

EQUITY – LEAGUE

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

SPRING 2010

Welcome to Our Spring 2010
Issue of *Now Playing*



The New year brought with it some major changes in the Equity-League Funds, and some further changes are in progress, or are being planned. At the same time, there are some old issues that continue to be of concern, so we want to discuss them again. Here is a preview of what we'll cover in this issue of *Now Playing*:

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We Heard You—Improvements in the OAP (CIGNA) Mandatory Mail Order Drug Program

We are pleased to tell you about a new service... called "FlexPay."

It offers a more "budget friendly" way of purchasing a 90-day supply of mail order drugs.

As was previously announced, effective January 1, 2010, the use of the CIGNA Tel-Drug mail order pharmacy for "maintenance" drugs is required—after the first time a new prescription has been written and refilled at a local pharmacy. Using mail order prescriptions will nearly always result in lower copays for the same quantities of drugs, so using mail order will save money for you and the Fund. However, we have encountered certain situations (some of which were pointed out by you) in which the implementation of this program has created some unexpected hardships for participants. Consequently, the Trustees have made some modifications to the program.

A Temporary Waiver for Participants on Prescription Drug Assistance Programs

We have learned that some of our participants participate with local pharmacies—through State agencies or pharmaceutical companies directly—to avail themselves of various financial assistance programs for those who need high cost drugs and meet certain income criteria, or other tests.

One example is the ADAP program that most, if not all, States have in place. Under this program, those with limited incomes can receive State assistance to help them meet the out-of-pocket costs of expensive prescription drugs.

CIGNA participates in some of these programs, and is in the process of adding others. But the Trustees have agreed that if any participant would suffer a significant increase in copay cost by using the Mail Order drug program, instead of using a retail pharmacy or other source of drugs, that participant should appeal to the Fund Office for a waiver of the requirement that maintenance drugs be filled via mail order, until and unless CIGNA's mail order company is able to replicate the assistance the participant is receiving in their current program.

Installment Payment Program Now Available When 90 Day Mail Order Supplies Substantially Increase Copays

While drugs purchased through mail order are

almost universally significantly less costly per day than those purchased at retail pharmacies, retailers generally fill prescriptions with 30 day (or shorter) supplies, while mail order prescriptions are generally filled with 90 day supplies. Similarly, while the copays the Fund requires for mail order drugs are generally the same or less per day for mail order drugs versus those purchased on a retail basis, the required copay per prescription will be higher for the mail order program (again because of the 90 day mail order supply versus the 30 day retail supply). 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 new service that is now available.

This program is called "FlexPay" and it offers an optional way of purchasing a 90-day supply of mail order drugs. FlexPay allows you to divide your normal up-front copay cost for a three-month supply of prescription drugs into three smaller payments.

How does FlexPay work? Your copay for a 90 day drug supply will be divided into three equal payments. The first payment will be automatically charged to your credit card when the order is shipped. The second payment will be charged on the 15th of the following month (second month). The third payment will be charged on the 15th of the following month (third month).

In order to use FlexPay, your coinsurance must be at least \$150 for the mail order prescription. If it is, the program is available for all mail order prescriptions. Please note that failure to comply with the payment arrangements could result in a delay of your next orders.

How do I enroll in FlexPay? Registering could not be simpler. Have a credit card handy when you call CIGNA Customer Service at 1.800.835.3784, and **be sure to mention** that you are interested in **the Equity-League FlexPay** program. You will

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Mail Order Drug Program

be able to sign up right over the phone. Your next mail order will be automatically charged to your card when the order is shipped. If you have any questions or concerns, or would like more details, please feel free to call CIGNA Customer Service at 1.800.835.3784, or the Fund Office, at 212.869.9380 (toll free 800.344.5220 outside of NYC).

Coordination of Benefits Under the CIGNA Tel-Drug Mail Order Program

Prior to 2010, CIGNA's Tel-Drug mail order pharmacy was unable to coordinate benefits

with the primary insurer, so they would not pay what the primary insurer did not. Beginning on January 1, 2010, the CIGNA Tel-Drug program can and will coordinate benefits with the primary insurer. What this means is that, once your annual Equity-League prescription drug deductible has been satisfied, the Fund will reimburse you for whatever your primary insurer did not pay, but no more than the Fund would have paid had it been primary, on the basis of the drug costs that would have been incurred under our mail order program.

New Premium Deadline Rules for the \$100 Quarterly Health Fund Payment

The \$100 quarterly contribution has been in effect for more than three years now, yet each quarter a significant number of participants still miss their payment deadlines. Each quarter, we send a bill to each eligible participant's mailing address, and then send a reminder letter (both in an envelope which indicates there is a health bill inside). We send reminder e-mails to those for whom we have accurate e-mail addresses, and we send a text message to those who have registered for that service. Nevertheless, deadlines are missed. As a result, many participants lose coverage altogether.

The due date for the \$100 quarterly contribution is the first of the month before any calendar quarter (e.g. December 1 for the quarter beginning on January 1). The Fund offers a grace period until the end of that month. Continuing this example, the \$100 contribution that is due on December 1 must be received by the Fund Office by December 31, for coverage commencing or continuing on January 1. If the contribution is not received by that date, coverage is lost (or in some cases COBRA like coverage will be available but at a cost more than 18 times the cost of the \$100 quarterly contribution).

In view of the continuing problem of late payments, the Trustees have decided to implement a new program that liberalizes the late payment rules for the \$100 contribution. Under this program, payments that are late for up to an additional 31 days (the end of January to continue our example) will be permitted, but there will be two penalties for such late payments. First, there will be a \$100 penalty (so the \$100 quarterly contribution will become \$200 for the quarter in which a payment is late). Second, coverage will not commence until a payment is received and will not be backdated once the payment is received. For example, if a payment for the quarter beginning on January 1 is received on January 15, it must be accompanied by an extra \$100, and coverage will not commence until January 15 (if you pay for dependent coverage, your dependents(s) would be covered on January 15th as well).

The new "extended grace" period will give more flexibility to participants. It will assure that if a payment is missed by a reasonable number of days it can be accepted. Moreover, it will give you more time to discover that

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New Premium Deadline Rules

you have missed the deadline. For instance, well before the end of January, you will have received your bank statement or credit card bill and if you see that the check you sent to Equity-League before the December 31 payment deadline has not been cashed, or the credit card payment you thought you made does not show up on your bill, you have time to correct the situation, albeit with a penalty. However, the need to pay much higher COBRA like premiums if you had coverage but failed to pay to continue is obviated. And the date when the opportunity for coverage is altogether lost is postponed. But all good things must end, and if you miss the 31 day extended deadline no coverage will be available at all, at any price. So you must be sure not to miss that liberalized deadline to avoid a complete loss of coverage.

The table below shows the new liberalized premium contribution schedule—**please note the premium due dates as they are critical to assuring that you do not lose coverage.**

The reason for an initial “**Due Date**” (shown in Column Two) being one month before coverage begins is to assure that coverage is in place in our records well before the start (or continuation) of that coverage. The “**Last Date to Assure Timely Coverage**” means that if we receive your payment by that date, we will assure that CIGNA’s records will reflect coverage accurately when you present your identification (ID) card at the doctor’s office, pharmacy or hospital. If your payment is received after that date, we cannot assure 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, but you may well be turned away from treatment until the records are corrected.

The “**Last Date for Penalty Avoidance**” is the last date that payment can be received without your incurring a late penalty. A payment made at this late date will still mean that

Contribution Due Dates For the \$100 Contribution for Employee Only Coverage*

Quarter Beginning On	Due Date for Your Contribution	Last Date to Assure Timely Coverage	Last Date for Penalty Avoidance	Last Date for Coverage to be Activated with a Major Penalty
January 1	December 1 of the preceding year	December 15 of the preceding year	December 31 of the preceding year	January 31
April 1	March 1	March 15	March 31	April 30
July 1	June 1	June 15	June 30	July 31
October 1	September 1	September 15	September 30	October 31

***Very Important Note: All of the above due dates are for actual receipt of payment.** It does not matter when your payment was mailed or otherwise transmitted to the Fund Office, it must be received by the Fund Office by the due dates shown. We recommend that you check your bank statements, credit card bills and similar records to assure that we have actually received your payment (or you can contact the Fund Office to check whether your payment has been received).

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New Premium Deadline Rules

your coverage will not be reflected in CIGNA's records when you present your ID card to a provider (CIGNA's records will not be accurate until about two weeks after we received payment), but coverage for the full benefit period will ultimately be secured.

Finally, the **“Last Date that Coverage Can Be Activated With a Major Penalty”** is the last date on which you can secure coverage at all, but with two 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 if you pay after the quarter begins, you will lose some coverage you otherwise would have received. In addition, it will still take about two weeks for coverage to be reflected in CIGNA's records, though it will be backdated to the date that payment was received. **Any payment received more than 31 days after the coverage period begins will not be accepted 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.**

For more information, and examples of how the rules described above work, log on to our website, www.equityleague.org and click on Current Health Fund Eligibility Rules. If you don't have a computer, you can request a copy of that information from the Fund Office.

Why have a rigid deadline? Why not let participants pay whenever they remember to do so? After all, even highly organized people can sometimes forget to make a payment. Why must the Fund be so rigid and unfeeling about its deadline? Why can't you just pay a late fee, like you do for your credit card or some car payments? Why does the Fund have to behave like an insurance company?

Those are certainly reasonable questions. The fact is that in many important ways, the Fund does not have to behave like an insurer. The Fund does not have to make a profit (in fact it never does). It doesn't have to pay commissions to sales people, and never does. It does

not have to pay or provide stock options to the Board of Trustees who govern the Fund (they receive no compensation from the Fund). The Fund doesn't have to pay taxes on any earnings it makes on its investments or self-insurance program, as long as the proceeds are used for the exclusive benefits of those covered under the plan (which they always are).

But regardless of the advantages the Fund can offer to its participants through its self-insuring approach to funding the plan, it must behave like an insurer in certain key respects—if it is to remain financially sound (i.e., able to meet all of its benefit obligations). For instance, the reason the Fund must be tough regarding its deadline for receiving premiums is that it is acting as an insurer for your benefits. That is a very solemn responsibility that requires the Fund to behave like an insurer in at least one critical aspect - its need to spread risk among all those who are covered. If it fails to do that, the long term (and even the short term) solvency of the Fund can be threatened.

In at least two key respects, buying insurance is very different from buying almost anything else. First, insurance is designed, at least in part, to cover unknown future risks. No one knows with certainty, even those who are supremely healthy, or those who are burdened with chronic conditions, how much health care they will need in a future period. Second, when people participate in an insurance program they are pooling their resources so that those who are fortunate enough not to encounter a loss subsidize those who do. If risks are not unknown, or resources are not pooled, no insurance program can be sustained.

When many who are uncertain of future costs pool their resources through insurance, those covered are protected, whether they have unexpected costs or not. If people were permitted to buy insurance after an illness or injury occurred, they might, quite rationally, wait until they knew of a problem, before they paid a premium. If that were the case,

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Premium Deadline Rules

the pooling nature of insurance would be lost (only those who knew of a cost would pay a premium and the risk would not be spread over many people but rather only those who have known losses). The consequence would be that premiums would soar, to the point where only the very sickest would find them a good value. And this process would continue indefinitely as the higher the premiums grew, the less likely it would be for people to purchase such coverage in advance, driving premiums still higher. Worse still, the insurer would never be able to predict who would

drop out, converting the actuarial science of setting premiums into pure guesswork, which would put the solvency of the insurer (in this case the Fund) at great risk. Consequently, unlimited post-payments of premiums cannot be permitted by any insurer over the long run (and possibly the short run as well).

The Fund's new, more liberal, grace period approach is designed to provide more flexibility for plan participants, while at the same time protecting the financial strength of the Fund.

A Warning About Forgoing Employee Health Coverage—Through Equity League or Elsewhere

If we don't receive your \$100 contribution on a timely basis for the first quarter in which you qualify for health coverage (or re-qualify), the Health Fund will assume that you do not wish to have coverage for the Benefit Period in question (the period for which you have earned benefit eligibility). Therefore, 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 quarter, unless you earned coverage eligibility anew for that quarter, on the basis of weeks worked during the accumulation period for coverage that begins that quarter.

For example, if you are eligible for 12 months of coverage starting January 1, 2011 but do not pay your premium by December 31, 2010, for at least the first quarter beginning on January 1, 2011, you will forgo an entire year's coverage, unless you re-qualify in a succeeding accumulation period. To continue the forgoing example, let us assume you worked 12 weeks in the last quarter of 2009, and eight weeks in the first quarter of 2010, and had no

covered employment during the second and third quarters of 2010. If you forgo coverage on January 1, 2011, you will not be permitted to pay for coverage beginning on April 1 because you declined the offer to pay for the first quarter for which you earned eligibility, and you will not qualify for coverage again when your work weeks are tested after calendar year 2010 has finished. This is because the 12 weeks you worked in 2009 will no longer be available when the accumulation period that fell in calendar year 2010 is examined. Even if you work 12 consecutive weeks in the first quarter of 2011, you will not be offered coverage again until July 1, 2011, because the 12 month accumulation period ending in the first quarter of 2011 will not be considered until the test for coverage beginning on July 1, 2011 is performed. Therefore, it is very important that you make your decision to forgo coverage very carefully.

We see instances all the time in which someone forgoes coverage because he/she believes that earning additional weeks is guaranteed, only to discover later that an unexpected

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Forgoing Health Coverage

show closing, or a sudden illness, prevent that future work. But there is another reason to be very careful about forgoing coverage as an employee—the coordination of benefits “trap.”

Coordination of Benefits With Other Entertainment Industry Employers—The Wrong Decision Can Lead to Minimal Coverage

The Health Fund (like many other Funds and employers), coordinates benefits with certain 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 Equity-League is the primary insurer, it pays benefits first, on the basis of its benefit plan, then the other insurer pays the balance of what was unpaid by the primary insurer. This balance is generally attributable to things like coinsurance and certain plan limitations. If the reverse is true (Equity-League is secondary), we pay what the other insurer did not, subject to certain limits.

But the primary/secondary rule is used even if you never took coverage with the insurer which should have been primary. One of the most important rules for determining which plan is primary and which is secondary has to

do with which coverage became “available” (you were eligible for) first. If you became eligible under another plan (such as SAG or AFTRA) before you became eligible for Equity-League coverage, 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 Equity-League and did not, many other plans will pay as secondary, even though you didn’t take Equity-League coverage.

Why does such a policy exist? For one thing, it helps to avoid differences between plans with regard to which one 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 plan was available. Plan costs are driven, in part, by the number of participants who are primary. 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 “which plan offered coverage first” rule, helps to assure that each plan assumes its fair share of primary coverage when two or more plan options exist.

But the primary/secondary rule is used even if you never took coverage with the insurer which should have been primary.

Why Keeping Your Contact Information Up-to-Date With the Fund Office is Critical

Unfortunately, we see benefit disasters in the Fund Office every day. Coverage 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 web-site, 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. If changing all of your contact information is too burdensome because you have a multitude of contact channels, please at least update the communication channel that is most likely to be used by you and we will be sure to use that channel (in addition to others).

Special Enrollment Rule Clarification

Our special enrollment provisions have long permitted participants who experience certain changes in their lives or coverage (e.g., they acquire a dependent or their employer stops contributing for coverage) to enroll in the health plan outside the open enrollment period (or calendar quarter for employee coverage). The Trustees have recently approved an extension of this policy to anyone who involuntarily loses other health coverage and now wants to enroll in Equity-League Health Fund coverage (failing to pay a premium due under the other plan does not constitute an “involuntary” loss of coverage). Such participants may be accepted into the Health Plan for the balance of any eligibility period they have already earned (this does not apply to those who have merely failed to make their \$100 contribution or pay their dental or dependent premiums on a timely basis). Coverage would commence the first of the month following the later of: a) notification of the change was received by the Fund Office, and, b) the date of the involuntary loss of coverage. Such coverage is only available if you apply for it within 30 days of the involuntary loss of the other coverage.

Coverage of Telephonic Mental Health Therapy Under The CIGNA OAP

The Trustees recognize that plan participants who are in mental health therapy may go on the road and wish to continue their therapy with the same therapist. In such situations, the Fund does consider telephonic therapy sessions to be covered, if therapy was begun in the standard way (in the therapist’s office) and the telephonic sessions are temporary (those who are making a permanent move must seek their therapy in a actual office or other covered facility).

Important Reminder About Your Right to Request a Pension Benefit Statement

If you would like to receive a detailed statement of the pension credit you’ve earned under the Equity-League Pension Plan, and whether you are vested, please contact the Retirement Services Department at the Fund Office via mail, fax or email. (You must make this request in writing.) You are entitled to receive a pension benefit statement, upon request, only once every 12 months. The address of the Fund Office is 165 West 46th Street, 14th Floor, New York, NY 10036. Our Retirement Services fax number is 212.869.1824, and their e-mail address is, pension@equityleague.org.

Change In Grace Period for Employers Submitting Contributions to the 401(k) Plan

The Trustees of the 401(k) Fund have agreed to amend the grace period for employers to make contributions to the 401(k) Plan. In response to a number of employers who have difficulty submitting payments by the current Due Date (generally five business days after the close of the work week for which the contributions are due) the Fund will allow a ten business day interest-free grace period. This new grace period aligns the 401(k) Fund deadlines more closely with the Pension and Health Funds from a timing standpoint, allowing employers to contribute to all three Funds at the same time, a convenience for both the Fund and employers.

Important Notice Regarding Coverage During a Medical Leave for Eligible Dependent Children Who Are Full Time–Students (“Michelle’s Law”)

Eligible dependents under the Plan include unmarried dependent children who are full time students at a postsecondary institution (i.e. college, university, or other accredited and state licensed technical school with a minimum of two years of required instruction). If such a dependent child is on a medically necessary leave of absence, coverage may be continued under the Plan for up to one year.

A dependent child who is covered under the Plan as a full-time student, who would otherwise lose health coverage under this section because he or she takes a medically necessary leave of absence that would cause the loss of student status, may be entitled to up to a one year extension of coverage due to the medically necessary leave of absence. In order to be eligible for this extension, the Plan must be provided with a written certification from the child’s treating physician that (1) the child is suffering from a serious illness or injury; and (2) the leave of absence from the postsecondary institution is medically necessary. Coverage may continue for up to one year from the first day of the medically necessary leave unless the dependent child would otherwise lose coverage (e.g. because he or she reaches age 25). Any required payments for dependent coverage would need still to be made during the one-year extension.

If you have any questions about the information contained in this notice, please contact the Fund Office.

A dependent child who is covered under the Plan as a full-time student ... may be entitled to up to a one year extension of coverage due to the medically necessary leave of absence.

Why It is Important to Understand the Differences Between the Equity-League Funds and the AEA

The Equity-League Funds are Trust Funds established for the sole purpose of providing health, pension and 401(k) benefits to employees represented by Actors’ Equity Association (AEA) and who are employed by certain producers that have entered into collective bargaining agreements with AEA. So the Trust Funds themselves are completely separate from AEA. Precisely half of the Trustees who manage the Equity-League Trust Funds represent AEA, the other half of the Trustees represent producers who have entered into collective bargaining agreements with AEA that require contributions be made to the Trust Funds.

We often hear from plan participants who blame “the Union (AEA)” for any perceived shortcomings in terms of design or administration of the Funds. But remember that AEA does not control the Funds and is a separate entity from the Funds.

Understanding this distinction is not only important in terms of addressing any concerns regarding the operation of the Funds to the appropriate entity, but it is also important for communication purposes. For instance, if you have a change in your contact information and merely let AEA know, you cannot expect that the Funds will know about the change. In addition, if you wish to appeal a decision made by one of the Funds, it is the Trustees of the Funds that you should appeal to, not AEA.

Naturally, you are free to register your thoughts about the Funds with AEA, in hopes that the Trustees who represent AEA will support changes in the Funds, but those Trustees must persuade the producer representatives of the merit of a change if that change is to be adopted.

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A Correction: The Motion Picture & Television Fund Health System is Not Yet in the CIGNA Network

In the last edition of *Now Playing*, we reported that the Motion Picture & Television Fund's Health Centers have been added to the CIGNA Open Access Plus (OAP) network. This is not correct. CIGNA is still working on negotiating a contract with this network (they had erroneously reported to us that the contract had been completed). We expect that a contract will eventually be completed, and will report on this as soon as it happens, but in the meantime, this provider is still not participating in the network.

LORT Participants Will Now Receive Employer 401(k) Contributions

Participants employed under the terms of a LORT contract will now be receiving employer contributions under the Equity-League 401(k) Plan. These contributions are in addition to any salary deferral contributions that are already being made into the Plan. Participants will receive a Media Payment (employer contribution) equal to the percentage required under each LORT theatre category, on the basis of the weekly category minimum salaries for each actor, stage manager and assistant stage manager. For a complete description of this new and exciting benefit, please visit our website: www.equityleague.org and click on the 401(k) tab.

The Current Health Fund Summary Plan Description (SPD) is Available Online

The current Health Fund Summary Description (SPD), the most detailed description of Health Plan benefits that is readily accessible to participants, is available online at the Equity-League website www.equityleague.org, in the PDF format that most computers already have installed (if it is not installed on your computer it can be easily downloaded free of charge). The PDF file is searchable, so that you can easily look up any term in the SPD.

The current SPD was printed in April of 2005. Many aspects of the health benefits Plan have changed since that time. Therefore, the website includes a page that explains all of the changes.

A New Health Fund SPD is Expected to be in Your Hands by this Spring

We are currently working on a new Health Fund SPD. It should be in your hands sometime this Spring. The new version will also be posted online, and we have changed the format so that any subsequent changes to the SPD can be reflected within the online version of the SPD itself (so you won't have to look anywhere else for the most up-to-date description of plan benefits).

Many of you were kind enough to participate in a recent survey that gave us important insights into how you use the SPD and how you would like to see it changed, to make it more useful to you. We thank you for helping us with this project and hope the outcome meets with your approval.

...the most detailed description of Health Plan benefits that is readily accessible to participants, is available online at the Equity-League website www.equityleague.org

Dental Coverage Must Be Paid for the Full Year Once Dental Coverage is Elected

Dental coverage is offered on a fully self-pay basis, to participants who qualify for medical coverage. Premiums for this coverage are based on the claims and administrative expenses incurred during a full year and are calculated on the assumption that all of those who are enrolled in the program will pay their premiums for the full year.

It has come to our attention that a small number of participants stop paying dental premiums at some point during the year (e.g., when they believe they will not have any more dental work done that year) and then enroll in the dental plan again the following year. If such a pattern were to occur regularly, it would affect the premium levels for the entire plan, because premiums would fall short of estimates (which were based on the assumption that everyone would pay for a full year). As a result, those premiums would have to be increased, hurting everyone else in the program, even those who paid their premiums for the full year.

Consequently, beginning in January of 2011, anyone who applies for dental coverage during open enrollment will have their prior dental premium payment history reviewed. If they had coverage at any time during the prior calendar year and stopped paying for the coverage at some point during the year, they will be required to pay the premiums that were due for the balance of that year, before coverage for the new year is activated.

For example, if someone paid for coverage from January 1, 2010 through June 30, 2010 and then stopped paying premiums, that person would not be permitted to enroll in the dental plan again on January 1, 2011, unless dental premiums for the July 1, 2010 through December 31, 2010 period were paid. We therefore suggest that if you are enrolled in the dental program you continue to pay premiums through the entire year, unless you plan to permanently drop the coverage.

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This newsletter is a publication of the Board of Trustees of the Equity-League Trust Funds. Additional copies are available upon request, or online at our website (www.equityleague.org). For any questions about the newsletter or your benefits, contact The Fund Office, Equity-League Pension, Health and 401(k) Funds, 165 West 46th Street, 14th Floor, New York, NY 10036-2582. To call the Fund Office from the NYC area, phone 1-212-869-9380; if you're calling from outside the NYC area, call the Fund Office toll-free at 1-800-344-5220.

To the extent that any of the information contained in this newsletter is inconsistent with the official Plan documents (which, of course, includes the Trustees' rights to amend or modify the Plans at any time), the Plan documents will govern in all cases. No official (other than the Trustees) has any authority to interpret the Plans, or other official Plan documents, or to make any promises to you about them.