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Enhanced Reimbursement for Emergency Ambulance Service

Medical emergencies happen, and when they do it may be necessary to call for transportation by ambulance to a local hospital.

If the ambulance service that transports you or your covered dependent is a Non-Network provider, the reimbursement from the Health Plan would currently be at the Plan's Non-Network rate of 60% of the scheduled allowance (see page 11 of the 2005 AFTRA Health Plan SPD for a definition of scheduled allowance). That means that you would be required to pay 40% of the scheduled allowance, plus any amount that exceeds that allowance. In addition, any payment would be subject to satisfaction of the Non-Network deductible.

Effective for services rendered on and after April 1, 2010, the Health Plan has been amended so that if the ambulance service is a Non-Network provider, the Plan will pay 80% of the scheduled allowance and you will pay 20% — and the Network (not the Non-Network) deductible will apply. Of course, if the ambulance service is a Network provider, the Plan will pay 90% of covered charges and you will pay 10%, plus the Network deductible.

It's important to note that while this enhanced reimbursement increases the percentage of the scheduled allowance that the Health Plan will pay for Non-Network ambulance services, the Plan still cannot pay for any billed amount which exceeds the Plan's scheduled allowance. The amounts charged by Non-Network providers can vary significantly, as there are no contractual limits to what they can charge. If you receive services without prior knowledge of a Non-Network provider's fees and you feel that the charges are excessive, it is within your rights to contact the provider to discuss these charges. Even though Non-Network providers are not contractually or otherwise obligated to do so, some are willing to adjust the charges and/or work out payment plans with their patients.

Immediate Enrollment in Health Plan Permitted after COBRA Subsidies from Former Employers End

The AFTRA Health Fund's Board of Trustees has amended the active Health Plan to permit the immediate enrollment of qualified performers and/or their dependents in the AFTRA Health Plan after certain subsidized periods of COBRA coverage provided through their former employers end.

This new rule will be applied to timely written requests for enrollment in the active Health Plan with effective dates on or after July 1, 2009. Under this new rule, to qualify for enrollment after the start of a Coverage Period both the COBRA coverage and the premium subsidies must be provided through a former employer. Enrollment after the start of a Coverage Period is not available when the COBRA coverage is being subsidized by someone other than the former employer, such as premium subsidies provided by the federal or a state government.

The AFTRA Health Plan requires that qualified performers enroll themselves and any dependents they wish to cover at the start of their four-quarter Coverage Period. However, not all qualified performers enroll in the active Health Plan when they first have the opportunity to do so. A common reason is that they already have other health coverage through an employer. Unfortunately, a few individuals who make this choice then experience an involuntary job loss and their families no longer have access to that other health coverage. Sometimes the severance agreements offered to individuals in this situation by their former employers include premium subsidies paid for a short period of time if they elect COBRA through the former employer.

The change adopted by the Trustees gives qualified performers and/or their dependents the flexibility to accept a subsidized period of COBRA coverage

through a former employer without jeopardizing their right to enroll in the active Health Plan once that employer subsidy ends. Prior to this change, individuals who qualified to enroll in the active Health Plan but instead elected subsidized COBRA provided by a former employer could not enroll in the active Health Plan until the start of their next four-quarter Coverage Period, or until they exhausted the full term of their COBRA coverage (i.e., 18 to 36 months), whichever came first.

Example

Here is an example of how this new rule works:

Let's assume that your spouse was terminated by his/her employer and received three months of fully subsidized COBRA coverage as part of a severance agreement. At the end of that three-month period, under the new rule, your spouse would not have to exhaust the remaining 15 months of COBRA coverage with the former employer to enroll in the AFTRA Health Plan. Your spouse could drop their COBRA coverage at the end of the three-month subsidized coverage and you could add him/her as a dependent in the middle of your Coverage Period (provided you notify AFTRA H&R in writing within 30 days of the termination of the COBRA coverage and pay the Health Plan premium). Therefore, in this example, you and/or a dependent no longer need to remain on the former employer's COBRA coverage until the beginning of your next Coverage Period.

Reminder about notice and documentation requirements:

If you or a dependent experiences a change in employment status that affects your health coverage, call Participant Services at 1-800-562-4690. You may enroll yourself and/or your dependent in the AFTRA Health Plan starting the day after the other coverage ends. But to take advantage of this right, qualified performers must inform the Eligibility Department in the AFTRA H&R New York office in writing and provide a certificate or letter of creditable coverage from the other health plan within 30 calendar days of the change in employment status.

Senior Citizen Health Program Changes and Clarifications Announced

The AFTRA Health Fund's Board of Trustees recently changed certain rules governing the administration of the Senior Citizen Health Program (the "Senior Program") and clarified others. The health benefits available under the Program remain the same — the changes and clarifications relate to qualification and enrollment issues.

Qualified Performers with AFTRA-Covered Earnings of at Least \$10,000 Will Qualify for the Active Health Plan Only, Not the Senior Program

Currently, participants enrolled in the Senior Program who meet the minimum AFTRA-covered earnings requirement for **Individual level coverage** in the active Health Plan¹ may remain in the Senior Program or enroll in the active Health Plan. **On and after January 1, 2011, participants who fall into this category will no longer have the option of remaining in the Senior Program, since they had sufficient earnings to qualify for active Health Plan coverage.** If they wish to retain coverage through the AFTRA Health Fund, they must enroll in the active Health Plan and pay the required quarterly premiums. Participants will be sent notification prior to the termination of their Senior Program coverage and will be given the opportunity to enroll in the active Health Plan. For participants who decide to enroll in the active Plan, the active Plan will be their primary coverage and Medicare their secondary coverage.

Currently, participants in the Senior Program who meet the minimum AFTRA-covered earnings requirement for **Family level coverage** in the active Health Plan² cannot remain in the Senior Program. **This rule remains the same.** Once they qualify for Family coverage under the active Health Plan, they can enroll in the active Plan by paying the required quarterly premium, or they will lose coverage under the AFTRA Health Fund because the Senior Program is no longer available to them. For participants who enroll in the active Health Plan, the active Plan pays as their primary coverage and Medicare pays as their secondary coverage.

Please note that, effective January 1, 2011, participants who are enrolled in the Senior Program at the Family level and cover one or more dependents and then qualify for coverage under the active Health Plan at the Individual level will be allowed to enroll in the active Health Plan at the Family level of coverage. They will not be subject to Individual level premium buy-up rates to cover their dependents.

Also note that Senior Program participants who enroll in the active Health Plan will be able to later reenroll in the Senior Program if they have four consecutive quarters with less than \$10,000 in total AFTRA-covered earnings.

Finally, it is important to understand that at no time will participants in the Senior Program lose access to coverage under the AFTRA Health Fund due to this change unless they decide not to enroll in the active Health Plan when that is the only option available to them based upon their AFTRA-covered earnings.

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¹ As of the printing of the March 2010 *Benefits Update*, performers with covered earnings of at least \$10,000 but less than \$30,000 in four consecutive calendar quarters or less qualify for active Health Plan coverage at the Individual level. Visit www.aftrahr.com for current premiums and buy-up rates.

² As of the printing of the March 2010 *Benefits Update*, performers with covered earnings of \$30,000 or more in four consecutive calendar quarters or less qualify for active Health Plan coverage at the Family level. Visit www.aftrahr.com for current premiums.

The coverage options available to Senior Program participants with AFTRA-covered earnings on and after January 1, 2011 are illustrated in the following chart:

If you are enrolled in the Senior Program with coverage at the:	With AFTRA-Covered Earnings of less than \$10,000: <i>No Change in Senior Program</i>	With AFTRA-Covered Earnings of at least \$10,000 but less than \$30,000: <i>Change in Senior Program Effective January 1, 2011</i>	With AFTRA-Covered Earnings of more than \$30,000: <i>No Change in Senior Program</i>
Individual Level without dependent(s)	You maintain your current coverage in the Senior Program at the retiree only premium rate.	You may enroll in the active Health Plan at the participant only premium rate.	You may enroll in the active Health Plan at the participant only premium rate.
Individual Level with dependent(s)	You maintain your current coverage in the Senior Program at the retiree only and buy-up rates for 1 or 2+ dependents.	You may enroll in the active Health Plan at the participant only and buy-up rates for 1 or 2+ dependents.	You may enroll in the active Health Plan at the participant and spouse/ domestic partner, participant and children, or full family premium rates, whichever apply.
Family Level without dependent(s)	You maintain your current coverage in the Senior Program at the retiree only premium rate.	You may enroll in the active Health Plan at the participant only premium rate.	You may enroll in the active Health Plan at the participant only premium rate.
Family Level with dependent(s)	You maintain your current coverage in the Senior Program at the retiree and spouse/domestic partner, retiree and children, or full family premium rates, whichever apply.	You may enroll in the active Health Plan at the participant and spouse/domestic partner, participant and children, or full family premium rates, whichever apply.	You may enroll in the active Health Plan at the participant and spouse/ domestic partner, participant and children, or full family premium rates, whichever apply.

Coverage Period to Coincide With Calendar Year

Currently, the 12-month Coverage Period for a new participant in the Senior Program begins on the first day of the quarter following his or her initial enrollment. For example, if a qualified individual enrolled in the Senior Program on June 1, 2009, his or her annual Coverage Period going forward was fixed as July 1–June 30. This procedure is not going to change for new enrollees in the Senior Program, or for former participants who are seeking to reenroll in the Senior Program after they no longer qualify for the active Health Plan following a mandatory transition as described on page 3.

However, effective January 1, 2011, all participants enrolled in the Senior Program will have their respective annual Coverage Periods

changed to a calendar year cycle of January 1–December 31. This change will align the Senior Program’s annual coverage election opportunities and Coverage Periods with those of Medicare. No Senior Program health benefits are affected by this change.

Using the July 1 through June 30 enrollment period from the prior example, this means that on January 1, 2011, the Coverage Period of the participant who enrolled in the Senior Program on June 1, 2009 will be changed from July 1–June 30 to January 1–December 31. In other words, if a qualified individual enrolls on June 1, 2011, coverage will begin on that date and at the beginning of the next calendar year his or her Coverage Period going forward will be fixed as of January 1–December 31.

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The calendar year-based Coverage Period will affect the timing of when former participants may reenroll in the Program if they experience a break in coverage. Such changes may only be made at the beginning of a Coverage Period, which will be January 1 beginning next year. At the start of a Coverage Period, former participants in the Senior Program who still qualify may reenroll, regardless of the reason they terminated their enrollment.

Dependent Enrollment Rules Clarified

The Trustees clarified rules governing the enrollment of dependents as follows:

- First time participants in the Senior Program who wish to cover dependents must make that election at the time of their initial enrollment.
- Senior Program participants are not permitted to add dependents after their initial enrollment unless there is an acceptable qualifying event
- Former Senior Program participants who transitioned to the active Health Plan, then no longer qualify for the active Plan and re-qualify for the Senior Program, **may only reenroll dependents they were covering under the Senior Program before their transition to the active Health Plan.** They may not enroll a new dependent unless there has been an acceptable qualifying event.
- Finally, Senior Program participants must notify the Eligibility Department in the AFTRA H&R New York office in writing in order to continue coverage in the Program for enrolled dependents who are turning age 65.

If you have any questions about these changes or clarifications to the Senior Program and how they affect you, please contact Participant Services at 1-800-562-4690.

In Memoriam

J. Nicholas Counter III, former AFTRA H&R Trustee

J. Nicholas (Nick) Counter III, a longtime Trustee of the AFTRA Health & Retirement Funds and a major figure in the motion picture and television industries, died on November 6, 2009 after taking ill at his home in Ventura County California. He was 69.

During his 27 years as president of the Alliance of Motion Picture and Television Producers (AMPTP), Mr. Counter successfully negotiated more than 300 labor contracts. The New York Times reported that he united “the Alliance’s diverse film and television companies into a cohesive bargaining unit,” and that he “was particularly proud of his service as a trustee of 14 union health and pension funds, and of the Motion Picture and Television Fund.” Mr. Counter retired from both the AMPTP and the AFTRA H&R Board of Trustees in March 2009.

In a statement of remembrance, AFTRA National President Roberta Reardon and AFTRA National Executive Director Kim Roberts Hedgpeth, who is also an AFTRA H&R Trustee, remembered Mr. Counter for his many years of “principled leadership” as president of the AMPTP. “Nick balanced his responsibility to his constituents with an approach to organized labor that was always respectful, fair-minded and honest.”

Mr. Counter is survived by his wife, Jackie; a son, Nicholas; a daughter, Samantha Kurtzman-Counter and son-in law, Alex Kurtzman; and a grandson, Jack.

Conversion Plan to Terminate December 31, 2010

The Conversion Plan, which currently provides limited medical coverage to fewer than 100 participants, was closed to new enrollments effective February 3, 2010 and will no longer be available to current enrollees after December 31, 2010. In addition, the Conversion Plan premiums will increase effective April 1, 2010. Individuals currently enrolled in the Conversion Plan will receive advance notification of the increase in premiums.

The Conversion Plan previously was available only to those participants who were no longer eligible for active AFTRA Health Plan coverage, had exhausted their COBRA benefits (if they were eligible for COBRA) and were not entitled to, qualified for, or enrolled in any other health care coverage, such as other group health plans, Medicare or Medicaid. The benefits offered through the Conversion Plan were not as comprehensive as those offered under the active Health Plan. (The details of this limited Plan are explained on page 29 in the 2005 Health Plan SPD.)

Due to the administrative costs of keeping this Plan open for so few participants, the Trustees decided to discontinue the Conversion Plan. To provide sufficient time for those who are currently enrolled in the Plan to transition to other health care coverage, the Conversion Plan will be available through the end of the calendar year 2010, subject to timely payment of premiums.

If you have any questions about the Conversion Plan, please contact Participant Services at 1-800-562-4690.

Update: Federal COBRA Premium Subsidy Extended

We previously advised you of a 65% reduction in COBRA premiums under the American Recovery and Reinvestment Act of 2009 (ARRA) for eligible individuals who suffered an involuntary termination of employment and a loss of health care coverage between September 1, 2008 and December 31, 2009. If you elected to continue AFTRA Health Plan coverage through COBRA, the maximum period of the subsidy was nine months — through November 2009 if you started claiming the subsidy as of March 2009.

The Department of Defense Appropriations Act 2010, signed by President Obama on December 19, 2009, has extended the original nine-month maximum duration of the subsidy to 15 months, and the length of the eligibility period for this subsidy from December 31, 2009 through February 28, 2010. The Act further changed the requirements such that COBRA-eligible individuals need only have an involuntary termination of employment by February 28, 2010 in order to be eligible for the subsidy (coverage does not have to have terminated by that date). In addition, individuals who chose not to continue their COBRA coverage under the AFTRA Plan after their eligibility for the subsidy expired in 2009 may have an opportunity to retroactively reinstate their COBRA coverage.

You can find a Summary of Premium Reduction Provisions under ARRA on our Web site at www.aftrahr.com. Remember that you must not be eligible for any other group health plan coverage, or coverage under Medicare or Medicaid, in order to be eligible for the subsidy. If you have any questions about the COBRA premium subsidy extension, call Participant services at 1-800-562-4690.

Breaking News

On March 2, 2010, President Obama signed the Temporary Extension Act of 2010 which extends the subsidy eligibility period discussed in this article by one month — through March 31, 2010. Refer to www.aftrahr.com, “Current News” for more detailed information.

Change of address? Adding a dependent? Visit www.aftrahr.com for most recent versions of forms

A new Performer Address Change Form and a new version of the AFTRA Health Plan Enrollment Form were recently published, and other forms are in the process of being revised. To ensure that you're using the correct Health and Retirement Plan Forms, always visit www.aftrahr.com to download the most current versions. Simply click "Forms" on the top menu from any page at www.aftrahr.com to access our Health forms and Retirement forms pages.

Do You Have a Nurse's Phone Number? Now You Do!

As a participant in the AFTRA Health Plan, CIGNA's 24-hour Nurseline, 1-800-768-4695, is your direct line to a Registered Nurse, 24 hours a day, 7 days a week, 365 days a year.

At midnight on a Saturday when you need help deciding if it is time to pack the family up and head to the emergency room, call Nurseline. The nurse will ask you a few questions about your symptoms and situation and then direct you to care that will make you more comfortable. If you need to go to the doctor or hospital, the nurse can help you access the appropriate services. If your condition doesn't require immediate care the nurse will give you self-care tips to make you more comfortable until you see the doctor.

Speak to a CIGNA healthcare professional when you need one, any time, day or night. Please note that the Nurse-line service is a courtesy service — there is no requirement that you call Nurseline. Refer to your AFTRA Health Plan SPD and Benefits Updates and notices for information about services that require preauthorization or preapproval.

IMPORTANT CONTACT INFORMATION

CIGNA HealthCare www.cignasharedadministration.com	1-800-768-4695
CIGNA's 24-hour Nurseline	1-800-768-4695
AFTRA H&R Participant Services	1-800-562-4690
AFTRA H&R Web Site	www.aftrahr.com

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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 with the Health Plan SPD booklet. While every effort has been made to make this Summary of Material Modifications (SMM) as complete and as accurate as possible, it does not restate the existing terms and provisions of the Plan other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPD (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 SPD 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 Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or eligibility 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).