part A, which provides hospital benefits; Part B, which provides medical benefits; and Part D, which provides prescription drug benefits. There is also a Part C alternative to Parts A and B, coverage by a Medicare-approved insurer, such as an HMO or a PPO. Most of these Part C insurers offer Part D coverage as well, but if they don't, participants in Part C plans can obtain Part D coverage from another Medicare-approved Part D provider. Parts A, B, and D require you to pay a deductible before they pay benefits. You are also required to pay a premium for Part B coverage and most Part D coverage. Part D coverage is available only through providers approved by Medicare. It is not available directly from Medicare. You (and your dependents) may become eligible for Medicare upon turning 65, after the first 18 months of end-stage renal disease (ESRD), or if you have been deemed totally and permanently disabled by the Social Security Administration (SSA). What you'll find here is an explanation of what happens to your medical benefits under the Fund when you become eligible for Medicare. For more information on Medicare, please refer to medicare.gov or contact the Fund Office.

COORDINATION (COB) WITH MEDICARE

Here's how your Medicare eligibility is linked to your eligibility for Fund benefits.

1. If you're still eligible for Fund benefits through employment and become eligible for Medicare as a result of turning age 65, you are eligible for Medicare even though you are still working. If you are covered by the Fund through employment, you will continue to be eligible for the same benefits as any other participant. The Fund will generally remain the primary payer of your medical benefits, and Medicare (if you have signed up for it) will be secondary. This means that, after the Fund pays its benefits, you can submit a claim to Medicare for amounts not covered by the Fund. (A covered spouse will be treated the same way upon turning 65.) However, you also have the option of electing to either stop participating in the Fund, in which case Medicare would be your only health insurance, or not enrolling in Medicare, in which case the Fund would provide your only health coverage. Remember that if the Fund should be primary and you do not enroll in it, and Medicare discovers this, they may try to reimburse you as if you have taken Fund coverage — that is with Medicare as the secondary payer, even if that is incorrect.
2. If you're eligible for Fund benefits, but not through employment (COBRA coverage for example), and are eligible for Medicare as a result of turning age 65,

Medicare will be your primary coverage, and you should sign up for it as soon as you're eligible. However, you also may have the option (if you satisfy the Fund's eligibility requirements; see later on in this book) of self-paying for secondary coverage through the Fund's Medicare Supplemental Plan, which is provided through Cigna. (If you are eligible for Medicare because you have been diagnosed with ESRD or are totally and permanently disabled, you would also be eligible for the Medicare Supplemental Plan.) If you sign up for the Medicare Supplemental Plan, you will be eligible for out-of-network medical benefits only. However, you will have both network and out-of-network prescription drug and vision coverage. Once Medicare has paid its benefit, the unpaid portion of an expense can be submitted under the Medicare Supplemental Plan. (The total benefits paid under both Medicare and the Medicare Supplemental Plan cannot exceed the expense incurred.) In addition, your benefits from the Fund will be calculated as if you are enrolled in Medicare in both Part A and Part B, even if you haven't, so be sure to sign up for Medicare as soon as you're eligible. If you do not enroll in Medicare (either Part A or Part B), the Fund's Medicare Supplemental Plan will not reimburse you for any amount that would have been covered by Medicare had you enrolled.

3. If you're eligible for Fund benefits through employment and become entitled to Medicare because of ESRD, this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the individual becomes entitled to Medicare, Medicare pays first and this Plan pays second.

Rules governing the coordination of Medicare are complex, and this is only a very brief overview. You should contact the Fund Office at 1-212-869-9380 or 1-800-344-5220 (outside NYC) if you need additional information.

IMPORTANT REMINDER! To receive all the benefits available to you, you should file a claim under each plan that covers the patient for the medical expenses that were incurred. However, anyone who claims benefits through the Fund must provide the Fund with all the information it needs to apply the COB rules.

WHAT SECONDARY COVERAGE DOES THE FUND PROVIDE FOR THOSE ELIGIBLE FOR MEDICARE?

If you sign up for the Fund's Medicare Supplemental Plan, you will be eligible for secondary medical benefits from the Fund, with Medicare as your primary payer of these benefits. The Fund will also provide you both Medicare Part D prescription drug and vision coverage. Once Medicare has paid its benefit related to a **hospital** or medical charge, the balance of that expense can be submitted under the Fund's Medicare Supplemental Plan for coverage on an out-of-network basis. Certain benefits with Medicare do have limits. If you incur services beyond the limit covered by Medicare, the Medicare Supplemental Plan will cover the benefit (subject to Plan rules), but at the out-of-network level up to the Plan's **maximum reasonable charge**. In addition, Medicare does not cover some benefits at all — i.e., **Acupuncture**. In those cases, the Medicare Supplemental Plan would pay for these benefits (subject to Plan rules), but at the out-of-network level and up to the Plan's **maximum reasonable charge**.

Network benefits are not available under the medical portion of the Fund's Medicare Supplemental Plan because Medicare does not allow participation in preferred provider organizations like the Open Access Plus network. (Medicare sets the fees paid to doctors and other providers under the Medicare program and will not recognize arrangements negotiated by the PPO.) In the event your doctor does not participate in the Medicare program, the Medicare Supplemental Plan would only pay the amount it would have paid as secondary had Medicare paid on a primary basis.

If you are enrolled in Medicare Parts A and B, you may also have the option of electing Medicare Part C (Medicare+Choice, also known as Medicare Advantage), which provides an HMO alternative to the "fee for service" coverage provided by Parts A and B. Whether Part C coverage is available in your area depends on whether an HMO offers it (not all HMOs do). Note that if you elect Part C coverage, you will not be eligible to participate in the Fund's Medicare Supplemental Plan.

Other health care resources once you reach 65. Unfortunately, negotiating the health care system doesn't get any easier as you get older. The resources available through the Actors Fund and the AFL-CIO can help you locate health insurance and health care once you reach age 65. Another resource for Medicare-eligible **participants** is American Association of Retired Persons (AARP). You can reach AARP through its toll-free number, 1-888-OUR-AARP (687-2277), or its website, aarphealthcare.com. The website has a useful tool that helps identify the key features of standard Medicare supplement plans and which of those plans are available in your state.

IF YOU ARE COVERED BY THE FUND AND ENTER INTO A MEDICARE PRIVATE CONTRACT

Under the law, a Medicare **participant** is entitled to enter into a Medicare private contract with certain health care practitioners under which you agree that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If you enter into such a contract, the Fund will NOT pay any benefits for any health care services and/or supplies the Medicare **participant** receives pursuant to such contract.

Whenever the Fund is secondary to Medicare, **the Fund** will assume the amount payable as follows:

1. Part A of Medicare **has been paid by Medicare, even** for a person who did not apply for Medicare if that person is eligible for Part A without paying a premium;
2. Part B of Medicare **has been paid by Medicare, even** for a person who is entitled to be enrolled in Part B, but is not enrolled in Part B; and
3. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

SUBROGATION EXPENSES FOR WHICH A THIRD PARTY MAY BE LIABLE

The Fund has the right, whether by subrogation or reimbursement, or any other equitable or legal relief available under state or federal law, to recover from you, your dependents, or any other person or trust in possession of such monies sought by the Fund all benefits paid by the Fund on your or your dependents' right or behalf for injuries or disabilities that you or your dependents have suffered as a result of the negligence or wrongdoing of others for which you receive a "Recovery." Recovery includes without limitation any amount awarded to or received by way of court judgment, arbitration award, settlement, or any other arrangement from any source, including but not limited to any third-party or third-party insurer or from your uninsured or underinsured motorist, homeowners or other insurance coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by you or on your behalf, and without regard to whether you or your dependent have been "made whole" by the Recovery. Accordingly, the Fund does not recognize the "Make Whole Doctrine." The Recovery includes any and all amounts regardless of whether or not any portion thereof is designated for medical expenses. The Recovery also includes all monies received regardless of how held and includes monies directly received by the **participant** or eligible dependent, as well as any monies held in any account or trust on their behalf, such as an attorney-client trust account.

If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to the Fund for benefits and receive such benefits, the Fund shall then have a first-priority lien on any Recovery for the full amount of the benefits that are paid to you and/or your dependents. The Fund shall recover the full amount of benefits paid without regard to any claim of fault on the part of you or your dependents, whether under comparative negligence or otherwise, but no more than your Recovery. In addition, in the event you and/or your dependents fail to seek to recover any monies from the third party that caused the injuries, the Fund shall be subrogated to your right of recovery against that third party or any other source. You and your eligible dependents are responsible for all expenses incurred to obtain payment from third parties, including attorney fees, which amounts will not reduce the amount due to the Fund as restitution. Accordingly, the Fund expressly rejects the "Common Fund" doctrine with respect to the payment of attorney fees.

You may be required to sign an agreement prior to benefits being paid as follows:

If you or your dependent's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable nor paid under any coverage of the Fund unless you contractually agree in writing, in a form satisfactory to the Fund, to do all of the following:

1. Provide the Fund with a written notice of any claim made against the third party for damages as a result of the injury or illness;
2. Agree to reimburse the Fund for benefits paid by the Fund from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party or from your own uninsured or underinsured motorist, homeowners, or other insurance coverage;
3. Ensure that any Recovery is kept separate from and not commingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Fund is held in trust for the sole benefit of the Fund until such time as it is conveyed to the Fund;
4. Execute a lien in favor of the Fund for the full amount of the Recovery that is due for benefits paid by the Fund;
5. Periodically respond to information requests regarding the status of the claim against the third party and notify the Fund, in writing, within 10 days after any Recovery has been obtained;
6. Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the Recovery to which the Fund is entitled in trust for the sole benefit of the Fund and to comply with and facilitate the reimbursement to the Fund of the monies owed to it (as described and defined below);
7. Assign, upon the Fund's request, any right or cause of action to the Fund;
8. Fully cooperate with the Plan Administrator in all respects in the Fund's enforcement of its equitable (or other) rights to restitution and keep the Fund informed of any important developments in your action;
9. Not settle, without the prior written consent of the Plan Administrator, any claim that you or your eligible dependents may have against a third party, including an insurance carrier or any other source;
10. Agree to the entry of judgment against you and, if applicable, your dependent in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the costs of such collection, including but not limited to the Fund's attorney fees and costs; and
11. Take all other action as may be necessary to protect the interests of the Fund.

If you or your dependent fails to comply with any of the aforementioned requirements, no benefits will be paid with respect to the injury or illness. If benefits have already been paid, they may be recouped by the Fund.



Should you seek to recover any monies from any third party that caused your injuries, it is the Fund's rule that you must give notice of same to the Fund Office within 10 days after either you or your attorney first attempts to recover said monies, and if litigation is commenced, you are required to give notice to the Fund of any pretrial conferences within five days of the same. Representatives of the Fund reserve the right to attend such pretrial conference.

The Fund's lien is contractual and is a lien on the proceeds of any compromise, settlement, judgment, and/or verdict received from either the third party or his/her insurance carrier or any other source. By applying for and receiving benefits from the Fund in such third-party situations, you must reimburse the Fund the full amount of the benefits that are paid to you and/or your dependents from the proceeds of any such compromise, settlement, judgment, and/or verdict, to the extent permitted by law. By applying for benefits, you agree that the proceeds of any recovery, if paid directly to you, will be held by you, separate from and not commingled with any other funds, in constructive trust for the Fund.

By accepting benefits, you agree that the proceeds of any recovery paid to any other person or entity other than you, including but not limited to a trust, an attorney, or any agent thereof, shall be held by such other person, entity, or trust in constructive trust for the Fund. The Fund reserves the right to seek recovery from such person, entity, or trust and to name such person, entity, or trust as a defendant in any litigation arising out of the Fund's subrogation or restitution rights. By applying for benefits, you agree that, any lien the Fund may seek will not be reduced by any attorney fees, court costs, or disbursements that you might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the Fund for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of the "Common Fund" doctrine theory for the recovery of attorney fees.

Remember, the Fund does not require you to seek any recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Fund for any of the benefits that you applied for and accepted. However, the Fund is entitled to obtain restitution of any amounts owed to it either from any funds received by you or your eligible dependents, regardless of whether you or your eligible dependents have been fully indemnified for losses sustained at the hands of the third party.

In addition, in the event that you do not pursue any and all third parties and responsible sources, the Fund is authorized to pursue, sue, compromise, or settle (at the Board's discretion) any such claims on your behalf, and you agree to execute any and all documents necessary to pursue said claims and, furthermore, to fully cooperate with the Fund in the prosecution of such claims. In accordance with this authority, a Fund representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Fund's equitable (or other) right to obtain restitution. To this end, by participating in the Fund, you and your eligible dependents acknowledge and agree to the terms of the Fund's equitable (or other) rights to full restitution. You and your eligible dependents also agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator, including the signing of any documents or agreements necessary for the Fund to obtain full restitution.

In the event you fail to notify the Fund as provided for above, and/or fail to reimburse the Fund as provided for above, the Fund reserves the right, in addition to all other remedies available to it by law or equity, to withhold any other monies that might be due you from the Fund for either past or future claims, until such time as the Fund's lien is discharged.

Any amounts received from a third party or other source by judgment, settlement, or otherwise must be applied first to reimburse the Fund for the amount of medical expenses paid on behalf of a **participant** or dependent. The Fund's lien is a lien of first priority. Where the recovery from the third party or other source is partial or incomplete, the Fund's right to reimbursement takes priority over the **participant's** or dependent's right of recovery, regardless of whether or not the **participant** or dependent has been made whole for his or her injuries or losses.

The benefits under this plan are secondary to any coverage under no-fault or similar insurance.

VISION PLAN

VISION PLAN SUMMARY

A vision care benefit provided through Davis Vision, Inc. (also known as “Visionworks”) is automatically provided to anyone who is covered under the Cigna Plan or an HMO. Under the Fund, you have a choice of using **network providers** or going to any licensed provider that you wish. However, the benefits for network and out-of-network care are different.

NETWORK

When you go to an optical provider in the Davis Vision network, the Fund covers the full cost of an eye exam every 12 months and select eyeglasses and select frames once every 24 months. There is a \$25 **copay** for covered contact lenses purchased through a Davis Vision provider.

OUT-OF-NETWORK

If you go to an optical provider outside the Davis Vision network, the same kinds of products and services are covered, but the Fund pays up to the comparable amount it would reimburse a **network provider** in the same geographic area for the same service, except that for contact lenses that are considered **medically necessary**, the maximum reimbursement is \$225. Non-network providers may not accept these amounts as payment in full, and you will be responsible to pay any additional amount.

HOW THE VISION PLAN WORKS — MORE DETAIL

Eligible Fund **participants** and dependents also participate in the Vision Care Plan, which is administered by Davis Vision Inc.

How the Plan Works: The Vision Care Plan covers a wide range of vision-related services and products. While you can go to any optical provider, you generally pay less when you use a provider in the Davis Vision network.

To locate a Davis Vision **Network provider** near you, call 1-800-999-5431 or visit the Davis Vision website, davisvision.com.

NETWORK BENEFITS

To use a Davis Vision **network provider**, call the provider to schedule an appointment and identify yourself as a **participant** in the Fund (this applies to covered dependents as well). Here’s how your expenses are covered when you use a **network provider**.

Eye Exams: A free professional eye examination, including dilation if indicated, once every 12 months.

Frames: Any fashion, designer or premier-level frame from Davis Vision’s **network** will be covered in full every 24 months. A \$100 credit, plus a 20% discount in excess of the \$100, will also be available for any frames selected outside of the Davis Vision frame collection within a **network provider’s** office. **Participants** will be responsible for any amount in excess of \$100.

Eyeglass Lenses: The following lenses are provided free once every 24 months:

1. Plastic or glass single-vision, bifocal, or trifocal lenses in any prescription range;
2. Glass gray no. 3 prescription lenses;
3. Oversize lenses;
4. Post-cataract (lenticular) lenses;
5. Fashion, sun, or gradient-tinted plastic lenses;
6. Polycarbonate (impact resistant) lenses;
7. Ultraviolet (UV) coating; and/or
8. Blended invisible bifocals.

Eyeglass Lens Coatings: Ultraviolet and scratch coatings are provided to you at no cost. In addition, **participants** are able to purchase the following:

1. \$30 for intermediate vision lenses;
2. \$35 for standard anti-reflective coating. Premium ARC is \$48 and Ultra ARC is \$60;
3. \$55 for high-index (thinner and lighter) lenses;
4. \$65 for plastic photosensitive lenses; and/or
5. \$75 for polarized lenses.

Contact Lenses: The Fund provides coverage for standard, daily-wear, disposable, or planned replacement types of contact lenses, in lieu of eyeglasses, once every 24 months. Anyone under age 18 will have contact lenses covered every 12 months. Contact lenses from Davis Vision’s Contact Lens Collection will be covered in full at a **copay** of \$25. This also includes your evaluation, fitting, and follow-up care. If you select contact lenses outside of the Davis Vision collection, a \$115 credit, plus a 15% discount in excess of this amount, will be applied toward the purchase, in addition to the evaluation, fitting, and any follow-up care. This network credit allowance will also apply at participating retail locations. **Participants** will also be responsible for any amount above \$115. **Medically necessary** contact lenses will be covered in full, with prior approval. The **copay** is \$25. A mail order replacement contact lens service, Davis Vision, is also available. Call 1-800-536-7123 for more information on this convenient, cost-saving service.

IF YOU GO TO AN OUT-OF-NETWORK VISION PROVIDER

If you go to an optical provider outside the Davis Vision network, the same kinds of products and services are covered (e.g., eye exams once per year and glasses or contacts once every two years), but the Fund pays only up to the “benefit level” for each covered service. The benefit level, which varies with the product or service, is comparable to the amount that a **network provider** in the same geographic area would be reimbursed for the same service, except that the maximum reimbursement for contact lenses that are considered **medically necessary** is \$225.

Out-of-network providers may, and often do, charge more than the benefit level, and you will be responsible for any charges above the benefit level. In addition, if you go to a provider that is not part of the Davis Vision network, you must pay the full cost of the items you purchase and then submit a claim for reimbursement. You also do not receive the Davis warranty, described below, and cannot use LENS 123 for contact lens replacements.

INFORMATION ABOUT LOW VISION SERVICES

You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the Plan maximum. Up to four follow-up care visits will be covered during the five-year period.

INFORMATION ABOUT LASER VISION CORRECTION SERVICES

Davis Vision provides you and your eligible dependents with the opportunity to receive laser vision correction services at discounts of up to 25% off a **participating provider’s** normal charges or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the **participating provider**. For more information, please visit davisvision.com or call 1-800-999-5431.

DAVIS VISION CONTACTS REPLACEMENT CONTACT LENSES BY MAIL

With free membership and access to a mail order replacement contact lens service, Davis Vision Contacts provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-855-589-7911 or visit the Davis Vision Contacts website at davisvisioncontacts.com.

WARRANTY INFORMATION

A one-year eyeglass breakage warranty is included at no additional cost on eyeglasses purchased from a Davis Vision provider.

All Davis Vision network eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The warranty applies to all network eyeglasses (i.e., spectacle lenses, Davis Vision collection frames, and national retailer frames [where their exclusive collection is not displayed]).

You can get claim forms from the Fund Office, by downloading them from the Fund’s website (equityleague.org), or by calling Davis Vision Customer Service toll-free at 1-800-999-5431. Claims should be submitted to Davis Vision at this address:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

VISION PLAN — INELIGIBLE EXPENSES

The Vision Care Plan does not cover the following expenses, even through the Davis Vision network:

1. Medical treatment of eye disease or injury (some such treatments may be covered under the medical benefit plan);
2. Vision therapy;
3. Replacement of lost or stolen eyewear;
4. Special lens designs or coatings, other than those described in this section;
5. Non-prescription (plano) lenses;
6. Contact lenses and eyeglasses in the same benefit cycle (e.g., 24-month benefit period);
7. Two pairs of eyeglasses instead of bifocals; and/or
8. Services not performed by a licensed optometrist or optician.

VOLUNTARY SELF-PAY DENTAL BENEFITS

DENTAL PLAN SUMMARY

Dental coverage is offered as a voluntary, self-pay benefit, provided only if you pay the entire cost of the coverage you elect. Individual and family coverage are available in a Dental HMO (DHMO) or a Dental PPO (DPPO), both insured by Cigna.

CIGNA DENTAL HMO (DHMO)

If you choose the DHMO, coverage is provided only for those services listed on Cigna's Patient Charge Schedule and only for treatment by a dentist participating in the Cigna DHMO network.

However, many basic and preventive services are provided at no cost to you; others have a fixed copay. The DHMO generally has significantly lower premiums than the DPPO. There is no annual limit on covered expenses, but coverage for some major services can be lower or higher than under the DPPO. In addition, due to individual state law mandates, the DHMO plan is not offered in certain states. For a complete listing of states that do not offer the DHMO benefit, please visit the Dental Coverage Frequently Asked Questions area, under the "Health" section of our website, equityleague.org.

CIGNA DENTAL PPO (DPPO)

If you choose the DPPO, you may use either network or out-of-network providers. However, your out-of-pocket costs will be less when your care is rendered by a dental provider in Cigna's DPPO network. There is an annual limit of \$2,000 and a \$1,500 lifetime limit on orthodontic procedures.

DENTAL BENEFITS IN DETAIL

If you want dental coverage, you can enroll in either the Cigna DPPO or the Cigna DHMO, both of which are offered on a voluntary, self-pay basis. If you want to enroll for self-pay dental coverage, you must submit a separate enrollment form and pay the entire cost of the coverage you elect. If you buy voluntary dental coverage, you can also enroll your eligible dependents (as defined on pages 44 and 45) when you first enroll or at open enrollment. If you enroll, the Fund Office will send you detailed information about your coverage. (Benefits for residents of different states may vary because of the requirements of state laws.) The information you receive will explain which services are covered, as well as those that are not covered; cost-sharing provisions, including annual deductibles, coinsurance, and copays; applicable limits on certain benefits; how to claim benefits; and the procedure to follow in the event your claim for benefits is denied. However, as noted below, if you dropped dental coverage in the prior 12 months, you will need to pay for dental coverage for that period before you can enroll.

What you will find here is a brief overview of self-pay dental coverage provisions. More information is available through the Fund Office at 1-212-869-9380 or 1-800-344-5220 (outside NYC).

ELIGIBILITY FOR THE SELF-PAY DENTAL PLAN

You become eligible for self-pay dental coverage at the same time you qualify for regular Fund health coverage; that is, once you complete the number of weeks of covered employment required for either six months or 12 months of Fund coverage. (See page 40 for more information.) Once you sign up for dental benefits, you can keep your dental coverage as long as you continue to pay your required dental premiums on time. Therefore, your dental coverage continues, even if your other Fund benefits don't.

When you enroll for dental coverage, you enroll with the understanding that dental coverage is provided on an annual basis. If you enroll for dental coverage and withdraw (e.g., cease paying premiums for dental coverage during the year) before the end of the calendar year, you will forfeit the right to continue coverage the following January 1 unless you pay the premiums that were due from the time you withdrew until the end of that calendar year.

For example, let's assume you elected coverage for the start of a calendar year and paid premiums from January through March, then stopped paying premiums for the balance of that calendar year. If you applied at open enrollment for coverage commencing in the following calendar year, you would not be permitted to enroll, unless you paid the premium for the April – December period from the prior calendar year first. This rule does not apply if you dropped dental coverage at the time you lost medical coverage through employment and became eligible to reenroll in dental coverage because you requalified for Fund coverage through employment after incurring a gap in coverage.

An application for dental coverage can be found online at equityleague.org by clicking on the "Health" tab and then the "Health Forms" link.

FAMILY DENTAL COVERAGE

You can extend your voluntary, self-pay dental coverage to your eligible family members as long as they meet the definition of "eligible dependent" as explained on pages 44 and 45. If you elect it, you pay the full cost of family coverage.

ENROLLING FOR SELF-PAY DENTAL COVERAGE

Once you're eligible, the Fund Office will inform you, in writing, when your coverage can take effect. To sign up for coverage, you can download a self-pay dental enrollment form from our website, equityleague.org. Go to the "Health" section

and click on “Health Forms.” This form is located under the Enrollment Form tab labeled Cigna Dental Enrollment Form.

If you wish to enroll just yourself in the Dental PPO (DPPO), then you can simply remit payment and the enrollment form is not required. However, if you wish to enroll in the Dental HMO (DHMO) or wish to enroll any of your dependents in dental coverage under either the DPPO or DHMO plans, then you must return your enrollment form and make your initial quarterly payment to the Fund Office by the deadline indicated in the information packet. You may also enroll your dependents directly online at equityleague.org, through your Self-Service Portal account. If you are enrolling in the DHMO, you must select a primary dental care provider. If you do not name one once the coverage is elected, Cigna will automatically assign one to you in the first available dental office within a 25-mile radius from your place of residency. If you subsequently wish to change your assigned primary care dentist, you will need to inform Cigna and wait until the first of the subsequent month in order to do so.

Dental annual enrollment is held in the fall each year; if you don't sign up when you're first eligible, your next opportunity to do so will be the following November, in which case your coverage would start on the first of the following year assuming your eligibility for medical coverage is continuing. You could also sign up the next time you're eligible for Fund benefits based on **covered employment** after a gap in such coverage. However, as noted above, if you dropped dental coverage in the prior 12 months (other than if you dropped it the same time that you lost medical coverage through employment), you will need to pay for dental coverage for that period that you did not have dental coverage before you can enroll.

Self-pay quarterly dental premiums are subject to change each January 1. For the current premium rates, log on to our website, equityleague.org.

SWITCHING DENTAL COVERAGE

If you sign up for a self-pay dental coverage option and want to switch to the other option, you will have to wait until the next fall open enrollment period. The only exception would be if you were going on tour for nine months or more. Contact the Fund Office at 1-212-869-9380 or 1-800-344-5220 (outside NYC) for more information.

MORE DETAIL REGARDING THE TWO TYPES OF SELF-PAY DENTAL COVERAGE AVAILABLE

You have two choices for voluntary, self-pay dental coverage: the Cigna DPPO and the Cigna DHMO.

THE CIGNA DPPO

Under the DPPO, how your eligible dental expenses are reimbursed depends on whether your care is rendered by a dentist in Cigna's DPPO network. When you use a Cigna DPPO dentist, your care is considered network and reimbursed at a higher level. Covered dental treatment rendered by a provider who is not in Cigna's DPPO network is considered out-of-network care and subject to higher cost-sharing thresholds. You can see both network and out-of-network dentists for your care, but only eligible expenses are reimbursable. See page 37 for more information.

THE CIGNA DHMO

The DHMO is the dental equivalent of an HMO in that you are limited to using providers in the Cigna DHMO network exclusively. There is no coverage if you see a dentist who is not in the Cigna DHMO network. And while the DHMO covers essentially the same services as the DPPO, only services listed on its schedule of benefits are eligible for reimbursement.

IMPORTANT REMINDER! If you enroll for voluntary, self-pay dental coverage, be sure to read the information you get from the Fund Office for important information about your benefits.

SUMMARY OF THE CIGNA DENTAL PPO BENEFITS

The following chart compares how some common covered expenses are reimbursed under the network and out-of-network portions of the Cigna DPPO. Note that all applicable deductibles and maximums cross-accumulate between network and out-of-network benefits. (For example, benefits paid under both the network and out-of-network parts of the plan count toward the overall \$2,000 limit on annual benefits for each covered person.) For more details, visit our website, equityleague.org, or contact the Fund Office at 1-212-869-9380 or 1-800-344-5220 (outside NYC).

| | Network | Out-of-Network |
|--|--|--|
| Annual Deductible | None | None |
| Preventive and Diagnostic Services (exams, cleanings, x-rays, fluoride applications, sealants, space maintainers, emergency care to relieve pain, and histopathologic exams) | 100% | 70% of reasonable and customary maximum reimbursable charges (MRCs) |
| Basic Restorative Services (fillings, root canals, osseous surgery , extractions, customary charges for periodontal scaling and root planning, denture adjustments and repairs, oral surgery anesthetics, repairs to crowns, inlays, and bridges, surgical extractions of impacted teeth) | 80% | 60% of reasonable and customary charges |
| Major Restorative Services (crowns, dentures, bridges, prosthetics over implants) | 50% | 40% of reasonable and customary charges |
| Orthodontia | 50% (up to <i>lifetime maximum</i> of \$1,500) | 40% of reasonable and customary charges (up to <i>lifetime maximum</i> of \$1,500) |
| Annual Maximum on Benefits Payable | \$2,000 | \$2,000 |

If you have enrolled online with Cigna, you can log on to get information at myCigna.com. You can also get information by calling 1-800-Cigna24 (1-800-244-6224).

For more information on the Cigna DPPO, call the Fund Office (1-212-869-9380 or 1-800-344-5220 outside NYC) or go to our website (equityleague.org) and click on the Benefits Explained link under the “Health” section to choose the Cigna DPPO Overview.

SUMMARY OF THE CIGNA DHMO BENEFITS

The DHMO covers essentially the same services as the DPPO but, in almost every case, at a higher level. It also covers certain services the DPPO does not cover (orthodontia for adults, for example). The DHMO covers many dental services in full, with no **copay** required. When a **copay** is required, all you pay is a low preset fee for your care. There are no deductibles to meet, no claims to file, no reasonable and customary limits, no coinsurance, and no annual limit on what the DHMO will pay toward your eligible dental expenses. DHMO benefits are paid according to a Patient Charge Schedule, which is subject to change. To see the current Patient Charge Schedule, go to equityleague.org. You may also call the Fund Office at

1-212-869-9380 or 1-800-344-5220 (outside NYC) for a copy. Keep in mind that if you receive treatment from a dental provider who is not in Cigna’s DHMO, those expenses will not be covered. Also note that the specific coverage available to you under the DHMO may vary depending on where you live; you should review the material you get from the Fund Office to confirm which services are covered, and which are not.

To be considered for reimbursement under either the Cigna DPPO or DHMO dental plans, a dental service must be an eligible expense, which means it must be provided or performed by a dentist (or, for some treatments such as teeth cleaning, by a licensed dental hygienist working under a dentist’s supervision) and be for reasonably necessary dental care. Your Cigna materials will have more information about eligible expenses.

THE SUPPLEMENTAL WORKERS' COMPENSATION PLAN

SUPPLEMENTAL WORKERS' COMPENSATION PLAN (SWC)

SWC benefits are paid in addition to benefits payable under state Workers' Compensation laws. If you get sick or injured while performing, SWC benefits replace part of your income.

In order to collect SWC benefits, you must:

1. Have been injured/become ill while working under an Actors' Equity contract that requires contributions to the Fund for SWC,
2. Become unable to continue to perform under that contract or perform any other similar work (e.g., acting, singing, or dancing) as a result of the work-related illness/injury, and,
3. Apply for, and be eligible for, state Workers' Compensation benefits as a result of that work-related illness/injury.

WHEN DOES SWC COVERAGE BEGIN AND END?

You become covered under the SWC plan as soon as you begin working in **covered employment**. Your coverage ends when your **covered employment** ends.

HOW MUCH IS THE SWC BENEFIT?

The SWC benefit is 100% of your weekly salary, up to a maximum of 75% of the production contract minimum weekly salary at the time of injury. The SWC benefit is reduced by any amount that is payable under the applicable Workers' Compensation or occupational disease laws of the state in which you are working.

HOW LONG DO SWC BENEFITS LAST?

Benefits are payable only while you are receiving Workers' Compensation benefits, and generally no longer than 104 weeks. During those 104 weeks you will be considered disabled if you are unable to perform your usual occupation (e.g., acting, singing or dancing). Your benefits can be extended beyond 104 weeks if the following conditions are met: (1) continue to receive Workers' Compensation benefits after the 104 weeks and (2) Workers' Compensation determines that you are totally disabled and unable to work in any occupation for which you are reasonably qualified. In addition, no benefits will be paid for any period after your Workers' Compensation benefits end.

IMPORTANT REMINDER! SWC Plan benefits are reduced by any amount payable by your state Workers' Compensation benefit.

HOW TO FILE AN SWC CLAIM

There are two things you need to remember to do before you file for SWC Plan benefits: (1) you must notify your employer, and (2) you must make sure a claim has been filed under state Workers' Compensation law. Then you may file a claim for supplemental benefits from this Plan. Also, see page 59 for important information on the claims process.

IMPORTANT REMINDER! Even though time and salary loss may not occur, a record of the injury or sickness should be on file in your employer's place of business, since that's where bills and reports will be sent if you need medical attention at a later date.

Filing a Claim for Benefits. The claims process is explained separately, and in detail, in the Actors' Equity "Work-Related Injury Checklist" (which is available from any Actors' Equity office). Here is a summary of those rules:

1. Immediately report the work-related illness or injury to your stage manager.
2. Get a SWC Plan claim form (available from the Fund Office or from any Actors' Equity office).
3. Get the name and address of your employer's Workers' Compensation carrier and give it to your **physician**.
4. Once you and your attending **physician** have completed your claim form, submit it to the Actors' Equity office.
5. Provide the Actors' Equity office with copies of all benefit checks and accompanying Explanations of Benefits (EOBs). (This last step is required because SWC Plan benefits are adjusted to reflect your Workers' Compensation benefits.)

IMPORTANT REMINDER! DO NOT USE YOUR PERSONAL HEALTH INSURANCE COVERAGE FOR THE TREATMENT OF WORK-RELATED ILLNESSES OR INJURIES!

On-the-job illnesses and injuries are not considered eligible expenses under medical plans, so if you become ill or injured on the job, do not file a claim with Cigna (or any other insurance carrier). See the “Claims and Appeals Procedures” section starting on page 57 for other important information about the SWC Plan claims procedures.

The SWC Plan is a “self-insured” plan, which means the Fund has not purchased insurance coverage to guarantee the payment of this benefit. The money used to pay SWC Plan benefits comes directly out of the assets of the Fund.

TAXABILITY OF SWC BENEFITS

Benefits paid through the SWC Plan are considered taxable wages and, as such, subject to voluntary federal income tax withholding. Therefore, you will get an IRS Form W-4S, Request for Federal Income Tax Withholding From Federal Sick Pay. You may elect or decline voluntary federal tax withholding on benefits paid. If the Form W-4S is not returned to the Fund Office, no federal taxes will be withheld. For information on

state tax withholding, please contact the Fund Office. The benefit is subject to Social Security and Medicare taxes for the first six months of the benefit, and your share of these taxes will be deducted from the payment. At the end of the calendar year, the total of all payments made to you that year by the SWC benefit will be reported to you and the IRS on Form W-2.

EXCLUSIONS AND LIMITATIONS UNDER THE SWC PLAN

The SWC Plan does not cover loss of time from work due to a suicide attempt, whether while sane or insane; an act of war, whether declared or undeclared; or air travel, unless you are traveling as a passenger (and not as a pilot or crew member) during necessary travel time that is considered **covered employment**.

ELIGIBILITY FOR, AND PARTICIPATION IN, EMPLOYEE MEDICAL/VISION BENEFITS

HOW INITIAL OR REINSTATED ELIGIBILITY IS DETERMINED

If you work in **covered employment** for at least 11 weeks in a 12-month “accumulation period” (any 12-month period ending with the last Sunday of each month), you earn eligibility for medical/vision coverage. That coverage begins two months later (i.e., you satisfy a two-month “waiting period”). For example, if you accumulate 11 weeks of **covered employment** during the 12 months ending on the last Sunday in December of a given year, you will be eligible for coverage beginning on March 1 the following year. If you worked at least 11, but less than 19 weeks, you earn six months of coverage eligibility. If you work 19 weeks or more in an accumulation period, you earn a full 12 months of coverage eligibility.

If you don’t have at least 11 weeks of **covered employment** in an accumulation period at the end of a month, you won’t be

eligible for Fund coverage. However, your work history will continue to be examined at the end of each calendar month until you are eligible for coverage.

AN EXAMPLE OF WHEN BENEFITS BEGIN

Suppose you have 19 weeks of **covered employment** in the eligibility period starting with the first Sunday of January in a given year and ending with the last Sunday of December in a given year. Since you would have 19 weeks in **covered employment** as of the end of December, you would be eligible for benefits for 12 months of coverage beginning March 1 of the following year and ending February 28 (or 29 if a leap year) of the subsequent year.

In this example, if you had less than 19 weeks, but at least 11 weeks, of **covered employment** in the January–December accumulation period of any year, you would instead have six months of coverage starting March 1 and ending on August 31. The Fund would then look at the number of weeks of **covered employment** that you earned in the 12-month period ending in June to see if you qualified to continue coverage starting as of September 1.

| Health Fund Eligibility Periods | | | |
|---|--------------------------|-------------------|----------------------|
| Accumulation Period Starts | Accumulation Period Ends | Waiting Period | Benefit Period |
| Work Weeks in the 12 Months Counting from the First Sunday in | To the last Sunday in | Two months | Beginning each month |
| November | October | November–December | January 1 |
| December | November | December–January | February 1 |
| January | December | January–February | March 1 |
| February | January | February–March | April 1 |
| March | February | March–April | May 1 |
| April | March | April–May | June 1 |
| May | April | May–June | July 1 |
| June | May | June–July | August 1 |
| July | June | July–August | September 1 |
| August | July | August–September | October 1 |
| September | August | September–October | November 1 |
| October | September | October–November | December 1 |

Please note that special eligibility rules may apply for staff (employees of the Union, Fund, and Broadway League), and foreign actors employed under agreements with Actors’ Equity Association. Contact the Fund Office for more information.

THE SAME WEEK CAN ONLY BE USED TO EARN COVERAGE ONE TIME

If you earn six months of coverage, your eligibility will be tested again six months later. As a result, some of the weeks included in the 12-month period examined will also fall into the 12 months that enabled you to earn the six months of coverage you enjoyed. In such a case, any weeks that were used to make you eligible for the six months of coverage can never be counted again.

For example, let's assume you earned six months of coverage beginning on March 1 of any year because you had 18 weeks of **covered employment** during a calendar year. Let's assume that all of those weeks fell into the last six months of that year (i.e., between approximately July 1 and December 31). When your eligibility for the quarter beginning on September 1 is tested, the period used will begin on or about July 1 of the prior year and end on or about June 30 of the current year (depending on the days of the work week). In this case, 11 of the weeks you earned during the July 1 through December 31 period will be excluded, because you already used them to earn the coverage that commenced on March 1. Those weeks cannot be used a second time, but the other seven weeks earned during that period can be used. Therefore, if you worked at least four weeks between January 1 and June 30, you will earn at least six months of additional coverage beginning on September 1.

HOW WEEKS THAT SPAN TWO QUARTERS ARE PLACED INTO A PARTICULAR QUARTER

Work weeks of **covered employment** always include, and end on, a Sunday. In contrast, months can end on any day of the week. When a month ends on any day other than a Sunday, it means that at least one day of that week will fall into the next month and at least one day will fall into the month that just ended.

For example, the month ending on December 31, may fall on a Thursday, which means the week that began Monday, December 28 has four days that fall into the month ending on December 31 and three days that fall into the following month, which begins on January 1. In order to decide where to place a given week that has a least a day in two months, the Fund uses one of the following two rules.



The default rule is to place the week in the month in which it ends. However, the **participant** has the option of having it applied to the prior month. In order to use the month in such a way, the **participant** needs to inform the Fund Office by the end of the month (December 31 in this example). If the **participant** does not so inform the Fund Office, the default method of allocating the week will be used and, as a result, the week will count toward the month in which it ends.

ELIGIBILITY DOES NOT CONSTITUTE COVERAGE — YOU MUST ALSO MAKE A TIMELY \$100 CONTRIBUTION

When you first become eligible for Fund medical and vision coverage, we'll notify you. 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 or before the due date. 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 on the next page 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 the coverage you have become eligible for. Why is this important? Because you may not wish to activate 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 that of 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 months of coverage because you expect to earn 12 months of coverage by the end of the next month. 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.

If the Fund does not receive your \$100 contribution on or before the due date for the first month in which you qualify (or requalify for coverage), the plan will assume that you do not wish to have coverage for the benefit period in question. 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 month unless you earned coverage eligibility for that month on the basis of the following accumulation period or satisfy one of the special enrollment rules discussed on page 45.

For example, if you qualify for either six or 12 months of coverage as of January 1, 2017, but do not pay your premium by January 1, 2017, for at least the first quarter of coverage you were offered, beginning on January 1, 2017, you will be forfeiting coverage earned, unless you requalify in a succeeding accumulation period. To continue the example, let us assume you worked for 11 weeks in the three-month period November 2015 through January 2016 (four weeks in November 2015, four weeks in December 2015, and three weeks in January 2016), eight weeks in the three-month period February to April 2016, and had no **covered employment** during the rest of 2016 or in January 2017. If you fail to pay timely for your 12 months of coverage starting January 1, 2017, you will still have the opportunity to pay and enroll for coverage beginning

on February 1, 2017, or March 1, 2017, as you would be eligible for six months of coverage at the start of either period. As of April 1, 2017, though, you would not qualify for coverage since you only earned eight weeks of **covered employment** during the 12-month accumulation period from February 2016 through January 2017. The 11 weeks that you worked between November 2015 and January 2016 are no longer available because they do not fall within the February 2016 – January 2017 accumulation period for coverage starting April 1, 2017. Even if you work 11

consecutive weeks in the quarter starting February 2017, you will not be offered coverage again until July 1, 2017, since those weeks fall outside the accumulation period for April 1, 2017, coverage. 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 ensuring that you do not lose coverage.**

**Contribution Due Dates For the \$100 Contribution for Employee-Only Coverage
(All Dates Below Reflect the Last Day the Fund Office Must Receive Payment.
Payments Must Be Received on or Before Midnight Pacific Time on That Date to Meet the Deadline)**

| Quarter Beginning | Last Date to Ensure Timely Coverage | Last Date to Have Coverage on Day One and Avoid a \$100 Penalty | Last Payment Date for Coverage — Coverage Does Not Start Until You Pay for Coverage Plus a \$100 Penalty |
|--------------------------|--|--|---|
| January | December 15 of the previous year | January 1 | January 31 |
| February | January 15 | February 1 | March 3 (if leap year, March 2) |
| March | February 15 | March 1 | March 31 |
| April | March 15 | April 1 | May 1 |
| May | April 15 | May 1 | May 31 |
| June | May 15 | June 1 | July 1 |
| July | June 15 | July 1 | July 31 |
| August | July 15 | August 1 | August 31 |
| September | August 15 | September 1 | October 1 |
| October | September 15 | October 1 | October 31 |
| November | October 15 | November 1 | December 1 |
| December | November 15 | December 1 | December 31 |

Very Important Note: All of the above due dates are for actual receipt of a valid payment (e.g., not a “bad check”).

The above deadline/penalty/coverage loss rules also apply to any other self-pay coverage(s) you may elect when you first become eligible for medical coverage through employment (i.e., dental and/or dependent coverage). However, if you do not pay for all of the coverage(s) you intend to elect at the same time, the \$100 and delayed coverage penalty applies separately to each coverage paid for on a different date after the deadline (e.g., if you are eligible for coverage on January 1 and pay for medical coverage on January 5, there is a \$100 penalty, and the medical coverage begins on January 5, but if you don't pay for dental coverage until January 10, that dental premium payment is subject to an additional \$100 penalty, and dental coverage begins January 10).




Unfortunately, no coverage can be elected more than 30 days after it became available, even with a penalty payment.


Premiums For Continued Self-Pay Coverages Once They Have Been Initially Elected – Premiums for dental, dependent premiums, COBRA*, Self-Pay After COBRA Extension, and Medicare Supplemental coverage are all due the first day of a quarter/month to which they apply, and if premiums are not received within 30 days of the first day of the month/quarter (e.g., by January 31 for a premium due January 1) coverage will irrevocably terminate as of the end of the prior month (e.g., December 31 for a premium that was due January 1 — until and unless you earn coverage through employment once again). It does not matter when your payment was mailed or otherwise transmitted to the Fund Office (other than for COBRA payments). **Payments related to COBRA must be postmarked (not necessarily received) by the applicable deadline.** Valid payment must be received by the Fund Office by the applicable




deadline set forth above. Therefore, you should consider paying online through the Fund's website, *equityleague.org*, or sending by a method that guarantees delivery and keeping a copy of the proof as to when the payment was mailed.

***Premiums for COBRA When You First Qualify:** There are special rules as to when the initial premiums for COBRA are due when you first qualify. These rules are explained beginning on page 50.

The “**Last Date to Ensure Timely Coverage**” means that if we receive your payment by that date, we ensure that Cigna’s records 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 ensure 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** on 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 Have Coverage on Day One and Avoid a \$100 Penalty**” is the last date that payment can be received without your incurring a late penalty. If you pay at this late date, 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 one week after we receive payment), but coverage will be secured.

Finally, the “**Last Payment Date For Coverage – Coverage Does Not Start Until You Pay for Coverage Plus a \$100 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 for which you had been eligible. It will still be backdated to the date that payment was received. The Fund will not accept any payment received more than 30 days after the coverage period begins 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.

The Fund does permit those who earn coverage through employment and who earn continuing coverage for six months to postpone coverage for up to one quarter and elect COBRA-like coverage for that period, but they must pay the full cost of such coverage. This is typically elected only when a **participant** expects to accumulate 19 weeks of work during the next accumulation period. If you do not earn a year of coverage starting within three months, you will not be permitted to continue COBRA-like coverage.

A WARNING ABOUT DECLINING EMPLOYEE HEALTH COVERAGE — THROUGH EQUITY-LEAGUE OR ELSEWHERE

If we do not receive your \$100 contribution on or before the due date for the first quarter in which you qualify for health coverage (or requalify), the Fund will assume that you do not wish to have coverage for the benefit period in question (i.e., the entire six or 12 months of coverage for which you qualified). Remember that 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 month, unless you earned coverage eligibility anew for that month, on the basis of weeks worked during the accumulation period for coverage that begins that month, or you fall into a Special Enrollment situation, described on page 45.

For example, if you qualify for either six or 12 months of coverage as of January 1, 2017, but do not pay your premium by January 1, 2017, for at least the first quarter of coverage you were offered, beginning on January 1, you will be forfeiting coverage earned unless you requalify in a succeeding accumulation period. To continue the example, let us assume you worked for 11 weeks in the three-month period November 2015 through January 2016 (four weeks in November 2015, four weeks in December 2015, and three weeks in January 2016), eight weeks in the three-month period February to April 2016, and had no **covered employment** during the rest of 2016 or in January 2017. If you fail to pay timely for your 12 months of coverage starting January 1, 2017, you will still have the opportunity to pay and enroll for coverage beginning on February 1, 2017, or March 1, 2017, as you would be eligible for six months of coverage at the start of either period. As of April 1, 2017, though, you would not qualify for coverage since you only earned eight weeks of **covered employment** during the 12-month accumulation period from February 2016 through January 2017. The 11 weeks that you worked between November 2015 and January 2016 are no longer available because they do not fall within the February 2016 – January 2017 accumulation period for coverage starting April 1, 2017. Even if you work 11 consecutive weeks in the quarter starting February 2017, you will not be offered coverage again until July 1, 2017, since those weeks fall outside the accumulation period for April 1, 2017, coverage. Therefore, it is very important that you carefully consider the implications of failing to pay and forgoing coverage.

We see instances all the time where someone does not pay for coverage because they believe that earning additional weeks is guaranteed, only to discover later that an unexpected show closing or a sudden illness prevents that anticipated future

work. But there is another reason to be very careful about coverage as an employee: the COB “trap.”

COB With Other Employers — The Wrong Enrollment Decision Can Lead To Minimal Coverage – The Fund (like many other group health plans) coordinates benefits with other employment-based coverage in the following way. We determine which plan is “primary” and which is “secondary,” on the basis of the Fund’s rules (which are generally based on well-established insurance industry rules), and then pay appropriately (primary or secondary) on the basis of those rules. If the Fund is primary, it pays benefits first on the basis of its benefit plan; then the other plan pays the balance of what was unpaid by the primary plan. This balance is generally attributable to things like deductibles, coinsurance, plan limits, and the like, subject to certain limitations. If the reverse is true (the Fund is secondary), we pay what the other plan did not, subject to certain limits.

Remember, for other entertainment industry health coverage, the primary/secondary rule is used even if you never took coverage with the plan that should have been primary. One of the major rules of who is primary and who is secondary has to do with which coverage became “available” (you were eligible for) first. If you became eligible for another group health plan within the entertainment industry before you became eligible for coverage under the Fund, we will pay as secondary, whether you took the coverage you qualified for earlier or not. That means if the other plan would have paid 80% of a claim, we’ll only pay 20%, whether you actually have that coverage or not! The reverse is true as well. If you had the opportunity to take coverage with the Fund and did not, many other plans will pay as secondary even though you didn’t take coverage with the Fund. See page 26 for more information on COB rules.

Why does such a policy exist? For one thing, it helps to arbitrate differences between plans about which is primary. In addition, it helps to protect the plans with the lowest contributions and best benefits from being selected simply because the contributions are lower and benefits better, even if another source of benefits was available. Remember that plan costs are driven in part by the number of **participants**. If a plan received more than its fair (random) share of **participants** who have primary coverage, the plan that was selected most often would have its costs driven up disproportionately, hurting all of those who are covered. Using the “who offered coverage first” rule helps to ensure that each plan assumes its fair share of primary coverage when two or more plan options exist.

BECOMING ELIGIBLE AFTER A GAP IN COVERED EMPLOYMENT

If your coverage ends for any reason, you can become eligible again by completing at least 11 weeks of **covered employment** within one of the 12-month look back periods.



VOLUNTARY SELF-PAY HEALTH COVERAGE FOR YOUR DEPENDENTS

You can enroll your eligible dependents for medical, vision, and dental coverage when you first elect coverage. If you elect dependent coverage, you are required to pay the applicable premium for dependent coverage. Also note that you will lose dependent coverage if you fail to make a payment when due. If both of a **child’s** parents are eligible for employee coverage from the Fund and one of those parents elects coverage for that **child**, reduced rates apply for that coverage. Contact the Fund Office for current dependent care rates.

FOR HEALTH FUND PURPOSES, YOUR ELIGIBLE DEPENDENTS INCLUDE:

1. Your spouse to whom you are legally married under the applicable laws (the Fund treats same-sex spouses the same as opposite-sex spouses);
2. Your dependent **children** until the end of the month in which they reach age 26, regardless of whether the **child** has access to health insurance coverage through an employer or is a student, married or unmarried, a tax dependent of the **participants**, or any factor other than the relationship between the parent and **child**;
3. Your unmarried **disabled children** of any age (if the **child** became disabled while covered by us before 19 as your dependent). If, however, your dependent **child’s** disability occurs after reaching age 19, he or she can still qualify under the Fund for health coverage until the last month of his or her 26th birthday; and/or
4. A **domestic partner**. (Also see “**Domestic Partner Coverage**” on page 46 for more information. See page 13 for the definition of “**domestic partner**.”)

Your dependents are eligible for coverage when you first become eligible (or when they first become your dependent, if later). For dependent coverage to be in effect, you must complete an enrollment form and pay the applicable premium. If you do not enroll them at the same time as your coverage starts, you will need to wait until open enrollment to enroll them, unless you fall under one of the Special Enrollment situations described below.



When you enroll a dependent, you should be prepared to provide proof of dependent status (for example: a marriage certificate, birth certificate, proof of residence, and/or proof of financial dependency). Please be sure to notify the Fund Office when there is any change in dependent status.

When Does Coverage Start for Existing Dependents?

Provided that the Fund receives timely payment and the necessary enrollment information, your dependents' coverage will start when your coverage starts.

When Does Coverage Start for New Dependents? In order to cover a new dependent before open enrollment, you must inform the Fund Office and provide proof of the new dependent within 31 days of your marriage or the birth or adoption of the **child**. You will also be required to pay any additional premium required. Provided the Fund receives such timely proof and any required payment, coverage can begin the first of the month in which the Fund receives notice of the dependent or the first day of the following month. **Children** born to or placed for adoption at birth with a parent who is covered by the Fund are covered automatically for a period of 31 days from their birth. In order to continue coverage beyond the 31 days, an application for dependent **child** coverage, and any applicable premium required for that coverage, must be received by the Fund Office within 31 days of the birth of the **child**. If you do not enroll a new dependent within the initial 31 days, you will still have an additional 31 days to enroll and pay for your new dependent's coverage, but you will need to pay an additional \$100 penalty payment, and coverage will not take effect until the premium and \$100 penalty are paid. If you do not enroll a new dependent within the initial 31 days or the extended 31-day penalty period, you will then need to wait until open enrollment to add them to your coverage.



ANNUAL OPEN ENROLLMENT FOR EMPLOYEE MEDICAL/VISION, DEPENDENT MEDICAL/VISION, AND DENTAL COVERAGE

Once your medical/vision or dental coverage has started, you may only change coverage (e.g., from Cigna Plan to HMO, DHMO to DPPO, change the status of a dependent) during an annual "open enrollment" period, held each November with coverage being effective January 1 of the following year. If you do not enroll yourself or your dependents when first eligible, you will normally have to wait for up to a full year, until the next open enrollment period, unless you earn medical/vision eligibility through **covered employment** again (after a "gap" — meaning a period without coverage) or qualify under a Special Enrollment situation described in the next section. A notice regarding the open enrollment is sent to all of those who are eligible each October.



In order to change your election during open enrollment, the Fund Office must receive both your payment and your election form by November 30. If you miss that deadline, you can submit your election and payment up to December 31, by paying a penalty of \$100. Under no circumstances will any enrollment changes after December 31 be permitted.

SPECIAL ENROLLMENT SITUATIONS

You may be able to enroll yourself and/or your dependents outside the annual open enrollment period, for a portion of a coverage period you had earned but not enrolled for, if any of the following situations apply.

1. You get married, enter into a domestic partnership, or have a **child** (by birth, adoption, or placement for adoption) after you are first eligible. However, you must apply and pay for this coverage within 31 days of the event. If this is not done within the initial 31 days, you still have an additional 31 days to enroll and pay for this coverage, but only if you pay an additional \$100 penalty; coverage will not start until payment is received. Coverage can begin on the first day of the month in which the Fund Office receives notice of the dependent or it can begin the first day of the following month.
2. You become eligible for Fund coverage through **covered employment** while you were covered through self-pay, in which case dependent coverage will be effective the same date as yours, provided you timely enroll and pay for dependent coverage. If you do not enroll and pay by the initial deadline, you still have an additional 30 days to enroll and pay for this coverage, but only if a \$100 penalty is paid; coverage will not start until payment is received.
3. You declined to pay the required quarterly premium or declined to enroll your dependents because you or your dependent was covered under another medical and/or dental plan, and you (or your dependent(s)) lose that coverage. The Fund must receive your request for coverage, proof of the loss of the other coverage, and any necessary payment within 31 days of the loss of coverage. If you do not enroll and pay within the initial 31-day deadline, you still have an additional 31 days to do so, but you will have to pay a \$100 penalty in addition to any applicable premium (and coverage does not begin until payment is received). Loss of coverage means you or your dependent loses coverage under a health plan for any of the following reasons: termination of employment; reduction in hours worked; your spouse dies; you and your spouse divorce or legally separate; your dependent loses dependent status; you move out of an HMO (medical and/or dental plan coverage) service area, your coverage terminates, and no other group coverage is available; you or your dependent's plan stops offering coverage to a group of similarly situated individuals; you or your dependent incurs a claim that would meet or exceed a lifetime limit on all benefits; your or your dependent's employer stops contributing toward coverage; the other coverage was COBRA continuation and you or your dependent reaches the maximum length of time for COBRA continuation; or the other plan terminates. Loss of coverage does



not include failure to pay premiums on a timely basis, termination of coverage for cause (such as making a fraudulent claim), or you or your dependent voluntarily dropping coverage.

4. You are required to provide dependent coverage through a Qualified Medical Child Support Order (QMCSO).
5. You and your dependents may also enroll in the Fund if you (or your dependents) have coverage through Medicaid or a state Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment and make any necessary payment within 60 days after the Medicaid or CHIP coverage ends. If you make your request and necessary payment on a timely basis, coverage will begin on the first day of the month following the month in which Medicaid/CHIP coverage ended or the first day of the month in which you received notice of the coverage loss.
6. You and your dependents may also enroll in the Fund if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment and make the necessary payment within 60 days after you (or your dependents) are determined to be eligible for such assistance. Coverage can begin on the first day of the month in which the Fund Office receives notice, or it can begin the first day of the following month.

A further discussion regarding "Life Events" that can affect coverage eligibility for you and for your dependents appears on Page 73.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is an order issued by a state court or agency that requires an employee to provide coverage under a group health plan to a child. A QMCSO usually results from a divorce or legal separation. Whenever such an order is received, its qualified status is determined in accordance with QMCSO procedures adopted by the Fund. (You can get a copy of these procedures free of charge by contacting the Fund Office, 1-212-869-9380, 1-800-344-5220.)

You can make a change in dependent coverage by completing the form found at the Fund's website equityleague.org by clicking on the "Health" tab and then the "Health Forms" link.

DOMESTIC PARTNER COVERAGE

THE FUND DEFINES DOMESTIC PARTNERS AS FOLLOWS:

Two unmarried* adults (both of whom are 18 years or older) of the same or opposite sex who:

1. Resided with each other for six months prior to the application for benefits and who intend to live continuously with each other indefinitely;
2. Are not related by blood closer than the law would permit by marriage;
3. Are financially dependent on each other;
4. Have an exclusive close and committed relationship with each other;
5. Have not terminated the domestic partnership; and
6. If eligible under (1) and living in a state or municipality providing for the registration of domestic partnerships, have registered as **domestic partners**.

* You are considered married if you are legally separated.

PROCEDURE FOR VERIFYING DOMESTIC PARTNER STATUS

You must satisfy the following requirements in order to cover a **domestic partner** under the Fund's Medical and Vision Plans.

A **participant** who seeks **domestic partner** coverage is required to submit a) an affidavit attesting to the **domestic partner** status, and b) either a domestic registration, or a declaration of financial interdependence with two items of proof from the following list:

1. Proof of a joint bank account;
2. Proof of a joint lease/mortgage of mutual residence;
3. Joint billing statements of residential utilities (e.g., utility, Internet, or telephone bills);
4. Joint insurance documents (e.g., property, life, or automobile insurance contracts);
5. Joint credit card accounts;
6. Joint loan agreements;
7. Joint car ownership;
8. Other titles or deeds that are jointly held; and/or
9. Other proof that would be sufficient to establish financial interdependence in the circumstances of a particular case.

(A sample affidavit and declaration is available on the Fund's website.) In addition, those who live in states or municipalities offering a **domestic partner** registry will be required to show proof that they have registered as **domestic partners**.

Proof of the ongoing nature of the domestic partnership may be requested annually.

IF A DOMESTIC PARTNERSHIP ENDS

If you are providing Fund coverage for a **domestic partner** and your domestic partnership ends for any reason, you must immediately file a written notice of dissolution of the domestic partnership with the Fund. You can re-apply for **domestic partner** coverage for a new **domestic partner**, but except in

the case of a court-granted dissolution, you must wait one year following the date your previous domestic partnership ended.

Tax implications: The Fund cannot be responsible for any tax or other financial effects of **domestic partner** health benefits coverage. All or part of **domestic partner** health benefits coverage may be considered taxable income under federal and/or state tax rules unless you self-pay for the coverage. If you are eligible for **domestic partner** coverage, you and your **domestic partner** should consult with a personal tax advisor on the tax implications of such coverage.

WHEN HEALTH FUND COVERAGE ENDS FOR YOU OR YOUR DEPENDENTS

Your coverage. Your Fund coverage normally ends on the earliest of the following events:

1. You fail to meet any of the Fund's eligibility requirements;
2. The date the Fund or any benefit plan it offers terminates;
3. The date you fail to pay premiums owed for your coverage; or
4. The date the Fund is amended to terminate coverage for those in your situation.

Dependent coverage. If your dependents are enrolled for Health Fund coverage, their coverage will normally end on the earliest of the following:

1. The date the Fund terminates;
2. The date you are no longer eligible (for any reason, including your death);
3. The date the Fund is amended to terminate coverage for a category to which the dependent belongs;
4. The date the dependent no longer meets the definition of a "dependent" under the Fund (including death of the **participant**, divorce, or a **child** reaching age 26); or
5. The date premium payments on behalf of the dependent end.

If your dependents' coverage ends because you failed to pay the premium when due, coverage can be reinstated only by meeting one of the qualifying events listed in the "Voluntary Self-Pay Health Coverage for Your Dependents" section on page 44. If you die while you are covered, your covered dependents will continue coverage only until the end of the month in which you died *or*, if later, until the end of the period for which you paid for coverage before your death (provided they pay for such coverage).

COBRA, HIPAA, AND OTHER INFORMATION YOU SHOULD KNOW IF YOUR OR YOUR DEPENDENTS' MEDICAL/VISION OR DENTAL COVERAGE ENDS INVOLUNTARILY

Here's important information about your options if you or your covered dependent(s) lose Fund coverage. These options include the following:

1. The right to buy a temporary extension of health care coverage under the Consolidated Omnibus Budget Reconciliation Act, the federal law known as COBRA;
2. The right available to individuals with at least 10 separate years of vesting service under the

Equity-League Pension Fund (the Pension Fund's two-for-one rule does not apply) to self-pay Fund coverage after COBRA coverage is exhausted for a maximum of 18 months;

3. Enrollment in Marketplace coverage. Note that if you do not enroll when you first lose coverage, you may not be able to enroll in the Marketplace until open enrollment or, if you elect COBRA, your COBRA period is exhausted.

Also see page 56 for information about the Actors Fund's Artists Health Insurance Resource Center (AHIRC) and other health-related services.

SELF-PAY COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that the Fund offer you, your spouse, and other eligible dependents the opportunity for a temporary continuation of health care coverage at group rates in certain instances where your coverage would otherwise end (called "qualifying events"). You, your spouse, and other eligible dependents covered under the Plan when a qualifying event occurs are known as "qualified beneficiaries." (**Domestic partners** are not entitled to COBRA coverage by law, but the Plan offers coverage that is similar to COBRA coverage to such **domestic partners**.)

Continued coverage under COBRA applies to certain of the health care benefits described in this SPD. You don't have to prove good health to get COBRA coverage, but you are required to pay the full cost of coverage for both you and/or any covered dependents.

However, from time to time, individual states and/or the federal government have provided subsidies for COBRA coverage to those who meet certain criteria. For the most up-to-date information on this issue, please read your COBRA notice carefully and/or visit our website.

Domestic Partners: The Fund offers self-pay coverage under the same rules as COBRA to **domestic partners** on the same basis as if they were spouses. Please note that under current law, **domestic partners** are not "spouses" under federal law and, thus, are not eligible for COBRA and may not be entitled to certain subsidies for COBRA coverage.

COBRA benefits are the same as those covering people who are not on continuation coverage. You should also keep in mind that each individual entitled to COBRA coverage as the result of a qualifying event has a right to make his or her own election of COBRA coverage. (For example, your spouse can elect COBRA coverage even if you do not.)

Qualifying COBRA Events: The following chart shows when you and your eligible dependents would qualify for continued COBRA coverage, as well as the number of months your COBRA coverage could be continued. You will note from the qualifying events listed in the table on page 49 that failure to pay a premium on a timely basis is not a COBRA qualifying event, and so does not entitle you to COBRA coverage.

QUALIFYING COBRA EVENTS

| If You Lose Coverage Because: | These People Would Be Eligible: | For COBRA Coverage Up To: |
|--|--|---|
| Your employment terminates* | You, your spouse, your other eligible dependents | 18 months |
| Your working hours are reduced | You, your spouse, your other eligible dependents | 18 months |
| You die* | Your spouse, your other eligible dependents | 36 months |
| You divorce | Your spouse, your other eligible dependents | 36 months |
| Your domestic partnership terminates | Your domestic partner | 36 months |
| Your dependent children no longer qualify as eligible dependents | Your eligible dependent children | 36 months |
| You become entitled to Medicare benefits less than 18 months before the qualifying event | Your spouse, your other eligible dependents | 36 months from the date of your entitlement to Medicare |

*If you die while covered, dependent COBRA coverage will not be triggered until the end of the period for which you have paid for your own coverage, if your dependents pay the necessary premiums for coverage during this period. For instance, if you paid for coverage for January through March in any given year and died on January 31, your dependents could continue coverage through March 31 before beginning their 36 months of COBRA coverage, if they pay the required premiums for the months of February and March.

If you and your eligible dependents are eligible for COBRA coverage because your employment terminated or your working hours are reduced, you may be eligible to extend the COBRA coverage for up to 11 months beyond the initial 18-month period. COBRA coverage is available for up to 29 months from the date of the initial qualifying event if you or any qualified beneficiary is determined by the SSA to be disabled. The disability would have had to have started some-time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The additional 11 months are available to employees and enrolled dependents if notice of such disability is provided in writing to the Fund Office within 60 days after the latest of: (a) the date of the SSA's determination of disability; (b) the date of the initial qualifying event; or (c) the date of the loss of coverage due to the initial qualifying event and written notice is provided before the end of the initial 18-month COBRA continuation period.

Newborn Children: If you have a newborn **child**, adopt a **child**, or have a **child** placed with you for adoption while your continued coverage under COBRA is in effect, you may add the **child** to your coverage. To add coverage for the **child**, you must notify the Fund Office within 31 days of the **child's** birth, adoption, or placement for adoption. The maximum period of coverage for the **child** will be measured from the same date

as for other qualified beneficiaries with respect to the same qualifying event, and not from the date of the **child's** birth, adoption, or placement for adoption.

Second Qualifying Event: If your covered dependents experience an additional qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continuation coverage, not to exceed a total of 36 months from the date of the first qualifying event. For example, if you did not work enough weeks to continue to receive benefits into the next benefit period, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if you die (a second qualifying event), your covered dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination). This extension may be available if you die, get divorced, or become entitled to Medicare benefits (under Parts A or B or both) or if your dependent **child** stops being eligible under the Plan as a dependent **child**. To be eligible for this second qualifying extension of benefits, you must notify the Plan within 60 days after the second qualifying event occurs.

Notice of COBRA Eligibility: Your employer must notify the Fund Office of your death no later than 60 days after a loss of

coverage due to this event. However, your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status. You or your eligible dependents are responsible for informing the Fund Office of a divorce, a **child's** loss of dependent status under the Fund, a second qualifying event entitling an eligible dependent to additional COBRA coverage, or if a dependent is determined to be disabled or determined to no longer be disabled within 60 days of the later of (1) the date of the qualifying event or, (2) the date that coverage should have ended due to the qualifying event. If you do not notify the Fund by the end of that period, your dependents will not be entitled to COBRA continuation coverage. The Fund must notify you and/or your covered dependents of your right to COBRA continuation coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred.

DEADLINE FOR COBRA ELECTION

Once the Fund Office mails notice of your eligibility for COBRA to you, you will have 60 days to elect COBRA coverage — measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you. If you do not make an election within that 60-day period, you will irrevocably lose your right to COBRA coverage. However, if you choose to make an early election, your payment will be due 45 days from the date you make that election, or the 30th day after the first of the month of COBRA coverage, whichever is later.

PROCEDURES FOR PROVIDING NOTICE TO THE FUND

You (or your eligible dependents) must give the Fund Office written notice as soon as possible, but no later than the applicable deadline given above, under these circumstances:

1. Divorce or legal separation;
2. A **child** is no longer a dependent;
3. A second qualifying event that entitles an eligible dependent to additional COBRA coverage;
4. A dependent is determined to be disabled by the SSA; or
5. A dependent who had been disabled under Social Security receives notice that he or she is no longer considered disabled.

Send your notice to: Fund Office Equity-League Health Trust Fund, 165 West 46th Street, 14th Floor, New York, NY 10036-2582.

Be sure to include the following in your notice:



1. Your name;
2. The name(s) of your eligible dependent(s), including your spouse;

3. Your Social Security number and the Social Security number(s) of your eligible dependent(s);
4. Your address;
5. The nature and date of the event you are reporting to the Fund;
6. If the event is a divorce, a copy of the divorce decree;
7. If you are requesting a disability extension, the name of the person who has been determined disabled by the SSA, the date of such determination, and a copy of the disability determination letter; and
8. If you are reporting a second qualifying event, the name of the qualified beneficiary(ies), the date of the second qualifying event, and other applicable proof of the second qualifying event (for example, a copy of the divorce decree if the divorce constitutes the second qualifying event).

PAYING FOR COBRA COVERAGE — MEETING PAYMENT DEADLINES IS CRITICAL

You have to pay the full cost of continued coverage under COBRA plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, you must pay 150% of the full cost of continued coverage during the 19th to 29th months of coverage. If you are a New York resident, you may be eligible to receive a subsidy from New York State for a portion of the cost of your COBRA coverage. Contact the Fund Office for more details about this program.

The following rules apply in making your COBRA payments.

1. Initial payment. You should make your first payment when you file your COBRA election form— that is, within 60 days from the date your Fund coverage would otherwise end (or, if later, within 60 days of the date the Fund sent you the COBRA notice). Alternatively, if the Fund receives payment for coverage without the election form, such payment will be considered an election of coverage and you must include payment due for all coverage periods as of the time you make payment. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office or the 30th day after the first of the month of COBRA coverage, whichever is later. Your first payment should cover the period from the date your Fund coverage ended (and COBRA coverage began) through the date you make your first payment. 
2. Ongoing payments. All subsequent payments are due on a quarterly basis, but can be made on the first day of each month for that month's coverage (for example, by June 1 for June coverage). You also have a grace period of 30 days from the due date (i.e., July 1 for June 1 coverage). 

The Fund Office does not send monthly bills for COBRA coverage, and it is your responsibility to see that your payment is sent to the Fund Office by the applicable due date whether or not you receive a bill. *In no event may your payment be made more than 30 days after the due date or your coverage will terminate.* If you do pay after the first of the month for coverage that month, you risk going to a provider and having that provider deny treatment, because Cigna's records will show that you are not covered (this will occur for up to seven days after your payment is actually received). So we encourage you to pay your premiums by the due date.



COBRA Premiums: COBRA premiums are generally reviewed at least once a year and are subject to change. You will be notified by the Fund Office if the amount of your monthly payment changes. You should also be aware that if benefits change for active employees, your coverage will change as well.

WHEN COBRA COVERAGE ENDS

Your COBRA coverage will end for any of the following reasons:

1. You have used up your COBRA extension (i.e., you continued coverage for the maximum 18-, 29- or 36-month period, as applicable).
2. The Fund stops providing health care coverage. (If the coverage is replaced, you may be continued under the new coverage.)
3. You did not timely pay your premium (or completely failed to pay your premium), in which case your COBRA coverage will end on the last day of the month for which premiums were paid.
4. You become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply to you.
5. You are continuing coverage during the 19th to 29th months of a disability, and the SSA deems you no longer disabled. Your coverage will end as of the month that begins 30 days after the determination that you are no longer disabled. You are required to notify the Fund Office in writing within 30 days of any such final determination.
6. You or a covered dependent becomes entitled to Medicare.

COBRA coverage may also be terminated for any reason the Fund would terminate coverage of a **participant** or beneficiary who is not receiving continuation coverage (such as fraud).

You will be obligated to repay the Fund for all costs the Fund incurs in connection with you and/or your dependent's coverage beyond the period identified above.

Once your COBRA coverage ends, it cannot be reinstated. There are no exceptions to this rule.

Important Note: You may find that more affordable health insurance coverage is available to you through an ACA Marketplace (exchange) than through the Fund's COBRA benefits. Therefore, we encourage anyone who becomes eligible for COBRA coverage through the Fund to investigate his/her options on the Marketplace, either directly at health-care.gov, or by contacting the Actors Fund, which is an official ACA "Navigator" authorized to guide you through your ACA options and enrollment in a plan offered by a Marketplace.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, as noted above. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

If you have questions: Questions concerning coverage through the Fund or your COBRA continuation coverage rights should be addressed to the Fund Office. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit HealthCare.gov.

SPECIAL SELF-PAY AFTER COBRA (SPAC) FOR THOSE WHO HAVE EXHAUSTED COBRA COVERAGE

When your COBRA** coverage ends, you may be eligible for the Fund's Self-Pay After COBRA (SPAC) Coverage. SPAC Coverage is available to all Health Plan **participants** who have earned a vesting service in 10 separate years under the Equity-League Pension Fund (and not lost those years to any applicable break in service rules applicable under the Pension Fund). In determining years of vesting service for purposes of eligibility for SPAC Coverage, the Pension Plan's two-for-one rule does not apply. Each year of work counts as only one year of vesting service, no matter how many weeks you may work in **covered employment** that year. Two or more weeks of **covered employment** in one calendar year equals a year of vesting service.

If you do not continue coverage immediately after COBRA** coverage ends or you stop paying for Fund coverage at any time, you will not be eligible for coverage again unless you satisfy the eligibility requirements described in "How Eligibility is Determined."

Under the SPAC Coverage program, the Fund will establish a “bank” for a **participant** who accumulates at least 10 years of service as defined above. Such **participants** will have 18 months of extended health coverage eligibility placed in an SPAC Coverage “bank” account.

In addition, for each additional year of vesting service (as defined above) that such **participants** earn beyond the 10 years required to qualify for the initial 18-month extension, they will have one additional month of SPAC Coverage eligibility added to their “bank” account. These added eligibility months can be used as of the first of the month following the completion of a **participant’s** 18 months of COBRA** coverage, 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. Once the total number of additional months is exhausted, there are no additional months beyond the 18-month COBRA** coverage period.

** Participants enrolled in a New York State HMO Plan and who complete 18 months of New York State continuation coverage (“mini-COBRA”) immediately following 18 months of COBRA, will be eligible to elect up to 18 month of SPAC coverage to the extent permitted by their HMO.

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

| Years of Vesting Service* | SPAC Coverage Months |
|---------------------------|----------------------|
| 10 | 18 |
| 15 | 23 |
| 20 | 28 |
| 25 | 33 |
| 30 | 38 |


*As noted above, years earned through the Pension Plan’s two-for-one rule do not count towards eligibility for SPAC Coverage under the Health Plan.

If you are eligible to self-pay, you may also enroll your eligible dependents. The same time rules apply as for active coverage; that is, if you do not enroll your dependents when they are first eligible for coverage, you must wait for open enrollment, unless you satisfy a Special Enrollment exception. If you die while you are covered, your covered dependents will continue coverage only until the end of the month in which you died, or, if later, until the end of the period for which you paid for coverage before your death (provided they pay for such coverage).

SPECIAL EXTENDED COVERAGE WHEN YOU ARE HOSPITALIZED

The worst possible time for your health coverage to end is when you are in the middle of an emergency **hospitalization**. Therefore, if your eligibility for medical benefits under this Plan ends while you are **hospitalized** and your medical coverage under the Plan was in effect when your **hospital** stay began, you may be eligible for limited extended coverage.

In order to qualify for the special extended coverage, your **hospitalization** must have been in connection with a non-elective medical treatment that can only be performed on an inpatient basis. This special extended coverage is limited to covered expenses incurred in connection with such a **hospitalization**, until the earliest of:

1. The date you are no longer **hospitalized**;
2. The date you become eligible for other medical coverage (including but not limited to a group health plan, Medicare, Affordable Care Act Marketplace plan, or individual plan); or
3. 90 days from the date your medical benefits under the Plan would otherwise cease without the special extension. 

Important Note: This special extended coverage does not apply if you were eligible to continue your health coverage under the Plan (including COBRA coverage) but your coverage terminated because you failed to pay the required premium on a timely basis.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This notice is provided to you in accordance with the requirements of the Women's Health and Cancer Rights Act of 1998.

If the Fund provides medical and surgical benefits in connection with a mastectomy, the Fund will also provide benefits for certain **reconstructive surgery**. In particular, the Fund will provide, to a **participant** or beneficiary receiving or claiming benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. **Surgery** and reconstruction of the other breast to produce a symmetrical appearance; and/or
3. Prostheses and physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation between the attending **physician** and the patient. To the extent permitted by applicable law, this coverage is subject to applicable **copays**, referral requirements, annual deductibles and coinsurance provisions that may apply under the Fund. If you have any questions, please contact the Fund Office.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Fund may not, under federal law, restrict benefits for any **hospital** length of stay in connection with childbirth for the mother or the newborn **child** to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider or **physician**, after consulting with the mother, from discharging the mother or her newborn **child** earlier than 48 hours (or 96 hours, as applicable). In any case, the Fund may not, under federal law, require that a provider obtain authorization from Cigna for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MILITARY LEAVE

If you enter military service, you will be provided continuation and reinstatement rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA protects employees who leave for and return from active duty in the uniformed services (including the Army, Navy, Air Force, Marines, Coast Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service). If

you elect continuation coverage under USERRA, you and any eligible dependents covered under this Plan when your leave began may continue coverage for up to 24 months.

If you are on active duty for 31 days or less, you (and your eligible dependents covered under the Fund when your leave began) will continue to receive the health care coverage that you would otherwise have received under the Fund. If, however, you are on active duty for more than 31 days, you can continue coverage for yourself (and your eligible dependents covered under the Fund when your leave began) for up to 24 months by paying the applicable COBRA rate for such coverage. Payment under USERRA and termination of coverage for nonpayment of USERRA work just like COBRA coverage (described above).



In addition, you and your dependents may be eligible for health care coverage under TRICARE (the Department of Defense's health care program for uniformed service members and their families). This Fund coordinates benefits with TRICARE, with the Fund paying first and TRICARE paying second.

If you are called to active duty, you must notify the Fund Office in writing as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible dependents covered under the Plan on the day your leave started. Unlike COBRA coverage, if you do not elect USERRA for your dependents, they cannot elect it separately.

When you are discharged (not less than honorably) from the uniformed services, your full eligibility will be reinstated on the day you return to work with an employer contributing to this Fund, provided that you return to employment within:

1. 90 days from the date of discharge, if the period was more than 180 days, or
2. 14 days from the date of discharge, if the period of service was at least 31 days but less than 180 days, or
3. On the next regularly scheduled working day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.



FAMILY AND MEDICAL LEAVES OF ABSENCE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

1. The birth, adoption, or placement with you for adoption of a **child**;
2. The need to provide care for a spouse, **child**, or parent who is seriously ill; or
3. Your own serious illness.

You are generally eligible for a leave under the FMLA if you:

1. Have worked for the same **Contributing Employer** for at least 12 months;
2. Have worked at least 1,250 hours over the previous 12 months; and
3. Work at a location where at least 50 employees are employed by the **Contributing Employer** within 75 miles.

If you qualify for FMLA leave, your employer may be obligated to continue to contribute to the Fund on your behalf. The Fund will accept such contributions and treat such work as **covered employment** provided:

1. Your leave was properly granted under the FMLA,
2. Your employer makes the required notification to the Fund, and
3. Your employer makes the required contributions.

Of course, any changes in the Fund's terms, rules, or practices that go into effect while you are away on leave apply to you and your dependents, the same as to active employees and their dependents. Call your employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under COBRA (see page 48).

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Effective June 1, 2009, GINA prohibits discrimination by group health plans such as the Fund against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Fund is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Fund.

GINA requires the HIPAA Privacy regulations to be amended, effective May 21, 2009, to treat genetic information as protected health information. GINA prohibits the use of genetic information for underwriting purposes and makes the definitions of genetic information and underwriting consistent with GINA.

IMPORTANT GOVERNMENT NOTICE REGARDING THE PLAN'S GRANDFATHERED PLAN STATUS

The Board believes that the Fund is a “grandfathered plan” as such term is defined under 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 the Affordable Care Act was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the Plan may not include certain consumer protections of the Affordable Care Act that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., **copayments**, coinsurance, deductibles). 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 and extension of coverage to dependents until age 26. 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 Department of Labor at 1-866-444-3272 or dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

IMPORTANT NOTICE REGARDING ANNUAL DOLLAR LIMITS

In accordance with applicable law, annual dollar limits shall not apply to “essential health benefits” as such term is defined under Section 1302(b) of the Affordable Care Act and applicable regulations.

IMPORTANT NOTICE REGARDING TERMINATION OF HEALTH CARE COVERAGE FOR CAUSE, INCLUDING FRAUD OR INTENTIONAL MISREPRESENTATION

As always, the Fund reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively (as opposed to prospectively) except in certain instances, such as failure to pay premiums or you or your covered dependent(s) commits fraud or intentional misrepresentation (for example, in enrollment materials, on a claim or appeal for benefits, or in response to a question from the Plan Administrator or its delegates). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days’ notice. Failure to inform the Fund Office that you are, or your dependent is, covered under another group health plan or other material information (such as you become divorced from your covered spouse) or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund and the Trustees, or any of their designees, are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Fund, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any provider by reason of negligence, by failure to provide care or treatment, or otherwise.

THE FUND OFFICE IS HERE TO HELP YOU WITH YOUR BENEFIT QUESTIONS

If you have any questions about eligibility for Health Fund benefits, please call the Fund Office during normal business hours at 1-212-869-9380/toll-free 1-800-344-5220 or visit our website (equityleague.org) at any time, day or night.

OTHER HEALTH-RELATED SERVICES AVAILABLE TO YOU

Even though they aren't provided under the Equity-League Health Trust Fund, here are some health care resources available through the Actors Fund and the AFL-CIO you should know about. Additional information about other health insurance options is located under the Health Section of our website, equityleague.org.

ARTISTS HEALTH INSURANCE RESOURCE CENTER (AHIRC) OF THE ACTORS FUND

The AHIRC provides an array of helpful services, including the following:

1. Help finding affordable health insurance and health care coverage nationwide through the Actors Fund website, actorsfund.org/ahirc;
2. The AHIRC has also been officially designated as an ACA "Navigator," a provider of expert assistance in understanding the options available under the ACA Marketplace plans; and
3. Telephone or in-person counseling at its offices in New York and Los Angeles and monthly health insurance workshops on both coasts for the uninsured and union members about to lose their insurance.

To speak with a counselor or to get information on monthly workshops, call the Resource Center in New York at 1-917-281-5975 or in Los Angeles at 1-855-491-3357.

You can also find a wealth of information about obtaining health insurance and health care on the Actors Fund website, actorsfund.org.

THE SAMUEL J. FRIEDMAN HEALTH CENTER

The Samuel J. Friedman Health Center for the Performing Arts in New York City, located at 729 Seventh Avenue, 12th Floor, New York, NY 10019, provides free health care to uninsured and underinsured members of the entertainment community. It also provides primary and specialty care with expedited referrals within the Mount Sinai Health System. For more information on the center, please call 1-212-489-1939.

SOCIAL SERVICES

The Actors Fund's Social Services address the needs of the entertainment professional through an individual case-management approach. Counseling and support services for entertainment professionals who are coping with significant health problems are available, including linkage to community-based organizations, as well as emergency financial aid for the payment of health insurance premiums and medical bills.

PHYLLIS NEWMAN WOMEN'S HEALTH INITIATIVE

The Phyllis Newman Women's Health Initiative identifies and addresses important health issues for women in the entertainment community. For more information on the Actors Fund's Social Services and the Phyllis Newman Women's Health Initiative, please call 1-212-221-7301 in New York or 1-323-933-9244 in Los Angeles.

AFL-CIO RESOURCES

The AFL-CIO's "Union Plus" Program offers discounts on prescription drugs and vision and other types of medical care. For more information on these programs, log on to unionplus.org or call them toll-free at 1-800-452-9425.

CLAIMS FILING PROCEDURES AND APPEALS

This section describes the Fund's formal procedures for filing claims for benefits. It also describes the procedures to follow if you wish to appeal a claim that has been entirely or partially denied. Important terms relating to claims and appeals are defined here and not in the "Key Medical Benefits Terms, Definitions and Benefit Elaborations" section.

For the Cigna Plan or Cigna Dental benefit-related concerns that involve a person, a service, the quality of care or contractual benefits, you should start with Cigna's Member Services at its toll-free number, 1-800-244-6224, or write to Cigna at the address that appears on the back of your Benefit Identification Card or on the explanation of benefits or claim form. Customer Service will do its best to resolve your issues. If Cigna needs more time to review or investigate a complaint of (1) a denial of, or failure to pay for, a referral, or (2) a determination as to whether a benefit is covered under the Fund, Cigna will try to get back to you on the same day.

Concerns regarding the quality of care, choice of or access to providers, or provider network adequacy will be forwarded to Cigna's Quality Management Staff for review. Cigna will provide written acknowledgment of your concern within 15 days, with the appropriate resolution information to follow in a timely manner.

AUTHORIZED REPRESENTATIVES

Most actions involving claims and appeals can be taken either by you or by an authorized representative you have previously designated to act on your behalf. The form you'll need to designate an authorized representative is available through the Fund Office. The Fund, ProAct or Cigna (or HMO, if applicable) can request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an **Urgent Care Claim** (defined below) without your having to complete the authorization form.

DEFINITION OF A CLAIM

A claim for benefits is a request for Fund benefits made in accordance with the Fund's reasonable claims procedures, including filing a claim (where necessary). The claims procedure varies depending upon the specific benefit you are requesting. A specific written request for eligibility relating to a particular period will be treated as a claim under the procedures. When the procedure requires that you file a claim for benefits offered under this Fund, you must submit a completed claim form.

The following are not considered claims for benefits:

1. Simple inquiries about the Fund's provisions that are unrelated to any specific benefit claim.
2. A request for prior approval of a benefit that does not require prior approval by the Fund.

3. Presentation of a prescription to a pharmacy that exercises no discretion on behalf of the Fund.

The claims procedure varies depending on:

1. The type of benefit you're claiming. If you have to file a claim, it must be filed with the appropriate organization listed later in these procedures (for example, Cigna, an HMO, or the Fund Office). You can get a claim form through the Fund Office or from the applicable organization.
2. What type of claim you're filing. The different types of claims are described below.

TYPES OF CLAIMS

The claims procedures for HMO benefits, Medical Plan benefits (including prescription drug benefits), Vision Plan benefits, and SWC Plan benefits will vary depending on whether your claim is for a Pre-Service Claim, an **Urgent Care Claim**, a Concurrent Care Claim, a Post-Service Claim, an SWC Claim, or an Eligibility Claim. Read the following sections carefully to determine which procedure is applicable to your request for benefits. This information about the types of claims is provided as general guidance in accordance with current U.S. Department of Labor (DOL) regulations. There may be other, more specific information in materials you receive from Cigna, ProAct, or your HMO.

For specific information on the type of claim or if you have any questions on these procedures, contact the Fund Office, Cigna, ProAct, Davis Vision or your HMO, or the organization responsible for making the claims determination (the "applicable organization").

PRE-SERVICE CLAIMS

A Pre-Service Claim is a claim for a benefit for which the Fund requires approval of the benefit (in whole or in part) before medical treatment is received. Certain medical and prescription care requires precertification in order to be covered, regardless of whether you are in the Cigna and ProAct Plans or an HMO. You must follow the Pre-Service rules in order to be eligible for Cigna/ProAct Plans or HMO benefits. In general, these precertifications will determine the **medical necessity** of a particular service or supply.

If you are enrolled in an HMO, the requirements of any precertification program are outlined in your HMO member handbook. In order to file a Pre-Service Claim, an Urgent Claim, or a Concurrent Claim (discussed below), contact your HMO at the number on your ID card.

The Cigna Plan includes pre-admission certification (PAC) and continued stay review (CSR). Under the requirements of the program, there is a \$250 penalty if you fail to certify a scheduled **hospital** stay before the admission or, in the case of emergency, within 48 hours of your admission.

To file a Pre-Service Claim for ProAct benefits, call 1-833-636-1400. For Cigna precertification benefits, call 1-800-CIGNA24 or 1-800-244-6224.

URGENT CARE CLAIMS

An **Urgent Care** Claim is any claim for medical care (including prescription drugs) for which the application of the time periods for making Pre-Service Claim determinations could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function. Medical care would also be considered an **Urgent Care** Claim if, in the opinion of a **physician** with knowledge of the claimant's medical condition, delaying treatment would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an **Urgent Care** Claim is determined by the applicable organization, applying the judgment of a prudent layperson with an average knowledge of health and medicine. Alternatively, any claim that a **physician** with knowledge of your medical condition determines is an **Urgent Care** Claim, within the meaning described above, will also be treated as an **Urgent Care** Claim.

Claims involving **Urgent Care** may be submitted by telephone to the organization responsible for administering the particular benefit you are requesting. (See "Submitting Claims" on page 59 for names and telephone numbers or check the back of your ID card.)

CONCURRENT CARE CLAIMS

A Concurrent Care Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination, or extension of a benefit. (An example of this type of claim would be an inpatient **hospital** stay originally certified for five days that are reviewed at three days to determine if the full five days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. A reconsideration of a benefit with respect to a Concurrent Care Claim that involves the termination or reduction of a benefit will be made by the applicable organization as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

POST-SERVICE CLAIMS

A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

WHEN AND HOW POST-SERVICE CLAIMS MUST BE FILED

A Post-Service Claim should be filed within the time frames for each benefit in the section called "Submitting Claims." Failure to file within the time required will invalidate or reduce a claim unless you show proof that it was not reasonably possible for you to file the claim within such time.

CLAIMS WHEN YOU GO TO A NETWORK PROVIDER OR ARE IN AN HMO

If you receive care from a **network provider** under the CIGNA Plan or from your HMO, you do not have to submit a claim.

CLAIMS WHEN YOU GO TO AN OUT-OF-NETWORK PROVIDER

Here's what to do if you receive treatment from an out-of-network provider and need to submit a claim.

1. Get a claim form from the Fund Office and complete the employee's portion of the form (including your name and Social Security number, the patient's name, and the patient's date of birth).
2. Have your **physician** complete the **Attending Physician's Statement** section of the claim (including date of service, CPT-4 code or **hospital** services, ICD-9 [the diagnosis code]), billed charge, number of units [for anesthesia and certain other claims], federal taxpayer identification number [TIN] of the provider, billing name and address and, if treatment is due to accident, accident details). Alternatively, your **physician** can submit a completed HCFA 1500 or UB 92 universal health insurance claim form or submit a HIPAA-compliant electronic claim.
3. Attach any other itemized **hospital** bills or doctor's statements that describe the services rendered.
4. Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. Incomplete claim forms will be returned to you for completion, resulting in delayed payment of eligible expenses.
5. Mail any further bills or statements for services covered by the Fund to the applicable organization as soon as you receive them.

ELIGIBILITY CLAIMS

An eligibility claim is a specific request for you or a dependent to be covered by the Fund for a particular period of time. You do not have to fill out any claim forms to make an eligibility claim. However, you must provide the Fund Office with a written description of the facts surrounding your claim so that your claim can be properly reviewed.

SUBMITTING CLAIMS

Your claim will be considered to have been filed as soon as it is received by the organization responsible for the initial determination on the claim. See below for where to submit your claims.

CIGNA PLAN NETWORK CLAIMS

If you are enrolled in the Cigna Plan, you are generally not required to file a claim in order to be reimbursed for care rendered by Cigna **network providers**, since those claims are submitted directly to Cigna by the **network provider**.

CIGNA OUT-OF-NETWORK CLAIMS

If you need to submit a claim for care received from out-of-network providers, file your claims with Cigna at the address that appears on the back of your ID card.

For claim and/or appeal submissions, please follow the instructions on the back of your ID card. You may also visit mycigna.com to download any applicable forms or call 1-800-244-6224.

If you have lost your ID card, please visit mycigna.com to print a temporary version and request a new one or call 1-800-244-6224.

You must submit your claim within 12 months of the date charges are incurred. (The claim will not be reimbursed if it is submitted later unless you show written proof that you submitted the claim as soon as was reasonably possible.)



HMO CLAIMS

If you are enrolled in an HMO, you are generally not required to file a claim for benefits. However, if you do need to file a claim, you can do so by contacting your HMO at the address and phone number listed on your ID card and/or shown in your HMO material. Your HMO material will also describe the claims filing deadlines and procedures.



Please note that HMOs are subject to the regulations that apply to such entities in their respective states and that those requirements may lead to different rules and coverage than provided under the Cigna Plan.

PRESCRIPTION DRUG BENEFIT CLAIMS

When you present a prescription to a pharmacy to be filled under the terms of this Fund, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures.



If you have a prescription filled at an out-of-network pharmacy, you should submit a claim for reimbursement with ProAct to:

ProAct Inc.
1230 US HWY 11
Gouverneur, NY 13642
Attn: DMR Dept.

You must submit your claim within 12 months of the date charges are incurred. (The claim will not be reimbursed if it is submitted later unless you show written proof that you submitted the claim as soon as was reasonably possible.)

VISION PLAN BENEFIT CLAIMS

If you receive services from a Davis Vision provider, you are not required to submit a claim form.



If you receive services from a provider who is not in the Davis network, you must submit a claim for reimbursement to:

Davis Vision Inc.
Vision Care Processing Unit
P.O. Box 1525
Latham NY 12110
1-800-999-5431

Claims must be submitted within two years of the date charges are incurred.

Vision Care Plan claim forms are available through the Fund Office.

SWC PLAN CLAIMS

See page 38 for what to submit along with your claim, then send it to:

Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

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

Claims for SWC need to be filed within 12 months from the date of your Workers' Compensation award. You can get a claim form for an SWC benefit from any Actors' Equity office. You must complete the form in its entirety and attach a statement from your **physician**. For ongoing SWC payments, proof of continued eligibility of Workers' Compensation must be submitted within 12 months of the date of the Workers' Compensation payment for a particular period in order to receive the SWC payment for that period.

ELIGIBILITY CLAIMS

Submit claims for eligibility under the Fund to the Fund Office at:

Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

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

Eligibility Claims must be filed within 90 days of the start of the period for which you are claiming coverage.

NOTIFICATION OF CLAIM DETERMINATION

PRE-SERVICE CLAIMS

For properly filed Pre-Service Claims, you and/or your health care provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The response time may be extended up to 15 days if necessary due to matters beyond the control of Cigna, and you will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the applicable organization needs additional information from you, the extension notice will specify the information needed. In that case, you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.



During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days from your receipt of the notice or the date you respond to the request (whichever is earlier). The applicable organization then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination. If your claim is either entirely or partially denied, you have the right to appeal the denial of your Pre-Service Claim. See the following sections on appeals procedures for more information.



Note that in the event you improperly file a Pre-Service Claim, the organization responsible for making the claims determination will notify you of the proper procedures to be followed in filing a claim as soon as possible, but not later than five days after receipt of the claim. This notification may be oral, unless you (or your representative) request a written notification. You will only receive notification of a procedural failure if your claim is received by the organization responsible for making the claim determination and it includes your name, your specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested. Unless the claim is properly refiled, it will not constitute a claim.



URGENT CARE CLAIMS

For a properly filed request for precertification of an Urgent Care Claim, the notification deadlines are different from those for Pre-Service Claims. The applicable organization will respond to you and/or your doctor with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 48 hours after the organization receives the claim. The determination will also be confirmed

in writing or electronically within three days.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the organization responsible for making the decision will notify you and/or your doctor as soon as possible, but not later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. Notice of the decision will be provided within 48 hours after the specified information is received, or at the end of the period given for you to provide this information, whichever is earlier. If you and/or your doctor don't provide the specified information within 48 hours, your claim will be denied.

If your claim is entirely or partially denied, you have the right to appeal the denial of your Urgent Care Claim. See the following sections on appeals procedures for more information.

If you improperly file an Urgent Care Claim, the organization will notify you and/or the provider of the proper procedures to be followed in filing a claim as soon as possible but not later than 24 hours after receipt of the claim. You (or your representative) must provide the specific information within 48 hours after receiving the notice. Unless the claim is properly refiled, it will not constitute a claim.

CONCURRENT CARE CLAIMS

With regard to a Concurrent Care Claim, any request by a claimant to extend approved treatment will be acted upon within 24 hours of receipt of the claim, provided it is received at least 24 hours before the expiration of the approved treatment. All other Concurrent Care Claim determinations, such as one involving a reduction of treatment, will be decided sufficiently in advance of the reduction so as to allow you to appeal the determination. If your claim is entirely or partially denied, you have the right to appeal the denial of your Concurrent Care Claim. See the following sections on appeals procedures for more information.

POST-SERVICE CLAIMS (INCLUDING ELIGIBILITY CLAIMS)

For all Post-Service Claims (including Eligibility Claims) other than SWC claims, you will ordinarily be notified of the decision within 30 days from receipt of the claim by the organization responsible for making the claims determination. This period may be extended once for up to 15 days if the extension is necessary due to matters beyond the control of the organization responsible for making the claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the organization expects to render a decision. If an extension is needed because you must supply additional information, the extension notice will specify the information required. You have 45 days from receipt of the notification to supply the additional information; otherwise, your claim will be denied. During the period

in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days from your receipt of the notice or until the date you respond to the request (whichever is earlier). The applicable organization then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from the receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days from your receipt of notice or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

For SWC claims, if the claim is denied, the Fund will notify you of the decision within 90 days after receipt of your claim. Under special circumstances, the Fund Office may extend the period to decide your claim for up to an additional 90 days, in which case you would be so advised prior to the end of the initial 90-day period. This notice of extension will explain the need for the extension and when the Fund expects to make a decision.

Written notice of decision. When a claim is denied you will receive a written notice of a denial (whether it's denied in whole or in part). This notice will provide the following information:

1. The specific reason(s) for the determination;
2. Reference to the specific Fund provision(s) on which the determination was based;
3. A description and explanation of any additional information necessary to perfect the claim;
4. A description of the appeal procedures and applicable time limits;
5. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
6. If an internal rule, guideline, or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
7. If the determination was based on the absence of **medical necessity** or because the treatment was experimental or investigational or otherwise considered an ineligible expense, you will receive an explanation

of the scientific or clinical judgment for the determination, applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge; and

8. For **Urgent Care Claims**, the notice will describe the expedited review process applicable to **Urgent Care Claims**. For **Urgent Care Claims**, the required determination may be provided orally and followed with written notification.

For Pre-Service, Urgent, or Concurrent Care Claims, you will receive notice of the determination even when the claim is approved.

APPEALS PROCEDURES AND REQUEST FOR REVIEW OF DENIED CLAIMS

If your claim is wholly or partially denied or if you disagree with the decision made on a claim, you may ask for a review. The Fund maintains a mandatory appeals process, which varies depending on the type of claim you are appealing, the nature of the benefit involved (e.g., medical or vision), and the organization to which you are making your appeal. The Fund also offers a voluntary level of review for Cigna medical and ProAct pharmacy benefits after you have exhausted all other mandatory appeals, as described in this section.

The following levels of review are provided under the Fund. For HMO benefits, please consult the materials from the HMO, since the appeals rules may be different:

1. The Fund maintains a one-level appeals process for Vision Claims, SWC Claims, and Eligibility Claims, and such appeals are made to the Trustees of the Fund.
2. The Fund maintains a two-level appeal process for the Cigna Medical and ProAct Prescription Plans. These are referred to as “level one” and “level two” appeals. Both of these levels of appeal for medical benefits are handled by Cigna, with ProAct handling the ones for prescription benefits.
3. For the Cigna and ProAct Plans, there is also a voluntary level of appeal to the Trustees of the Fund, but only after all levels of appeals to Cigna and ProAct have been denied.

WHERE AND WHEN TO DIRECT A CLAIMS APPEAL

CLAIMS APPEALS UNDER THE CIGNA PLAN

If you wish to file an appeal regarding Cigna Plan medical benefits, the following applies.

Appeals should be made to Cigna HealthCare at the address below within 365 days after you receive a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting the appeal. Appeals may be made orally by calling Cigna HealthCare at 1-800-244-6224 Monday through Friday during normal business hours and asking to be connected to the National Appeal Unit. Written appeals should be sent to:



Cigna HealthCare Inc.
National Appeals Unit (NAU)
P.O. Box 188011
Chattanooga, TN 37422

Cigna will acknowledge your appeal in writing within five working days after it has received the appeal. This acknowledgment will include the name, address, and telephone number of the person designated to respond to your appeal and will indicate what information, if any, must be provided.



For **hospital** and medical claims, Cigna maintains a two-step appeals procedure (“level one” and “level two”) and, depending on the nature of the appeal, classifies appeals as either “Grievance and Appeals of Administrative and Other Matters” or “Appeal of Utilization Review Decisions.” All appeals should be directed to the address and phone number above.



For appeals that are not approved by Cigna after two levels of review, there is also a voluntary third-level of appeal before the Board. There is a description of this procedure starting in the section of this book entitled “Appeals to the Trustees.”

CLAIMS APPEALS UNDER THE PROACT PHARMACY PLAN

If you wish to file an appeal regarding ProAct prescription drug benefits, the following applies.

Appeals should be made to ProAct at the address below within 180 days after you receive a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting the appeal. Appeals can be submitted by fax at 1-844-712-8129 to the attention of ProAct’s Clinical Appeals Department. Written appeals should be sent to:

ProAct Inc.
c/o Clinical Appeals Department
1230 US Highway 11
Gouverneur, NY. 13642

Requests for urgent ProAct appeals will be acted on within 3 business days of receipt.



For appeals that are not approved by ProAct after two levels of review, there is also a voluntary third-level of appeal before the Board. There is a description of this procedure starting in the section of this book entitled “Appeals to the Trustees.”

For prescription claims, ProAct maintains a two-step appeals procedure. All appeals should be directed to the address and phone number listed above.

HMO APPEALS

If you have coverage through an HMO instead of the Cigna Plan, your HMO is responsible for hearing appeals. You should follow the procedures on the back of your ID card or in your member handbook for the address. The appeals procedures and timing of notification will be included in your Explanation of Benefits (EOB) as well as in your HMO member materials. These procedures may or may not be similar to the ones under the Cigna Plan, described above.

APPEALS TO THE TRUSTEES

VISION, SWC, AND ELIGIBILITY APPEALS AS WELL AS THIRD-LEVEL APPEALS OF CIGNA AND PROACT CLAIMS DECISIONS

The Fund maintains only a one-level appeals process for Vision Claims, SWC Claims, and Eligibility Claims. The Fund also maintains a third-level appeals process for second-level appeals that have been denied by Cigna and/or ProAct. Appeals of these kinds should be made to the Administrative Committee of the Board within 180 days of the initial claims determination for Vision, SWC, and Eligibility Claims or 180 days of the final level of review for a voluntary review of Cigna and/or ProAct claims. Appeals should be submitted to:

Board of Trustees, Administrative Committee
c/o Executive Director
Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

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

Appeals can also be e-mailed to: appeals@equityleague.org.

APPEAL PROCEDURES — REVIEW PROCESS

In connection with your appeal, you have the right to review documents relevant to your claim. A document, record, or other information is considered relevant if it was relied upon by the applicable organization in making the decision; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Fund policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts (if any) who gave advice on your claim, without regard to whether their advice was relied upon in deciding your claim.

Who reviews your claim – Your claim will be reviewed by a person at a higher level of management than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination, and the decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not **medically necessary** or was investigational or experimental), a health care professional who has appropriate training and experience in the same or a similar specialty will review your case.

In the case of Cigna level two appeals, the appeal is conducted by Cigna's Administrative Appeal Committee, made up of at least three persons, and no one involved in the prior decisions may vote on this committee. In the case of level two appeals involving **medical necessity** or clinical appropriateness, Cigna's Administrative Appeal Committee will consult with at least one **physician** reviewer in the same or a similar medical specialty as the care under consideration. You may address this committee in person or by conference call. HMOs generally follow similar procedures, but you can learn about a particular HMO procedure by contacting that HMO directly.

APPEALS PROCEDURES — TIMING OF NOTICE OF DECISION ON APPEAL

ALL CIGNA OR PROACT CLAIMS APPEALS

You will receive a notice of decision on a level one or level two review within 30 days after Cigna or ProAct receives a level one or level two appeal (within 15 days if the appeal relates to a Pre-Service Claim).



If more information is needed to make the determination, Cigna or ProAct will notify you in writing to request an extension of up to 15 days and will specify any additional information needed to complete the review. You are not obligated to grant Cigna an extension.

If you are dissatisfied with the outcome of your first appeal, and you file a level two appeal with Cigna (within 365 calendar days from the date on the letter denying your first appeal), or with ProAct (within four months from the date on the letter denying your first appeal), you will receive a notice of the decision on appeal within 30 days (within 15 days if the appeal relates to a Pre-Service Claim). In cases where Cigna's or ProAct's Appeal Committees needs additional time and/or information, they may request an extension, which you are not required to grant.



IF YOUR LEVEL ONE OR LEVEL TWO APPEAL INVOLVES AN URGENT CARE CLAIM, you may request an expedited review, in which case you will receive a response within the time frames described below for **Urgent Care** Claims.

Urgent and Concurrent Care Claims – You will receive notice of a decision within 48 hours after Cigna or ProAct receives all the necessary information, but in no event later than 72 hours after the appeal is received. The notice will be given orally, with a written notice transmitted within two working days of the decision.

HMO CLAIMS APPEALS

The timing of notification of appeals of claims denied by an HMO will be included on your Explanation of Benefits (EOB) as well as the member materials provided by your HMO.

VISION CLAIMS, SWC CLAIMS, ELIGIBILITY CLAIMS, AND THIRD-LEVEL CIGNA AND PROACT APPEALS

The Administrative Committee of the Board will make a determination on your appeal at the next regularly scheduled meeting of the Administrative Committee following the Fund's receipt of your request for review of your claim. However, if your request for a review is received by the Fund within 30 days before the date of such meeting, the benefit determination on appeal will be made by the Administrative Committee no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances require a further extension of time for processing, your benefit determination will be rendered not later than the third meeting of the Administrative Committee. If such an extension is required, the Fund shall, not later than the commencement of the extension, provide you with written notice of the extension, describing the special circumstances and the date as of which your benefit determination will be made.

You will be notified of the decision on review within five days of the Administrative Committee making the benefit determination.

APPEAL PROCEDURES — NOTICE OF DECISION ON REVIEW

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

1. The specific reason(s) for the determination;
2. Reference to the specific Fund provision(s) on which the determination was based;
3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
4. A statement describing any available voluntary appeal procedures and your right to obtain information about these procedures;
5. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
6. If an internal rule, guideline, or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
7. If the determination was based on the absence of **medical necessity**, because the treatment was experimental or investigational, or due to some other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge; and

8. A statement that you and the Fund may have other voluntary alternative dispute resolution options, such as mediation.

ADDITIONAL INFORMATION ON VOLUNTARY APPEALS TO THE TRUSTEES OF CIGNA OR PROACT

The third-level of appeal to the Trustees of adverse determinations by Cigna or ProAct is completely voluntary.

1. If you choose not to make a voluntary third-level appeal to the Trustees of the Fund, the Fund will not assert a failure to exhaust administrative remedies where you or your authorized representative elects to pursue a claim in court rather than through the voluntary level of appeal.
2. Where you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Fund agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process.
3. The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Fund, as indicated above.
4. Upon your request, the Fund will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeals process, including specific information regarding the process for selecting a decision-maker and any circumstances that may affect the impartiality of the decision-maker.

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

For **Urgent Care** and applicable Concurrent Care voluntary appeals, the Administrative Committee, or its designee, will review your appeal and notify you within 72 hours after receipt of your initial claim.

For required Pre-Service and applicable Concurrent Care coverage determinations, 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.

For Post-Service and applicable Concurrent Care appeals, the Administrative Committee's review will be completed no later than the date of the Administrative Committee's meeting that immediately follows your request for review. However, if your request for review is filed within 30 days before such meeting, a benefit determination will be made no later than the date of the second meeting following the Fund's receipt of your request for review. If special circumstances require a further

extension of time, you will be notified of the extension and the date as of which the benefit determination will be made. You will receive a notice of the decision on review within five days of the Administrative Committee making the benefit determination.

If you have any questions, please call the Fund Office.

FREQUENTLY ASKED QUESTIONS (FAQ) REGARDING APPEALS

In this section of this book, we provide some answers to frequently asked questions regarding appeals. However, should any of these answers conflict with those in the previous section, the language in the previous section takes priority.

How can I appeal?

If you are seeking coverage for a period of time that you have been told you are not eligible, you must first make a written claim for a specific period of coverage to the Executive Director. You may send it to the Executive Director at the Fund Office by traditional mail, e-mail, or fax. The time limit is listed under “Eligibility Claims” on page 59. We also recommend that you keep proof of the date that you submitted your claim. For example, you should retain a copy of the e-mail or fax confirmation page, or certified mail receipt with regard to the delivery of such a request. Upon receipt of your claim, the Executive Director will review it to determine whether it can be approved by him, based on the merits, any proof attached to your request, and the applicable plan rules and policies of the Fund. If the Executive Director approves your claim, there is nothing further you need to do. You will be informed in writing when your coverage will start. However, the Fund Office is required to strictly enforce the existing benefits, rules, and procedures of the Fund, so the Executive Director will not typically be permitted to approve your claim if it requires the waiver of existing benefits, policies, or procedures of the Fund.

If your claim is denied, you must appeal in writing and should include any information you wish the Trustees to consider. As described above, you must make such appeal within 180 days of the date the Fund denied your claim for coverage. You may also ask (in writing) that your initial claim to the Executive Director be forwarded to the Trustees as your appeal. The Executive Director will forward your appeal to the Administrative Committee. The procedure for SWC benefits is the same. For all other benefits, you must appeal to the provider of those benefits (Cigna, ProAct, Davis Vision, or the HMO).

Appeals directly from second-level appeals denied by Cigna, ProAct or of vision claims denied by Davis Vision:

An appeal to the Health Fund from a final appeal by Cigna, ProAct or claim denial by Davis Vision, 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 e-mail your appeal to the Fund Office.

Can I present my appeal in person?

All appeals are presented to the Administrative Committee 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. 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 timely received.

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 generally not been successful with their appeals for the acceptance of late premium payments. The Administrative Committee regards being on the road as very much part of an actor’s life and, therefore, does not view it as an extenuating circumstance. Instead, the expectation is that actors who are traveling will make the necessary arrangements to receive their mail and timely pay their Health Fund premiums. We also note that the 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 occasionally the Trustees may change plan benefits, they would first need to consider the cost and feasibility of any change. For example, an appellant requested that two unused weeks of work from a prior year be used, in combination with nine weeks from the current year, to earn coverage under the Health Fund, which requires at least 11 weeks of work for six months of coverage (19 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 calendar days of the meeting of the Administrative Committee. This letter informs you of the decision and the reason(s) for that decision and describes 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).

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, 2018, and your appeal was granted on April 1, 2018, coverage would typically be backdated to January 1.

What if my appeal was denied?

Generally speaking, a decision by the Administrative Committee 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 are subsequently discovered by you, a new appeal may be made, subject to the applicable deadlines. In the absence of any new material information, 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.

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. You may also lose the right to enroll in other alternate coverage. Consequently, allowing coverage to lapse is a very serious decision.

Who are the Trustees?

By law, half the Trustees for the Fund are appointed by the Union (Actors' Equity Association) and the other half are appointed by the Broadway League. 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 Fund is a separate legal entity from the Union. The Trustees receive no compensation from the Fund for their services as Trustees.

Is there any charge to me for making an appeal?

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

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to get benefits until after you have completed the mandatory claims and appeal procedures and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which services of any type (including, without limitation, medical, **hospital**, prescription drug, dental, and vision) were provided (or requested). If the claim is for SWC benefits, no lawsuit may be started more than one year after the Trustees' decision on appeal. For an eligibility claim, no lawsuit may be started more than three years after the start of the period for which you sought coverage.

OTHER IMPORTANT INFORMATION YOU SHOULD KNOW

FUND CHANGE OR TERMINATION

The Trustees intend to continue the benefits described in this SPD indefinitely. However, the Trustees reserve the right, in their sole and absolute discretion, to terminate the Fund in whole or in part at any time; to modify or amend the Fund in whole or in part; and to change or discontinue the type and amounts of benefits offered by the Fund and the eligibility rules for extended or accumulated eligibility (even if extended eligibility has already accumulated) for **participants** (including retirees) and their beneficiaries.

You should also know the following about the benefits and eligibility rules for active, retired, or disabled Health Fund **participants**:

1. They are not guaranteed.
2. They may be changed or discontinued by the Board.
3. They are subject to the rules and regulations adopted by the Board.
4. They are subject to the Agreement and Declaration of Trust that establishes and governs Fund operations.
5. They are subject to the provisions of any group insurance policies purchased by the Trustees.

The nature and amount of Fund benefits are always subject to the actual terms of the Fund as it exists at the time a claim occurs.

HIPAA PRIVACY RIGHTS AND PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you certain rights with respect to your health information, and it also imposes certain obligations on the Fund as a group health plan. The following describes the ways your health information is protected under HIPAA when that health information is disclosed to or used or disclosed by the Board in its capacity as the sponsor of the Fund. These rules do not apply to any disability, death, or other non-health benefits provided under the Fund.

As a covered entity under HIPAA, the Fund is required both to maintain the privacy of your protected health information (PHI) and to provide you with information about both its obligations and your rights concerning your PHI. The text of the Fund's HIPAA Privacy Notice (as well as a summary of that notice) is posted on the Fund's website, *equityleague.org*. You can also get copies of these materials by contacting the Fund Office. Other covered entities under HIPAA, such as doctors, pharmacies, **hospitals**, and insurers, will provide you with copies of their own privacy notices. The statement that follows is not intended and cannot be considered to be the Fund's Notice of Privacy Practices.

Your PHI is information about you, including demographic information, that:

1. Is created or received by the Fund, or by your health care provider or a health care clearinghouse (and is not related to your non-health benefits under the Fund; e.g., disability);
2. Relates to your past, present, or future physical or mental condition;
3. Relates to the provision of health care to you;
4. Relates to the past, present, or future payment for the provision of health care to you; and
5. Identifies you in some manner.

Since the Fund is required to keep your PHI confidential, before the Fund can disclose any of your health information to the Board as the sponsor of the Fund, the Board must agree to keep your PHI confidential. In addition, the Board must agree to handle your protected health information in a way that enables the Fund to comply with HIPAA. Toward that end, the Board has adopted the following procedures in connection with PHI received from, or on behalf of, the Fund.

1. The Board understands that the Fund will only disclose your PHI to the Board for the Board's use in Fund administrative functions and such disclosures explained in the Notice of Privacy Practices distributed to you by the Fund. In all cases, the Board will receive only the minimum amount of PHI necessary for the Board to perform Fund administrative functions. Such Fund administrative functions may include assisting **participants** in filing claims for benefits under the Fund or filing an appeal of a denied claim. The Board may also receive PHI as necessary

for the Board to perform its fiduciary and administrative duties as required by ERISA.

2. The Board will not use or disclose your PHI for any reason other than for the Fund's administrative functions, as otherwise expressly permitted in this policy, as required by law, or if the Board has your written authorization.
3. The Board will not use or disclose PHI for employment-related actions or decisions or in connection with any pension or other employee benefit plan sponsored by the Board, unless it receives your express written authorization.
4. If the Board discloses to any of its agents or subcontractors any of your PHI that it receives from the Fund, the Board will require the agent or subcontractor to agree to the same restrictions that govern the Board's use or disclosure of your PHI under this policy.
5. The Board will promptly report to the Fund's Privacy Officer if it becomes aware of any use or disclosure of your PHI that is inconsistent with the uses and disclosures allowed under this policy.
6. The Board will allow you or the Fund to inspect and copy your PHI that is in its custody and control to the extent required of the Fund under HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to receive copies of your health information maintained by the Fund.)
7. The Board will make your PHI available to you, or to the Fund, in order to allow you or the Fund to amend the information, to the extent required under HIPAA, and the Board will incorporate any such amendments that the Fund has accepted in accordance with HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to request an amendment to your PHI maintained by the Fund.)
8. The Board will keep a written record of certain types of disclosures that it makes, if any, of your PHI for reasons other than for your medical treatment, payment for that medical treatment, or health care operations or with your written permission. This written disclosure record will include those types of disclosures made during at least the previous six years. The Board will make this disclosure record available to the Fund so that the Fund can provide you, upon request, with a copy of that list of disclosures. (You should review the Notice of Privacy Practices to learn more about your rights to request a log of certain types of disclosures of your PHI made by the Fund.)
9. The Board will make available its internal practices, books, and records relating to its use and disclosure of PHI that it receives in its capacity as the sponsor of the Fund to the Secretary of the U.S. Department of Health and Human Services to determine the Fund's compliance with HIPAA.
10. The Board will, if feasible, return or destroy all PHI received from the Fund in whatever form or medium (including in any electronic medium under the Board's custody or control) when PHI is no longer needed for the Fund administration functions for which the disclosure was made, and the Board will retain no copies. This includes all copies of any data or compilations derived from, and allowing identification of you or your beneficiary who is the subject of, the PHI. If it is not feasible to return or destroy all of the PHI, the Board will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
11. The following categories of employees under the control of the Board are the only employees who may obtain PHI in the course of performing the duties of their job with or on behalf the Board: the Executive Director, the Director of Operations, the Fund's IT personnel, and all other Fund staff routinely responsible for administration of Fund eligibility and claims for the Fund. Additionally, the individual Trustees may receive health information from the Fund in the course of hearing appeals or handling other Fund administration functions. These employees and the individual Trustees will be permitted to have access to and use the PHI only to perform the Fund administration functions that the Board provides for the Fund.
12. Additionally, the individual Trustees will be permitted to have access to and use your PHI, but only to perform the Fund's administrative functions that the Board provides for the Fund as described in this policy.
13. If any of these employees or individual Trustees use or disclose your PHI in violation of HIPAA and the rules set forth in this policy, those employees or Trustees will be subject to disciplinary action and sanctions, up to and including the possibility of termination of employment or affiliation with the Board. If the Board becomes aware of any such violations, it will promptly report the violation to the Fund's Privacy Officer and will cooperate with the Fund to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects on you.

There are also some special rules under HIPAA related to "electronic health information." Electronic health information is generally PHI that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks, and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the Internet, an extranet (which uses Internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, the Board has taken action with respect to the implementation of security measures (as defined in 45 Code of Federal Regulations §164.304) for electronic PHI. Specifically, the Board:

1. Has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Fund;
2. Ensures that the adequate separation required to exist between the Fund and the Board is supported by reasonable and appropriate administrative, physical, and technical safeguards in its information systems;
3. Ensures that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect that information;
4. Reports to the Fund if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in its information system; and
5. Complies with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic PHI by the issuance of additional regulations or other guidance pursuant to HIPAA.

COLLECTIVE BARGAINING AGREEMENT/CONTRIBUTING EMPLOYERS

The Fund is established and maintained in accordance with one or more collective bargaining agreements (CBAs or agreements). A copy of any such agreement(s) may be obtained upon written request to the Fund Office and is available for examination during normal business hours at the Fund Office. In addition, a complete list of bargaining units participating in the Fund may be obtained upon written request to the Fund Office and is available for examination by covered persons and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Participants and their beneficiaries may also receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is participating in the Fund and, if the employer or employee organization is participating, its address.

FUND INTERPRETATION

The Board and/or its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply, and interpret the Fund, including this book, the Trust Agreement, and any other Fund documents, and to decide all matters arising in connection

with the operation or administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to do the following:

1. Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Fund;
2. Formulate, interpret, and apply rules, regulations, and policies necessary to administer the Fund in accordance with the terms of the Fund;
3. Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Fund;
4. Resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Fund, including this book, the Trust Agreement, or other Fund documents;
5. Process and approve or deny benefit claims; and/or
6. Determine the standard of proof required in any case.

All determinations and interpretations made by the Board and/or its duly authorized designee(s) are final and binding upon all **participants**, beneficiaries, and any other individuals claiming benefits under the Fund. The Board may delegate any other such duties or powers as it deems necessary to carry out the administration of the Fund.

SEVERABILITY

If any provision of this SPD is held invalid, unenforceable, or inconsistent with any law, regulation, or requirement, its invalidity, unenforceability, or inconsistency will not affect any other provision of the SPD, and the SPD shall be construed and enforced as if such provision were not a part of the SPD.

CONSTRUCTION OF TERMS

Words of gender shall include persons and entities of any gender; the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the SPD.

APPLICABLE LAW

The Fund shall be construed and enforced according to the laws of the State of New York to the extent not preempted by ERISA and any other applicable federal law.

NO VESTED INTEREST

Except for the right to receive any benefit payable under the Fund in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of the Fund and shall not have any right, title, or interest in any **Contributing Employer** or the Union because of the Fund.

ASSIGNMENT OF PLAN BENEFITS

Your right to receive any benefit or reimbursement under the Fund is not alienable by you by assignment or any other method of transfer and is not subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law. You cannot pledge benefits owed to you for the purpose of obtaining a loan.

Accordingly, benefits are not subject to any creditor's claim or to legal process by any creditor of any covered individual, except under a QMCSO and to the extent as may be required by law. For more information on QMCSO, please refer to page 46.

YOUR RIGHTS UNDER ERISA

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a **participant** in the Equity-League Health Trust Fund, you are entitled to certain rights and protections under ERISA, which provides that all Fund **participants** shall be entitled to the following:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Fund, including insurance contracts, collective bargaining agreements, detailed annual reports, an updated summary plan description, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain copies of all Fund documents and other Fund information on written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each **participant** with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health coverage for yourself, spouse, or dependents if there is a loss of coverage under the Fund as a result of a "qualifying event." You or your dependents may have to pay for such coverage. The Fund recommends that you review this SPD and the documents governing the Fund on the rules governing your COBRA continuation coverage rights.

PLAN FIDUCIARIES

In addition to creating rights for Fund **participants**, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate the Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other Fund **participants** and beneficiaries. No one, including your employer, your union, or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCING YOUR RIGHTS

If your claim for a welfare benefit is denied in whole or in part you have the right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules. You have the right to have the Fund review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Fund, such as Fund documents and annual reports, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical **child** support order, you may file suit in a federal court. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Health Fund benefits, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should call the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, at the number listed in your telephone directory. You may also write to EBSA at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration (EBSA)
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You can also get certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542 or visit its website at dol.gov/ebsa.

PLAN FACTS

The following information will help you properly identify your Plan if you have any questions about your benefits.

Official Name of Fund
Equity-League Health Trust Fund
Employer Identification Number 13-6092981
Plan Number 501
Plan Year June 1–May 31

Type of Plan: Welfare/health plan providing group comprehensive medical, prescription drug, vision, and SWC benefits.

Funding: The Fund maintains a trust that includes all employer contributions and, in some cases, employee contributions, and investment income, from which all benefits and administrative expenses of the Fund are paid. The amount of the employer contributions and the employees on whose behalf contributions are made is determined in accordance with the provisions of the applicable collective bargaining or other written agreements. The collective bargaining or other written agreements set forth the conditions under which employers are required to contribute to the Fund and the rate(s) of contributions. The Fund Office will provide to **participants** and beneficiaries, upon written request and as required by law, information as to whether a particular employer is contributing to the Fund on behalf of employees. Copies of such agreements may be obtained upon written request to the Fund Office and are available for examination during normal business hours at the Fund Office. The Fund may charge a reasonable amount for such copies.

Trust contributions to the Fund are held in a trust pursuant to the Trust Agreement entered into between Actors' Equity and The Broadway League (formerly the League of American Theatres and Producers, Inc.).

Plan Administrator: The Equity-League Health Trust Fund is administered by a joint Board of Trustees composed of 11 Union Trustees and 11 Employer Trustees whose names appear in this book. The office of the Board of Trustees may be contacted at:

Board of Trustees of the Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

Plan Sponsor: The Equity-League Health Trust Fund is sponsored by the joint Board of Trustees. The office of the Board of Trustees may be contacted at:

Board of Trustees of the Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

Participating Employers: The Equity-League Health Trust Fund will provide you, upon written request, with information as to whether a particular employer is contributing to the Fund on behalf of employees working under a collective bargaining agreement, as well as the address of such employer. Additionally, a complete list of employers sponsoring the Fund

may be obtained upon written request to the Fund Office and is available for examination at the Fund Office.

Agent for Service of Legal Process
Board of Trustees of the Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

Legal process may also be served on any individual Trustee or the Executive Director.

Executive Director
Arthur J. Drechsler
Equity-League Health Trust Fund
165 West 46th Street, 14th Floor
New York, NY 10036-2582

OTHER ADMINISTRATIVE AND FUNDING INFORMATION

This section provides important information about the parties involved in providing and administering Fund benefits. You may want to refer to this section for information if a question arises concerning a particular benefit.

CIGNA MEDICAL PLAN

Hospital and medical benefits under the medical portion of the Cigna Plan are self-insured by the Fund, which guarantees the payment of benefits. The Fund pays Cigna fees for providing claims administration, network access, and medical management services.

For Cigna's mailing address, check the back of your ID card. You may also reach Cigna at: 1-800-CIGNA24 (1-800-244-6224) or *cigna.com*.

PROACT PRESCRIPTION PLAN

Prescription drug benefits are also self-insured by the Fund. The Fund has contracted with ProAct to administer the program. In addition to forwarding to ProAct amounts required to pay Fund benefits, the Fund also pays ProAct an administrative fee.

You can reach ProAct at: 1-833-636-1400 or *secure.proacr.com*.

HEALTH MAINTENANCE ORGANIZATIONS

Benefits under health maintenance organizations (HMOs) are guaranteed by each HMO that has a contract with the Fund. The HMO pays for or provides all covered services to Fund **participants**, and the Fund pays premiums to the HMO to provide these benefits. Contact information should be provided by the HMO. If you have any difficulty reaching your HMO, please contact the Fund Office.

SELF-PAY DENTAL BENEFITS

Self-pay dental benefits are insured by Cigna. **Participants** who elect dental coverage pay all premiums required to provide these benefits; no portion of the cost of this coverage is provided through the Fund. Cigna can be contacted at the following addresses:

For the PPO Plan:

Cigna HealthCare
P.O. Box 188037
Chattanooga, TN 37422-8037
1-800-244-6224 *Cigna.com*

For the DHMO Plan:

Cigna HealthCare
P.O. Box 188046
Chattanooga, TN 37422-8037
1-800-244-6224 *Cigna.com*

VISION CARE PLAN

Vision care benefits are self-insured by the Fund. The Fund has contracted with Davis Vision Inc. to provide claims and other administrative services. The Fund pays Davis Vision Inc. a fee for these administrative services, in addition to forwarding to it the amounts required to pay Fund benefits. Davis Vision Inc. can be contacted at the following address:

Davis Vision
Capital Region Health Park, Suite 301
711 Troy-Schenectady Road
Latham, NY 12110
davisvision.com
1-800-999-5431

SWC PLAN

The SWC benefit is self-insured by the Fund. Actors' Equity Association handles all claims and other administrative services on behalf of the Fund. You can contact Actors' Equity at the following address:

Actors' Equity Association
165 West 46th Street, 15th Floor
New York, NY 10036

LIFE EVENTS AFFECTING HEALTH BENEFITS (e.g., BIRTH, DEATH, DISABILITY, MARRIAGE, DIVORCE, CHILDREN GROWING UP, RELOCATION)

Many of life's events can have an important impact on your benefits. Here are five common categories of events that can affect benefits, along with some advice on how to deal with them.

YOU MOVE, GO ON THE ROAD, OR OTHERWISE CHANGE YOUR CONTACT INFORMATION

PERMANENT MOVES

Moving, for many of us, is an exciting experience, associated with the thrill of living in a new environment and exploring new opportunities. In other cases, it involves accommodations to changing conditions in our lives. Regardless of the circumstances, it is critical that you let the Fund know where you can be reached, by mail and e-mail, so that important materials, such as benefit notices and your health contribution bill and late premium reminders, can reach you on a timely basis.

KEEP IN CONTACT

It is your responsibility to be aware of the rules of the Fund. Unfortunately, we see benefit disasters in the Fund Office every day. Coverage being cancelled for lack of a timely premium payment and opportunities to enroll in coverage lost are just two examples. The Fund offers many options for maintaining communication with you regarding critical matters that can affect your benefits, such as our website, regular mail, e-mail, and text messaging. But none of those options work if we do not have your most up-to-date contact information. Please remember that when your contact information changes in any way, you should inform the Fund Office immediately. In this regard, it is also your responsibility to notify the Fund Office immediately if any of the following occurs:

1. Change of address, e-mail, or cell phone number,
2. Marriage, divorce, or legal separation,
3. Birth or adoption of a **child**,
4. You become financially responsible for a **step-child**,
5. You or your spouse has other coverage or health insurance, including TRICARE,
6. You or your dependents are involved in an accident for which you may file benefit claims,
7. You or your spouse becomes eligible for Medicare,
8. You retire, or

9. If your unmarried dependent **child** is or becomes incapable of sustaining employment by reason of mental impairment or physical handicap prior to his or her 19th birthday and while covered by the Fund.

Make sure you also add Equity-League and Cigna to your contact lists as part of your e-mail settings to ensure that all e-mail communications regarding your benefits are received.

In addition, your spouse or other family member must notify the Fund Office in the event of your death.

As a reminder, you need to inform the Fund Office separately even if you have updated your information with Actors' Equity, since the Fund is a separate legal entity. If changing all of your contact information is too burdensome because of many changes or temporary situations, please at least update the communication channel that you are most likely to use.

ON THE ROAD

Going on the road often represents the fulfillment of one of the dreams associated with being in the theater. But being on the road can place your health and other benefits in jeopardy if you do not take steps to ensure that you either: a) make all health benefit contributions that will be required by you during your time on the road before you leave or b) establish a clear and reliable means for contacting you by mail, e-mail, or text message on a *timely* basis, so that you can receive benefits materials and other information while you are away. Having your mail forwarded, or changing your mailing address, may not be practical if your location on the road, or the duration of your stay, is uncertain. Fortunately, e-mail and text messaging offer reasonably reliable alternatives to regular mail for the traveler. However, this only works if your contact information is up to date. Make sure we have your latest contact information in our database, as that information is what the Fund Office relies on to make contact with you.

If you are or will be receiving maintenance prescription drugs while you are on the road, you can either have these filled at a ProAct 90 Day retail pharmacy or through ProAct's mail order program. If you wish to have these prescriptions filled through the mail order program, you simply need to provide them information on where to send your drug order (this will not affect the permanent contact information you have on file with the Fund Office).

CHANGES IN CONTACT INFORMATION (e.g., PHONE NUMBER OR E-MAIL ADDRESS)

Changes in contact information of any kind need to be communicated to us as soon as possible, so that we will always have the most current and accurate information. You can lose one or more of your benefits in a very short period of time (depending on the circumstances) if we are unable to contact you. You can change the contact information you have on file with the Fund at any time through our Self-Service portal located on the home page of our website, equityleague.org. In addition, as the Fund continues going green, you can also elect to

receive paperless future health bills and newsletters electronically. You can also elect to receive text message reminders of when health premiums are due. These options can be located from the “Contact Information” tab under Communication Preferences within your online Self-Service portal account.

Important Note – Actors’ Equity Association (AEA) and the Equity-League Benefit Funds are Separate Entities and Changing Your Contact Information With One Entity Does Not Change It With the Other: The Equity-League Benefit Funds and AEA are completely separate entities, with separate locations and governance. Informing the Equity-League Benefit Funds of a change in your contact information will automatically change your information for all three Funds (Health, Pension, and 401(k)), unless you specify otherwise, but it will not change your contact information with AEA. The reverse is true as well. **Notifying AEA of a change in your contact information will not change your contact information on file with the Equity-League Benefit Funds.** Therefore, if you wish to change your contact information with both the Fund and AEA, you will need to contact each separately. We regret this inconvenience, but the need to maintain separate data is both a practical and regulatory necessity, for a number of reasons. For instance, many participants wish to maintain separate contact information because they want to receive information from the Fund in one location and information for AEA in another. The Fund Office has no way of knowing the participant’s preference. Consequently, it does not want to assume any change made to Equity-League’s records should be transmitted to AEA. In addition, federal regulations (e.g., HIPAA) place significant constraints on entities who handle data that could be considered confidential and do not permit the Fund to share such data unless some very complex rules are navigated on a case-by-case basis, making the automatic sharing of data impractical at least with the technologies the Fund has at its disposal at the present time.

YOU ADD OR LOSE DEPENDENTS, OR THEY REACH AGE 26 OR 65

Among the most memorable and joyous days in most people’s lives are those in which a new member is added to your family. Marriage, birth, adoption, and assuming guardianship, or formalizing a relationship with a **domestic partner**, can all lead to the addition of a “dependent” who is eligible for benefits through you. In the world of benefits, a dependent is not necessarily someone who depends on you for support, but rather a person who bears a specific legal relationship to you in terms of benefit eligibility. For example, under the Fund, your spouse/**domestic partner** and **children** are generally eligible for health benefits if you are, so long as the full premium for their coverage is paid on a timely basis. The table below shows the rights of your dependents to benefits under the Fund.

| | Spouse | Domestic Partner | Child to age 26 |
|--------|---|--|---|
| Health | Coverage is available on a fully self-pay basis | Coverage is available on a fully self-pay basis once the partner has lived with you for at least six months and meets other criteria (see page 46) | Coverage is available on a fully self-pay basis |

When a dependent spouse or **domestic partner** reaches the age of 65, he or she will be eligible for Medicare. Therefore, the benefits described in the Medicare section of this book will apply.

ADDING A DEPENDENT

When you welcome a new family member through marriage, birth, adoption, or becoming a guardian, your new dependent may be eligible for benefits. If you are eligible for health benefits through employment, you may add your newly acquired dependent by completing an Enrollment Form and paying the premium required for such coverage. Coverage for the dependent becomes effective either on the first day of the calendar month or the first day of the calendar month following the month in which the Fund received the necessary dependent enrollment documents and payment (except for newborn **children**, who are enrolled on a timely basis and covered from their dates of birth). You must apply to the Fund for coverage for that dependent within 31 days of he/she becoming a dependent or he/she may not enroll in the health plan until the next open enrollment period (November for a January effective date of coverage, if you are covered by employment for health benefits at that time). There is one exception to the rule. A dependent may be added up to 31 days following the aforementioned deadline with the payment of a \$100 penalty, but coverage does not begin until the day payment (including the \$100 penalty) is received by the Fund Office. If the payment for dependent coverage is received after that penalty period, the dependent(s) in question will be required to wait for the next open enrollment period. For example, if you added a dependent on June 15 and applied for (and paid for) that coverage on July 16, coverage would either begin on the first day of the month in which the Fund received the notice — July 1 — or begin on August 1. But if you missed the July 16 deadline, the dependent could be added up until August 16, if payment for coverage and the \$100 penalty are received by the Fund Office no later than August 16. However, coverage for the added dependent would not commence until the date payment was received. If payment was not received by August 16, the dependent would have to wait for coverage until the next open enrollment period.

LOSING A DEPENDENT THROUGH DIVORCE, DEATH, A CHILD REACHING AGE 26, OR THE DISSOLUTION OF A DOMESTIC PARTNERSHIP

DIVORCE

A divorce will make your former spouse ineligible for benefits, except for the right under COBRA to pay for coverage. You can review this information in more detail beginning on page 48.

DISSOLUTION OF A DOMESTIC PARTNERSHIP

If your domestic partnership dissolves and your former partner was covered for health benefits at the time the dissolution took place, he/she will be given the option of paying for COBRA-like benefits. However, other than COBRA-like benefits, your former partner will not be entitled to any benefits from the Fund as your dependent.

DISABILITY — YOU OR YOUR DEPENDENT BECOMES DISABLED

A disability can be devastating to you and/or your dependents. If you become disabled, it can threaten your income and benefit eligibility for you and your dependents. Your disability can be temporary and not related to work. It can also be temporary, but connected to your employment. Finally, your disability can be total and permanent in nature. These three scenarios each have different impacts on your benefits.

YOU BECOME TEMPORARILY DISABLED FOR NON-WORK-RELATED REASONS

If you become temporarily and/or partially disabled for reasons not related to your work in the theater, you may become eligible for certain short-term disability benefits that must be provided by employers in certain states (e.g., New York). However, most states do not require that such benefits be provided by employers. Therefore, if you become disabled, your income from the theater ceases, as do any contributions to the Fund. You will continue to be eligible for any health coverage earned through employment prior to your disability. If your eligibility for health coverage ends because you ceased working, you will be offered COBRA coverage. Any dependents who were covered will become eligible for COBRA as well.

YOU BECOME TEMPORARILY DISABLED ON THE JOB

If you become disabled as a result of your work in the theater, all states in the United States provide some form of Workers' Compensation benefits, which vary by state. In addition, you may be eligible for SWC benefits provided by the Fund. You must apply for such benefits by completing an SWC form. The impact of your disability on your health benefits will be the

same as if you become disabled off the job. Therefore, if you become disabled, your income from the theater ceases, as do any contributions to the Fund. You will continue to be eligible for any health coverage earned through employment prior to your disability. If your eligibility for health coverage through the Fund ends because you ceased working, you will be offered COBRA coverage. Any dependents who were covered will become eligible for COBRA as well.

YOU BECOME PERMANENTLY AND TOTALLY DISABLED

You may become eligible for certain benefits if you become totally and permanently disabled. If you are totally disabled while you are covered by the Fund, COBRA coverage is available for up to 29 months from the date of the initial COBRA qualifying event if you or any qualified dependent is determined by the Social Security Administration to be disabled (you may also become eligible for Medicare coverage). To qualify for the COBRA disability extension, such a disability would have to have started by the 60th day from the start of COBRA continuation coverage and last until the end of the 18-month period of continuation coverage. Notice of such a disability must be provided to the Fund Office within 60 days of the latest of: 1) the date SSA determines you are disabled, 2) the date of the initial qualifying event, and 3) the date of the loss of coverage due to the initial qualifying event.

YOUR DEPENDENT CHILD BECOMES DISABLED

If you have a dependent **child** who becomes disabled and incapable of self-sustaining employment before reaching the age of 19 and while covered by the Fund, that **child** can qualify under the Fund for health coverage that lasts as long as yours does, and in some cases longer, as per COBRA rules. If, however, your **disabled child's** disability occurs after reaching age 19, he or she can still qualify under the Fund for health coverage until the last month of his or her 26th birthday. Written evidence of the **child's** handicap must be sent to the Fund Office within 31 days of the age when coverage would usually end, and when requested by the Fund Office thereafter.

YOU LEAVE COVERED EMPLOYMENT

YOU RETIRE OR CEASE WORKING

If you retire from the theater or cease working for a period of time, you will be eligible to continue any health coverage you have earned through employment, and if your coverage ends because you ceased working, you will be offered COBRA coverage. You may be able to continue coverage even longer if your years of service in the theater are sufficient. See "Fund Extension Coverage for Those Who Exhaust COBRA Coverage" on page 51.

YOU LEAVE COVERED EMPLOYMENT FOR OTHER EMPLOYMENT WHERE BENEFITS ARE AVAILABLE

Many actors find employment outside the theatre, such as in film or television. In such instances, you may be able to qualify for health benefits in those industries. Alternatively, you may become employed outside of acting, but in an environment where benefits are available to you. In such cases, you'll probably want to try to ensure that there will be no gap in benefits. Depending on the facts and circumstances, you may wish to continue health coverage with the Fund through COBRA, if that is available.

YOU LEAVE COVERED EMPLOYMENT WITH NO BENEFITS AVAILABLE FROM OTHER SOURCES

If you were covered for health benefits before your employment ended, you'll want to consider whether COBRA coverage makes sense for you. In some situations, COBRA will be your best alternative, but other individual health benefit options, such as coverage offered through the Marketplace, may be a better value. If you are 59½ or older, you may wish to begin withdrawing amounts from any 401(k) account you may have. If you are age 60, you may be able to begin collecting pension benefits as well.

YOU REACH THE END OF YOUR LIFE OR YOU BECOME TERMINALLY ILL

If you should become **terminally ill**, benefits may be the last thing on your mind, but the Fund offers a number of benefits that can defray your expenses in dealing with such an illness and help relieve you of at least some of your worries. If you become unable to work and have earned health coverage prior to that, you will be eligible for continued health coverage under COBRA.

BENEFITS AVAILABLE TO YOUR DEPENDENTS AFTER YOUR DEATH

If you pre-decease any of your dependents, they will have to struggle with the grief of such a loss. But they may also have to face changes in their financial situations. If they were covered by the Fund at the time of your death, help may be available to them.

HEALTH BENEFITS FOR DEPENDENTS OF DECEASED PARTICIPANTS IN THE FUND

If you had health benefits earned through employment prior to your death and covered your dependents, your dependents' coverage will end as of the end of the month of your death or, if later, at the end of the period for which you had paid for such dependent coverage before your death. After such coverage ends, they will be entitled to elect and pay for 36 months of COBRA benefits from the time they would otherwise have lost coverage because of your death. If you and your dependents were already on COBRA at the time of your death, your dependents will be entitled to 36 months of COBRA coverage reduced by the number of months they were on COBRA before your death. COBRA Extension Coverage earned by you does not apply to your dependents, so their coverage will end as of the end of the month of your death; no COBRA extension is available if you are on COBRA Extension Coverage when you die.



CRITICAL DUE DATES THAT CAN RESULT IN LOSS OF COVERAGE – DON'T JEOPARDIZE YOUR COVERAGE

There are a number of critical due dates that, if ignored, can lead to a loss of coverage or a severe financial penalty. The table that follows summarizes a number of the most important ones.

CRITICAL PREMIUM DUE DATES

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 the Fund's Lockbox; it must reach us on or before the due dates shown.

DUE DATES FOR THE \$100 QUARTERLY PREMIUM FOR EMPLOYEE COVERAGE

The table below shows the annual premium contribution schedule. Please note the premium due dates as they are critical to ensuring that you do not lose coverage.

| Contribution Due Dates For the \$100 Contribution for Employee-Only Coverage (All Dates Below Reflect the Last Day the Fund Office Must Receive Payment. Payments Must Be Received on or Before Midnight Pacific Time on That Date to Meet the Deadline) | | | |
|---|--|--|---|
| Quarter Beginning | Last Date to Ensure Timely Coverage | Last Date to Have Coverage on Day One and Avoid a \$100 Penalty | Last Payment Date for Coverage — Coverage Does Not Start Until You Pay for Coverage Plus a \$100 Penalty |
| January | December 15 of the previous year | January 1 | January 31 |
| February | January 15 | February 1 | March 3 (if leap year, March 2) |
| March | February 15 | March 1 | March 31 |
| April | March 15 | April 1 | May 1 |
| May | April 15 | May 1 | May 31 |
| June | May 15 | June 1 | July 1 |
| July | June 15 | July 1 | July 31 |
| August | July 15 | August 1 | August 31 |
| September | August 15 | September 1 | October 1 |
| October | September 15 | October 1 | October 31 |
| November | October 15 | November 1 | December 1 |
| December | November 15 | December 1 | December 31 |

For more complete information on the above premium due dates please see page 42.

PREMIUM DUE DATES FOR ALL OTHER COVERAGE

COBRA, COBRA-like Gap Coverage, COBRA Extension Benefits For Those with 10 Years of Vested Service, Medicare Supplemental Coverage, Dental Coverage, and Dependent Coverage Premiums are due the first of the month for that month's/quarter's coverage; if the premium is not paid within 30 days of its due date, coverage will be irrevocably lost (until and unless it is re-earned).

HELP US REMIND YOU THAT YOUR \$100 PAYMENT IS DUE, HAVE THE CREDIT UNION PAY YOUR \$100, OR PAY IN ADVANCE TO AVOID LOSING COVERAGE

Remember that, in addition to mailing a bill and reminder notice to your mailing address, we can remind you of your \$100 payment via e-mail (including electing electronic health billing invoices) and text message alerts, if we have your up-to-date contact information. (In the case of text messages, you must give us permission because such messages can have a cost from your wireless carrier — there is no charge from the Fund Office). To activate text message notices, just elect this communication preference through your online Self-Service portal account authorizing us to contact you via text message. Simply log on to your account through the Equity-League website, equityleague.org, to do so. Once you make that election, you will receive automatic reminders that your premiums are due. You can also authorize the Actors Federal Credit Union (AFCU) to make ongoing payments on your behalf (you must apply to the AFCU for this service). Lastly, you may pay the Fund in advance for the full number of quarters for which you have already earned eligibility.

CRITICAL DUE DATES THAT CAN RESULT IN LOSS OF COVERAGE

There are a number of critical due dates that, if ignored, can lead to a loss of coverage or a severe financial penalty. The table that follows summarizes a number of the most important ones.

| Nature of Deadline (If a deadline begins with "Cigna" or "ProAct," it applies to you only if you are enrolled in the Cigna medical and/or dental plans and ProAct prescription plan; if you are covered for medical care and prescription drugs by an HMO, the HMO's rules apply to you.) | Date/Time of Deadline | Penalty for Missing Deadline |
|---|---|--|
| Cigna Pre-Admission Certification: Pertains to all non-emergency inpatient admissions to medical treatment facilities, such as hospitals and substance abuse treatment facilities (Cigna must be notified of emergency admissions within 48 hours of the admission.) | Prior to admission (non-emergencies) or within 48 hours of admission (for emergency admissions). | \$250 additional deductible is assessed in addition to any regular plan deductible; an inappropriate admission may not be covered at all. |
| Cigna Precertification: Pertains to certain outpatient services such as outpatient surgery , high-tech radiology (MRI, CAT Scans), injectable drugs, etc. A full list of these services is listed on page 2 of this book. (Cigna must be notified in advance by you or your provider so it can determine whether the services will be covered.) | As far in advance of the date of service as possible. | Treatment may be denied and expenses may not be covered at all. |
| Refund of an Overpayment: If you overpay the Fund, you may be able to recover the overpayment for a strictly limited period. | 12 months from the date of the overpayment. | Any overpayment, regardless of its size, will not be refunded. |
| Refund of a Pre-Payment: If you have already paid for coverage and wish to cancel that coverage and receive a refund. | Request must be received no later than the day before that coverage period was to begin (e.g., December 31 for coverage that is to begin on January 1 of the following year). | Any pre-payment will not be refunded. |
| Coordination of Benefits Penalty (with Other Entertainment Health Plans such as SAG-AFTRA): You must elect the first health coverage for which you become eligible as an employee, even if that coverage is more expensive and/or has poorer benefits than those provided by the Fund. If you were eligible for other coverage before you became eligible for coverage by the Fund, the Fund will function as the secondary insurer (and will not pay any benefits the primary insurer paid or would have paid had you actually taken the primary coverage). | As soon you as you become eligible for employee coverage. | Fund benefits are "secondary" (e.g., we might pay 20% of the cost if the plan you were eligible for would have paid 80% if you were covered, even though you don't actually have that coverage). |

Nature of Deadline

(If a deadline begins with “Cigna” or “ProAct,” it applies to you only if you are enrolled in the Cigna medical and/or dental plans and ProAct prescription plan; if you are covered for medical care and prescription drugs by an HMO, the HMO’s rules apply to you.)

Date/Time of Deadline

Penalty for Missing Deadline

Coordination of Benefits Penalty For Self-Pay Benefits When Medicare Is

Primary: If you’re eligible for Fund benefits not through employment (e.g., COBRA coverage), the Fund will become secondary as soon as you become eligible for Primary Parts A and B Medicare coverage, whether you actually elect that coverage or not.

As soon as you become eligible for Primary Medicare coverage.

Fund benefits are “secondary” (e.g., we might pay 20% of the cost if the Parts A and B coverage you were eligible for would have paid 80% if you were covered, even though you don’t actually have that coverage).

Dependent Enrollment: Your existing dependents will become eligible for self-pay dependent coverage (medical and/or dental) benefits as soon as you become eligible.

The day your coverage begins. If you do not enroll your current dependent(s) by the required deadline, there is an additional 30-day grace period to enroll your dependent(s) coverage, but only if a \$100 penalty payment is satisfied. Coverage is not retroactive.

Your dependents will have to wait for coverage until at least January of the following year (if you remain eligible at that time) or when you next become eligible.

Open Enrollment Deadline: If you declined dental coverage for yourself and/or your dependents or you declined medical coverage for your dependent(s), you have an opportunity to enroll for such coverage in November of each year (if you are still eligible for such coverage) for coverage to begin January 1 of the following year. Open Enrollment elections will also be permitted each December, but only if an additional \$100 penalty payment is made for each new election.

An election form for these optional coverages, and payment for them, must be received by the Fund Office no later than November 30th (or December 31st, with a \$100 late penalty payment.)

You (your dependents, as applicable) will have to wait until the next open enrollment period (if you are still eligible) or when you earn coverage again.

Special Enrollment: When you/your dependents declined coverage because you/they had coverage elsewhere and that coverage is lost, and you are eligible for coverage by the Fund by virtue of having accumulated the requisite work weeks.

Application and payment for coverage must be made within 31 days of the loss of other coverage. If the dependent enrollment is not done within the initial 31 days, an additional 31 days to continue this coverage is offered, but only if a \$100 penalty payment is satisfied, and coverage begins only when the Fund receives the dependent premium and penalty payment.

You/your dependent(s) will have to wait for the later of: the next open enrollment period or your next period of eligibility after a gap in coverage unless you experience another special enrollment situation.

COBRA Election Deadline: You/your dependents must elect COBRA coverage initially on a timely basis.

60 days from the later of the date the Fund Office mails your COBRA eligibility notice or the day when you lose coverage.

Loss of COBRA eligibility.

COBRA Deadline for Notice of a Loss of a Dependent or Other Qualifying Events: You/your eligible dependent(s) are responsible for notifying the Fund Office of: a divorce, a **child’s** losing dependent status under the Fund, the occurrence of a second qualifying event that entitles a dependent to additional COBRA coverage, a dependent who is determined disabled by the Social Security Administration (SSA), or when a dependent who has been disabled under SSA receives notice he/she is no longer considered disabled.

Within 60 days of the later of: a) the date of the qualifying event or b) the date coverage should end due to the qualifying event.

Eligibility for COBRA coverage for your dependents will be lost.

| Nature of Deadline (If a deadline begins with “Cigna” or “ProAct,” it applies to you only if you are enrolled in the Cigna medical and/or dental plans and ProAct prescription plan; if you are covered for medical care and prescription drugs by an HMO, the HMO’s rules apply to you.) | Date/Time of Deadline | Penalty for Missing Deadline |
|---|--|--|
| Submitting Cigna, ProAct and SWC Claims: You must submit claims for out-of-network services and SWC benefits on a timely basis. | Within 12 months of the date charges were incurred. In the case of the initial SWC claim, 12 months from the date of your WC award and, for ongoing SWC payments, 12 months from the date that Workers’ Compensation issued payment for a particular period. | Any Cigna or ProAct claim will not be reimbursed (unless you show written proof the claim was submitted as soon as was reasonably possible); late SWC claims will not be reimbursed. |
| Submitting Davis Vision Claims: You must submit claims for out-of-network services on a timely basis. | Within 24 months of the date charges were incurred. | Any Davis Vision claim will not be reimbursed (unless you show written proof the claim was submitted as soon as was reasonably possible). |
| Submitting Eligibility Claims | Within 90 days of the start of the period for which you are claiming coverage. | Your claim will not be heard. |
| Cigna Appeals of Claim Denials must be submitted on a timely basis (first- and second-level appeals). | 365 days from the date you receive a denial notice. | Your appeal will not be granted. |
| ProAct Appeals of Claim Denials must be submitted on a timely basis (first- and second-level appeals). | 180 days from the date you receive your denial notice for a first level appeal; 4 months from the date you receive your first level appeal denial notice for a second level appeal. | Your appeal will not be granted. |
| Appeals to the Trustees (for Vision, SWC, and Eligibility Claims). | Within 180 days of the initial claims determination. | Your appeal will not be heard by the Trustees. |
| Voluntary Third Level Appeal from Cigna/ProAct Denials | Within 180 days from the denial of the second level appeal. | Your appeal will not be heard by the Trustees. |
| Dependent Disability: If your dependent child becomes disabled and incapable of self-sustaining employment before reaching the age of 19 and while covered by the Fund, that child can qualify for coverage under the Fund for as long as you have Fund coverage. If the disability occurred after 19, your child can qualify under the Fund for health coverage until the last month of his/her 26th birthday. | Written evidence of the child’s disability must be sent to the Fund Office within 31 days of the age when coverage would usually end (and as requested by the Fund Office thereafter). | The opportunity for this special coverage will be forfeited. |

CONTACTING THE EQUITY-LEAGUE FUND OFFICE

BENEFIT-RELATED QUESTIONS OR SUGGESTIONS REGARDING

401(k) Fund: 401k@equityleague.org
Health Fund: health@equityleague.org
Pension Fund: pension@equityleague.org

General questions or suggestions not specific to a particular Fund or benefit:

ELFoffice@equityleague.org

Employer Contributions and Collections

Accountsreceivable@equityleague.org

Problems or Suggestions Regarding Our Website

Webmaster@equityleague.org

Privacy Issues or Concerns

Privacyofficer@equityleague.org

Complaints and Appeals

appeals@equityleague.org

Protect Your Personal Information When You Transmit it to the Fund Office

According to the Health Insurance Portability and Accountability Act (HIPAA), the Fund may not transmit or access Protected Health Information (PHI) insecurely. Due to federal privacy regulations, we cannot respond to a request via e-mail if it contains a **participant's** PHI. An example of a request involving PHI would be a question like "I will have the required number of weeks by the last week of July. What benefit period will I be able to use my health insurance?" If you have such a question (one involving your personal information, such as your work history or Social Security number), you should call the Fund Office directly in order for Equity-League to provide you this information. You can also arrange for the transmission of secure e-mails to the Fund Office by requesting a secure e-mail account by calling the Fund Office or sending an e-mail to elfoffice@equityleague.org. If you have a general question that does not involve personal PHI and pertains to the overall requirements under the health plan, such as "Is there a deductible that must be satisfied for the prescription drug plan?" we can answer those via e-mail.

If you have a request that involves your personal PHI, please feel free to call, write, stop in at our office, or send us a fax.

We are located at:

165 West 46th Street, 14th Floor
New York, NY 10036

Phone: 1-212-869-9380

Toll Free (Outside NYC) 1-800-344-5220

Fax: Accounts Receivable 1-212-398-2826;

Health 1-212-869-3323;

Retirement 1-212-869-1824

Office Hours

(Eastern Time – Mondays through Fridays,
except holidays)

9:30 AM to 5:30 PM

IMPORTANT FORMS FOR USING, OR MAKING CHANGES TO, YOUR HEALTH COVERAGE

There are two basic kinds of forms that are used by the Health Fund: claim forms and change forms. Claim forms are used for non-network providers (when you use network providers they bill Cigna, ProAct or Davis Vision directly, so you do not have to file a claim) or to file a Supplemental Workers' Compensation (SWC) claim. Change forms are used when you are making a change to your coverage (e.g., adding a coverage for you or your dependent(s)). Here is a brief description of some common forms. Most of the forms are available online, and all can be obtained by calling, writing, or visiting the Fund Office.

CLAIM FORMS

When you use non-network providers (i.e., go out-of-network), a claim will need to be filed with Cigna, ProAct or Davis Vision. (If you are enrolled in an HMO and you have coverage for out-of-network services, you should submit that claim to your HMO.) Some providers will file claims for you if you assign them authority to do so, but many providers will require you to complete and file your own form. There are separate claims forms for Cigna Medical, Cigna Dental, ProAct Prescription Drug, and Davis Vision claims that can be located and downloaded under the "Health" section of the Fund's website, *equityleague.org*. In addition, all SWC claims must be made by completing a special SWC claim form.

COVERAGE CHANGE FORMS

The Fund has a number of forms that are used to make coverage changes. The forms that are used most frequently are:

DEPENDENT COVERAGE FORM

This form is used to add, delete or change the coverage of your dependents. In order to make such changes, you'll need to provide the dependent's name, date of birth, Social Security number, and relation to you. You will also be asked to attach the appropriate birth or marriage certificates. Dependents can only be added at specific times, and those times are explained

beginning on page 44 of this book.

DENTAL ENROLLMENT FORM

This form is used to enroll you and/or your dependents in the Cigna DHMO or DPPO plan (the Cigna DHMO is referred to as the "Cigna Dental Care" plan on the form). If you choose the DHMO, you must declare your first and second choices for the dental office that will serve as your primary care dentist. That step is not necessary if you are enrolling in the Dental PPO plan.

DOMESTIC PARTNER AFFIDAVIT AND DECLARATION OF FINANCIAL INTERDEPENDENCE FORMS

These forms are used to name someone as a **domestic partner**. They need to be completed in full and notarized. Once this has been done, they are submitted along with the Dependent Coverage Form to establish coverage.

If the state or municipality in which you reside provides for the registering of **domestic partners**, you must register with such state or municipality and also attach a copy of the registration to the **Domestic Partner Affidavit**. If you submit proof of **domestic partner** registration, you do not need to submit the Declaration of Financial Interdependence, or further proof of financial interdependence.

HMO ENROLLMENT FORMS

An HMO enrollment form is required to be completed when a **participant** who lives in an HMO area becomes eligible for coverage through employment, and elects HMO coverage. This form also needs to be completed in the event HMO coverage is elected during the annual Open Enrollment Period, which is held during the month of November of each year (this can also be done during December of each year, but only if a \$100 penalty payment is made) for an effective date of January 1 of the following year.

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Diabetic Services and Supplies 13
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