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A Message from the Board of Trustees

Dear Performer,

We are pleased to provide you with this booklet describing the comprehensive benefits available to you and your family through the AFTRA Health Fund. In this booklet you will find information on eligibility for benefits, covered services, how to file a claim and your rights under the AFTRA Health Plans. Please read this booklet carefully and keep it available for quick reference. As changes are made, we will provide you with written updates. Please keep these with your booklet so you will always have current information about your benefits.

This booklet, called the "summary plan description" summarizes the key features of the Plan. It also constitutes the AFTRA Health Fund's plan document. All words written in bold face throughout the text indicate a defined term that can be found in the "Glossary of Terms" beginning on page 7. Complete details of the Plan are also contained in the other official Plan documents, including the Agreement and Declaration of Trust (the "Trust Agreement") of the AFTRA Health Fund, which legally govern the operation of the Plan. All official Plan documents are available for your inspection at the Fund office during normal business hours, and all statements made in this booklet are subject to the provisions and terms of those documents. In case of a conflict or inconsistency between the official Plan documents and this booklet, the official documents will govern in all cases.

The Board of Trustees has made every effort to make the Health Fund responsive to your needs. Our ability to maintain a high level of benefits

depends on your cooperation. By complying with the rules and following the instructions contained in this booklet, you can help the Health Fund deliver the best benefits possible in the most efficient and cost-effective manner.

The Trustees may modify or eliminate (without prior notice to you) any benefits and the eligibility requirements for benefits described in this booklet. The Trustees have the authority and discretion to interpret the plan of benefits and make final determinations regarding them. No benefits are guaranteed.

There may be times when the booklet does not answer your specific questions about your health benefits. If that happens, call the Fund office at 1-800-562-4690.

Sincerely,
THE BOARD OF TRUSTEES
AFTRA HEALTH FUND



AFTRA Health Fund Board of Trustees

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About the AFTRA Health Fund

The AFTRA Health Fund began providing health and related benefits in 1956 to performers and their families. It was the first such fund for any of the performing arts and resulted from collective bargaining agreements between the American Federation of Television and Radio Artists and industry contributing employers.

The AFTRA Health Fund is known as a "jointly-trusted" fund. It is maintained under the direction of a Board of Trustees made up of equal numbers of Union and contributing employer representatives. The Board of Trustees is responsible for setting the benefits and policies of the Fund, establishing the rules and regulations necessary for carrying out those benefits and policies and generally overseeing the operations of the Fund. The Health Fund staff, headed by the Executive Director, is responsible for the day-to-day operations of the Fund. The Board of Trustees and the Fund staff are assisted in their duties by professional consultants and advisors who provide necessary expertise in their respective areas. These professionals include Fund counsel, an investment consultant and investment managers, health benefit experts, actuaries and certified public accountants.

The Health Fund maintains two offices. The main office is located in New York City and a satellite office is located in Los Angeles.

The AFTRA Health Fund is not a Union subsidiary, agency or department. It is an independent organization. No Union dues are used to pay for benefits or operational expenses except that regular contributions are made by the Union to purchase health coverage for its employees. Health Fund benefits for participants

and their **dependents** are funded by employer contributions and, in many cases, participant contributions. The rate of employer contributions is set by the collective bargaining agreement that covers the particular performance. In some cases, the collective bargaining agreement expresses the contribution as a single rate applicable to both the AFTRA Health Fund and the AFTRA Retirement Fund, and the decision on allocating between the two Funds is delegated to the Trustees.

AVISO DE ASISTENCIA CON TRADUCCIONES EN LENGUAJES APLICABLES

Este folleto contiene un resumen en inglés de los derechos y beneficios de su Plan bajo AFTRA Health Fund. Si tiene alguna dificultad en entender cualquier parte de este folleto póngase en contacto con la oficina de la AFTRA Health Fund a la dirección 261 Madison Avenue, New York, NY 10016 o 5757 Wilshire Boulevard, Los Angeles, CA 90036. Las horas de oficina son de 9 A.M. a 7 P.M. (E.S.T.) de lunes a viernes. También pueden llamar a la oficina al teléfono (212) 499-4800 (NY) o (800) 367-7966 (CA).



Information to be Provided to the Fund Office

It is your responsibility to make sure that you have an up-to-date AFTRA Health Fund enrollment card on file. This card provides us with your current mailing address, a list of your **dependents** and the beneficiaries you have chosen.

You may obtain an enrollment card from any AFTRA Health Fund or AFTRA Local office. It is important that all of your **dependents** are accurately listed on the enrollment card. Failure to file an enrollment card or to keep it up-to-date may cause delays in the processing of your claims. In some cases, it could even prevent you from exercising certain rights.

CHANGES TO YOUR DEPENDENTS

If you gain or lose a **dependent** by reason of marriage, divorce, birth, adoption, death or otherwise, you must advise the New York Fund office promptly. It is particularly important that you contact the Fund office as soon as possible if you marry or divorce. It is also important to inform the Fund office if a child is over age 21 and loses full-time student status. In the event of divorce or student status change, COBRA rights (the right to continue Health Plan coverage for a period by making periodic payments) may be applicable. All changes must be in writing and supported by appropriate documentation (birth certificate, marriage certificate, etc.). Failure to notify the Fund office of a qualifying event may result in a delay in processing **dependent** claims. It could also result in the loss of certain benefits.

A CHANGE IN MAILING ADDRESS

Please notify the New York Fund office in writing of any change in your address. Our records need to be up-to-date so that we may contact you. Please remember this Fund and the Union are separate entities. Change of address must be submitted to both.

A CHANGE IN A PREVIOUSLY NAMED BENEFICIARY DESIGNATION

If you wish to change the beneficiary of your Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance, contact any Fund office or AFTRA Local for a new enrollment card. Send the completed enrollment card to the New York Fund office.

ELIGIBILITY FOR OTHER COVERAGE

If you or your **dependents** are covered under any other group health insurance plans, you should inform either the New York or California Fund office of that fact, providing in writing the names of the plans, the policy numbers, the names of the carriers, effective dates and the addresses of their claims paying offices. This information is required so that benefits can be properly coordinated among the plans.

PROVIDING INFORMATION—YOUR RESPONSIBILITY

There are times that you will be required to furnish information or proof necessary to determine your or a **dependent's** right to an AFTRA Health Plan benefit. When inaccurate information and/or proof is provided, this

ultimately can result in the improper use of Plan assets, which adversely affects the ability of the AFTRA Health Fund to provide the highest possible level of benefits.

Accordingly, if you or a **dependent** fails to submit the requested information or proof, makes a false statement, or furnishes fraudulent or incorrect information, your or your **dependent's** benefits under the AFTRA Health Plan (and participation in the AFTRA Health Plan—even if you or your **dependent** would otherwise meet the eligibility requirements) may be denied, suspended or discontinued at any time and for any length of time (including permanently) by duly authorized representatives of the Fund office, the Trustees or any of their designees in their sole and absolute discretion.

Of course, if the AFTRA Health Fund makes payment for benefits that are in excess of expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or fraud or for any other reason (including for example, your failure to notify the Fund office regarding a change in family status), the AFTRA Health Fund reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.



Glossary of Terms

To help you understand how the AFTRA Health Plans work, it's important for you to know the meaning of the terms defined here. When they appear in the text they are highlighted to remind you they are defined terms.

Coinsurance is the portion you pay for most **covered expenses**, in addition to the **deductible** and any copayment. For example, if the plan pays 80% of covered expenses, the 20% you have to pay is your **coinsurance**.

Contributing employer is the AFTRA Health and Retirement Funds and any employer who is required and permitted under the Trust Agreement to contribute to the AFTRA Health Fund under the terms of a collective bargaining agreement with AFTRA or a written agreement with the Fund.

Copayment is the portion you pay before you pay your **deductible** and **coinsurance**.

Covered earnings are those payments made to you by a **contributing employer** for work under a collective bargaining agreement that provides for contributions to the AFTRA Health Fund.

Covered expenses are the costs of services or supplies for which the Fund will pay all or a portion. The description of each program will set forth those expenses it covers.

Covered roster artist is an individual (whether or not part of a group) bound by an exclusive recording agreement with the record label (signed to the sideletter agreement) as of

the last day of the immediately preceding semi-annual Schedule C period.

Custodial care means all services and supplies, including room and board, provided primarily to assist a covered individual in the activities of daily living, regardless of the practitioner or provider by whom they are prescribed, recommended or performed.

Deductible is that initial part of each year's **covered expenses** under a particular program for which you are responsible and for which you will not be reimbursed by the Fund.

Dependents are your:

- a. legal spouse, who for purposes of this definition includes a same-sex spouse to whom you are legally married in the state of Massachusetts (for tax liability, see the definition of **domestic partner** below);
- b. unmarried children to the end of the calendar year in which they reach the age of 21;
- c. unmarried children who are over age 21 and attending school or college as full-time students. Your children will continue to be eligible until they are no longer full-time students or until the end of the calendar year in which they reach the age of 23, whichever is earlier; and
- d. unmarried children of any age who would otherwise lose coverage because of the Plans' age limitations but continue to be dependent on you due to an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or which lasts (or can be expected to last) for a continuous period of at least 12 months. You must provide proof of your child's handicap to the Fund office in order for coverage to continue.

For the purpose of this definition, children must be unmarried children who are chiefly dependent upon you for support and maintenance. They may include your biological children, legally adopted children (including a child placed for adoption during the waiting period before the adoption becomes final), stepchildren (including stepchildren of same-sex spouses married in Massachusetts) and foster children. You may be required to provide proof of dependency in a form satisfactory to the Plan.

Children may also include your unmarried child who meets the requirements of b, c or d above, but is not chiefly dependent on you for support or maintenance if the child is recognized under a qualified medical child support order (QMCSO) as having a right to enrollment under the Plan. Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing QMCSOs from the Plan Administrator.

Domestic partner is:

A person of the same sex who has an exclusive relationship with an unmarried covered **performer** over the age of 18 and who:

- a. is at least 18 years old;
- b. is unmarried;
- c. has shared a principal residence with the covered **performer** for at least six months prior to enrollment and is committed to do so indefinitely;
- d. shares responsibility with the covered **performer** for each other's living expenses;
- e. is not related to the other;
- f. is the sole **domestic partner** of the other and neither has any other **domestic partner**;
- g. does not have a spouse or other domestic partner in the last six months who is still living; and

- h. is not entitled to health insurance coverage through an employer and has not declined such coverage.

With the exception of the Glossary of Terms and the sections on **COBRA**, wherever the terms **dependent** or **dependents** are used, they will be understood to include **domestic partners**.

After the requirements for a **domestic partner** relationship are met, coverage for a **domestic partner** will begin on the first day of the month following receipt by the Fund office of fully executed and notarized documents, including the "Declaration of Same-Sex Domestic Partnership for Enrollment or Eligibility", birth certificates, the "Registration of Domestic Partnership" and the "Affidavit of Dependency for Tax Purposes" if your **domestic partner** qualifies as a **dependent** under the IRS code, section 152. However, if your **domestic partner** does not qualify as a **dependent** under the IRS code, any federal or state taxes due as indicated on the invoice you will receive from the Fund office must be paid at the time you pay the premium for coverage to become effective. For additional information, contact the Fund office.

Experimental procedure means:

- a. any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is under investigation and the use of which is limited to research;
- b. techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
- c. procedures which are not proven in an objective way to have therapeutic value or benefit; and

d. any procedure or treatment whose effectiveness is medically questionable.

Family qualifying year refers to eligibility for coverage under the Senior Citizen or Early Retiree Program. A **Qualifying year** is a year during which an individual had **covered earnings** at least equal to the greater of \$2,000 or the amount required as of the last day of such Base Year to qualify for a year of eligibility under the AFTRA Family Health Plan.

Hospital is an institution that:

- a. is primarily engaged in providing, by or under the supervision of **physicians**, inpatient diagnostic, surgical and therapeutic services for the diagnosis, treatment and rehabilitation of injured, disabled or sick persons;
- b. maintains clinical records on all patients;
- c. has bylaws in effect with respect to its staff of **physicians**;
- d. has a requirement that every patient be under the care of a **physician**;
- e. provides 24-hour nursing service rendered or supervised by a registered nurse;
- f. has in effect a **hospital** utilization review plan;
- g. is licensed pursuant to any state or agency of the state responsible for licensing **hospitals**; and
- h. has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals and Healthcare Organizations.

The term **hospital** does not include any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility or facility for care of the aged. Nor does it include any facility when used for the treatment of alcohol or chemical dependency, except as may be authorized by the program administrator, ValueOptions.

Illness means a sickness, disorder or disease and includes pregnancy.

Injury means accidental bodily **injury** which is sustained directly and which is independent of all other causes.

Medical provider is a licensed or board certified practitioner of the healing arts, including but not limited to, a **physician**, nurse, physiotherapist, speech therapist, chiropractor, acupuncturist, mid-wife, podiatrist or optometrist, acting within the scope of such license or certification and performing services that are **medically necessary**.

Medically necessary describes any service, supply, treatment or **hospital** confinement, or part of a **hospital** confinement which is:

- a. effective and essential to the treatment of the **injury** or **illness** for which it is prescribed or performed;
- b. based on valid medical need according to accepted standards of medical practice and meets generally accepted standards of medical practice;
- c. an appropriate level of care provided in the most appropriate setting, based on the diagnosis and condition, and that could not have been omitted without an adverse effect on the person's condition or quality of medical care;
- d. not primarily for the comfort, convenience or administrative ease of the licensed doctor or other health care provider, or for you and/or your covered **dependents**; and
- e. ordered by a **physician** (except where the treatment is rendered by a medical provider and is generally recognized as not requiring a **physician's** order).

Mental health disorders are those conditions categorized as mental disorders in the

most recent edition of the International Classification of Diseases, whether or not involving a biological, chemical or other type of disorder which might not otherwise be considered mental or nervous. Conditions for which the primary diagnosis and treatment is for alcohol or chemical dependency are not included in **mental health disorders** but are covered separately.

Network Hospital is a **Hospital** participating in a preferred provider network, in which the Covered Individual is enrolled by reason of his or her status under the Plan.

Network Provider is a medical provider, laboratory or radiology facility participating in a preferred provider network, in which the Covered Individual is enrolled by reason of his or her status under the Plan.

Non-Network Hospital is a **Hospital** that does not participate in a preferred provider network in which the Covered Individual is enrolled by reason of his or her status under the Plan.

Non-Network Provider is a **medical provider**, laboratory or radiology facility not participating in a preferred provider network, in which the Covered Individual is enrolled by reason of his or her status under the Plan.

Non-Participating Dentist is a dentist that is not within the DentalGuard Preferred provider network offered by The Guardian Life Insurance Company.

Non-Participating Pharmacy is a pharmacy that is not participating in a preferred provider network of pharmacies maintained by Medco Health Solutions.

Participating Dentist is a dentist that is within the DentalGuard Preferred provider network offered by The Guardian Life Insurance Company.

Participating Pharmacy is a pharmacy participating in a preferred provider network of pharmacies maintained by Medco Health Solutions.

Performer is an employee on the basis of whose services a **contributing employer** is obligated to contribute to the AFTRA Health and Retirement Funds pursuant to a collective bargaining agreement by and between the employer and AFTRA.

Physician means a duly licensed doctor of medicine authorized to perform medical or surgical service within the lawful scope of his or her practice.

Prescription drugs are drugs that are obtainable only by a **physician's** or dentist's written prescription, dispensed by a licensed pharmacist, and approved for their intended use by the United States Food and Drug Administration.

Qualifying year refers to eligibility for coverage under the Senior Citizen or Early Retiree Program. It is a Base Year during which an individual had **covered earnings** equal to the greater of:

- the amount required as of the last day of such Base Year to qualify for a year of eligibility under the AFTRA Individual Health Plan;
- \$2,000

Related employee is an employee (other than a temporary employee) of AFTRA or the AFTRA Health and Retirement Funds.

Scheduled allowance is the maximum dollar amount of a **medical provider's** fee for a particular service in a particular geographic area, which will be taken into account (prior to application of any **deductible, co-insurance** or maximum) in determining benefits under the Plan. In the case of a fee billed by a **Network Provider**, the **scheduled allowance** shall be deemed equal to the discount fee. For Major Medical benefits, in the case of a fee billed by a **Non-Network Provider**, the **scheduled allowance** will be based on the highest amount charged for the specific service by 70% of **medical providers** in the geographic area.

Staff Performer is a performer who is a full-time employee of a radio or television station or network.



Health Plans



The AFTRA Health Plans: Individual and Family

The AFTRA Health Fund provides two health plans: the Individual Health Plan and the Family Health Plan. Both Plans offer Hospital, Major Medical, Prescription Drug, Mental Health and Chemical Dependency, Wellness and Dental Programs. In addition, both Plans will provide you, but not your **dependents**, with life insurance, accidental death and dismemberment (AD&D) insurance and loss of voice coverage.

NOTE: For purposes of ERISA, the Individual Health Plan and the Family Health Plan are part of a single plan and where there is a reference to the Plan, it is intended to be a reference to both.

THE INDIVIDUAL HEALTH PLAN provides you with health care coverage (if you pay the premium on a timely basis) but does not cover your **dependents**. However, once you qualify for coverage under this Plan, in most cases, you may purchase coverage for your **dependents** under the Family Health Plan. For information on purchasing coverage under the Individual Health Plan refer to page 16.

THE FAMILY HEALTH PLAN provides health care coverage for you and your **dependents** (if you pay the premium on a timely basis).

The only difference between the Individual and the Family Health Plans is that the Individual Health Plan provides coverage only for the participant while the Family Health Plan provides coverage for the participant's **dependents** as well.

The Plan for which you qualify is determined by your AFTRA **covered earnings** as described in "The Minimum Earnings Requirements" section that follows.



Eligibility Requirements

You qualify for health care coverage under the Individual Health Plan or the Family Health Plan if you meet one of the following minimum **covered earnings** requirements and you become enrolled in coverage by paying any required premium on a timely basis.

THE MINIMUM EARNINGS REQUIREMENTS

THE INDIVIDUAL HEALTH PLAN

You must have **covered earnings** of at least \$10,000 but less than \$30,000 in four consecutive calendar quarters or less.

THE FAMILY HEALTH PLAN

You must have **covered earnings** of at least \$30,000 in four consecutive calendar quarters or less.

WHEN ELIGIBILITY BEGINS

Generally, you will become eligible for the AFTRA Health Plan on the first day of the second calendar quarter following the quarter in which you meet the minimum **covered earnings** requirements, as shown in the following chart. Remember, for coverage to begin, you must enroll by paying any required premium on a timely basis. To enroll your spouse or dependents, you must be enrolled in the Plan.

SCHEDULE OF EFFECTIVE DATES FOR COVERAGE

End of Quarter in Which The Minimum Covered Earnings Requirements Are Met	Your Eligibility Begins on the Next
September 30	January 1
December 31	April 1
March 31	July 1
June 30	October 1

SPECIAL RULE FOR STAFF AND RELATED EMPLOYEES

A different rule than the **covered earnings** and effective dates for coverage requirements described above applies if you are eligible for coverage because you:

- a. are classified as a full time employee (**Staff Performer**) of a radio or TV station or network that is a **contributing employer** and have **covered earnings** in that capacity; or
- b. are a **Related Employee**, that is, you are either classified as an employee (other than a temporary employee) of the AFTRA Health and Retirement Funds or have **covered earnings** as an employee (other than a temporary employee) of AFTRA or its locals. A person that would otherwise be a Related Employee is not eligible to participate in the plan if he or she is designated by his or her employer as:
 - a. a temporary employee; or
 - b. an independent contractor and not as an employee at the time of any determination, even if he or she is later retroactively reclassified as a common-law or other type of employee pursuant to applicable law or otherwise.

In these cases, eligibility will begin on the first of the month following your completion of 30 days of employment with that **contributing employer**. If your scheduled annual **covered earnings** are at least \$10,000 and less than \$30,000, you will qualify for Individual Plan coverage. If your scheduled annual **covered earnings** are \$30,000 or more, you will qualify for Family Plan coverage.

In addition, a **Staff Performer** moving into the AFTRA Health Plans as part of a unit from a **contributing employer's** group health plan will become eligible for coverage immediately (with no 30-day waiting period) upon termination of that employer's coverage, if:

- a. the **Performer** has an annual compensation rate of at least \$10,000 in **covered earnings** and was covered under the employer's plan for at least 30 days immediately preceding the transfer; and
- b. the transfer was made according to the terms of a collective bargaining agreement with AFTRA.

SPECIAL RULE FOR COVERED ROSTER ARTISTS

There is a special eligibility rule for certain royalty artists signed to certain record labels that have signed the **Covered Roster Artists** sideletter attached to the 2002 AFTRA Code of Fair Practice for Sound Recordings (the "2002 AFTRA Sound Code").

The **Covered Roster Artists** sideletter to the 2002 AFTRA Sound Code provides that, effective January 1, 2004, the signatory record label is required to make Special Payment to the Health

Fund on your behalf to provide one year of Individual Health Plan coverage if:

- you are a **covered roster artist** bound by an exclusive recording agreement with the record label; and
- your royalty earnings from that label over the current and immediately preceding six-month reporting period for the Funds are insufficient for you to qualify for Individual Plan coverage.

If you meet these two qualifications, and the record label makes the Special Payment as required, you will be eligible to enroll in the Individual Health Plan. If you choose to enroll, you will be required to pay the Individual Health Plan premium. You may also "buy up" to Family Health Plan coverage under the normal "buy-up" rules. The Special Payment will provide one year of coverage beginning as described on page 16.

A Special Payment is also required to be made under the **Covered Roster Artists** sideletter by the signatory record label at its next periodic contribution date on behalf of each newly signed individual artist who completes a royalty agreement with the label.

As long as you remain a **covered roster artist** and your record label continues to make the Special Payment (and you continue to pay the required participant premium), you will continue to be covered by the Health Plan, even if your earnings are insufficient to qualify under the general eligibility rule. Of course, if you otherwise have sufficient AFTRA-covered earnings to qualify for Individual or Family Plan coverage, you will be eligible to participate in either the Individual or Family Health Plan (as applicable) subject to the general requirements for partici-

pation (see page 14). Indeed, no Special Payment is required to be made by a label on behalf of roster artists who have sufficient earnings in the current or immediately preceding reporting periods from that label to qualify for the Individual Health Plan.

Eligibility under this special rule will begin as follows:

Your eligibility begins:	If the label makes the annual lump sum Special Payment in the quarter ending:
January 1	September 30 of the prior year
April 1	December 31 of the prior year
July 1	March 31
October 1	June 30

If you have questions about when the Special Payments are required to be made, contact the Sound Recording Department of AFTRA. For questions about coverage under the Plans, please contact the Fund office.

WHEN COVERAGE BEGINS

INDIVIDUAL PLAN

In order to be a participant in, and receive coverage under, the Individual Plan, you will need to pay a quarterly premium of \$300 (unless you are covered under the Senior Citizen Program in which case a different premium applies; see page 61). Coverage does not begin when your eligibility begins. It begins when the required premium is paid in a timely manner. This premium must be paid to the Fund in advance of each quarter.

The Fund office sends invoices on a quarterly basis. The invoice will indicate a due date. Your premium payment is due by that date. To remain covered, quarterly payments are due on the following dates:

Coverage Period	Premium Due Date
July 1 - September 30	June 15
October 1 - December 31	September 15
January 1 - March 31	December 15
April 1 - June 30	March 15

PURCHASING COVERAGE FOR YOUR DEPENDENTS

If you do not earn enough to qualify for Family Health Plan coverage, you may purchase coverage for your **dependents** when you become eligible for the Individual Health Plan. Payments are quarterly and must be made at least 15 days prior to the start of the quarter for which coverage is being purchased.

The quarterly premium for this “buy-up” is set by the Trustees and may change from time to time. You can find the current cost of the “buy-up” by calling the Fund office in New York.

If you decide to buy up to Family Plan coverage, you will still need to pay the Individual Plan premium plus the Family Plan “buy-up” premium, but you will not need to pay the Family Plan dependent premium described in the following sections. (See “When a Dependent’s Coverage Begins” for a description of what happens when you decline coverage.)

FAMILY PLAN

If you qualify for Family Health Plan coverage, you will need to pay a quarterly premium for yourself, your spouse and/or **dependents** to become (or remain) enrolled in the Family Health Plan, as follows:

- Participant only—\$300 per quarter;
- Participant and spouse—\$525 per quarter;
- Participant with children—\$525 per quarter, regardless of the number of **dependent** children you cover;
- Participant with spouse and dependent children—\$575 per quarter, regardless of the number of **dependent** children you cover.

(The Family Plan Premium also applies to a retiree, a spouse and **dependent(s)** of retirees covered under the Senior Citizen Family Plan.) As with the Individual Plan, in general, each quarterly payment is due on the 15th of the month preceding the first day of each calendar quarter. Please note that it is your responsibility to make your payment on time even if you don't receive an invoice from the Fund office. If you do not receive an invoice at least two weeks before the due date, call the Fund office and ask for an invoice.

WHEN A DEPENDENT'S COVERAGE BEGINS

Coverage for your **dependents** (which includes a **domestic partner**) under the Family Health Plan will begin, provided the required premium payment is paid on a timely basis, on the later of:

- the day your Family Health Plan coverage becomes effective;
- the day a person becomes a **dependent** (if you acquire a **dependent**, inform the New

York Fund office within 30 days or you will lose the opportunity to enroll your dependent until the beginning of your next eligibility period);

- any anniversary of the day your Family Health Plan coverage first became effective, you previously had chosen not to cover your **dependent** and then elect to do so; or
- the day your **dependent** loses coverage under another plan provided you notify the Fund office within 30 days of the loss.

Remember, coverage does not begin when your eligibility begins. It begins when the required premium is paid in a timely manner.

IMPORTANT

If you begin to pay the required premium but then fail to make a quarterly premium payment during an eligibility period, you cannot enroll again until at least one year following the end of that eligibility period. If you do not pay the premium at the beginning of your eligibility period, you cannot enroll until the next time you qualify for Plan benefits.

You may elect to cover all, some, or none of your **dependents**, but the election choices you make at the beginning of your eligibility year cannot be changed for the duration of that year. If you elect coverage for your **dependents** but then stop paying the required premium before the end of your eligibility year, coverage for your **dependents** will cease for the remainder of that year and will not be available again until the end of your following eligibility year. Once you have elected any dependent, you must continue paying for that **dependent**. Ceasing

payment for one will be considered ceasing for all and will result in the loss of **dependent** coverage described previously. If you decline coverage for your spouse or any **dependent** at the start of your eligibility year, you cannot enroll that **dependent** until the start of the next year for which you qualify for Family Plan benefits.

An exception to this rule will be made if you elect not to pay the premium at the beginning of your eligibility period because you, your spouse or **dependents** had coverage under another plan, but you (or your **dependents**) then lose that coverage because employer contributions cease or because of a loss of eligibility resulting from a change in family status (i.e., legal separation, divorce, termination of employment, reduction in hours, exhaustion of COBRA, children's aging out of coverage, or moving out of an HMO service area) other than a failure to pay participant premiums or termination of coverage for cause (such as fraud). In that event, you will be given the opportunity to purchase coverage for them and

yourself provided that you notify the Fund in writing within 30 days of the qualifying event. If you both provide this notice and pay the required premium on time, the coverage will begin on the date of the change. If the other coverage was COBRA coverage, this exception only applies after the COBRA coverage is exhausted.

Finally, an exception may also be made if you acquire a new **dependent** through marriage, birth, adoption, or the placement of a child for adoption. In that event, you may add the new **dependent** to coverage by providing written notice to the Fund within 30 days of the marriage, birth, adoption or placement for adoption. (This does not apply to **domestic partner** coverage. See Glossary, page 7 for eligibility requirements for a **domestic partner**.) If you provide this notice and pay the required premium on time, the coverage will become effective on the date of the event. The following chart illustrates the premium requirements. These premiums are subject to change.

PLAN	WHO IS COVERED	PREMIUM REQUIRED
INDIVIDUAL PLAN (Covered Earnings of at least \$10,000, but less than \$30,000)	Participant only	\$300 per quarter
	Participant plus one or more dependents	\$300 plus a buy-up premium per quarter
FAMILY PLAN (Covered Earnings of \$30,000 or more)	Participant only	\$300 per quarter
	Participant plus spouse or same-sex domestic partner	\$525 per quarter
	Participant with children	\$525 per quarter
	Participant with spouse and children	\$575 per quarter

HOW COVERAGE CONTINUES

DURATION OF COVERAGE

In general, once you meet the minimum **covered earnings** requirements for the Individual Health Plan, you will be covered for four consecutive calendar quarters (unless you are covered as a **Staff Performer** or **Related Employee**) provided you continue to pay the required premium on a timely basis.

Once you meet the regular minimum **covered earnings** requirements for the Family Health Plan, you and those persons who continue to qualify as your **dependents** will be covered for four consecutive calendar quarters (unless you are covered as a **Staff Performer** or **Related Employee**) provided you continue to pay the required premium on a timely basis.

You can continue coverage beyond your initial coverage period without interruption by meeting the **covered earnings** requirements on the same schedule as that for your initial coverage. For example, if you met the **covered earnings** requirements by September 30th, for continuous coverage you must meet them again in the four consecutive calendar quarters ending the next September 30th.

Generally, if you are covered as a **Staff Performer** or **Related Employee**, your coverage continues as long as you remain in that employment and the terms of your employment continue to meet the initial eligibility rules. In addition, if you have been continuously covered (not including COBRA, Senior Citizen, Early Retiree, or Extended Coverage During Disability) for at least five years, your actual **covered earnings** may continue to qualify you for cov-

erage under the general eligibility rules.

If you are a **covered roster artist**, as long as your employer continues to pay the annual lump sum contribution, and you continue to pay the required participant premium, you will continue to be covered for the period that you are a covered roster artist.

WHEN COVERAGE ENDS

Your coverage will end on the earliest of:

- the first day of the period for which your **covered earnings** are no longer sufficient to provide you with coverage (except for **covered roster artists**, see page 15);
- the date a change in the Plan results in the termination of your coverage;
- the end of the quarter following the quarter in which your employment ends if you are a **Staff Performer** and have been continuously covered (not including COBRA, Senior Citizen, Early Retiree, or Extended Coverage During Disability) for less than five years;
- the end of the month following the month in which your employment ends if you are a **Related Employee** and have been continuously covered (not including COBRA, Senior Citizen, Early Retiree, or Extended Coverage During Disability) for less than five years (if you have been continuously covered for at least five years, your actual **covered earnings** may continue to qualify you for coverage as detailed earlier in this section);
- the date you fail to pay any required premiums (i.e., participant premiums, COBRA premiums);

- the last day of the calendar month in which you enter active duty in the United States Armed Forces, except as may be otherwise provided by law;
- the date determined by the Executive Director, at his/her discretion, if you are a **Related Employee** employed by the H&R Funds and your employment is terminated for gross misconduct; or
- the date the Plan terminates.

A **dependent's** coverage will end on the earliest of:

- the date your coverage under the Plan ends;
- the date the individual is no longer a **dependent**;
- the date a **dependent** child marries;
- in the case of a spouse, the date a divorce becomes final;
- the date you fail to pay any required premiums (i.e., participant premiums, COBRA premiums);
- the date the Plan is changed and that change terminates the **dependent's** coverage.

EXTENDED COVERAGE DURING DISABILITY

For the purposes of the Health Plans, you will be considered disabled if you provide proof that, due solely to **illness** or **injury**, you are prevented from engaging in your regular occupation or employment. Your **dependent** will

be considered disabled if you provide proof that, due solely to **injury** or **illness**, the individual is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health. This provision does not apply to persons covered through the COBRA option (see page 23).

If you are disabled at the time your health care coverage ends under the Individual or Family Health Plans, your coverage and coverage for any **dependents** can be extended under the same terms as before you became disabled provided you pay the necessary premium. Any extension of health care coverage may continue for as much as 24 months, but will end once:

- you have other coverage or become eligible for another group policy or for Medicare; or
- you are no longer disabled.

If one of your **dependents** is disabled at the time your coverage under the Family Health Plan ends, the coverage of that disabled **dependent** will be extended for as long as 24 months for those covered expenses incurred because of the disability. Benefits will be extended until the earlier of:

- the date the **dependent** becomes eligible for Medicare or for another group health plan; or
- the date the **dependent** is no longer disabled.

EXTENDED COVERAGE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH

IF YOU HAD ACTIVE COVERAGE UPON YOUR DEATH

If at the time of your death you had active coverage under the Family Health Plan based on your **covered earnings**, your **dependents** will continue to be covered for the remaining time for which you qualified for active Family Health Plan coverage prior to your death, subject to timely payment of premiums.

ELIGIBLE FOR SENIOR CITIZEN COVERAGE UPON YOUR DEATH

If you die and you and your spouse are covered by the active Health Plan immediately before your death, your spouse may also be eligible for additional extended coverage if you had completed enough **Qualifying Years** to be eligible for Senior Citizen Program coverage. While your surviving spouse is receiving this extended coverage, the coverage may also apply to surviving **dependent** children who were covered by the Health Plan at the time of your death, provided that they continue to meet the definition of **dependent** children on page 7 of this benefit booklet.

If you had enough **Qualifying Years** for family coverage under the Senior Citizen Program (at least 20 **Qualifying Years**, including 15 **Family Qualifying Years**) at the time of your death, this coverage will be available if your spouse pays the spousal premium, as well as the child **dependent** premium for any children to receive this coverage. If you had enough **Qualifying Years** for individual coverage at the time of your death, but not family coverage,

under the Senior Citizen Program, then your surviving spouse will be required to pay the full “buy-up” cost in order to receive this coverage.

The coverage cannot begin before the date you would have reached age 65. That means that, for some surviving spouses and **dependents**, active coverage will terminate before they are entitled to this extended coverage. Those individuals may elect to remain covered during this “gap” period (until the date you would have reached age 65) by paying the full buy-up cost for coverage, but only if at least one of these two conditions were met at the time of your death:

- You reached age 55 and were eligible for benefits based on **covered earnings**; or
- You were covered under the Family Plan Early Retiree Program.

You will be treated as if you had at least 20 **Qualifying Years**, including 15 **Family Qualifying Years** if you meet at least one of the following conditions:

- You were enrolled in the Family Plan Senior Citizen Program prior to January 1, 2003; or
- As of January 1, 2003, you had reached age 60 and, prior to that date, you had a sufficient number of **Qualifying Years** to be eligible for Senior Citizen Program coverage.

In order for your surviving spouse and **dependents** to receive extended coverage, your surviving spouse must notify the Fund office in writing within 90 days after the latest of:

- the date of your death;
- the date your coverage as an active would have ended; or
- the date you would have reached age 65.

Extended coverage for both a surviving spouse and **dependents** will end upon the surviving spouse's remarriage or if any required payment is not made on time. Coverage for children will also end if they no longer meet the definition of **dependent** on page 7 of this booklet.

As with all coverage under the Plan, the Trustees may modify or discontinue extended coverage to a spouse and **dependents** at any time at the Trustees' sole discretion. Plan benefits do not become vested or non-forfeitable for any person.

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you take at least a week of unpaid FMLA leave, your employer is required to continue contributions to the Fund on your behalf for the entire period of unpaid leave, unless the employer has already paid either the maximum amount required under the collective bargaining agreement or the COBRA rate. Whether or not your employer is required to continue contributing, your coverage through the Fund will continue. However, if you do not return to work

after your FMLA leave ends, you may be required to repay the amount your employer paid before or during your leave that applies to your coverage during your leave, unless you do not return because of a serious health condition of you or a family member or other circumstances beyond your control. If you do not return to work after your FMLA leave ends, you may be eligible for COBRA continuation coverage, described on the next page.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE (USERRA)

If you are covered by the AFTRA Health Fund and enter the United States Armed Forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your **dependent's**) health coverage under the Plan during your military service for a period of up to 18 months. If your military service is 30 days or less, your coverage continues at the same cost as before. As long as the ordinary participant premiums are paid, your coverage continues. If your military service exceeds 30 days, you will need to pay the applicable COBRA premium in order to remain covered.

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage reinstated when you return to employment with the same **contributing employer** following honorable discharge, provided that you return to employment within the time periods prescribed by law. No waiting period or exclusion will be imposed in connection with such reinstatement (unless the

waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury determined by the Secretary of Veterans' Affairs to be connected with your military service. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

CONTINUATION OF COVERAGE THROUGH COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan, under certain circumstances, in the event that you or your family members lose your coverage. This section generally explains continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your continuation coverage rights under the Plan.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact Participant Services at 1-800-562-4690.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your **dependent** children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because one of the following qualifying events happens:

- your hours of employment are reduced;
- you have insufficient earnings in covered employment; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse has insufficient earnings in covered employment;

- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- you become divorced or legally separated from your spouse; or
- your spouse becomes enrolled in Medicare (Part A, Part B, or both).

Your **dependent** children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee has insufficient earnings in covered employment;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parents become divorced or legally separated;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); or
- The child stops being eligible for coverage under the Plan as a "**dependent** child."

Children who are born to or placed for adoption with a former covered employee during the period of the employee's continuation coverage are

qualified beneficiaries and are entitled to COBRA continuation coverage for the same maximum period as the other qualified beneficiaries with respect to the same qualifying event. You may also add a new spouse to your coverage while you are on COBRA continuation coverage, but the new spouse is not thereby a qualified beneficiary. In order to add a newly acquired **dependent**, you must notify the Fund office within 30 days of the marriage, birth or placement for adoption and pay the required premium within 45 days of returning your election form. You must include payment for all months retroactive to the date you acquired the **dependent**.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will generally offer COBRA continuation coverage to qualified beneficiaries only after the Fund office has been notified that a qualifying event has occurred.

For station staff and employees of AFTRA or one of its affiliated local unions, or Funds staff, your employer has the responsibility to notify the Fund office if the qualifying event is:

- the end of employment or reduction in hours of employment; or
- the death of the employee.

Your employer's notice must be sent within 30 days of the occurrence of any of these events.

With respect to employees who are not station staff, employees of the Funds or AFTRA or one of its affiliated local unions, the Funds staff, rather than your employer, makes the determination as to whether you have met the **covered earnings** requirements to maintain eligibility.

For all other qualifying events (i.e., divorce or legal separation, or a **dependent** child's losing eligibility for coverage as a **dependent** child), regardless of the employer, it is your responsibility to notify the Eligibility Department within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to the Fund office. The notice must identify the qualifying event, the date on which it occurred and the names of the covered individuals whose coverage under the Plan will be lost due to the event. In the case of a divorce or legal separation, the separation decree or the final divorce papers must accompany the notice. An employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

Once the Fund office is notified that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA coverage, coverage will begin when you would otherwise lose coverage under the Plan. In order to elect COBRA coverage, qualified beneficiaries must return the "COBRA Election Authorization Form" to the Fund office on a timely basis.

If you (or another qualified beneficiary) timely elect (and pay for) continuation coverage, you (and/or the qualified beneficiary, as applicable) are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If continuation coverage is not timely elected (and paid for), group health coverage under the Plan will end.

Special Note: In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under the federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Election of COBRA coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have a right under federal law to request enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your AFTRA health coverage ends because of the qualifying event listed above. You will also have the same special right to enroll in another group health plan at the end of continuation coverage provided you maintain COBRA coverage for the maximum time available to you.

DURATION OF COBRA CONTINUATION COVERAGE

Please remember that COBRA continuation coverage is only a temporary continuation of your health coverage under the Plan. When the qualifying event is the death of the employee, your divorce or legal separation, or a **dependent** child's losing eligibility as a **dependent** child, COBRA continuation coverage may last for up to a total of 36 months.

When the qualifying event is the end of employment, the reduction of the employee's hours of employment, or insufficient **covered earnings** and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment, the reduction of the employee's hours of employment, or insufficient **covered earnings** and you elect COBRA, COBRA continuation coverage lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-month Period of Continuation Coverage

The 18-month period of COBRA continuation coverage may be extended for up to an additional 11 months (for a total of up to 29 months of continuation coverage) if you or any family member covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Fund office of the SSA disability determination within 60 days of the date of the determination and before the end of the initial 18-month continuation coverage period. With the notification, you must also submit a copy of the Social Security award. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to this notice requirement. Notice must be sent to the Fund office with any appropriate documentation at the address listed on page 84.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family member experiences another qualifying event while receiving 18 months of COBRA continuation, your spouse and **dependent** children may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the notice of the second qualifying event is properly submitted to the Plan. This extension may be available to your spouse and any

dependent children receiving continuation coverage if you die or you get divorced or legally separated. This extension is also available to your **dependent** child when he or she is no longer eligible under the Plan as a **dependent** child. In all of these cases, the extension is available only if the second event would have caused the spouse or **dependent** child to lose coverage under the Plan had the first qualifying event not occurred. You (or your family member) must make sure that the Fund office is notified of the second qualifying event within 60 days of the second qualifying event and submit any required documentation, such as a final divorce decree. This notice must be sent to the Fund office at the address listed on page 84.

PAYING COBRA PREMIUMS

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount that you and other qualified beneficiaries will need to pay will be 102 percent of the cost to the group health plan (including both employer and participant contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent, provided the disabled individual elects the extension).

The monthly premium rates may be adjusted due to changes in coverage. Even in the absence of any changes in coverage, premiums charged for continuation coverage may change on a yearly basis or as otherwise permitted by applicable law. After you or your family members experience a qualifying event, you will receive an election form that notifies you of the actual premium that will apply.

If you (or another qualified beneficiary) elect COBRA continuation coverage, send your premium payment when you return the COBRA Election Authorization Form. You must make your first premium payment for continuation coverage no later than 45 days after the date of your election (this means 45 days after the date that your Election Form is postmarked, if mailed). If you (or another qualified beneficiary) do not make your first premium payment within this 45-day period, you (or the qualified beneficiary, as applicable) will lose all rights to COBRA continuation coverage under the Plan and your coverage will terminate (as of the date it would otherwise terminate under the Plan).

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Payment is due on the first day of the month for which the payment applies. That means that the payment for coverage for the month of June is due on June 1. As long as you make a monthly payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. After you pay the initial payment, the Plan will not send monthly notices of payments due for subsequent periods, so you need to be sure to make the monthly payments.

Although monthly payments are due on the dates described above, you will be given a grace period of 30 days to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a monthly payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan and your coverage will terminate as of the last date for which you made a timely payment. Once continuation coverage is lost, it cannot be reinstated.

EARLY TERMINATION OF CONTINUATION COVERAGE

The law provides that COBRA continuation coverage may be cut short prior to the expiration of the applicable 18, 29 or 36-month period for any of the following reasons:

- The group health coverage provided to you is terminated and the Trustees no longer provide any group health coverage;
- The premium for continuation coverage is not paid on a timely basis (within the applicable grace period);
- The individual first becomes, after electing COBRA coverage, covered under another group health plan (as an employee or otherwise) that does not contain any preexisting condition exclusion or limitation applicable to the individual;
- The individual first becomes, after electing COBRA coverage, enrolled in Medicare (Part A, Part B, or both);
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination; you

are required to notify the Fund office in writing within 30 days of any such final determination;

- You, or the former covered employee makes a false statement, or furnished fraudulent or incorrect information; or
- Your employer withdraws from the AFTRA Health Plan but continues to cover a classification of employees under another group health plan (in which case you may be transferred to such other group health plan).

IF YOU HAVE QUESTIONS

If you have questions about the Plan or your COBRA continuation coverage, you should contact the Eligibility Department at the Fund office (see page 84 for contact information) or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of the Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP THE PLAN INFORMED OF CHANGES

In order to protect your family's rights, you should keep the Fund office informed in writing of any changes in the addresses of your family members and any changes in your marital status. You should also keep a copy, for your records, of any notices you send to the Fund office.

CONVERTING TO LIMITED MEDICAL COVERAGE WHEN COBRA ENDS

If you have exhausted your full period of COBRA benefits and do not become entitled to, qualified for or enrolled in any other health care coverage, program or policy providing similar benefits such as Medicare, Medicaid, or Champus, you may purchase a limited medical plan through the AFTRA Health Fund for yourself and any dependents who were covered under COBRA. If you purchase this coverage and then become entitled to, qualified for or enrolled in any other health care coverage, you must notify the Fund office and this coverage will be terminated.

The benefits available through the AFTRA Health Fund's limited medical plan are not the same as those offered under the Individual or Family Health Plans. You may obtain this coverage without showing evidence of good health. However, the Trustees retain the right to cancel this program at any time and return a pro-rated portion of the premium.

Here's how it works. After you meet an annual \$500 per person deductible, the Plan will pay 90% of scheduled allowances and covered charges for Network hospital, medical and surgical expenses (60% for Non-Network)—up to an annual maximum benefit of \$50,000. It is important to note that the following benefits are **not** covered under this limited plan:

- Prescription drugs
- Wellness benefits
- Mental health and chemical dependency

- Dental expenses
- Vision benefits
- Private duty nursing
- Stop loss, i.e., the reimbursement of certain expenses at 100%
- Disability extensions
- COBRA
- Life insurance
- Accidental death coverage
- Loss of voice coverage

When your COBRA coverage ends, you will receive a notice along with an application from the Fund office notifying you of your right to purchase limited coverage and its cost. The cost will change annually. The application must be returned with your first quarterly premium payment within 45 days of the notification date listed on the front of the application form.

CERTIFICATES OF CREDITABLE COVERAGE

When your Plan coverage ends, you and/or your **dependents** are entitled by law to, and will be provided with, a “Certificate of Creditable Coverage.” Certificates of Creditable Coverage indicate the period of time you and/or your **dependents** were covered under the Plan (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may

be necessary if you and/or your **dependents** become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Plan ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your **dependents** under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- on your request, within 24 months after your Plan coverage ends;
- when you are entitled to elect COBRA;
- when your coverage terminates, even if you are not entitled to COBRA;
- when your COBRA coverage ends.

You should retain the Certificate of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund office.



Comprehensive Benefits Under the AFTRA Health Plans

We live longer and healthier lives. One reason is that medical care has improved enormously and its access, at least in this country, is nearly universal for those who have good health coverage. That is what the AFTRA Health Plan provides—good coverage that enables you to afford quality health care wherever you may be.

Before we describe the benefits you will enjoy when you earn eligibility for the AFTRA Health Plans, you need to know how the Plans work. The AFTRA Health Fund provides access to networks of health care providers. These networks are organized to offer quality health care at discounted prices, thus saving you money and conserving the assets of the Funds. Various networks specialize in either hospital and medical, mental health and chemical dependency, prescription, or dental services. If you use **Network Providers**, their charges will be lower than their regular rates and, in most instances, your out-of-pocket expense will be less. You will also have less paper work. However, it is your responsibility to exercise care in the selection of any health care provider.

Depending on where you live, you should have a Preferred Provider Directory from PHCS or Blue Cross of California. Since any directory will become outdated, before receiving services, it is recommended that you verify with your provider that he or she is still in the network. When you call for an appointment with a **Participating Provider** be sure to identify yourself as a person covered by the PHCS or Blue Cross preferred provider network and confirm that the provider is in the network.

Additional details regarding the networks (including contact information) will be found in the following pages. The use of **Network Providers**, except in the case of treatment of chemical dependency or hospitalization for **mental health disorders**, is not mandatory. The choice is always yours. A list of **Network Hospitals** or **Network Providers** is provided to you automatically, without charge, as a separate document.

To make it easier to understand, we have divided the presentation into seven sections. Remember, however, the AFTRA Health Plan is a comprehensive and integrated plan that covers all of your major health needs.

SECTION	PAGES
The Hospital Program	32
The Major Medical Program	37
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The Prescription Drug Program	48
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Life Insurance Benefits, AD&D Insurance Benefits and Loss of Voice Benefit	56
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The Hospital Program

The company that provides the network of **hospitals** offered by the AFTRA Health Plans in most states is Private Healthcare Systems (PHCS). Blue Cross of California provides the network in California. Aicare Medical Management (AMM) provides **hospital** pre-certification, private duty nursing and case management services for all areas of the country.

For a list of **Network Hospitals** call PHCS at 1-888-960-7427 or access their Web site at www.phcs.com. In California, for a list of **Network Hospitals**, check the Blue Cross Web site at www.bluecrossca.com. You can also check the AFTRA Health & Retirement Funds' Web site at www.aftrahr.com.

WHAT THE HOSPITAL PROGRAM PAYS

The Hospital Program will pay for a major portion of each covered inpatient hospital stay. The reimbursement amount will differ depending on whether you use a **Network** or **Non-Network Hospital**. There will be a \$100 **copayment** for each **hospital** confinement.

NETWORK HOSPITALS

If you use a **Network Hospital**, the Hospital Program will pay 90% of the first \$10,000 of each individual's **covered expenses** in that year (excluding the \$100 **copayment**). However, after **Network Hospital covered**

expenses total \$10,000 in a year, the Fund will pay 100% of the additional **Network Hospital covered expenses** (although you will still be responsible for the \$100 **copayment** for each stay). Therefore, the annual maximum out-of-pocket expense (excluding **copayment**) for **covered expenses** for **Network Hospitals** will be \$1,000.

NON-NETWORK HOSPITALS

If you use a **Non-Network Hospital**, the AFTRA Health Plan Hospital Program will pay 60% of the first \$7,000 of each individual's **covered expenses** in that year (excluding the \$100 **copayment**). However, after **Non-Network Hospital covered expenses** total \$7,000 in a year, the Fund will pay 100% of the additional covered **Non-Network Hospital** expenses (although you will still be responsible for the \$100 **copayment** for each stay). Therefore, the maximum out-of-pocket expense (excluding **copayments**) for **Non-Network Hospitals** is \$2,800.

EXCEPTIONS

There are two exceptions. The Plan will pay 80% of the **covered expenses** after the **copayment** and you will pay 20%:

- if the **hospital** is located in a part of the country in which there are no **Network Hospitals**; or
- if the confinement was the result of a medical emergency which precluded the use of a **Network Hospital**.

LIFETIME MAXIMUM

The maximum the AFTRA Health Fund will pay for hospital and prescription drug benefits com-

bined during the lifetime of any one covered individual is \$1,000,000. Note: There is a separate \$1,000,000 lifetime maximum for Major Medical, including mental health and substance abuse treatment (see page 39).

IMPORTANT

All **hospital** admissions must be pre-certified except in the case of an emergency admission which must be authorized within 72 hours. For pre-certification or to notify of an emergency, call Alicare at 1-866-663-7486.

If you are hospitalized due to a **mental health disorder**, you **must** receive pre-authorization from ValueOptions at 1-800-704-1421.

HOSPITAL PRE-CERTIFICATION IS MANDATORY

You or your doctor must call Alicare at 1-866-663-7486, before you are admitted to any **hospital** to arrange certification for the admission. In any confinement because of an emergency, either you or the **hospital** or the doctor must call within 72 hours after admission. Failure to get Alicare certification for a **hospital** confinement can result in a 20% penalty of the **hospital** benefit which otherwise would be paid. In addition, if a subsequent review reveals that the stay or any portion of the stay was not medically necessary, any benefits for those days will be denied.

If the confinement is for treatment of a **mental health disorder** or for treatment of chemical dependency, the certification must be obtained through ValueOptions. See the Mental Health and Chemical Dependency Programs on pages 44-47 for more information on ValueOptions.

A SPECIAL NOTE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any **hospital** length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you are pregnant, please call Alicare to arrange for hospitalization for the delivery of your baby. In all cases, you will be certified for hospitalization for at least 48 hours for a normal delivery and 96 hours for a Cesarean section. Federal law requires that you be informed that you have a right to at least a stay of these lengths without certification, although you and your doctor may still decide that you can leave the **hospital** sooner. Certification for longer periods will generally be required.

INFORMATION YOU WILL NEED TO CERTIFY HOSPITALIZATION

When you call Alicare or ValueOptions for pre-certification, you will need the following:

- name, address, date of birth and Social Security number of patient;

- name and Social Security number of the Plan participant, if different from the patient;
- date of proposed **hospital** admission;
- admitting diagnosis, surgical procedure to be performed and proposed length of stay;
- name, address and telephone number of the **hospital**; and
- name, address and telephone number of the attending **physician**.

EXPENSES COVERED BY THE HOSPITAL PROGRAM

The AFTRA Health Plans **Hospital** Program will pay **covered expenses** for the following **hospital** charges, provided that the services are **medically necessary**.

INPATIENT CARE

- semiprivate room and board, floor nursing and other daily **hospital** charges;
- use of an operating room, delivery room and treatment rooms and equipment;
- administration of anesthesia;
- laboratory tests and x-rays;
- dressings;
- drugs and medications used during hospitalization which are listed in the official formularies and which are commonly available for purchase by the hospital; and

- confinement because of maternity including nursery charges for well baby care of the newborn child while the mother is confined.

OUTPATIENT CARE

- hospital** charges if surgery has been performed;
- hospital** charges for emergency treatment that is provided within 72 hours of the event that caused an injury;
- hospital** charges for emergency treatment of an illness of an unexpected nature that is provided within 24 hours of the onset of the illness;
- pre-admission testing and x-rays ordered by the physician taken in the **hospital's** outpatient department within seven days of a scheduled admission (these charges will be covered even if the admission is postponed or cancelled);
- charges for use of an Ambulatory Surgical Facility if the services provided would have been payable as **hospital** expenses and do not exceed the amount which would be payable if they were incurred on an inpatient basis (up to a \$1,500 maximum if surgery is performed in a non-network facility);
- charges for dialysis performed in a **hospital** or in a non-profit, free-standing facility provided the covered individual is not yet eligible for Medicare and that the individual is not able to receive dialysis at home; and

- charges for a legal abortion performed either in a **hospital** outpatient department or in an Ambulatory Surgical Facility.

EXPENSES NOT COVERED BY THE HOSPITAL PROGRAM

The following expenses are not covered under the **Hospital** Program:

- hospitalization primarily for treatment of **mental health disorders** (see the Mental Health and Chemical Dependency Programs on pages 44-47);
- confinement, services or supplies primarily for the treatment of chemical dependency including alcohol and drug addiction (see the Mental Health and Chemical Dependency Programs on pages 44-47);
- professional services by **medical providers** not employed by the **hospital** (professional medical services are covered under the Major Medical Program as described on pages 37-43);
- nursing, other than floor nursing services (see the Major Medical Program on pages 37-43);
- any admission that does not require a **hospital** bed setting except as specifically provided under Outpatient Care as listed on page 34;
- hospitalization primarily for diagnostic studies, x-ray examinations, basal metabolism tests, electrocardiograms or physical therapy (see the Major Medical Program and the Wellness Program on pages 37-43 and pages 50-51);
- X-ray therapy, radium therapy, radioactive isotopes, blood or blood plasma (see the Major Medical Program on pages 37-43);
- convalescent, custodial or rest care or care in a sanitarium;
- procurement of special braces, appliances or equipment (see the Major Medical Program on pages 37-43);
- any loss for which mandatory automobile no-fault benefits are recovered or recoverable;
- confinement, treatment, services or supplies while not covered by the Plan;
- any item listed under General Exclusions and Limitations (see page 64).

CASE MANAGEMENT

Case Management is a service designed to help you, your family, your doctor and your other health care providers develop a treatment plan for high quality and cost effective treatment of catastrophic or chronic **injury** or **illness**. This service will be particularly helpful for those who require complex, high technology medical services. Case Management can help guide you through the maze of choices in selecting health care services, providers and procedures. While Case Management is not required, it can help you avoid unnecessary or unanticipated costs and will facilitate claims processing. Skilled nursing however, must be pre-authorized by a Case Manager to obtain benefits. Case Management is provided by Alicare. For more information, please call Alicare at 1-866-663-7486.

HOW TO SUBMIT HOSPITAL CLAIMS

All **hospital** claims should be sent directly to the New York Fund office. If for any reason you find that the **hospital** will not submit the claims for you, send an itemized original bill to the New York Fund office. All claims will be screened by the New York Fund office and you will be advised whether the claim is accepted and the amount paid or, if it is rejected, the reason for rejection.

Please note that all claims, **hospital** and Major Medical, should be submitted within 90 days of the date of the service (30 days from the date a primary provider made payment); in no event will claims be accepted that are more than 15 months old. For more detailed information, refer to the Claims and Appeals Procedures section on page 73.

IMPORTANT

Claims must be submitted within **15 months** of the date of service. Claims submitted after the 15-month deadline will not be paid. It is your responsibility to make sure the claim is submitted.



The Major Medical Program

The Major Medical Program of the AFTRA Health Plans covers most of the charges made by your doctors and other medical providers that are not included under the Hospital Program, the Wellness Program and the Prescription Drug Program. Together, all four programs give you the protection you need against catastrophic bills that can pile up while you are sick.

In addition, the Major Medical Program and the Wellness Program will also help you pay for a major portion of charges for your routine medical care. Please note that some charges are covered under the Mental Health and Chemical Dependency Programs rather than the Major Medical Program. Charges for **prescription drugs** will be reimbursed under the Prescription Drug Program. Throughout this booklet, we will remind you to check another program when it is appropriate.

You have a choice of using **Network Providers** or **Non-Network** doctors and other health care providers. The **Network Providers**, under a contract with PHCS or Blue Cross of California, have agreed to provide their services at a discounted rate. This means that your costs will usually be less if you use **Network Providers**; your cost will be greater if you use **Non-Network Providers**. The choice is yours.

While you make the choice that is best for you, it is also true that circumstances can dictate the use of a **Non-Network Provider. Hospitals,**

laboratories, **physicians** and other **medical providers** agree to join a Preferred Provider Organization (PPO) network individually and independently of each other. Therefore, it is possible to select a **Network Hospital** but be assigned a **Non-Network Provider** (such as an anesthesiologist) or for a network doctor to refer your laboratory work to a non-network laboratory.

In general, the use of a **Non-Network Provider** is more expensive. Unlike a **Network Provider**, a **Non-Network Provider** is not under contract to a PPO network and has not agreed to provide services at a discounted rate. Instead, **Non-Network Providers** are free to charge a typically higher rate for their services. Therefore, in cases where a **Non-Network Provider** is used, regardless of the circumstances and whether you had foreknowledge or control, the Fund has no choice but to reimburse at the non-network rate based on the **scheduled allowance**. The Fund cannot provide the benefit of a PPO discount unless we receive the discounted rate.

You should have a Preferred Provider Directory from either PHCS or Blue Cross California listing **Network Providers**. Since any directory will become outdated, before receiving services, it is recommended that you verify with your provider that he or she is still in the network. When you call for an appointment with a Participating Provider be sure to identify yourself as a person covered by the PHCS or Blue Cross preferred provider network and confirm that the provider is in the network. (For a list of network **physicians** call PHCS at 1-888-960-7427. To access Blue Cross of California or for a list of network **physicians,**

check the Blue Cross Web site at www.bluecrossca.com or the AFTRA Health & Retirement Funds' Web site at www.aftrahr.com.)

HOW THE MAJOR MEDICAL PROGRAM WORKS

THE DEDUCTIBLE

You will be required to pay a **deductible** before the Major Medical Program begins to pay for your health care. The deductibles will be tracked separately for Network and Non-Network claims. This means that a participant will have to meet the Network deductible by using **Network Providers** and meet the separate Non-Network deductible if they use **Non-Network Providers**.

- If you use **Network Providers** (physicians or other health care providers), your annual **deductible** will be \$200 for each individual with a maximum of \$400 for a family.
- If you use **Non-Network Providers** (physicians or other health care providers), your annual **deductible** will be \$400 for each individual with a maximum of \$800 for a family.

In other words, if you use both **Network** and **Non-Network Providers**, the **deductible** will be tracked separately and expenses applied toward one **deductible** will not apply to meeting the other **deductible**.

COPAYMENT

Each time you visit a primary care provider or specialist, you will be required to pay a \$10 **copayment** per visit.

COINSURANCE

If you use **Network Providers**, once the annual **deductible** is satisfied, the Major Medical Program will pay 90% of the next \$10,000 of each individual's annual **covered expenses**. It will pay 100% of in-network **covered expenses**, not including the **copayment**, over that amount for the remainder of the calendar year. If you use only **Network Providers**, your annual out-of-pocket costs for **covered expenses** will be no more than \$1,000 a year plus the **deductible** and each office visit **copayment**.

If you use **Non-Network Providers**, once the annual **deductible** is satisfied, the Major Medical Program will pay 60% of the **scheduled allowance** for each individual's **covered expenses** up to the next \$8,000 in a calendar year. It will pay 100% of the **scheduled allowance** for **covered expenses** over that amount for the remainder of the calendar year. Even though it will cost you more to use **Non-Network Providers**, your out-of-pocket costs for **covered expenses** will still be limited to \$3,200 per year plus the **deductible**, each office visit **copayment** plus any charges over the **scheduled allowances**. Exception: The Plan will pay 80% of the **scheduled allowance** after the **deductible** and you will pay 20%, if the provider is located in a part of the country in which there are no **Network Providers**.

If you use both **Network** and **Non-Network Providers**, the maximum you will have to pay for Major Medical **covered expenses** in a calendar year will be no more than \$4,200 plus the **deductible** and **copayment**. **Covered expenses** do not include those costs in excess of **scheduled allowances** plus any applicable **copayments**.

EXAMPLE: COMPARISON OF TYPICAL OUT-OF-POCKET COSTS

Network Provider		Non-Network Provider	
Billed Amount	\$150	Billed Amount	\$150
Negotiated Rate	\$100	Scheduled Allowance	\$110
Reimbursed at 90%	\$90	Reimbursed at 60%	\$66
Office Visit Copayment	\$10	Office Visit Copayment	\$10
Your Total Cost	\$20	Coinsurance (\$110-\$66)	\$44
		Amount above Scheduled Allowance (\$150-\$110)	\$40
		Your Total Cost (\$40 + \$44 + 10)	\$94

LIFETIME MAXIMUM

The maximum the AFTRA Health Fund will pay for Major Medical benefits (doctors and other **medical providers**) during the lifetime of any one covered individual is \$1,000,000. This includes charges for mental health and substance abuse treatment. However, a covered individual can apply for the full maximum to be reinstated once they have incurred at least \$1,000 of Major Medical expenses if they are not, at that time, incurring Major Medical expenses and can provide medical evidence of insurability to the Fund. Note that this lifetime benefit maximum does not include:

- benefits provided through the Hospital Program and the Prescription Drug Program for which there is a separate lifetime maximum (see page 32);
- the cost of benefits paid under the Dental Program; or
- the Life Insurance, AD&D Insurance and the Loss of Voice Benefit.

EXPENSES COVERED BY THE MAJOR MEDICAL PROGRAM

The Major Medical Program will cover only the following charges incurred by a covered individual:

- diagnosis and treatment by a **physician, surgeon or other medical provider.**
- occupational, physical, vision and speech therapy, as well as treatments by chiropractors and acupuncturists, but this will be limited to a combined maximum of 12 in any calendar quarter and will be reimbursed at the discounted rate. In addition, acupuncture and chiropractic visits will be limited to a combined total of eight of those 12 visits per quarter. Payment to chiropractors and acupuncturists who are **Non-Network Providers** is limited to \$45 per visit.
- laboratory tests and x-rays;
- anesthesia and its administration;
- contraceptive devices prescribed by a physician and deemed to be medically necessary that are not sold over the counter;

MAJOR MEDICAL

- private duty nursing by any qualified nurse provided the nurse does not live in your home and is not a member of your or your spouse's immediate family. Private duty nursing is limited to 504 hours in any calendar year. Aicare must pre-authorize this benefit or no benefits will be paid. The phone number is 1-866-663-7486;
- emergency transportation within the continental limits of the United States and Canada by:
 - a. professional ambulance (other than air ambulance) to or from a local **hospital**; or
 - b. a regularly scheduled airline or railroad or by air ambulance from the place in which you became disabled because of **illness** or **injury**. This transportation is limited to the first trip to and from a **hospital** qualified to provide special treatment for your **injury** or **illness** if such treatment is not available at any local **hospital**.
- treatments, services, supplies and equipment that would not normally be used in the absence of **illness** or **injury** including:
 - a. prosthetic appliances such as artificial limbs or eyes for initial replacement of natural limbs or eyes and for replacements that are functionally necessary;
 - b. trusses, braces or supports, casts, splints and crutches;
 - c. purchase or rental of durable medical equipment such as iron lungs, wheelchairs and hospital-type beds. If renting, the total

rental cost may not exceed the cost of purchase.

- d. oxygen and the purchase or rental of equipment for administering its use. If renting, the total rental cost may not exceed the cost of purchase;
- e. radium and radioactive isotopes;
- f. radiation therapy, chemotherapy and hemodialysis; and
- g. blood and blood plasma and their infusion.

IMPORTANT

Surgery on an eyelid, nose or breast will be subject to retrospective review for medical necessity—that is, the review is done after the surgery has been performed, and no coverage will be provided for expenses that the Fund does not deem medically necessary.

If you wish to know in advance whether you will have coverage for this type of surgery, the Plan does allow you to submit a voluntary request for preauthorization. A request for preauthorization will be considered only if submitted with sufficient information to evaluate whether or not the proposed surgery is medically necessary and to determine the benefit. Required information must include, but is not limited to:

- dated pre-operative photographs;
- diagnostic testing reports (e.g., MRI, CT Scan, X-ray, Visual Field tests);

- physical examination and patient history report;
- physician consultation report;
- ICD-9 Diagnoses Code(s);
- proposed CPT-4 Procedure Code(s) with associated fees;
- proposed surgical facility with the associated fee.

Decisions by the Fund to deny preauthorization may not be appealed. If you decide that you want to have the surgery even after preauthorization is denied, you may subsequently submit a claim for benefits, which, if denied, you will have the right to appeal.

A SPECIAL NOTE

If a participant or beneficiary is receiving treatment in connection with a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For participants and covered dependents receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and

- treatment of physical complications at all stages of mastectomy, including lymphedema.

This coverage is subject to all of the Fund's rules regarding benefits, including the same **deductible** and **copayment** provisions that apply to other medical and surgical benefits provided under the Plans, which are described in this booklet. If you would like more information on WHCRA benefits, call the Fund office.

EXPENSES COVERED BY THE MAJOR MEDICAL PROGRAM ON A LIMITED BASIS

The following services and procedures are not covered by the Major Medical Program except as noted, but may in some cases be covered by other programs offered by the AFTRA Health Plans.

- procedures on the teeth, nerves of the teeth, gums or alveolar process except:
 - a. charges for the removal of tumors or cysts or cutting procedures in the oral cavity will be covered but not charges for the care of teeth and gums or in connection with the extraction or replacement of teeth; and
 - b. charges for the treatment of fractures and dislocations of the jaw will be covered as will any other treatment when it is due to an accidental **injury** to sound, natural teeth. The service must be rendered within 24 months of the accident.

- cosmetic surgery is not covered except for procedures required as the result of:
 - a. an accidental **injury**;
 - b. reconstructive surgery that is incidental to or follows surgery for **injury**, infection or other diseases of the involved part; or
 - c. congenital disease or anomaly suffered by a **dependent** child if it has resulted in a functional defect.
- routine foot care or foot care in connection with corns, calluses, flat feet, fallen arches. Weak feet, chronic foot strain and orthotics are not covered except for:
 - a. open cutting operations;
 - b. partial or complete removal of nail roots; or
 - c. services prescribed by a **physician** who is treating the covered person for a metabolic disease such as, but not limited to, diabetes mellitus, peripheral vascular disease or arteriosclerosis.

EXPENSES NOT COVERED BY THE MAJOR MEDICAL PROGRAM

If you have questions about whether the AFTRA Health Plans will cover a particular service or procedure, please call the Fund office. For your information, we list here some of the expenses that are not covered by the Major Medical Program. As noted, these expenses may be covered by another program offered by the AFTRA Health Plans.

Charges for the following services are excluded:

- convalescent or **custodial care** or rest cures;
- cosmetic surgery, unless it is required because of an accidental injury, or reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part;
- treatment of mental health and chemical dependency disorders including alcohol and drug addiction (but see also the Mental Health and Chemical Dependency Program on pages 44-47), except for laboratory tests required with respect to medication prescribed in connection with a course of treatment authorized by ValueOptions;
- any treatment for learning disabilities, developmental disorders, mental retardation, autism or congenital disorders, including any treatment of deficits associated with these conditions;
- prescription drugs, except where the Plan provides only secondary coverage;
- dental care (see the Dental Program on page 52) except for: tumors or cysts, cutting procedures in the oral cavity (other than for the care of teeth and gums or in connection with the extraction or replacement of teeth), treatment of fractures and dislocations of the jaw and any other treatment when due to an accidental injury to sound, natural teeth when treatment is rendered within 24 months of the accident;

- routine foot care (however, charges are covered for open cutting operations, partial or complete removal of nail roots and any services prescribed by a provider who is treating the covered individual for a metabolic disease);
- transportation, except as provided on page 40; and
- any item listed under General Limitations and Exclusions (see page 64).

CASE MANAGEMENT

Case Management is a service designed to help you, your family, your doctor and your other health care providers develop a treatment plan for high quality and cost effective treatment of catastrophic or chronic **injury** or **illness**. This service will be particularly helpful for those who require complex, high technology medical services. Case Management can help guide you through the maze of choices in selecting health care services, providers and procedures. While Case Management is not required, it can help you avoid unnecessary or unanticipated costs and will facilitate claims processing. Skilled nursing, however, must be pre-authorized by a Case Manager to obtain benefits. Case Management is provided by Alicare. For more information please call Alicare at 1 866-663-7486.

HOW TO SUBMIT MAJOR MEDICAL CLAIMS

All claims for services covered by the Major Medical Program should be sent directly to the New York Fund office. In many cases, your doctor or other medical care provider will send in the claims for you. If they do not, you should send in the original itemized bill to the New York Fund office. Photocopies will not be accepted

unless the AFTRA Health Plan is secondary to another health plan. Please note that all claims, hospital and Major Medical, should be submitted within 90 days of the date of the service (30 days from the date the primary provider made payment); in no event will claims be accepted that are more than 15 months old. For more detailed information, refer to the Claims and Appeals Procedures section on page 73.

IMPORTANT

You can speed the payment of your claims by making sure that all bills submitted contain the following necessary information:

- participant's name and Social Security number;
- name of the patient, if different;
- dates of service;
- diagnosis;
- itemized breakdown of services and charges, and name and address of the provider; and
- information about coverage under other health care plans.

Failure to provide this information will delay the processing of your claim. Claims must be submitted within **15 months of the date of service**. Claims submitted after the 15-month deadline will not be paid. You are responsible for ensuring that your claims are submitted.

To speed processing of your claims, be sure to keep your current address on file in the New York Fund office.



The Mental Health and Chemical Dependency Programs

The Mental Health Program and the Chemical Dependency Program offer different benefits, but each is administered for the AFTRA Health Plans by ValueOptions at 1-800-704-1421.

To receive benefits under the Mental Health and Chemical Dependency Programs, you must have authorization from ValueOptions for all treatment before treatment begins. In the case of an emergency, you must notify ValueOptions within 72 hours of confinement. If you do not meet these requirements, you will not receive any coverage.

IMPORTANT

A treatment for mental health and chemical dependency must be pre-authorized. In an emergency, the preauthorization must be received within 72 hours of the commitment. You can reach licensed clinicians at ValueOptions, 24 hours a day, seven days a week.

Call 1-800-704-1421.

Claims must be submitted within **15 months of the date of service**. Claims submitted after the 15-month deadline will not be paid. It is your responsibility to ensure that claims are submitted.

TREATMENT COVERED BY THE MENTAL HEALTH PROGRAM

The Mental Health Program covers a vast number of mental health conditions. Among the conditions covered are anxiety, stress, eating disorders, depression, bi-polar disorders such as manic depression, and psychosis and schizophrenia. If you have a question about a particular mental health condition and whether the Mental Health Program covers it, call ValueOptions.

The Mental Health Program provides benefits for treatment, both on an inpatient and outpatient basis.

INPATIENT TREATMENT

When you require inpatient treatment of a **mental health disorder**, confinement must be preauthorized by ValueOptions and you must use ValueOptions' network of providers in order to receive benefits, including ancillary charges for medically necessary services. The Mental Health Program provides up to 30 days of inpatient care for each covered individual each calendar year. ValueOptions may authorize alternate structured outpatient benefits in lieu of a **hospital** stay. There is no coverage if you use a provider (or facility) that is not in ValueOptions' network.

OUTPATIENT TREATMENT

You must also have prior authorization from ValueOptions for treatment on an outpatient basis. Like inpatient treatment, you can only receive benefits for outpatient care from **Network Providers**. The benefits paid, including the annual maximums, are indicated in the chart on the following page. If you use a

provider out of ValueOptions' network, there will not be any coverage for treatment.

There is a maximum number of 40 visits per year.

HOW OUTPATIENT BENEFITS ARE PAID

	Network Only	Non-Network
Reimbursement for visits 1-40 in a year	100% of discounted fee less \$20 copay	None
Visits over 40	None	None

PRESCRIPTION DRUGS FOR MENTAL HEALTH DISORDERS

Prescription drugs used for the treatment of **mental health disorders** are available through the Prescription Drug Program. For information on the Prescription Drug Program, refer to page 48.

HOW THE CHEMICAL DEPENDENCY PROGRAM WORKS

The Chemical Dependency Program offers coverage for the treatment of chemical dependency, including alcohol and drugs. This program is administered by ValueOptions. ValueOptions will refer patients to counselors and to other services as appropriate. You cannot use a provider that is not preapproved by ValueOptions.

IMPORTANT

To receive reimbursement for treatment of chemical dependency, you must obtain a referral and preauthorization for treatment from ValueOptions. You also must complete your treatment program to receive the full reimbursement that the Plan would otherwise pay. You can reach ValueOptions' licensed clinicians 24 hours a day, seven days a week by calling 1-800-704-1421.

Claims must be submitted within **15 months of the date of service**. Claims submitted after the 15-month deadline will not be paid.

The program will provide benefits for up to three courses of treatment for chemical dependency during your lifetime. No charges incurred after the third course of treatment will be paid under this program. A course of treatment will be considered to have ended if the individual goes without treatment for a 90-day period. The Chemical Dependency Program will pay:

- 95% of allowable charges to a maximum of \$11,000 for a first-time course of treatment (maximum \$10,450 reimbursement). Should the covered individual fail to complete the course of treatment or terminate treatment against medical advice, the reimbursement will be reduced to 50% of allowable charges (maximum reimbursement \$5,500);
- 80% of allowable charges to a maximum of \$8,000 for a second-time course of treatment (maximum \$6,400 reimbursement). Should the covered individual fail to complete the course of treatment or terminate treatment

against medical advice, the reimbursement will be reduced to 40% of allowable charges (maximum reimbursement \$3,200); and

- 60% of allowable charges to a maximum of \$6,000 for a third-time course of treatment (maximum \$3,600 reimbursement). This reimbursement will be provided only for an emergency admission and detoxification and for outpatient treatment. Should the covered individual fail to complete the course of treatment or terminate treatment against medical advice, the reimbursement will be reduced to 30% of allowable charges (maximum reimbursement \$1,800).

IMPORTANT

The Chemical Dependency Program will only pay for three courses of treatment in a covered individual's lifetime.

TREATMENTS COVERED BY THE CHEMICAL DEPENDENCY PROGRAM

A course of treatment for chemical dependency may include:

- detoxification;
- rehabilitation treatment;
- hospital** charges (room and board, ancillary and **medical provider's** fees);
- outpatient program charges;
- residential treatment center fees; or
- adolescent care facility fees.

In the third course of treatment, the Plan only covers emergency admission and detoxification and outpatient treatment.

TREATMENTS NOT COVERED BY THE MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAMS

No benefit will be paid under the Mental Health and Chemical Dependency Programs for expenses incurred for:

- any service or facility not approved by ValueOptions;
- any treatment that is educational in nature;
- any treatment for learning disabilities, developmental disorders, mental retardation, autism, or congenital disorders including any treatment of deficits associated with these conditions;
- any treatment that does not meet the national standards of the American Psychiatric Association; for example, Erhard Forum, primal therapy, bio-energetic therapy, crystal healing therapy;
- any treatment that is experimental in nature;
- any treatment for smoking addiction, weight reduction, obesity, stammering, stuttering, sexual addiction;
- any treatment or consultation not provided in person but through some communication media;

- any treatment for a chemical dependency that does not require abstinence from the addictive substance;
- aversion therapy; or
- marriage counseling, except when provided in connection with treatment for a psychiatric disorder.



Prescription Drug Program

The Prescription Drug Program offers you the opportunity to buy your **prescription drugs** either at your retail pharmacy or by mail order.

The AFTRA Health Fund has arranged with Medco Health Solutions (Medco) to operate the Prescription Drug Program. A **prescription drug** is a drug that is obtainable only with a prescription written by a physician or dentist. It must be dispensed by a licensed pharmacist and approved for its intended use by the United States Food and Drug Administration.

Medco Health Solutions, Inc.
100 Parsons Pond Drive
Franklin Lakes, NJ 07417-2603
1-800-903-8343

RETAIL PHARMACIES

Medco has agreements with most of the pharmacies throughout the United States (**Participating Pharmacies**) to sell **prescription drugs** at discounted prices. Benefits are also payable at a lower rate if you purchase **prescription drugs** at other pharmacies (**Non-Participating Pharmacies**). Claims can be submitted to:

Medco Health Solutions, Inc.
P.O. Box 2277
Lee's Summit, MO 64063-2277
1-800-903-8343

MAIL ORDER

For maintenance medications (those **prescription drugs** you take on a continuing basis) you will find it less expensive to use the mail order service. Mail your order form to:

Medco Health Solutions, Inc.
P.O. Box 30493
Tampa, FL 33630
1-800-473-3455 (4-refill)

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

CALENDAR YEAR DEDUCTIBLE

You must satisfy a **deductible** each calendar year before the Program will pay or reimburse a portion of your expenses for **prescription drugs** purchased at **Participating Pharmacies** or **Non-Participating Pharmacies**. The annual **deductible** is \$75 for an individual or \$150 for a family. Purchases from the Mail Order Service are not subject to the **deductible** and do not count toward satisfying the **deductible**.

USING A PARTICIPATING PHARMACY

After you or your family have satisfied the **deductible**, you will only have to pay the greater of \$15 or 25% of the discounted network price when purchasing brand name **prescription drugs** at a retail **Participating Pharmacy**. If you purchase a generic equivalent at a retail **Participating Pharmacy** your **copayment** will be the greater of \$3 or 25% of the discounted network price. You may purchase up to a 30-day supply at one time. You will not have to fill out any claim forms. The retail **Participating Pharmacy** will submit the nec-

essary information electronically to be paid the remainder of the discounted price it charges.

USING A NON-PARTICIPATING PHARMACY

At a **Non-Participating Pharmacy**, you will have to pay the full retail price for **prescription drugs** and then submit a claim for reimbursement to Medco. Claim forms are available from all Fund offices. Once you have satisfied the **deductible**, you will have to pay the greater of \$15 or 30% of the discounted network price. In addition, you will have to pay the difference between the discounted price and the actual charge. Reimbursement is limited to purchases of no more than a 30-day supply at one time.

USING THE MAIL ORDER SERVICE

You should use the Mail Order Service for medications that you take on an ongoing basis. You pay only \$25 for each brand name prescription and each refill of that prescription that you order. If you order a generic equivalent, you pay only \$6 for each prescription and each refill of that prescription. For that payment you will receive up to a 90-day supply of the prescription drug. Send your prescriptions and payment in the pre-addressed Mail Order Service envelope, available from any Fund office or Medco. Allow 10 days for delivery. You will find in most cases that the cost for a prescription drug that you use on a continuing basis will be significantly less than if you purchase it at a retail pharmacy.

OUT-OF-POCKET MAXIMUM

If you purchase your **prescription drugs** from a **Participating Pharmacy** or through the Mail Order Service you can limit your annual out-of-pocket expense. The most you will pay for any covered family member each calendar

year for **prescription drugs** purchased through a **Participating Pharmacy** or through the Mail Order Service is \$1,500 plus the **deductible**. However, if you use a **Non-Participating Pharmacy** you will also have to pay the difference between the retail amount charged by the pharmacy and the amount you would have been charged if you used a **Participating Pharmacy**.

MEDICATIONS NOT COVERED

The Prescription Drug Program does not cover the following medications:

- medications not approved by the FDA or approved by the FDA for a different use;
- drugs used for cosmetic purposes;
- peridex and other similar dental care products;
- Viagra, or other drugs for erectile dysfunction, except if pre-authorized by the Fund office;
- medications, including (for example) vitamins, that can be purchased without a prescription;
- medications provided by a **physician**;
- drugs that are not **medically necessary**; and
- drugs for use by any person who is not covered by the AFTRA Health Plans.

In addition, the general exclusions described on page 64 (common to all health benefits under the Plan) are applicable to the Prescription Drug Program.



The Wellness Program

Keeping healthy is one of the best ways to manage your own health care costs. The Wellness Program makes it easier and less expensive for you to take better care of yourself.

The Program provides valuable coverage for preventive care, including:

- regular comprehensive physical examinations;
- immunizations; and
- tests to detect health problems.

IT'S YOUR CHOICE: NETWORK VS. NON-NETWORK PROVIDERS

When you use **Network Providers**, you receive a discounted rate and save money. But it's always your choice. You can use **Network** or **Non-Network Providers** or a combination of both.

And, when you utilize the benefits offered under the Wellness Program, you do not pay a **deductible**.

NETWORK PROVIDERS

When you use a **Network Provider**, after you pay a **copayment** of \$10 per visit, the Wellness Program will pay 80%—you pay 20% **coinsurance**—of **covered expenses** up to a maximum Fund payment of \$400 for an individual or \$1,200 for a family. Thus, the maximum payment for Wellness benefits is the lesser of \$400 for any covered individual and \$1,200 for the entire family. You will be responsible for all

charges that exceed the benefit maximum during a calendar year plus a \$10 per visit **copayment**.

NON-NETWORK PROVIDERS

When you use a **Non-Network Provider**, after you pay the \$10 **copayment** per visit, reimbursement will be 80% of **covered expenses**, but only those that are within the AFTRA Health Plan's **scheduled allowance**, as long as you do not exceed the annual maximum Wellness benefit of \$400 for each covered individual and \$1,200 for a family. You will be responsible for all charges that exceed the benefit maximum during a calendar year. A **Non-Network Provider** may bill you more than the AFTRA Health Plan's **scheduled allowance**; you will have to pay the difference—in addition to the 20% **coinsurance** and \$10 **copayment** per visit.

IMMUNIZATION FOR NEWBORNS

During the first year of life after the \$10 per visit **copayment**, the cost of immunization is covered at 80% of **covered expenses** (or, in the case of a **Non-Network Provider**, **covered expenses** within the **scheduled allowance**) and will not be applied to the annual Wellness benefit maximum limit.

COVERED SERVICES

The following chart provides a list of services covered under the Wellness Program:

SERVICES	FREQUENCY
Services for Children	
Routine Examinations	
Birth to age 1	Up to 8 visits
Age 1 to age 2	2 visits
Age 2 to age 18	1 visit per year
Childhood Immunizations	As medically necessary
Services for Adults	
Routine Examinations	
Ages 18 and older	As appropriate for age and sex.
Includes physical exam and such tests as:	
Pap Smear	
Mammogram	
Breast Exam	
Blood Work	
EKG	
Stress Test	
Prostate Exam	
Digital Rectal Exam	
Sigmoidoscopy	
Stool for Occult Blood	
Other routine tests as prescribed by a physician	
Adult Immunization	
Tetanus/Diphtheria	Every 10 years up to age 65
Influenza and others	Once every 12 months

HOW TO FILE WELLNESS CLAIMS

Send your Wellness claims to the New York Fund office. Bills for routine exams should contain a Wellness diagnostic code as the primary diagnosis. If an **illness** is diagnosed as a result of the Wellness visit, your doctor should include a secondary diagnostic code for the **illness**.

Claims must be submitted within **15 months of the date of service**. Claims submitted after the 15-month deadline will not be paid.



The Dental Program

The Dental Program provides benefits to reduce your out-of-pocket expenses for preventive dental services performed while the patient is covered for benefits.

In most cases, if you are covered by the Family Plan, the Dental Program will also cover your dependents' preventive dental expenses.

However, dental coverage is not provided for:

- the **dependents** of those participants covered under the Senior Citizen Program;
- those participants covered as Early Retirees and their **dependents**; and
- those surviving spouses covered on the basis of the participant's lifetime earnings.

The AFTRA Health Fund has arranged with The Guardian Life Insurance Company to administer this program and to provide access to its preferred provider network of dentists, DentalGuard Preferred.

The Guardian, through its DentalGuard Preferred provider network, has agreements with dentists (**Participating Dentists**) throughout the United States to provide preventive dental services at rates that are lower than the fees usually charged for such services.

If you choose, you may use dentists who are not members of the network (**Non-Participating Dentists**). You are also free to change your choice of dentist whenever you wish. However, if you choose to use a **Non-Participating Dentist**,

your out-of-pocket costs will be greater than if you used a **Participating Dentist**. The choice is yours.

The Guardian Life Insurance Company
P.O. Box 2459
Spokane, WA 99210-2459
(800) 765-6405

MAXIMUM BENEFIT

The benefit that will be paid by the AFTRA Health Fund under the Dental Program for Preventive Services is limited to \$1,000 for treatment of any one individual in any calendar year.

This maximum applies whether you use a **Participating Dentist, Non-Participating Dentist** or a combination of both.

DENTAL FEE LIMITS

A **Participating Dentist** is one who has agreed to be part of Guardian's DentalGuard Preferred provider network and accept as full payment a discounted fee for covered dental services. Your benefits paid under the Plan will be based on these discounted fees, if you use a **Participating Dentist**.

A **Non-Participating Dentist** is one who is not a member of Guardian's DentalGuard Preferred provider network. When using a **Non-Participating Dentist**, the maximum fee taken into account in computing the benefit you will receive is based on a schedule of the 85th percentile of prevailing charges. This means that your benefit will be based on no more than the highest fee that 85% of dentists in a geographic area charge for a given service.

Whether you use a combination of **Participating** and **Non-Participating Dentists**, there is no **deductible** required.

The Fund will pay 100% of the **Participating Dentist's** fee. If a **Non-Participating Dentist** provides the services, the Fund will pay 75% of the fee up to an amount equal to the 85th percentile of prevailing charges for the service in your dentist's geographic area.

FINDING AND USING A PARTICIPATING DENTIST

You should have a DentalGuard Preferred Directory of **Participating Dentists**. If you do not have a directory, you may get a list of **Participating Dentists** by calling Guardian at 1 (800) 765-6405 or by accessing the AFTRA Health & Retirement Funds' Web site at www.aftrahr.com. Since any directory will become outdated, before receiving services, it is recommended that you verify with your dentist that he or she is a DentalGuard Preferred provider.

You should present your dental program ID card when you go to a dentist. When you call for an appointment with a **Participating Dentist** be sure to identify yourself as a person covered by The Guardian's DentalGuard Preferred network and confirm that the dentist is in the network.

HOW TO SUBMIT DENTAL CLAIMS

The Guardian does not require any special claim form in order to process a dental claim, but will generally accept generic claim forms used by your dentist. **Participating Dentists** will file claims on your behalf directly to the Guardian for payment. Many **Non-Participating**

Dentists will file a claim for you as well, but you are responsible for doing so if your **Non-Participating Dentist** does not. All claim forms should be sent to the address that appears on your Dental Program ID card and at the beginning of this Dental Program section. For more detailed information, refer to the Claims and Appeals Procedures section on page 73.

The Guardian will make payments on behalf of the Fund and will then send you an explanation of the dental benefit payments.

IMPORTANT

Dental claims must be filed within **15 months of the date of service**. Claims filed later than 15 months from the date of service will not be paid. It is your responsibility to ensure that claims are filed.

COORDINATION WITH BENEFITS FROM OTHER DENTAL PROGRAMS

You may be covered by other group plans that also provide dental benefits. For instance, you may also be entitled to dental benefits under the Screen Actors Guild - Producers Health Plan or you may be entitled to dental benefits provided by a plan or under insurance through your spouse's employer. If you are, the Fund will coordinate the Dental Program's benefits with the benefits of the other plans. See the section of this Health Plan booklet entitled "Coordination of Benefits".

CONTINUATION OF COVERAGE

If your coverage terminates, you may be eligible for continuation of coverage under COBRA. For information on COBRA, please refer to the section beginning on page 23. COBRA applications must go directly to the New York Fund office.

LIST OF COVERED DENTAL SERVICES

The Dental Program covers only the specific Preventive Services named in this list. All covered dental services must be furnished by or under the direct supervision of a dentist. The service performed must be a usual and necessary treatment for the dental condition being treated.

PREVENTIVE DENTAL SERVICES OFFICE VISITS AND EXAMINATIONS

- initial or periodic oral examination (limited to one examination in any six-consecutive month period); and
- emergency palliative treatment and other non-routine, unscheduled visits.

DIAGNOSTIC SERVICES

- X-rays:
 - a. full mouth series of at least 14 films including bitewings, if needed (limited to once in any 60-consecutive month period);
 - b. bitewing films (limited to a maximum of eight vertical or four horizontal films in one visit, in any 12-consecutive month period);
 - c. other intraoral periapical or occlusal films; single films (limited to 4 periapical and 2 occlusal in any 12-consecutive month period);
 - d. extraoral superior or inferior maxillary films (limited to 2 in any 12-consecutive month period);

- e. panoramic film, maxilla and mandible allowed in combination with bitewings as an alternative to a full mouth series; and
- f. additional panoramic films only for treatment of accidents, cysts and tumors.

PROPHYLAXIS AND FLUORIDE TREATMENT

- prophylaxis, including scaling and polishing (limited to one treatment in any six-month period); and
- topical application of fluoride (limited to covered individuals under age 14 and limited to one treatment in any six-consecutive month period).

SPACE MAINTAINERS

- fixed, unilateral, band or stainless steel crown type;
- fixed, unilateral, cast type; and
- removable, bilateral type.

(Limited to covered individuals under age 6 and limited to initial appliance only. No additional payment will be made for adjustments made within the first six months of installation.)

FIXED AND REMOVABLE APPLIANCE

Coverage for minor treatment to control harmful habits—limited to a covered person under the age of 14.

DENTAL SEALANTS

Topical application of sealant limited to the unrestored permanent molar teeth of covered individuals under age 15 and limited to one treatment per tooth in any 36-consecutive month period.

DENTAL EXPENSES NOT COVERED

No benefits are payable under the Dental Program for expenses incurred for services or treatment other than the preventive services listed above (including consultations, restorative services, endodontic and periodontic services, oral surgery, prosthodontic services, anesthesia and orthodontic services).



Life Insurance

Accidental Death and Dismemberment Insurance Loss of Voice Benefit

If you meet the **covered earnings** requirements for either the Individual or Family Health Plan described on page 14, you (but not your **dependents**) qualify for the Plans' basic Life Insurance of \$30,000 and Accidental Death and Dismemberment Insurance of up to \$18,000.

These benefits are provided through a group insurance policy issued by ING to the AFTRA Health Fund, which, as policyholder, pays the premiums on the policy. The Plan also provides a Loss of Voice Benefit, which is not insured. You do *not qualify* for any of these benefits if you are covered under COBRA, Early Retiree Self-Pay, the Senior Citizen Program or the Conversion Plan. Please note, however, some senior citizens may be entitled to a death benefit under the Senior Citizen Program as described on page 63.

IMPORTANT

Your ING Certificate booklet provides complete information concerning your basic Life Insurance and Accidental Death and Dismemberment Insurance. The description of these benefits in this Summary Plan Description is intended only to alert you to the principal features of these benefits and actions you may be required to take to secure the advantages of these benefits. In the event of any inconsistency, the ING Certificate booklet will prevail.

LIFE INSURANCE

BENEFICIARY DESIGNATION

The life insurance benefit is a lump sum payment of \$30,000. The life insurance benefit will be paid to the beneficiary or beneficiaries you have named on the enrollment card filed with the AFTRA Health Fund office provided that the named beneficiaries survive you by at least 10 days. All claims must be submitted in writing to the New York Fund office within 90 days of your death or as soon as reasonably possible.

If you do not name a beneficiary, the Plan will pay your life insurance benefit in the following order:

- your spouse;
- your natural and adopted children;
- your parents;
- your siblings;
- your estate.

CONTINUED COVERAGE WHILE TOTALLY DISABLED

If, before your 60th birthday, you are covered by the AFTRA Health Fund and become **permanently** unable to work at any job suited to your education, training or experience, due to **illness** or **injury** as determined by Social Security, the basic Life Insurance coverage in effect at that time will continue at no cost to you. However, you must send written proof of your disability to the New York Fund office within one year of the date total disability began or as soon as reasonably possible.

LIVING DEATH BENEFIT

In the event of an **injury** or **illness** which is expected to result in your death within six months and from which there is no reasonable

chance of recovery, you may request prepayment of up to 50% of your life insurance benefit. This option is not available if your terminal condition is directly or indirectly the result of attempted suicide or if it is the result of an intentionally inflicted **injury**, whether you are sane or insane.

CONVERSION RIGHTS

If you cease to be eligible for the Plan's basic Life Insurance or your coverage is reduced, changed or cancelled, you may exercise a conversion privilege to purchase an individual life insurance policy from ING. You do not need to provide proof of good health. However, you must complete the application form and send it with the first premium payment to ING no later than 31 days after any portion of your group life insurance coverage ends.

For information on getting an application for conversion, contact the New York Fund office or ING. If you die during the 31-day period allowed for making application to convert, ING will pay the group life insurance benefits to the last beneficiary you named, whether or not you applied for an individual life insurance policy. Premiums for the new policy are based on your age on the date of the conversion.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

This benefit is paid if you are involved in an accident while you are insured for AD&D and if, within 180 days of the accident, you sustain any of the losses indicated in the table below as a direct result of the accident. The maximum benefit payable with respect to all losses suffered by any one individual is \$18,000.

IMPORTANT

AD&D Insurance coverage is not subject to continuation by reason of disability or exercise of conversion rights with respect to your basic Life Insurance, but is not affected by payment of the Living Death Benefit under the basic Life Insurance coverage.

For Loss Of:	The Benefit Is:
Life	\$18,000
Two hands ¹	\$18,000
Two feet ¹	\$18,000
Sight of two eyes ²	\$18,000
One hand and one foot ¹	\$18,000
One hand and sight of one eye ^{1,2}	\$18,000
One foot and sight of one eye ^{1,2}	\$18,000
One hand or one foot ¹	\$ 9,000
Sight of one eye ²	\$ 9,000

¹ "Loss of hand or foot" means that the limb is permanently severed at or above the wrist or ankle joint.

² "Loss of sight" means the total and irrecoverable loss of sight.

LOSSES NOT COVERED

No benefit is payable for any loss caused directly or indirectly by any of the following:

- suicide or intentionally self-inflicted **injury**, while sane or insane;
- physical or mental **illness**;
- bacterial infection or bacterial poisoning except for infection from a cut or wound caused by an accident;

- any armed conflict, whether declared as war or not, involving any country or government;
- injury** suffered while in the military service of any country or government;
- injury** that occurs when you commit or attempt to commit a felony; or
- use of any drug, narcotic or hallucinogenic agent:
 - a. unless prescribed by a doctor;
 - b. which is illegal; or
 - c. not taken as directed by a doctor or the manufacturer.

WHO WILL RECEIVE BENEFITS

The AD&D benefit is paid to you or, if payable by reason of your death, to the beneficiaries to whom any basic Life Insurance benefit would be payable (see page 56). All claims must be reported in writing to the New York Fund office within 90 days of the loss sustained or as soon as reasonably possible.

LOSS OF VOICE BENEFIT

You are entitled to a \$10,000 Loss of Voice Benefit if, while you are eligible for basic Life Insurance benefits, you suffer complete and irrevocable loss of your natural voice from an accidental **injury** or as a result of surgery and such loss prevents you from engaging in your usual occupation. Claims must be reported in writing to the New York Fund office as soon as reasonably possible.

This Loss of Voice Benefit is not part of a group policy; it is provided and administered by the AFTRA Health Fund. The Loss of Voice Benefit is not payable for a loss of voice caused by or contributed to by:

- war or act of war, declared or undeclared, or any act of international armed conflict, or conflict involving armed forces of any international authority; or
- an event which also gave rise to the death of the covered **Performer**.

The Senior Citizen Health Program

(A Program to Complement Your Medicare Coverage)

The Senior Citizen Health Program provides health care coverage to those:

- ❑ who have reached age 65;
- ❑ whose **covered earnings** during four consecutive quarters are insufficient to qualify them for active coverage under the Plan; and
- ❑ who meet the necessary requirements based on their history of AFTRA **covered earnings**.

The types of benefits provided through the Senior Citizen Health Program are generally those provided under the Individual and Family Plan (whichever is applicable) described elsewhere in this booklet. They include the Hospital, Major Medical, Wellness, Mental Health, Chemical Dependency, and Prescription Drug Programs. In addition, dental benefits are provided for the retiree but not for the retiree's spouse or dependents. Life, Accidental Death and Dismemberment Insurance and Loss of Voice Benefit coverages are not provided. However, you may qualify for the Senior Citizen Death Benefit defined on page 63.

The benefits provided under the Program are coordinated with Medicare benefits so that while total reimbursement from both plans may equal 100% of the Medicare allowable charge, it will never exceed that amount. However, the AFTRA Health Plan also provides benefits for services not covered by Medicare such as **prescription drugs**, dental, wellness and private duty nursing. In these instances, the payment of charges will be governed by the terms of the Individual and Family Plan, whichever is applicable.

IMPORTANT DEFINITIONS

A "Base Year" is the twelve-month period measured from December 1 through November 30.

A "**Qualifying year**" is any Base Year in which your **covered earnings** are at least \$2,000 or the amount required for Individual Health Plan eligibility as of the last day of that Base Year, whichever is greater.

A "**Family qualifying year**" is any Base Year in which your **covered earnings** were at least \$2,000 or the amount required for Family Health Plan eligibility as of the last day of that Base Year, whichever is greater.

ELIGIBILITY FOR THE SENIOR CITIZEN PROGRAM

To help you understand if you qualify for Senior Citizen health coverage, refer to the chart on page 60. It illustrates the earnings requirements necessary to qualify for Individual Plan coverage in each of the Base Years in the left-hand column.

If you are at least age 65 and have 15 or more **Qualifying years** (or 10 **Qualifying years** if on January 1, 2003 you were at least age 60) with earnings of at least the amount shown in the middle column, you will be entitled to purchase Individual Health Plan coverage. You may also purchase coverage for **dependents**, including your spouse, by paying the premium described on pages 60-62. The election to purchase coverage must be made at the time your

own Senior Citizen coverage becomes effective. *However, an exception can be made if you decline coverage for a spouse or **dependent** because they have coverage under another plan and lose that coverage, or you acquire a new dependent. In these instances, you can add the new dependent to coverage by providing written notice to the Fund within 30 days of the change in family status.*

You will also be eligible for Family Health coverage if you are at least age 65 and have earnings of at least the amount shown in the right hand column and:

- if you have 20 or more **Qualifying years**, 15 of which are Family **Qualifying years**; or
- if you were at least age 60 as of January 1, 2003, and had at least 15 **Qualifying years**, 10 of which are Family **Qualifying years**.

EARNINGS REQUIREMENTS FOR SENIOR CITIZEN HEALTH COVERAGE

Base Year	Individual Qualifying Year Covered Earnings	Family Qualifying Year Covered Earnings
1986 and prior	\$2,000	\$ 2,000
1987	\$2,500	\$ 2,500
1988	\$3,500	\$ 3,500
1989	\$3,500	\$ 3,500
1990	\$5,000	\$ 5,000
1991	\$5,000	\$ 5,000
1992 to 1993	\$7,500	\$ 7,500
1994 to 2001	\$7,500	\$15,000
2002	\$7,500	\$20,000
2003 to date	\$10,000	\$30,000

IMPORTANT

You must notify the New York Fund office in writing that you are qualified and wish to activate your coverage under the Senior Citizen Health Program. That coverage will only become effective when we receive your request.

SPECIAL CONSIDERATION FOR THOSE BORN BEFORE DECEMBER 1, 1937

You will be eligible for Senior Citizen Individual Health Plan coverage if, as of December 1, 1992:

- you were vested in a Regular Annuity based on at least 10 years of service credit under the AFTRA Retirement Plan (including at least five Base Years in which **covered earnings** were \$2,000 or more); or
- you had met all the requirements in effect at that time for Senior Citizen health coverage.

Note: As with all coverage under the AFTRA Health Plan, the Trustees may modify, amend or discontinue Senior Citizen coverage at any time for any particular group of individuals, whether or not they already have otherwise qualified for Senior Citizen coverage. Your rights to coverage or any particular level of coverage never become vested or non-forfeitable.

REQUIRED PREMIUMS UNDER THE SENIOR CITIZEN PROGRAM

If you are eligible for Individual Plan coverage under the Senior Citizen Program, you will pay \$120 per quarter for your own coverage in order to be enrolled in coverage. However, if you want to cover your dependents you do have to pay the Family Plan “buy up” premium (currently \$981 per quarter for one spouse or

dependent; \$1,683 for two or more dependents.)

If you have Family Plan coverage under the Senior Citizen Program, this means that, like all others with Family coverage, you too will be required to pay a quarterly premium as described below for yourself, your spouse and your **dependent** children if you want them to remain covered.

- Retiree only—\$120 per quarter;
- Retiree and spouse—\$345 per quarter;
- Retiree with children—\$345 per quarter, regardless of the number of **dependent** children you cover;
- Retiree with spouse and children—\$395 per quarter, regardless of the number of **dependent** children you cover

If you die, your surviving spouse who is age 65 or older and was covered at the time of your death will continue to receive health coverage on the same basis as before your death. Your spouse will be required to pay premiums to continue coverage. For more information on this coverage and the amount of the required premiums, see “Extended Coverage” on page 21.

Keep in mind that the cost of premiums is subject to change. Contact the Fund office, 1-800-562-4690, for current premium costs.

IF YOU HAVE \$30,000 OR MORE OF COVERED EARNINGS AND QUALIFY FOR ACTIVE COVERAGE

If you would otherwise be covered under the Senior Citizen Program but then have at least \$30,000 in **covered earnings** in any four con-

secutive calendar quarters, you will qualify for active Family Plan coverage and will not be covered under the Senior Citizen Program. Your AFTRA coverage will become primary to Medicare and you will regain eligibility for \$30,000 in Life Insurance, \$18,000 Accidental Death and Dismemberment Insurance (ADD), and a \$10,000 Loss of Voice Benefit, none of which are provided under the Senior Citizen Program. Coverage for yourself, your spouse and **dependent** children requires quarterly payments as described on page 19.

IF YOU ARE COVERED UNDER THE SENIOR CITIZEN PROGRAM AND HAVE COVERED EARNINGS OF AT LEAST \$10,000 BUT LESS THAN \$30,000

If you would otherwise have Individual Plan coverage under the Senior Citizen Program but then have at least \$10,000 but less than \$30,000 in **covered earnings**, you can choose to pay the required \$300 per quarter for yourself and become covered instead as an active participant, rather than under the Senior Citizen Program. Your AFTRA coverage would become primary to Medicare, and you would again become entitled to the Life Insurance, AD&D Insurance and Loss of Voice Benefit coverage described earlier. To cover your spouse and **dependent** children, you would still pay the same Family Plan “buy-up” premium you would have paid under the Senior Citizen Program (see bottom of page 60.)

If you are already entitled to Family Plan coverage through the Senior Citizen Program but then have at least \$10,000 but less than \$30,000 in **covered earnings**, you can choose to pay the \$300 quarterly premium and become eligible under the Individual Plan as an active participant, rather than under the Senior Citizen

Program. Again, your AFTRA coverage would become primary to Medicare and you would become entitled to the Life Insurance, AD&D Insurance and Loss of Voice Benefit coverage described earlier. Alternatively, you could choose not to pay the \$300 per quarter that is required for Individual Plan coverage as an active. By doing so you would remain covered just as you would have been under the Senior Citizen Program and would be required to pay \$120 per quarter for your own coverage, but you also would not be entitled to the additional benefits. In either case, if you have Family Plan coverage under the Senior Citizen Program, your **dependents** would remain covered provided you make the necessary quarterly payments as described on page 61.

HOW THIS PROGRAM WORKS WITH MEDICARE

The Senior Citizen Health Program will provide you and your Medicare-eligible **dependents** with coverage *secondary* to Medicare. Reimbursement for services covered by Medicare will be based on the difference between the amounts paid by Medicare and the amounts allowed by Medicare (not the actual provider charge). In no event will the AFTRA Health Plans pay more than the covered charges as determined by the Medicare allowances (less what Medicare paid). Reimbursement for services not covered by Medicare will be paid according to the provisions of the AFTRA Health Plans. Since Medicare is the primary payer, before the Health Plans begin to pay benefits, you must meet the non-network **deductible**.

Under some circumstances, certain providers opt out of Medicare and must alert their patients to that effect. If your provider does not accept Medicare, and you proceed to incur charges with

that provider, it will be treated as if you have chosen not to file a claim with Medicare and your claim will be processed as if you had received benefits from Medicare (see next section).

IF YOU ARE NOT ELIGIBLE FOR MEDICARE OR YOU DO NOT FILE A CLAIM WITH MEDICARE

Whether or not you are covered by Medicare, the Senior Citizen Health Program will reimburse you for Plan covered expenses as if you had received benefits from Medicare. See “Coordination with Medicare” on page 69.

IF YOU ARE A RESIDENT OF ANOTHER COUNTRY

If you live in another country, the Senior Citizen Health Program will reimburse you for your Plan covered medical expenses as though you had received benefits from Medicare.

IF MEDICARE DAYS ARE EXHAUSTED

If during your hospitalization you use up all your available Medicare days, the AFTRA Health Plans will pay for **medically necessary** additional Plan covered **hospital** days at the Medicare rate. Any amounts charged by the **hospital** that are above the Medicare rate will not be paid by the AFTRA Health Plans. These additional days must be **medically necessary** and be overseen by Alicare Medical Management (AMM), the company which administers under contract our Case Management program.

IF YOU USE A VETERANS' ADMINISTRATION (VA) HOSPITAL

If you are Medicare eligible and receive treatment at a **hospital** operated by the Veterans' Administration for an **illness** or **injury** which is not related to military service, the medical benefits paid by the AFTRA Health Plans will

be the amount you would have received if the service had been provided in a non-governmental facility with Medicare as the primary payor.

DEATH BENEFIT

In the event of your death (but not that of your spouse or **dependents**), a \$5,000 death benefit will be paid to your beneficiary if:

- you are covered under the Senior Citizen Health Program; and
- based entirely on earnings, you have qualified for 15 years of coverage as an active participant under the Individual and Family Health Plans. (Periods of Senior Citizen coverage, Early Retiree coverage, COBRA coverage, coverage as a spouse or other **dependent**, or coverage extended because of disability will not be counted towards this requirement.)

To receive the Death Benefit, your beneficiary must apply for this benefit and submit proof of your death to the New York Fund office within 36 months after the date of death.

Your retiree health benefits are offered through the AFTRA Health Plans and are not part of your benefits provided by the AFTRA Retirement Plan.

EARLY RETIREE COVERAGE

In the event you lose active coverage, you may continue your coverage under the AFTRA Individual or Family Health Plans after you have reached the age of 55, but before you have turned 65, if you meet the eligibility requirements described below. This continuation of benefits requires that you pay premiums for coverage. Early Retiree coverage provides the same medical benefits that are provided under

the Individual and Family Plans described elsewhere in this booklet. However, Early Retiree coverage does not include Life or AD&D Insurance, or Loss of Voice coverage, nor does it include dental benefits.

ELIGIBILITY REQUIREMENTS

To become eligible to pay for Early Retiree health benefits, you must meet each of the following requirements:

- you lose eligibility under the AFTRA Health Plans because your **covered earnings** no longer qualify you for coverage;
- you would be eligible for Senior Citizen coverage except for your age (to determine whether you would have qualified for Senior Citizen coverage, please see page 59);
- you have applied for and received AFTRA Retirement Plan benefits; and
- you make your first premium payment within 45 days after the date you would otherwise lose coverage.

If you are eligible for Early Retiree benefits based on these criteria, you will be able to buy coverage for yourself and your **dependents** by paying the normal premiums that would apply in the case of active coverage.

Premiums may change from time to time. For more information on the cost of coverage, contact the New York Fund office.

Your Early Retiree health benefits are offered through the AFTRA Health Plans and are not part of your benefits provided by the AFTRA Retirement Plan.

For information about surviving spouse coverage see page 21.



General Exclusions and Limitations

In addition to any limitations described under each benefit section, there are limitations and exclusions with regard to all benefits.

WHAT THE HEALTH PLANS DO NOT COVER

The Health Plans do not cover the following:

- services, supplies, or treatments that are not medically necessary. This exclusion also applies to any **hospital** confinement (or any part of a confinement) that is not recommended or approved by a **physician**.
- expenses in excess of the amounts allowed by the AFTRA Health Plans for services, supplies or treatment;
- expenses incurred for occupational, physical, vision and speech therapy beyond the first 12 treatments in a calendar quarter for any single injury or illness;
- expenses incurred for acupuncture and chiropractic beyond the first eight treatments in a calendar quarter; 12 visit limit for all above listed therapies combined;
- eye refraction, eyeglasses or their fitting;
- hearing aids or their fitting;
- circumcision;
- infertility treatment (IUI, IVF, ZIF,GIFT, TET, PROUST);
- foot orthotics;
- diseases contracted, injuries sustained or expenses incurred as a result of war, whether declared or undeclared, or any act of war;
- homeopathic treatment;
- an **injury** or **illness** that is covered (or would be covered except for election not to be covered by, or failure of the person to properly apply for payment) under any Workers' Compensation law, Occupational Disease law or similar laws;
- any charges which the covered person is not required to pay;
- services or supplies provided by or paid for by the U.S. Government or any other government, except:
 - a. benefits will be payable if there is a legal obligation to pay for charges without regard to the existence of any insurance or employee benefit plan; and
 - b. the Veterans' Administration or military **hospital** will be reimbursed in accordance with the Plan for charges incurred by a covered person for services or supplies which are not related to military service. (Except in the case of a person covered under the Senior Citizen Program who is eligible for Medicare, the medical benefits paid by the AFTRA Health Plans will depend on the amount you would have received if the service had been provided in a nongovernmental facility, with Medicare as the primary payor.)
- charges for cosmetic surgery, except as specifically provided (see page 41);

- services provided by a Christian Science Home or Sanitarium;
- custodial care;**
- hospice or home health care except where the Fund provides written pre-authorization, usually when this care is an alternative to hospitalization;
- hospitalization for a longer period of time than authorized by Alicare, except for a covered individual who is eligible for Medicare and who has received pre-authorization for the additional days of hospitalization, before such charges are incurred.
- experimental procedures;**
- any charge incurred as a result of an **injury** or **illness** that is caused by the act or omission of another person (except as provided under the Subrogation/Reimbursement Section; see page 71).
- expenses incurred for surgery involving the breast (other than for diagnosis and treatment of cancer), nose or eyelids, unless advance written authorization for surgery has been obtained from the Fund office;
- services, supplies or treatment provided by the covered person or the covered person's spouse, or by a child, parent or sibling of either the covered person or the covered person's spouse or by any person who normally lives in the covered person's home.



Coordination of Benefits

The Plan includes a coordination of benefits provision. This provision applies to the following benefits: Major Medical, Hospital, Dental, Prescription Drugs, Wellness, Mental Health and Chemical Dependency.

Each time you submit a claim, you have an obligation to advise the Fund of the existence of any other group insurance or health plan covering you, your spouse or any of your **dependents** covered by the Plans.

HOW COORDINATION WORKS

Coordination of benefits operates so that one of the plans (called the primary plan) will pay its benefits first as if the other plan (called the secondary plan) did not exist. The secondary plan may then pay additional benefits. If a primary plan is “closed panel” (that means that you can only get benefits from participating providers) and you obtain benefits from a nonparticipating provider, the secondary plan is treated as a primary plan (except for emergency services or authorized referrals paid or provided by the primary plan).

The general rule works like this: If you or your **dependents** are also covered under another group health plan or covered as both a participant and **dependent** under the Plan, the amount received from all plans will never be more than 100% of the allowable expenses. (See page 69 for a special rule that applies to individuals eligible for, but not covered under, the SAG-Producers Health Plan.)

Allowable expenses means necessary and reasonable expenses for health care services, supplies or treatment (including **deductibles, coinsurance** or **copayments**) that are covered, in whole or in part, by this Plan or another plan. However, it will not be an allowable expense to the extent that a primary plan reduced your benefits because you did not comply with that plan’s claims procedure, pre-certification, or second surgical procedure requirements. For example, allowable expenses do not include such things as the difference in cost between a private room and a semiprivate room in a **hospital** (unless the stay in a private room is **medically necessary** or one of the plans routinely covers it) or amounts in excess of usual and customary fees (if at least two plans compute their benefits on that basis). Where one plan calculates benefits based on usual and customary fees and the other calculates benefits based on negotiated fees, the primary plan’s arrangement is the allowable expense.

Benefits under the Plan will be coordinated with any group plan, whether insured or uninsured, providing coverage for **hospital**, medical, wellness, dental, or prescription benefits. This includes:

- group blanket or franchise insurance;
- group subscriber contracts and group-type contracts;
- uninsured group or group-type coverage arrangements;
- group Blue Cross and Blue Shield plans;
- group practice and any other group prepayment coverage;

- group and group-type coverage in “closed panel” plans;
- labor-management trustee plans;
- union welfare plans;
- employer organization plans;
- medical care portions of group long-term care contracts;
- automobile “no fault” and “fault” contracts;
- Medicare or any governmental benefits (as permitted by law) other than a state Medicaid plan.

However, it does not include:

- school accident-type coverage;
- Medicare supplemental policies;
- group or group-type **hospital** indemnity benefits of \$200 per day or less;
- non-group insurance or subscriber contracts;
- non-group coverage through “closed panel” plans;
- non-group coverage under other prepayment, group practice and individual practice plans.

Each contract, agreement or other group plan is considered a separate plan. The part of a contract, agreement or plan that considers benefits of other plans is considered a separate plan from the part of the contract, agreement or plan that does not.

Claims will be paid on an individual claim-by-claim basis, rather than a cumulative basis over the course of a calendar year. This means that, when you are covered by two separate plans and the Health Plan is a secondary payor, the Health Plan will, for each separate claim, pay the lesser of the amount it would have paid if it were primary or the amount of your out-of-pocket expenses for that particular claim (but not taking into account your out-of-pocket expenses for other claims in the calendar year). The total reimbursement during a calendar year from both carriers may in some cases amount to less than 100% of your charges. When the Plan is secondary, it never pays more for benefits than it would have paid for each claim, as it is submitted, had it been the plan that paid primary.

WHICH PLAN PAYS FIRST?

The order of payment between the two plans is determined according to the following rules (in order):

- If a person is covered by two group health plans and one plan does not have a coordination of benefits provision, that plan is always primary.
- Any plan that covers a person as a participant is primary over one that covers that person as a **dependent**.
- If a **dependent** child is covered under both parents' plans, and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. However, this provision does not apply

during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If a **dependent** child is covered under both parents' plans and there is no court decree allocating responsibility for the child's health care expenses or coverage, the plan of the parent whose birthday (month and day, but not year) is earlier in the year will pay benefits first. If the parents have the same birthday, the plan that covers a parent longer will pay first. If the parents of a **dependent** child are divorced or legally separated and neither parent is remarried, the plan of the parent with custody of the child pays benefits first. If the parent with custody remarries, the order of payment is as follows:

- a. the plan covering the parent with custody pays first;
- b. the plan of the spouse of the parent with custody pays second; and
- c. the plan of the parent not having custody of the child pays last.

If the other plan does not have this rule but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will govern. This Plan will provide coverage to a **dependent** child under any court agency order that it determines to be a Qualified Medical Support Order (QMCSO) under federal law.

- The plan that covers a person as an employee who is neither laid-off nor retired (i.e. an

active employee), or as that active employee's **dependent**, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's **dependent**, pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- The plan that covers a person as an employee, member, subscriber or retiree (or as that person's **dependent**) is primary to the plan that provides coverage under a right of continuation pursuant to federal or state law. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If none of the previous rules determines the order of benefits, the plan that covered an employee for the longer period of time without a break in coverage pays first; and the plan that covered that person for the shorter period of time pays second. To determine how long a person was covered by a plan, two plans are treated as one continuous plan as long as the person was eligible for coverage under the second plan within 24 hours after the first plan ended. The start of a new plan does not include a change in the amount or scope of a plan's benefits, in the entity that pays, provides or administers the plan's benefits, or from one type of plan to another (such as from a single employer plan to a multiple employer plan). The length of time a person is covered under a plan is measured from the first date of continuous coverage under that plan. If that date is not readily available, the date the person first became an eligible employee will be used to determine the length of time that person

was covered under the plan presently in force.

- ❑ If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

ADMINISTRATION OF COORDINATION OF BENEFITS

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits through this Plan must provide the Plan with all the information the Plan needs to apply the COB rules.

To administer the coordination of benefits program, the Plan reserves the right to exchange information with other plans involved in paying claims, to require that you or your health care provider furnish any necessary information, to reimburse any plan that made payments that this Plan should have made, and to recover any overpayment from your **hospital, physician, dentist, other health care provider, other insurance company, you or your covered dependent.**

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the plan that made the other payments in the amount the Plan determines to be proper under this provision. Any amounts paid will be considered to be benefits through this Plan and this Plan will be fully discharged from any liability it may have to the extent of such payment.

SPECIAL RULES FOR INDIVIDUALS ELIGIBLE FOR THE SAG-PRODUCERS HEALTH PLAN

If you would have primary coverage under the

SAG Producers Health Plan but have failed to pay the quarterly premium required by the SAG Plan, the AFTRA Plan will process your claims as if you continued to be covered under the SAG Plan and will only pay benefits on a secondary basis. The AFTRA Plan will determine what would have been paid for primary coverage by calculating what the AFTRA Plan would have paid as primary and then process the claim as secondary payer.

Keep in mind that, unlike the coordination of benefit rules described above, this rule applies even if you are not actually covered by the SAG Plan.

In addition, if a participant qualifies for coverage under both the AFTRA Health Fund and the SAG-Producer's Health Plan **on the same day**, there are special rules regarding the order of coverage as well as what happens if you pay the premium for one plan but not the other. If this applies to you, please contact the Fund office.

COORDINATION WITH MEDICARE

If you are covered by the AFTRA Health Plan on the basis of current employment status and you or your spouse are eligible for Medicare Part A, the AFTRA Health Plan is primary. You may elect to have Medicare as your primary insurer but, if you do, the Plan is prohibited by federal law from making any secondary payments on Medicare **covered expenses.** See "How This Program Works with Medicare" on page 62.

If you and/or your spouse are under age 65, are determined to be disabled by the Social Security Administration, become entitled to Medicare

after 29 months of disability and do not have active coverage, Medicare will pay your benefits first and the AFTRA Health Plans will pay second. In addition, if you or a **dependent** is disabled due to end-stage renal disease, the Plans will be primary during the period required.



Other Important Information

SUBROGATION/REIMBURSEMENT

Benefits payable by the Fund for the treatment of an **illness** or **injury** shall be limited in the following ways when the **illness** or **injury** is the result of an act or omission of another (including a legal entity) and when the participant or dependent pursues or has the right to pursue a recovery for such act or omission.

The Fund shall pay benefits for covered expenses related to such **illness** and **injury** only to the extent not paid by the third party and only after the participant or **dependent** (and his or her attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Fund.

By accepting benefits related to such **illness** or **injury**, you agree:

- that the Fund has established a lien on any recovery received by you (or your **dependent**, legal representative or agent);
- to notify any third party responsible for your **illness** or **injury** of the AFTRA Health Plans right to reimbursement for any claims related to your **illness** or **injury**;
- to hold any reimbursement or recovery received by you (or your **dependent**, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such **illness** or **injury** and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated (“made whole”) for your loss;
- that the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or **dependent** is made whole) and that the Fund’s claim has first priority over all other claims and rights;
- to reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the **illness** or **injury** from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the benefits paid.
- that the Fund’s claim is not subject to reduction for attorney’s fees or costs under the “common fund” doctrine or otherwise;
- that, in the event that you elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the Fund’s request, any right or cause of action to the Fund;
- not to take or omit to take any action to prejudice the Fund’s ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement;
- to cooperate in doing what is necessary to assist the Fund in recovering the benefits paid or in pursuing any recovery;

- to forward any recovery to the Fund within ten days of disbursement by the third party or to notify the Fund as to why you are unable to do so; and
- to the entry judgement against you and, if applicable, your **dependent**, in any court for the amount of benefits paid on your behalf with respect to the **illness** or **injury** to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Fund's attorneys' fees and costs.

No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plans. The Fund may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from a participant's or a covered **dependent's** future benefit payments (regardless of whether benefits have been assigned by a participant or covered **dependent** to the doctor, **hospital** or other provider), or any other remedy available to the Fund.

The Fund may permit you to turn over less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Fund's claim is subject to prior written approval by the Fund.

PLAN CHANGE OR TERMINATION

The Trustees reserve the right to amend, modify or terminate the Plans, in whole or in part, at any time and for any reason with respect to active or retired participants and their **dependents** that are or may become covered. The

Trustees may change or discontinue the types and amounts of benefits under the Plans and the eligibility rules, including the rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated. If the Plan is amended or terminated, the ability of employees, retirees or their family members to participate in and receive benefits from the AFTRA Health Fund may be modified or terminated. Benefits of both active and retired participants are not guaranteed, as the type and amount of benefits are always subject to the actual terms of the Plans. Under no circumstances will any Plan benefits become vested or non-forfeitable with respect to active or retired employees or their beneficiaries or **dependents**.

Plan benefits and eligibility rules if you are active, retired or disabled:

- are not guaranteed;
- may be changed or discontinued by the Board of Trustees;
- are subject to the rules and regulations adopted by the Board of Trustees;
- are subject to the Trust Agreement that establishes and governs the Fund's operations; and
- are subject to the provisions of the group insurance policies, if any, purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the AFTRA Health Plans as they exist at the time.

CLAIMS AND APPEALS PROCEDURES

The following sections outline the steps you must take to file a claim and to appeal a denial of a claim (whether a complete or partial denial) for benefits under the Plans. Please note that claims procedures differ for **hospital**, major medical, prescription, mental health/chemical dependency and dental claims. If you have any questions about these procedures, you can contact the Participant Services Department in the Fund office.

A CLAIM FOR BENEFITS

A “claim for benefits” is a request for a plan benefit made in accordance with the Fund’s procedures for filing benefit claims. Inquiries that are unrelated to a specific benefit claim, such as inquiries regarding benefits available under the plan, or the circumstances under which benefits might be paid, or eligibility for benefits, will **not** be treated as “claim for benefits” subject to these provisions (except for “pre-service claims” as described below). In addition, a request for prior approval of a benefit that does not require prior approval under the plan is **not** considered a “claim for benefits” under the new procedures. Retail and mail order pharmacy transactions through the Medco Network are point-of-service transactions and are **not** considered “claims for benefits” under these procedures.

In addition to special requirements as described below for “pre-service” and “urgent care” claims, a “claim for benefits” under the Plan must include all of the following information in order to be considered for payment by the Fund:

- patient name and address

- a bill on the provider’s letterhead
- CPT procedure codes
- ICD9 illness codes
- date(s) of service
- provider’s charge for service
- other information or proof reasonably required by the Fund

HOSPITAL PROGRAM

MAJOR MEDICAL PROGRAM

MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAMS

PRE-CERTIFICATION REQUIREMENTS

Before you are hospitalized, request private duty nursing or receive treatment for mental health or chemical dependency problems, you must receive pre-certification for these services as described in this section.

HOSPITAL PROGRAM

Before you are admitted to a **hospital, you or your doctor must first obtain pre-certification** by calling Alicare at 866-663-7486 and providing the following information:

- name, address, date of birth and Social Security number of the patient;
- name and Social Security number of the covered performer;
- date of the proposed **hospital** admission;

- admitting diagnosis, procedure to be performed and proposed length of stay;
- name and contact information for the **hospital**;
- name and contact information for the admitting physician.

If you are unable to call Alicare in advance of receiving **hospital** services because it is an emergency situation, you or the **hospital** must call Alicare within 72 hours after your admission into the **hospital** and provide the necessary information. A request for pre-certification as required under the plan is a “pre-service claim.” Pre-service claims are claims for benefits that require you to obtain pre-certification, that is, approval in advance of obtaining care. **Hospital** pre-service claims may also be considered “urgent care claims,” as defined on page 75.

IMPORTANT

If you fail to obtain pre-certification for **hospital** benefits, a 20% penalty will be applied.

MAJOR MEDICAL PROGRAM

Coverage of expenses for private duty nursing care **must be pre-certified in advance.** Prior to arranging for private duty nursing care, you must contact Alicare at 1-866-663-7486 and provide the following information:

- name, address and Social Security number of the plan participant;
- patient’s name; and
- name and contact information for the prescribing physician.

A request for pre-certification of private duty nursing, as required under the plan, is considered a “pre-service claim.” Private duty nursing “pre-service claims” may also be “urgent care claims,” as defined in these procedures.

IMPORTANT

If you fail to obtain advance pre-certification for private nursing care, the Fund will not cover the charges.

MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAMS

All claims for in-patient and out-patient mental health and chemical dependency services require pre-certification. Before receiving treatment for mental health or chemical dependency services, **you must first obtain pre-certification** by calling ValueOptions at 1-800-704-1421 and providing the following information:

- name, address and Social Security number of the plan participant;
- patient’s name; and
- other information or proof reasonably required by the Fund.

A request for pre-certification of mental health in-patient or out-patient services, or chemical dependency benefits, as required under the Plan, is considered a “pre-service claim.” A pre-service claim for mental health in-patient or out-patient services or chemical dependency benefits may also be considered “urgent care claims,” as defined on the following page.

IMPORTANT

If you fail to obtain advance pre-certification from ValueOptions for in-patient and out-patient mental health services or for chemical dependency benefits, the Fund will not cover the charges.

PROCEDURES FOR DECIDING CLAIMS**PRE-SERVICE CLAIMS**

If the required information is provided to Aicare for **hospital** or private duty nursing benefits, or ValueOptions for mental health and chemical dependency services, Aicare or ValueOptions, as appropriate, will notify you in writing of its decision concerning pre-certification within **15 days** of your initial call, unless additional time is needed due to matters beyond their control. Under those circumstances, Aicare or ValueOptions may extend the time to decide your claim up to **15 days**. Prior to the expiration of the initial 15-day period, they will notify you of the circumstances necessitating the extension of time. If the extension is necessary because of a failure to submit the required information, the notice shall describe the additional information necessary to decide the claim. In that case, you and/or your provider will have **45 days** from receipt of the notice to supply the additional information. During this 45-day period, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (i) 45 days or (ii) the date you respond to the request. Aicare or ValueOptions then has **15 days** to make a decision on your claim and to notify you of the determination. If the requested information is not provided within the time allowed, your claim will be denied.

URGENT CARE CLAIMS

An “urgent care claim” is a pre-service claim for medical care or treatment where the application of the time periods for making pre-service determinations:

- could seriously jeopardize the life or health of the patient or the ability to regain maximum function; or
- in the opinion of a physician with knowledge of the medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an “urgent care claim” will be determined by Aicare or ValueOptions applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. A claim that a physician with knowledge of the patient’s medical condition determines is an “urgent care claim” shall be treated as an “urgent care claim” for purposes of these procedures.

Aicare or ValueOptions will respond to you and/or your doctor with a determination regarding pre-certification of an “urgent care claim” for **hospital** benefits or private duty nursing by letter and/or phone as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the claim.

If an “urgent care claim” is received without sufficient information to make a determination, Aicare or ValueOptions will notify you and/or your doctor as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You

and/or your doctor must provide the specified information within **48 hours**. If the information is not provided within that time, your claim for pre-certification will be denied. Upon receipt of the requested information, notice of the decision will be provided no later than **48 hours**.

POST SERVICE CLAIMS

“Post service claims” are all claims for benefits, including **hospital**, private duty nursing and mental health and chemical dependency claims for which pre-certification has been obtained, after treatment or services have been rendered. Submit all **hospital**, Major Medical and mental health and chemical dependency claims directly to the New York Fund office.

The Fund will notify you in writing of its decision concerning your claim within **30 days** of receipt of your claim unless additional time is needed due to matters beyond the Fund’s control. Under those circumstances, the Fund may extend its time to decide your claim up to **15 days**. Prior to the expiration of the initial 15-day period, the Fund will notify you of the circumstances necessitating the extension of time. If the extension is needed because additional information is required to make a determination, the notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notice to supply the additional information. During this time, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (i) either 45 days or (ii) the date you respond to the request. The Fund then has **15 days** to make a decision on your claim and to notify you of the determination. If the information requested by the Fund is not provided within **45 days** of receipt of the Fund’s notice, your claim will be denied.

TIME PERIOD FOR SUBMITTING POST-SERVICE HOSPITAL/MAJOR MEDICAL/MENTAL HEALTH AND CHEMICAL DEPENDENCY CLAIMS

Once services have been rendered, claims for benefits should be submitted within 90 days of the date of service. Claims will not be accepted later than 15 months from the date of service.

PRESCRIPTION DRUG BENEFITS

IN-NETWORK POINT-OF-SERVICE TRANSACTIONS

The Fund provides prescription drug benefits through Medco. If you fill a prescription at a retail pharmacy participating in the Medco network, you need only submit your identification card to the pharmacist and pay the applicable **copayment**. You may fill a prescription at the mail order pharmacy by submitting a prescription and the applicable **copayment** directly to Medco in their pre-addressed envelopes.

OUT-OF-NETWORK

If you fill a prescription at a **non-participating retail pharmacy** you must submit a claim form along with the original pharmacy receipt directly to Medco at P.O. Box 2277, Lee’s Summit, MO 64063-2277. You may obtain a claim form by contacting the Fund office.

PROCEDURE FOR DECIDING OUT-OF-NETWORK PHARMACY CLAIMS

Medco will notify you in writing of its decision concerning your claim within **30 days** of receipt of your claim unless additional time is needed due to matters beyond Medco’s control. Under those circumstances, Medco may extend its time to decide your claim up to **15 days**. Prior to the expiration of the initial 15-day period,

Medco will notify you of the circumstances necessitating the extension of time. If the extension is needed because additional information is required to make a determination, the notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notice to supply the additional information. During this time, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (i) either 45 days or (ii) the date you respond to the request. Medco then has **15 days** to make a decision on your claim and to notify you of the determination. If the information requested by Medco is not provided within **45 days** of receipt of the Fund's notice, your claim will be denied.

TIME PERIOD FOR SUBMITTING POST-SERVICE CLAIMS

Once services have been rendered, out-of-network claims for pharmacy benefits should be submitted to Medco within 90 days of the date of service. Claims will not be accepted later than 15 months from the date of service.

DENTAL BENEFITS

The Fund provides dental benefits through The Guardian Life Insurance Company.

IN NETWORK/OUT-OF-NETWORK

If you obtain services from a dental provider in The Guardian network, you must pay the applicable copayment and you or your dentist must submit the bill for services rendered to:
The Guardian Life Insurance Company
P.O. Box 2459
Spokane, WA 99210-2459

If you obtain dental services from a dental provider who is not part of The Guardian network, you or your dentist must submit the bill for services rendered to the above address.

PROCEDURE FOR DECIDING DENTAL CLAIMS

The Guardian will notify you in writing of its decision concerning your claim within **30 days** of receipt of your claim unless additional time is needed due to matters beyond The Guardian's control. Under those circumstances, The Guardian may extend its time to decide your claim up to **15 days**. Prior to the expiration of the initial 15-day period, The Guardian will notify you of the circumstances necessitating the extension of time. If the extension is needed because additional information is required to make a determination, the notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notice to supply the additional information. During this time, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (i) either 45 days or (ii) the date you respond to the request. The Guardian then has **15 days** to make a decision on your claim and to notify you of the determination. If the information requested by The Guardian is not provided within **45 days** of receipt of the Fund's notice, your claim will be denied.

TIME PERIOD FOR SUBMITTING POST-SERVICE CLAIMS

Once services have been rendered, claims for dental benefits should be submitted to The Guardian within 90 days of the date of service. Claims will not be accepted later than 15 months from the date of service.

NOTICE OF DECISION

In the event that your claim for benefits under the plan is denied, in whole or in part, whether it is a “pre-service,” “urgent care” or “post-service claim,” you will be sent a written notice of a denial of a claim in the form of an Explanation of Benefits. This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based, or a statement that additional material or information necessary to consider the claim was not provided;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, a statement that the rule, guideline or protocol is available upon request at no charge;
- If the claim was denied based upon a lack of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the plan is available upon request at no charge.

YOUR RIGHT TO APPEAL A CLAIM

If your claim has been denied in whole or in part, you have a right to appeal the decision. If

your claim is a “pre-service,” “urgent care” or “post-service claim” as described above, appeals of adverse decisions are governed by these procedures.

RIGHT TO REVIEW DOCUMENTS AND OBTAIN OTHER INFORMATION

You have the right to review, and receive free of charge upon request, documents, records or information relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision, or if it was submitted, considered or generated (regardless of whether it was relied upon) in making the decision. A document is also relevant if it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making.

RIGHT TO INDEPENDENT REVIEW

A review of an adverse determination will not be by the same person who made the original determination, or a subordinate of that person. A review will not afford deference to the initial determination. The decision will be made on the basis of the record, including such additional comments, documents, records or other information that you submit, even if the documents or information were not considered or submitted in connection with the original decision.

CASES INVOLVING A MEDICAL JUDGMENT

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not **medically necessary**, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the

medical expert(s) whose advice was obtained will be identified.

APPEAL PROCEDURES

POST-SERVICE CLAIMS

This section applies to any “post-service claim” denied for charges incurred under the **Hospital**, Major Medical, Mental Health and Chemical Dependency, Prescription Drug and Wellness Programs as detailed in this summary plan description. The process for appealing “post-service claims” denied under the Dental Program appears in the next section.

Except for appeals involving “pre-service claims,” which are described below, appeals must be made in writing and must be sent to: AFTRA Health Fund, Appeals Department, P.O. Box 1806, Murray Hill Station, New York, NY 10156-1806. Your letter must be sent within 180 days of your receipt of the denial that you are appealing and should state the reasons why you believe the Fund's decision is incorrect. Your appeal should be accompanied by any additional comments, documents, records or other information that you wish to submit in support of your appeal.

If you are appealing a denial based upon the plan's medical necessity or experimental treatment exclusions, decisions on appeals generally will be made at the next regularly scheduled meeting of the Trustees Claims Appeals Committee following receipt of your appeal. However, if your appeal is received less than 31 days before the next meeting, your appeal may be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third

regularly scheduled meeting following receipt of your appeal may be necessary. You will be notified in writing in advance if this extension will be necessary. You will be notified of the Committee's decision concerning your appeal as soon as possible, but no later than five days after the decision has been reached.

For all other appeals that are subject to these procedures, a decision will be made by the Fund's Appeals Department within 30 days of receipt of the appeal. If the determination results in an adverse decision, you will be notified of the reason for the denial within 30 days of receipt of the appeal. You may make a second appeal by letter sent to the Fund at the address specified above within 180 days of your receipt of the decision of the Appeals Department. The determination on a second appeal will be made by a committee of senior Health Fund management made up of employees who were not involved in the original claim determination or the first appeal denial and who are not subordinate to those persons. A final determination will be made within 30 days. If the second appeal results in an adverse decision, you have the option to submit a further appeal voluntarily to the Trustees Claims Appeals Committee for a determination or you may pursue legal remedies as set forth below.

If you voluntarily elect to appeal to the Trustees Claims Appeals Committee, your appeal must be in writing and must be sent to the Fund at the address set forth above so that it is received within 60 days after your receipt of the notice of denial of your second-level appeal. Your appeal should set forth the reasons why you believe the decisions made in the first and second-level appeals were incorrect. Ordinarily, decisions on

optional appeals will be made at the next regularly scheduled meeting of the Trustees following receipt of your appeal. However, if your appeal is received less than 31 days before the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. You will be notified of the Committee's decision concerning your appeal as soon as possible, but no later than five days after the decision has been reached.

An appeal to the Trustees Claims Appeals Committee taken after a second level appeal to the Fund is strictly voluntary. The Fund will not assert your decision not to elect a voluntary appeal as a defense if you bring a lawsuit against the Fund. If you do choose to appeal to the Appeals Committee, the Fund agrees that any statute of limitations or other defense based on timeliness will be tolled during the time that the appeal to the Committee is pending. The decision of whether to appeal to the Appeals Committee will have no effect on your rights to any other benefits under the plan.

APPEAL OF POST-SERVICE DENTAL CLAIMS

In order to appeal a post-service dental claim denial you must submit your appeal to The Guardian Life Insurance Company, P.O. Box 2459, Spokane, WA 99210-2459 within 180 days of your receipt of the initial denial. The Guardian will notify you of the review decision within 60 days of your request for review and will advise you of your additional appeal rights if the denial is maintained.

PRE-SERVICE CLAIMS

You have the right to appeal an adverse pre-certification decision regarding **hospital**, private duty nursing, in-patient or out-patient mental health or chemical dependency services or prescription drug claims. If you do so, you must submit your appeal in writing within **180 days** of your receipt of the adverse decision and include the following information:

- Participant's name and Social Security number;
- Patient's name; and
- Provider's name.

Your appeal should be directed as follows:

- For Hospital or Private Duty Nursing**, send your appeal to Alicare Medical Management, 8C Industrial Way, Salem, NH 03079, Attention: Appeals Department.
- For Mental Health or Chemical Dependency**, send your appeal to ValueOptions, 340 Golden Shore, Long Beach, CA 90802, Attention: Clinical Appeals.
- For Prescription Drugs**, send your appeal to AFTRA Health and Retirement Fund, Appeals Department, P.O. BOX 1806, Murray Hill Station, New York, NY 10156-1806.

You will be sent a notice of Alicare's, ValueOption's or AFTRA's Appeals Committee decision on appeal within 30 days of their receipt of your appeal.

SPECIAL RULES FOR APPEAL OF URGENT CARE CLAIMS

In order to appeal a decision involving an “urgent care claim” for **hospital**, private duty nursing or mental health and chemical dependency benefits, your appeal can be submitted on an expedited basis orally or in writing.

Oral appeals for **hospital** or private duty nursing benefits can be made by calling Alicare at 1-866-663-7486 and providing the information indicated above. Written appeals should be addressed to Alicare Medical Management, 8C Industrial Way, Salem, NH 03079, Attention: Appeals Department.

Oral appeals for mental health and chemical dependency benefits can be made by calling ValueOptions at 1-800-704-1421, and providing the information indicated above. Written appeals should be addressed to ValueOptions, 340 Golden Shore, Long Beach, CA 90802, Attention: Clinical Appeals.

Alicare or ValueOptions will notify you of its decision on appeal of an “urgent care claim” within **72 hours** after receipt of your appeal.

NOTE: At all stages of the appeals process, the Fund may avail itself of any resource to decide the appeal, including, but not limited to, inquiries to you, the **medical provider**, or independent sources of information and appropriate health care professional opinions as the Fund may deem necessary.

NOTICE OF THE DETERMINATION OF YOUR APPEAL

All decisions on appeal will be in writing and will include the following information:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon, a statement that the rule, guideline or protocol is available upon request at no charge;
- If the determination was based on a lack of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim.

If your final appeal is ultimately denied in whole or in part, you have the right to file a lawsuit under the Employee Retirement Income Security Act of 1974 (ERISA) (see page 82).

DESIGNATED AUTHORIZED REPRESENTATIVE

You may submit a claim and appeal a denial of a claim on your own behalf. Alternatively, you may designate another individual, including a health care provider, to act as your representative. If you choose to designate someone else to act on your behalf, you must inform the Fund in writing. An “assignment of benefits” on a

claim without a separate written designation by you does not constitute a valid designation. If you revoke your designation of an authorized representative, the revocation will not be effective until written notice is received by the Fund. However, for “urgent care claims,” the Fund will permit a doctor or other health care professional who has knowledge of your medical condition to act as your authorized representative in the absence of a written designation. Once you have designated an authorized representative, all communications and notices from the Fund that would otherwise be sent to you will only be sent to your authorized representative, unless you advise the Fund to the contrary.

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

As a participant in the AFTRA Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

☐ Receive Information About Your Plan and Benefits

- a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

☐ Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or **dependents** if there is a loss of coverage under the Plan as a result of a qualifying event. You or your **dependents** may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

☐ Reduction or Elimination of Exclusionary Periods of Coverage for Pre-existing Conditions under your Group Health Plan, If You Have Creditable Coverage from Another Plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing

coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

❑ Prudent Actions by Plan Fiduciaries

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

❑ Enforce Your Rights

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

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

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

❑ Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN ADMINISTRATION

Most questions about your benefits can be answered by any Fund office. The New York Fund office will make Plan documents and insurance contracts available to you if you wish to study these materials.

If for some reason it becomes necessary to contact the U.S. Department of Labor, you will need the following information to identify your Plan.

NAME AND ADDRESS OF PLAN'S SPONSOR

Board of Trustees
AFTRA Health Fund
261 Madison Avenue
New York, NY 10016

EMPLOYER IDENTIFICATION NUMBER (EIN)

13-3467049

NAME OF PLAN

AFTRA Health Plan—Individual Health Plan
AFTRA Health Plan—Family Health Plan

TYPE OF PLAN

The Plan is an employee welfare benefit plan that provides life insurance, accidental death and dismemberment insurance, hospitalization, surgical and major medical benefits, dental, loss of voice benefits, wellness, mental health and chemical dependency benefits.

TYPE OF ADMINISTRATION

This Plan is administered by a Board of Trustees, 50% of whom represent management and 50% represent the union. Certain administrative items have been delegated to entities providing third party administrative services, including the Plan's dental (Guardian), prescription drug (Medco) and mental health and chemical dependency (ValueOptions) benefits. The insurer of those benefits (ING) administers life insurance and accidental death and dismemberment benefits.

CONTRIBUTIONS

Contributions are made to the Fund by **contributing employers** according to the terms of applicable collective bargaining agreements. As described in the Plan, contributions are also required by participants for themselves and their spouses or dependents.

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination during normal business hours. Participants and beneficiaries may also receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if so, the sponsor's address.

FUNDING METHOD

The AFTRA Health Fund maintains a Trust that includes all contributions to the Plans and investment income. The Fund is self-insured for all **hospital**, medical, dental, and loss of voice

benefits provided by the AFTRA Health Plan. However, life insurance and AD&D benefits are underwritten by ING. All benefits, premiums for insurance and administrative expenses are paid by the Trust.

PLAN NUMBER

002

PLAN ADMINISTRATOR

Board of Trustees
AFTRA Health Fund
261 Madison Avenue
New York, NY 10016
(212) 499-4800

PLAN YEAR

The Plan year is December 1 through November 30.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained according to a number of collective bargaining agreements. A copy of a collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries during normal business hours. For information on obtaining or examining a copy of your collective bargaining agreement, contact your union or the New York Fund office.

AGENT FOR PROCESS OF LEGAL SERVICE

The name of the person designated as agent for service of legal process on the AFTRA Health Plan and the address at which process may be served on such person are:

Dina Goldman, Executive Director
AFTRA Health Fund
261 Madison Avenue
New York, NY 10016

Service of legal process of a court upon a trustee of an employee benefit plan in his or her capacity as such shall also constitute service upon the employee benefit plan.

NO LIABILITY FOR THE PRACTICE OF MEDICINE

While the AFTRA Health Fund provides participants and covered **dependents** with health coverage, neither the Fund, the Plan Administrator nor any of their designees are engaged in the practice of medicine. None of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the AFTRA Health Fund, the Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

FACILITY OF PAYMENT

Every person receiving or claiming benefits through the Plans will generally be presumed to be mentally and physically competent and of

age. However, if the Plan Administrator (or its designee) determines that a person entitled to receive benefits hereunder is in the person's minority, or is physically or mentally incompetent to receive the payment or to give a valid release for benefits, the AFTRA Health Fund may make a distribution to the person's legally appointed guardian, committee or representative (upon proof of the appointment) or, if none, to another person or entity that the Trustees determine appropriate in their sole and absolute discretion. Any payment in accordance with this provision will discharge entirely the obligation of the Fund.

INTERPRETATION

Please note that no individual other than the Board of Trustees or its duly authorized designee(s) has any authority to interpret the Plan documents, including this Summary Plan Description or the other official Plan documents, or to make any promises to you about the Plan, or your benefits under the Plan, or to change the provisions of the Plan.

The Plan Administrator and its duly authorized designee(s) have the exclusive right, power, and authority, in their sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or the AFTRA Health Fund. Without limiting the generality of the foregoing, the Plan Administrator and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;

- Formulate, interpret and apply rules, regulations and policies necessary to administer the AFTRA Health Fund in accordance with the terms of the Plan;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Plan Administrator and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan.