

Inside this issue

- Mental health, chemical dependency benefit improvements effective Dec. 1, 2013 ..... 1
- Regulatory agencies provide clarification to Supreme Court DOMA ruling .....5
- Reminder: Health Plan premium increases effective Jan. 1, 2014...6
- Reminder: Report potential discrepancies for pre-2009 earnings before Dec. 31 .....8
- Health Fund Notice of Privacy Practices update.....9
- Health Fund Summary Annual Report.....9

This *Benefits Update* includes important information about your AFTRA Health and Retirement Plan benefits. Please keep this *Benefits Update* with your AFTRA Health and Retirement Plan documents and share this information with your family.

**Mental health, chemical dependency benefit improvements to be implemented effective Dec. 1, 2013**

**Changes include lower copayments and the availability of non-network benefits**

The Board of Trustees is pleased to announce improvements to the mental health and chemical dependency benefits for Health Plan participants effective Dec. 1, 2013, as outlined in this *Benefits Update*. Collectively, these changes expand benefits available to participants and reduce participants’ out-of-pocket costs for some covered services under the Plan’s mental health and chemical dependency benefits.

These changes also bring the Plan into alignment with requirements of the Mental Health Parity and Addiction Equity Act, which the Health Plan must comply with as of Dec. 1, 2013. This federal law requires mental health and chemical dependency benefits offered by any health plan to be generally equivalent to the medical benefits provided by the same health plan. If you want to review details of the copayments, coinsurance or other coverage levels of the Health Plan’s medical benefits, please refer to the 2011 Health Plan Summary Plan Description, which is available at [www.aftrahr.com](http://www.aftrahr.com) (“Health Fund” | “Health Plan SPD”).

**Non-network benefits available Dec. 1**

In addition to improvements to several specific benefit provisions (as outlined in the following section), one of the most significant changes is that, effective Dec. 1, 2013, benefits for mental health and chemical dependency services from providers who are not in the ValueOptions network will also be available. Currently, only services from ValueOptions’ network providers are covered. While you will soon have the flexibility to choose either a network or non-network provider, remember that you will maximize your Health Plan benefits and pay lower out-of-pocket costs if you choose a network provider.

continued on next page

If you (and/or your dependents) have Medicare or will become eligible for Medicare within the next 12 months, a federal law gives you more choices about your prescription drug coverage. If you are a participant in the Senior Citizen Health Program, please see your enclosed insert for more details.

### As of Dec. 1, 2013, pre-authorization through ValueOptions is required only for inpatient admissions

Currently, you must obtain authorization from ValueOptions for all mental health or chemical dependency treatment. Though it is recommended that you continue to contact Value Options at (800) 704-1421 before any type of mental health or chemical dependency treatment, as of Dec. 1, 2013, you will only be required to obtain pre-authorization from ValueOptions for inpatient mental health or chemical dependency treatment. (If it is an emergency inpatient admission, you must contact ValueOptions for authorization within 72 hours of admission).

As with hospitalizations for other illnesses and injuries, there is no specific dollar penalty for failure to pre-authorize inpatient mental health or chemical dependency treatment. However, it is still essential that you pre-authorize any inpatient admission. If you do not contact ValueOptions for authorization prior to receiving inpatient care and any part or all of your inpatient treat-

ment is later determined to be medically unnecessary or otherwise not covered by the Plan, you will be responsible for the charges that are not covered by the Plan.

By contacting ValueOptions before receiving services (either for inpatient pre-authorization or for assistance with arranging outpatient care), you will allow ValueOptions representatives to help you choose a provider qualified to deliver the appropriate level of care for your condition. ValueOptions staff can also assist you with choosing a provider in the ValueOptions network, if that is your choice.

### Overview of specific benefits and benefit changes

The following tables on pages 3–5 list all outpatient (first table) and inpatient (second table) mental health and chemical dependency benefit provisions under the Health Plan. Each table also shows how these benefits compare before and after Dec. 1, 2013. Please note that benefits which improved after Dec. 1 are shaded in red, while benefits that are unchanged after Dec. 1 are not shaded.

continued on next page

#### Important: Always pre-authorize inpatient care through ValueOptions

Whether you choose a network or non-network provider after Dec. 1, 2013, you must still contact ValueOptions at (800) 704-1421 for pre-authorization prior to receiving inpatient mental health or chemical dependency services from any provider (unless it is an emergency admission, in which case you must contact ValueOptions within 72 hours). If you don't pre-authorize inpatient mental health or chemical dependency services, you may be responsible for the entire cost of these services if they are later determined not to be medically necessary or otherwise not covered by the Plan.

#### Reminder: Keep information about your beneficiaries up-to-date

It is important that you keep your beneficiary information up-to-date — both your beneficiary for the life insurance benefit (if you have active coverage) or survivor benefit (if you have Senior Citizen Health Program Coverage) under the Health Plan, and the beneficiary for any pension benefits due to you under the Retirement Plan.

- If you are a Health Plan participant, you originally designated your life insurance (or Senior Program survivor benefit) beneficiary at enrollment. To update your beneficiary, complete the beneficiary section on a new Health Plan Performer Enrollment Form (or a new Senior Citizen Health Program Enrollment Form) available at [www.aftrahr.com](http://www.aftrahr.com) ("Forms" | "Health forms") and submit it to AFTRA H&R. **If you name your spouse as your designated beneficiary and then divorce or become legally separated, the divorce or separation does not automatically revoke your prior designation,** so keep your beneficiary information up-to-date.
- For your Retirement Plan benefits, if you are married when you retire, your spouse is automatically your beneficiary for your Retirement Fund benefits, unless your spouse consents in writing (on the Pension Application Form) to you naming another person. In order to designate a beneficiary or to change a beneficiary you previously designated, you must submit a completed Designation of Beneficiary Form, which is available at [www.aftrahr.com](http://www.aftrahr.com) ("Forms" | "Retirement forms"), to AFTRA H&R. Once you begin receiving pension payments, your beneficiary can't be changed. For additional information, refer to the Retirement Plan SPD, which is available at [www.aftrahr.com](http://www.aftrahr.com) ("Retirement Fund" | "Retirement Plan SPD").

<b>Outpatient mental health and chemical dependency benefits</b> (Benefits that improved after Dec. 1 shaded in red. Benefits unchanged after Dec. 1 not shaded.)		
<b>Benefit provision</b>	<b>Current benefit</b>	<b>Benefit effective Dec. 1, 2013</b>
<b>Network outpatient deductible</b>	None	None
<b>Non-network outpatient deductible</b>	Not applicable, because no non-network benefit currently provided	Expenses for mental health and chemical dependency benefits will apply to the major medical non-network deductibles of \$400 per individual; \$800 per family
<b>Network outpatient copayment</b>	Mental health – \$20/visit  Chemical dependency – no copayment	Mental health – \$10/visit  Chemical dependency – no copayment
<b>Non-network outpatient copayment</b>	Not applicable, because no non-network benefit currently provided	Mental health – \$10/visit  Chemical dependency – no copayment
<b>Network outpatient coinsurance (mental health only)</b>	First 40 visits – Plan pays 100% (no coinsurance) after visit copayment; Any additional visits – Plan pays nothing	First 40 visits – Plan pays 100% (no coinsurance) after visit copayment; Any additional visits – Plan pays 90% (10% coinsurance, excluding the visit copayments) until the individual's out-of-pocket maximum of \$1,000 is reached; Plan pays 100% (no coinsurance) thereafter (excluding visit copayments).
<b>Non-network outpatient coinsurance</b>	Not applicable, because no non-network benefit currently provided	Plan pays 60% of scheduled allowance (40% coinsurance, excluding the non-network deductible and visit copayments) until the individual's out-of-pocket maximum of \$3,200 is reached; Plan pays 100% (no coinsurance) thereafter (excluding visit copayments).
<b>Network outpatient out-of-pocket maximum (annual) (mental health only)</b>	None	Individual's out-of-pocket expenses for the 10% coinsurance (for any visits over 40 in a calendar year), not including copayments, will apply to the major medical network out-of-pocket maximum of \$1,000 per individual.
<b>Non-network outpatient out-of-pocket maximum (annual)</b>	Not applicable, because no non-network benefit currently provided	Individual's out-of-pocket expenses for the 40% of the scheduled allowances coinsurance, not including copayments, will apply to the major medical non-network out-of-pocket maximum of \$3,200 per individual (plus deductible and expenses that exceed the scheduled allowance)
<b>Network outpatient visit limit (mental health only)</b>	40 visits per individual per year	No limit on visits

continued on next page

<b>Inpatient mental health and chemical dependency benefits</b> (Benefits that improved after Dec. 1 shaded in red. Benefits unchanged after Dec. 1 not shaded.)		
Benefit provision	Current benefit	Benefit effective Dec. 1, 2013
<b>Network inpatient deductible</b>	None	None
<b>Non-network and out-of-area inpatient deductible</b>	Not applicable, because no non-network benefit currently provided	No deductible applied
<b>Network inpatient copayment (mental health only)</b>	\$100 per admission copayment	\$100 per admission copayment
<b>Network inpatient copayment (chemical dependency only)</b>	No copayment required	No copayment required
<b>Non-network and out-of-area inpatient copayment (per admission)</b>	Not applicable, because no non-network benefit currently provided	\$100 per admission copayment
<b>Network inpatient coinsurance/day limitation (mental health care only)</b>	100% of covered expenses for preauthorized admissions, with a 30-day limit, applied after \$100 copayment	No day limitation; Plan pays 100% of covered expenses for the first 30 days of care, then 90% of covered expenses thereafter, applied after \$100 copayment
<b>Network inpatient coinsurance/day limitation (chemical dependency treatment only)</b>	Up to three courses of preauthorized treatment:  First course of treatment (if completed) – Plan pays 95% of scheduled allowance for covered expenses  Second course of treatment (if completed) – Plan pays 80% of scheduled allowance for covered expenses  Third course of treatment (if completed) – Plan pays 60% of scheduled allowance for covered expenses, limited to emergency admission for detoxification and outpatient treatment only	No limit on the number of courses of treatment  Plan pays 95% of covered expenses for first course of treatment, 90% of covered expenses for all subsequent courses of treatment
<b>Non-network and out-of-area inpatient coinsurance</b>	Not applicable, because no non-network benefit currently provided	Plan pays 60% of covered expenses per individual (40% coinsurance, excluding \$100 copayment) until the individual's \$2,800 out-of-pocket maximum is reached; Plan pays 100% (no coinsurance) thereafter.  Out-of-area enhanced benefits paid at 80% <sup>1</sup> of covered expenses per individual (20% coinsurance, excluding \$100 copayment) until the individual's \$2,800 out-of-pocket maximum is reached; Plan pays 100% thereafter.

<sup>1</sup> While the general rule is that the Plan pays 60% of covered expenses for non-network hospital services, the Plan will pay 80% (instead of 60%) of the covered expenses for the first admission after the \$100 copayment and you will pay 20% if any of the following conditions apply:

- You receive services at a hospital located in a part of the United States where there are no network hospitals within 25 miles from where you live; or
- You are traveling or living outside the US and have no access to network hospitals. This applies only to a medical emergency, not a planned hospital stay outside the US; or
- A hospital admission is the result of a medical emergency which precluded the use of a network hospital.

Enrolled Health Plan participants and dependents who receive care as described above must call Participant Services at (800) 562-4690 to request the enhanced reimbursement so that an appropriate adjustment can be made.

<b>Inpatient mental health and chemical dependency benefits (continued)</b> (Benefits that improved after Dec. 1 shaded in red. Benefits unchanged after Dec. 1 not shaded.)		
Benefit provision	Current benefit	Benefit effective Dec. 1, 2013
<b>Network out-of-pocket inpatient maximum (annual)</b>	Covered individuals' out-of-pocket inpatient expenses <i>do not</i> count toward each individual's \$1,000 out-of-pocket maximum (which does not include the \$100 per-admission copayment)	Covered individuals' out-of-pocket inpatient expenses <i>do</i> count toward each individual's \$1,000 hospital network out-of-pocket maximum (which does not include the \$100 per-admission copayment)
<b>Non-network and out-of-area inpatient out-of-pocket maximum (annual)</b>	Not applicable, because no non-network benefit currently provided	Individual's expenses count toward the hospital non-network out-of-pocket maximum of \$2,800 per individual (plus \$100 copayment per admission)
<b>Non-network and out-of-area inpatient limit/lifetime limits</b>	Not applicable, because no non-network benefit currently provided	Coverage provided with no day or lifetime limits

**Important: ValueOptions is the Plan's only network for mental health/chemical dependency providers**

Even after the Dec. 1, 2013 changes, the ValueOptions network remains the Health Plan's only network for mental health and chemical dependency providers. To confirm the network status of a provider or for assistance with locating providers in your area, contact ValueOptions at (800) 704-1421. If you choose a provider for mental health or chemical dependency services that is in Cigna's PPO network<sup>2</sup> but not in Value Options' network, **those services will be processed as non-network**, and you will be responsible for the balance over the scheduled allowance.

## Regulatory agencies provide clarification to Supreme Court DOMA ruling

### All legal same-sex marriages will be recognized for federal tax purposes, regardless of the state of residence

On Aug. 29, 2013 the Internal Revenue Service and U.S. Treasury Department issued an important clarification to the recent Supreme Court ruling that declared unconstitutional a key provision of the Defense of Marriage Act (DOMA).

Federal regulators have ruled that all same-sex couples legally married in jurisdictions that recognize same-sex marriages will be treated as married for federal tax purposes, regardless of whether the couple lives in a state or other jurisdiction that recognizes same-sex marriage.

This means that, for the purposes of both the AFTRA Health and Retirement Plans, you will be considered

legally married if you were legally married in a state or other jurisdiction that permits same-sex marriage – regardless of the marriage laws of the state or other jurisdiction in which you currently live. AFTRA H&R had previously taken steps to treat same-sex spouses similarly to opposite-sex spouses to the full extent permitted by federal law, but the Funds were prevented from doing so in all cases due to the provision of DOMA that has since been struck down. Note that couples in domestic partnerships, civil unions or other relationships that are not marriages under state law are not considered to be married for federal tax purposes.

With respect to the Health Plan, the federal taxes that the Plan has been collecting from some participants who cover a same-sex domestic partner will no longer apply to those who are legally married. If you were legally married in a state or other jurisdiction that recognizes same-sex marriage, the value of your spouse's coverage will no longer be taxable income to you. Please note, however, this ruling applies only for federal tax purposes and does not affect any applicable state tax requirements.

continued on next page

<sup>2</sup> Cigna HealthCare provides the PPO network for the Health Plan's medical benefits.

If you have enrolled your same-sex spouse in the Health Plan, be sure to provide AFTRA H&R with your marriage certificate so that we can adjust your premium invoices accordingly, if necessary. Please note, however, that the taxes will continue to apply to same-sex domestic partners who are not married and are covered under the AFTRA Health Plan (unless they are otherwise tax dependents under federal law for these purposes or you qualify for individual coverage and pay the full buy-up premium).

With respect to the Retirement Plan, certain forms of retirement benefits and other rights and protections that were previously available under federal law only to opposite sex spouses will now extend to all legal spouses – including same-sex spouses legally married in jurisdictions that recognize their marriages and regardless of the state of residence. If you are legally married, whether to a

same-sex or opposite-sex spouse, it is important that you advise us of that marriage when you apply for retirement benefits.

The US Department of Treasury and the IRS will be issuing further guidance regarding the application of their ruling as well as the application of the Supreme Court decision to retirement plans and to previously paid taxes on health benefits. The AFTRA Health and Retirement Funds will continue to review and evaluate all guidance as it is issued and will advise you of any changes or other developments as they apply to these Funds. Participants are also encouraged to consult a financial advisor before making any financial decisions based upon the recent Supreme Court ruling.

For additional information and any future updates, please visit [www.aftrahr.com](http://www.aftrahr.com) and watch for upcoming *Benefits Updates*.

## Reminder: Health Plan premium increases effective Jan. 1, 2014

The Health Plan’s annual 5% premium increase will become effective for the first quarter of 2014 (premium due date Dec. 23, 2013). The current and new 2014 Health Plan premiums are listed below:

Type of coverage	Current quarterly premium	New quarterly premium effective Jan. 1, 2014
<b>Participant only (active coverage)</b>	\$400	\$420
<b>Participant and legal spouse or domestic partner only (active coverage)</b>	\$701 <sup>3</sup>	\$736 <sup>3</sup>
<b>Participant and child(ren) only (active coverage)</b>	\$701 <sup>3</sup>	\$736 <sup>3</sup>
<b>Full family (active coverage)</b>	\$769 <sup>3</sup>	\$807 <sup>3</sup>
<b>Retiree only (Senior Program)</b>	\$159	\$166
<b>Retiree and legal spouse or domestic partner only (Senior Program)</b>	\$461 <sup>3</sup>	\$484 <sup>3</sup>
<b>Retiree and child(ren) only (Senior Program)</b>	\$461 <sup>3</sup>	\$484 <sup>3</sup>
<b>Retiree full family (Senior Program)</b>	\$526 <sup>3</sup>	\$552 <sup>3</sup>

<sup>3</sup> The participant must qualify for family level coverage to receive coverage that includes any dependents at the premium levels indicated in this first table. See pages 6-14 of the 2011 Health Plan SPD for information on the qualification requirements for Health Plan coverage.

### The new 2014 premiums will change the total premium required for buy-up coverage

If you only qualify for individual level coverage under the AFTRA Health Plan (and do not qualify for family level coverage), you may choose to “buy up” to family coverage by paying a buy-up premium, in addition to the individual premium, each quarter. See pages 6-14 of the 2011 Health Plan SPD for information regarding qualification requirements for Health Plan coverage.

Type of coverage (Note: Buy-up premiums only apply to participants who qualify only for individual coverage)	Current quarterly premium	New quarterly premium effective Jan. 1, 2014	Quarterly buy-up premium	Total quarterly premium (individual premium plus buy-up premium) effective Jan. 1, 2014
<b>Participant only (active coverage)</b>	\$400	\$420	n/a	\$420
<b>Participant plus one dependent (active coverage)</b>	\$400	\$420	\$2,403	\$2,823
<b>Participant and plus two or more dependents (active coverage)</b>	\$400	\$420	\$4,577	\$4,997
<b>Retiree only (Senior Program)</b>	\$159	\$166	n/a	\$166
<b>Retiree plus one dependent (Senior Program)</b>	\$159	\$166	\$2,403	\$2,569
<b>Retiree plus two or more dependents (Senior Program)</b>	\$159	\$166	\$4,577	\$4,743

Please note that while total premium amounts required for buy-up coverage effective Jan. 1, 2014 (listed above) reflect a slight increase due to the change in the individual premium, the total amounts for buy-up coverage will likely rise again effective April 1, 2014. This is due to the expected increase in the buy-up premium, which is adjusted at the beginning of the second quarter each year. The increase to the buy-up premiums for April 1, 2014 will be announced when the new buy-up premiums are available.

**Remember that your premium payments must be made on time and for the full amount in order for you to maintain coverage under the Health Plan. If there is a shortage in your premium payment, or if your premium payment is not received by the due date, your Health Plan coverage may be terminated. Please be sure to remit the full current premium amount by the due date to avoid any cancellation or interruption of coverage.**

To view the current premium amounts at any time, visit [www.aftrahr.com](http://www.aftrahr.com) (“Health Fund” | “Premiums”).

Are you paying your premium by personal check or using an online bill payment service provided by your bank or other financial institution? If so, then don’t forget to include (or direct your bill payment service to include) your Account No. on the memo line of each payment check. Your Account No. is printed on your premium invoice. Also, if you have arranged for automatic premium payments to AFTRA H&R with your bank or other financial institution, you must notify your financial institution of the increased premium amount and confirm the current payment address as soon as possible.

## Reminder: Report potential discrepancies for pre-2009 earnings before end-of-year deadline

Effective Jan. 1, 2014, performers must report any potential discrepancies in reported earnings — and include supporting documentation — no later than five calendar years from when earnings were (or should have been) credited, as shown in the charts below:

<b>Application of Five-Year Limitation for Earnings Inquiries</b>	
<b>Calendar Year for Covered Earnings:</b>	<b>Earnings Inquiry Must Be Received By:</b>
2008 and all prior years	Dec. 31, 2013
2009	Dec. 31, 2014
2010	Dec. 31, 2015
2011	Dec. 31, 2016

<b>Record of Payment:</b>	<b>Record of Work:</b>
<ul style="list-style-type: none"> <li>● Pay stubs</li> <li>● Royalty statements (if you are a royalty artist under the Sound Recording Code)</li> <li>● W-2 Form/1099 Form</li> <li>● Detailed earnings statement from the Social Security Administration</li> </ul>	<ul style="list-style-type: none"> <li>● Session or work report</li> <li>● Proof of participation in AFTRA-covered work</li> <li>● Evidence documenting the type of work performed (e.g. personal services contract or agreement)</li> <li>○ It is recommended that you include a copy of your personal services contract even if other records submitted with your inquiry satisfy AFTRA H&amp;R's documentation and information requirements</li> </ul>

Remember, while AFTRA H&R works with SAG-AFTRA and contributing employers to determine and collect contributions on covered earnings that should be reported to AFTRA H&R, you know best the work that you have performed, and so it is important that you partner with AFTRA H&R to make sure that the information we have for you is accurate and complete.

If you have questions or need assistance, contact AFTRA H&R's Contribution Services by calling (800) 562-4690 or sending an e-mail to [earnings@aftrahr.com](mailto:earnings@aftrahr.com). For complete details, refer to the recently mailed August 2013 *Benefits Update* and the Policies for Covered Earnings Inquiries brochure, which is available at [www.aftrahr.com](http://www.aftrahr.com) ("News and updates" | "Brochures").



### Trustee leaves AFTRA H&R Board

Jean Bonini, a Producer (Employer) Trustee for AFTRA H&R for more than 15 years, left the AFTRA H&R Board effective July 31, 2013, in anticipation of her retirement from Sony Pictures Entertainment in August. The Board and staff of AFTRA H&R would like to thank Ms. Bonini for her years of service.

## Health Fund Notice of privacy practices update

Earlier this year, final regulations were issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that affect the Health Fund's treatment of protected health information (PHI). In accordance with these new rules, the Health Fund has updated its Notice of Privacy Practices (NOPP). The revised NOPP is available at [www.aftrahr.com](http://www.aftrahr.com) ("Legal Notices").

The changes to the NOPP include the following:

- A statement indicating that most uses and disclosures of psychotherapy notes, PHI for marketing purposes and disclosures that constitute sales of PHI require your express authorization. (Note: AFTRA H&R does not use participants' PHI for marketing purposes.)
- A statement of your right to be notified of breaches of your unsecured PHI
- A statement setting forth the definition of unsecured PHI

You may contact AFTRA H&R at any time to obtain a copy of the most recent NOPP by calling (800) 562-4690 or visiting [www.aftrahr.com](http://www.aftrahr.com) as directed above.

## Summary Annual Report for the AFTRA Health Plan

This is a summary of the annual report of the AFTRA Health Plan, EIN 13-3467049, Plan No. 502, for period Dec. 01, 2011 through Nov. 30, 2012 (the Plan Year). The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

### Insurance information

The Plan has contracts with The Guardian Life Insurance Company, Aetna Life Insurance Company and Union Security Life Insurance Company of New York to pay dental, life insurance, long-term disability and accidental death and personal loss claims incurred under the terms of the Plan. The total premiums paid for the Plan Year ending Nov. 30, 2012 were \$323,226. All other benefits are self-insured, with the Board of Trustees of the AFTRA Health Fund committing that the AFTRA Health Plan will

itself pay all claims other than dental, life insurance, long-term disability and accidental death and personal loss claims incurred under the terms of the Plan.

### Basic financial statement

The value of Plan assets, after subtracting liabilities of the Plan, was \$211,754,529 as of Nov. 30, 2012, compared to \$176,015,801 as of Dec. 1, 2011. During the Plan Year the Plan experienced an increase in its net assets of \$35,738,728. This increase includes unrealized appreciation and depreciation in the value of Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the Plan Year, the Plan had total income of \$147,064,461, including employer contributions of \$108,924,042, participant contributions of \$21,577,519, realized gains of \$2,104,185 from the sale of assets, earnings from investments of \$14,425,181 and other income of \$33,534.

continued on next page

Plan expenses were \$111,325,733. These expenses included \$16,601,931 in administrative expenses, and \$94,723,802 in benefits paid to participants and beneficiaries.

### Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- an accountant's report;
- financial information;
- information on payments to service providers;
- assets held for investment;
- fiduciary information, including non-exempt transactions between the plan and parties-in-interest (persons who have certain relationships with the Plan);
- loans or other obligations in default or classified as uncollectible;
- leases in default or classified as uncollectible;
- transactions in excess of 5% of the Plan assets;
- insurance information, including sales commissions paid by insurance carriers;
- information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the Plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Board of Trustees, AFTRA Health Fund at 261 Madison Ave., 7th Floor, New York, NY 10016-2312, or by telephone at (212) 499-4800. The charge to cover copying costs will be \$8.10 for the full annual report of the AFTRA Health Fund and \$15.48 for the AFTRA Retirement Fund, or \$.09 for any page thereof.

You also have the right to receive from the Plan administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying costs of these portions of the reports because these portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Board of Trustees, AFTRA Health Fund, 261 Madison Ave., 7th floor, New York, NY 10016-2312) and at the US Department of Labor in Washington, D.C., or to obtain a copy from the US Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

### Important contact information

- AFTRA H&R Participant Services, (800) 562-4690, [www.aftrahr.com](http://www.aftrahr.com)
- Cigna HealthCare, (800) 768-4695, [www.cignasharedadministration.com](http://www.cignasharedadministration.com)
- Cigna's 24-hour Nurseline, (800) 768-4695
- ValueOptions, (800) 704-1421

## AFTRA Health Fund Board of Trustees

### Producer Trustees

Marc Sandman, 2013 Co-Chairperson  
AFTRA H&R Board of Trustees  
Senior Vice President, Labor Relations  
ABC, Inc.  
500 South Buena Vista Street  
Burbank, CA 91521

Helayne Antler  
Senior Vice President  
Legal and Labor Relations  
Sony Pictures Entertainment  
10202 W. Washington Blvd  
Culver City, CA 90232

Ann Calfas  
Executive Vice President  
Employment Litigation & Labor  
FOX Group  
2121 Avenue of the Stars, 7th Floor  
Los Angeles, CA 90067

Andrea Finkelstein  
Senior Vice President  
Business Affairs  
Operations & Administration  
Sony Music Entertainment  
550 Madison Avenue  
New York, NY 10022

Keith Gorham  
Senior Vice President  
Labor Relations  
NBC Universal  
100 Universal City Plaza, 1280-3  
Universal City, CA 91608

Harry Isaacs  
Executive Vice President  
Labor Relations  
CBS Corporation  
4024 Radford Ave.  
Studio City, CA 91064

Jo Ann Kessler  
Vice President  
Director of Business Affairs  
Extreme Reach  
8 West 40th St. 20th Floor  
New York, NY 10018

Hank Lachmund  
Senior Vice President  
Labor Relations  
Warner Bros. Television  
300 Television Plaza, Bldg. 137  
Rm. 1009  
Burbank, CA 91505

Stephen Mirante  
Senior V.P., H.R. Specialty Services  
CBS Corp.  
51 West 52nd Street, 19th floor  
New York, NY 10019

David Silberman  
Executive Counsel, Labor Relations  
ABC, Inc.  
77 West 66th Street  
New York, NY 10023

Ron Wilcox  
Executive Counsel, Business Affairs  
Warner Music Group  
75 Rockefeller Plaza, 13th floor  
New York, NY 10019

### Union Trustees

Shelby Scott, 2013 Co-Chairperson  
AFTRA H&R Board of Trustees  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

David Browde  
c/o SAG-AFTRA  
260 Madison Avenue, 7th floor  
New York, NY 10016

Denny Delk  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

Mathis Dunn, Jr.  
Associate National Executive Director  
SAG-AFTRA  
5757 Wilshire Boulevard, 9th floor  
Los Angeles, CA 90036

David Hartley Margolin  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

Matt Kimbrough  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

Lynne Lambert  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

Roberta Reardon  
SAG-AFTRA  
260 Madison Avenue, 7th floor  
New York, NY 10016

Joyce Reehling  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

Sally Stevens  
c/o AFTRA H&R  
261 Madison Avenue, 7th floor  
New York, NY 10016

David White  
National Executive Director  
SAG-AFTRA  
5757 Wilshire Boulevard, 9th Floor  
Los Angeles, CA 90036

### Chief Executive Officer

Christine Dubois  
AFTRA Health & Retirement Funds  
261 Madison Avenue, 7th floor  
New York, NY 10016

## Notice of Grandfathered Health Plan Status

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Director or the Associate Director of Benefits at (212) 499-4800. You may also contact the US Department of Labor’s Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the US Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

### Important information

You should take the time to read this *Benefits Update* carefully and share it with your family. It is very important that you retain this notice, which is intended to serve as a Summary of Material Modification (SMM), with the 2011 Health Plan SPD and the 2013 Retirement Fund SPD. While every effort has been made to make this SMM as complete and as accurate as possible, it does not restate the existing terms and provisions of the Plans other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPDs (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the SPDs will govern in all cases. The Board of Trustees of the AFTRA Health and Retirement Funds or its duly authorized designee reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plans. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plans or any benefits provided under the Plans (or qualification for such benefits), in whole or in part, at any time and for any reason (including with respect to retirees and with respect to benefits already earned).

## Important Notice About Your Prescription Drug Coverage and Medicare — Medicare Part D Notice of Creditable Coverage

**Please review this important notice from the AFTRA Health Plan for Medicare-eligible participants, spouses and dependents regarding your prescription drug coverage, other AFTRA Health Plan coverage and Medicare.**

The annual enrollment period for Medicare's prescription drug coverage — Medicare Part D — is from Oct. 15 through Dec. 7, 2013. Therefore, it is time for you to consider whether you want to make any changes in your current prescription drug plan coverage.

During the upcoming enrollment period, you have the opportunity to enroll in a Medicare Part D prescription drug plan, or to keep your AFTRA Health Plan coverage (provided you pay your AFTRA Health Plan premiums on time and, if you are an active participant, provided you remain qualified for coverage under the AFTRA Health Plan).

Please read this Notice of Creditable Coverage carefully before you make your decision, and keep the notice where you can find it. This notice contains important information about the Medicare prescription drug coverage and the current prescription drug coverage offered under the AFTRA Health Plan. This information can help you decide whether or not you want to join a Medicare drug plan. This notice also provides you with some of the sources where you may find more information about the Medicare program and the options that are available to you. If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is contained in this notice.

**It is important to note that if you choose to enroll in a Medicare prescription drug plan, the AFTRA Health Plan's Senior Citizen Health Program will not provide you with prescription drug coverage.** However, it will continue to provide your other hospital and medical benefits in accordance with the Senior Program benefits

under the Health Plan. Therefore, if you qualify for the Senior Program under the AFTRA Health Plan and want prescription drug coverage under the Senior Program, you must not enroll in a Medicare Part D plan. If you are currently enrolled in a Part D plan, in order for you to receive prescription drug coverage under the Senior Program effective Jan. 1, 2014, you must terminate your enrollment in your Part D plan at the end of the calendar year by contacting your current plan or by calling (800) 633-4227 (800-MEDICARE).

### Medicare Part D prescription drug plans

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- In 2006, Medicare prescription drug (Part D) coverage became available to everyone with Medicare. You can get Part D coverage if you join a Medicare prescription drug plan or a Medicare Advantage Plan (Part C) (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. (Some plans might also offer more coverage for a higher monthly premium.)
- The AFTRA Health Plan has determined that its prescription drug coverage provides "creditable coverage." **That means the AFTRA Health Plan is, on average for all Plan participants, expected to pay out as much as, or even more than, the standard Medicare prescription drug coverage will pay. Because this Plan's coverage is "creditable coverage," if you are satisfied with the AFTRA Health Plan coverage, you may choose to keep your AFTRA Health Plan coverage and not enroll in a Medicare prescription drug plan at this time. If you later decide to join a Medicare drug plan, you will not pay a higher premium (a penalty).**

### When can you join a Medicare prescription drug plan?

People can enroll in a Medicare prescription drug plan when they first become eligible and during this year's annual open enrollment period from Oct. 15, 2013 through Dec. 7, 2013. If you decide to enroll in Medicare prescription drug coverage in a future year, you may do so during any subsequent Medicare Part D annual open enrollment period from Oct. 15 through Dec. 7 each year

continued on next page

**Save this notice**

**Remember: Keep this Notice of Creditable Coverage.** If you decide to enroll in one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

going forward. Also, if you lose your current creditable prescription drug coverage under the AFTRA Health Plan through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan. **But remember, as stated above, the AFTRA Health Plan's Senior Citizen Health Program will not provide prescription drug coverage if you enroll in a Medicare prescription drug plan.**

**What happens to your current coverage if you decide to join a Medicare prescription drug plan?**

Remember, your current AFTRA Health Plan coverage pays for health expenses, in addition to prescription drugs, some of which may not be covered by Medicare.

**If you are covered under the AFTRA Health Plan's Senior Citizen Health Program and choose to enroll in a Medicare Part D Plan, you will no longer have prescription drug coverage through the AFTRA Health Plan effective Jan. 1, 2014.** Medicare will provide your sole prescription drug coverage, although you will maintain the AFTRA Health Plan medical and hospital coverage. **Please note that the premium under the AFTRA Health Plan will not be reduced to reflect the termination of the prescription drug coverage.** If you decide to join a Medicare prescription drug plan and you lose your prescription drug coverage under the Senior Program, be aware that you and your dependents will be able to get your prescription drug coverage back (at the beginning of any future calendar year) once you drop your Part D coverage. In addition, if you decide to join a Medicare prescription drug plan and you drop your Senior Program coverage entirely, you will be eligible to re-enroll in the Senior Program effective Jan. 1 of any year provided you pay the required premium.

If you are not covered under the Senior Citizen Health Program but you are covered as an active participant under the AFTRA Health Plan and you choose to enroll in a Medicare Part D Plan, your coverage under the AFTRA Health Plan will not be affected. For participants with active coverage under the Health Plan, the Plan, by law,

will always pay before Medicare. Therefore, if you elect a Medicare Part D Plan in addition to the AFTRA Health Plan, you will have to pay the Part D plan premium in addition to the AFTRA Health Plan premium, though it is unlikely that there will be any benefits payable by the Medicare Plan, because it will always be secondary to the AFTRA Health Plan. As an alternative, you may drop AFTRA Health Plan coverage entirely, enroll in a Medicare Part D plan and rely solely on your Medicare health benefits and your Medicare Part D plan's prescription drug benefits. (However, you should note that included with active coverage under the Health Plan are other benefits – such as preventive dental benefits, a life insurance benefit, accidental death & personal loss benefits and a loss of voice benefit — which Medicare does not provide.)

If you are a participant with active coverage under the AFTRA Health Plan and you elect to drop your coverage under the Health Plan (or you no longer qualify for coverage), you will be able to re-enroll in the AFTRA Health Plan as of the beginning of your next coverage period, but only if you once again meet the Health Plan's earnings requirements and pay the required premium.

**When will you pay a higher premium (penalty) to join a Medicare prescription drug plan?**

You should also know that if you drop or lose coverage under the AFTRA Health Plan and don't enroll in a Medicare prescription drug plan **within 63 continuous days** after your AFTRA Health Plan coverage ends, you may be required to pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later on.

If your AFTRA Health Plan coverage ends and you go 63 continuous days or longer without **creditable** coverage (prescription drug coverage that is at least as good as Medicare's), you will pay more to enroll in Medicare prescription drug coverage. Your monthly premium for Medicare Part D coverage may go up by at least **1% of the Medicare base beneficiary premium per month** for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% (1% x 19 months)

continued on next page

higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug coverage. Finally, you may have to wait until the following October to enroll in another Medicare Part D plan.

### For more information about your Medicare prescription drug plan options

More detailed information about Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook. You should receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. More information about Medicare prescription drug plans can be found on the following websites:

- [www.medicare.gov](http://www.medicare.gov)
- [www.aarp.org](http://www.aarp.org)
- [www.medicarerights.org](http://www.medicarerights.org)

In addition, you may:

- Call your State Health Insurance Assistance Program (the telephone number for your state’s program will be found in the inside back cover of the “Medicare & You” handbook) for personalized help;
- Call (800) 633-4227 (1-800-MEDICARE). Teletype (TTY) users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this additional help, visit the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call (800) 772-1213. TTY users should call the SSA at (800) 325-0778.

### For more information about this notice or AFTRA Health Plan prescription drug coverage

If you have questions about this Notice of Creditable Coverage or your current AFTRA Health Plan prescription drug coverage, you may call Participant Services at (800) 562-4690 for further information. You can also visit our website at [www.aftrahr.com](http://www.aftrahr.com). You will receive this notice each year prior to the annual enrollment period, or if the AFTRA Health Plan’s prescription drug creditable coverage status changes. You may also request a copy of this notice at any time.

continued on next page

## Medicare Advantage (Part C) and the AFTRA Health Plan’s Senior Citizen Health Program

As you may know, the federal Medicare program is divided into four parts:

- *Part A* is free to eligible recipients and helps to pay for inpatient hospital care;
- *Part B* is optional, requires premium payments and helps pay for outpatient medical care (e.g., doctors’ bills, X-rays, lab tests, etc.);
- *Part D* is optional and, if elected, requires premium payments for prescription drug coverage; and
- *Part C*, called Medicare Advantage, is an option that Medicare beneficiaries can choose as an alternative to Parts A and B (and sometimes Part D). Under Medicare Advantage, private health insurance companies contract with the federal government to offer Medicare benefits – and sometimes additional benefits – through their own policies. These include:
  - managed care plans such as health maintenance organizations (HMOs);
  - preferred provider organizations (PPOs); and
  - fee-for-service plans.

**If you enroll or are enrolled in a Medicare Advantage Plan, you cannot enroll in, nor receive coverage under the AFTRA Health Plan’s Senior Citizen Health Program.** If you join a Medicare Advantage Plan, you can choose to terminate your coverage under the Medicare Advantage Plan at any time for any reason.

**If you decide to drop coverage in a Medicare Advantage Plan, you can enroll in the AFTRA Health Plan’s Senior Citizen Health Program for the first time or re-enroll effective Jan. 1, 2014 or any Jan. 1 thereafter provided that:**

- you meet all the qualification requirements for eligibility under the Senior Program;
- the Eligibility Department in the AFTRA H&R New York office receives your properly completed Senior Citizen Health Program Enrollment Form prior to Jan. 1; and
- you pay the required premium for coverage under the Senior Program by the due date specified on your invoice.

To learn more about qualification for the Senior Citizen Health Program and benefits available under the Health Plan, review the AFTRA Health Plan Summary Plan Description, visit [www.aftrahr.com](http://www.aftrahr.com) or contact Participant Services at (800) 562-4690.

**Save this notice**

**Remember: Keep this Notice of Creditable Coverage.** If you decide to enroll in one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

**Special note:**

While this Notice of Creditable Coverage is intended to provide some basic answers about Medicare Part D and other Medicare benefits, this brief document is not a full description of the Medicare Part D program or other Medicare programs or benefits. You should review this notice, as well as other Medicare information, very carefully and consider how it will affect your particular circumstances. No one at the AFTRA H&R office can advise you as to what decision to make. Whether to enroll in a Medicare Part C or Part D program and which program is best for you is your decision.

Please refer to the AFTRA Health Plan Summary Plan Description (SPD) for more complete information about the AFTRA Health Plan prescription drug and other benefits.

Date: September 2013

Name of Entity/Sender: AFTRA Health Plan  
Contact – Position/Office: AFTRA H&R office – Participant Services department

**Address:**

Headquarters:	Satellite office:
AFTRA H&R	AFTRA H&R
261 Madison Avenue	5757 Wilshire Blvd.
8th Floor	Ste. 372
New York, New York 10016	Los Angeles, CA 90036

Phone: (800) 562-4690

**Reminder: Medicare Part D's annual open enrollment period is Oct. 15 through Dec. 7, 2013**

The annual enrollment period for Medicare's prescription drug coverage – Medicare Part D – is from Oct. 15 through Dec. 7, 2013. If you are eligible for Medicare, it's important that you remember that this is your annual opportunity to consider whether you want to make any changes in your current prescription drug plan coverage.