

# AFTRA Health & Retirement Funds

Main Office: 261 Madison Ave., New York, NY 10016-2495 • 1-800-562-4690 • Phone (212) 499-4800 • Fax (212) 499-4925  
www.aftrahr.com

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Dear Participant,

The accompanying information is a supplement to the January 2005 AFTRA Health Plan Summary Plan Description (SPD), which you received in the mail some time ago. If you did not receive it, or have misplaced it, you may get a copy of the current Health Plan SPD at the AFTRA H&R Funds website, [www.aftrahr.com](http://www.aftrahr.com), or by calling the AFTRA H&R Funds office at 1-800-562-4690.

At its February 2006 meeting, the AFTRA H&R Board of Trustees took steps to restructure the AFTRA Health Plan so it will continue to provide valuable health care benefits to our participants. Although the Trustees have been required to make difficult changes to the AFTRA Health Plan, the changes to date have succeeded in stabilizing the Plan, thereby allowing the Trustees to take more measured steps to position the Health Plan to better weather the anticipated skyrocketing health care inflation in future years.

In 2003 and 2004, H&R Funds staff, AFTRA Trustees and union staff met with participants in AFTRA Locals throughout the country, soliciting their input, feedback and concerns about the changes that had been implemented in 2003 and 2004. Participants repeatedly expressed a desire to see a Health Plan structure with tiers reflecting different income levels and the opportunity to “buy up” within a tiered structure. Participants also asked the Trustees to make every effort to ensure that future changes in premiums or eligibility levels were gradual in order to provide participants adequate long-term notice of costs and eligibility requirements where possible.

As you’ll see on the attached pages, the Trustees have attempted to incorporate these concepts into the changes that will take effect in 2007. Two sets of changes will occur, the first on January 1, 2007, and the second on July 1, 2007. They should be added to your January 2005 Health Plan Summary Plan Description for future reference.

You will no doubt have questions about the changes. H&R Funds and union staff will work together to address your issues, and ongoing education and information resources will be provided to you up until the time the changes go into effect. Please be assured that the Trustees remain committed to providing its participants with the best quality benefits program with the resources available to them in this very difficult environment.

If you have questions, you can contact the Funds’ Participant Services Department or the Board of Trustees through the AFTRA H&R website [www.aftrahr.com](http://www.aftrahr.com) by clicking on “Contact Us”.

Sincerely,

Board of Trustees



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## **CHANGES TO THE AFTRA HEALTH PLAN EFFECTIVE JANUARY 1, 2007**

On January 1, 2007, there will be two changes to the AFTRA Health Plan. The first is an increase in premiums, and the second is a change in the Prescription Drug Program.

### **PREMIUMS**

For a detailed description about how premiums generally work, refer to the January 2005 AFTRA Health Plan Summary Plan Description (SPD) booklet, pages 16-18.

In order to provide sufficient advance notice of premium costs and thereby minimize the impact of sharp increases in premiums caused by continuing escalations in medical costs, the Trustees have approved a graduated approach to increases in premiums. Starting January 1, 2007, participant premiums will increase by 5% each year. The schedule of *quarterly* premiums through 2010 is therefore as follows and will apply effective January 1, 2007, whether or not the participant is in the middle of an eligibility cycle:

<b>QUARTERLY PREMIUMS</b>	<b>Current</b>	<b>1/1/2007</b>	<b>1/1/2008</b>	<b>1/1/2009</b>	<b>1/1/2010</b>
<b>Participant only</b>	<b>\$300</b>	<b>\$315</b>	<b>\$330</b>	<b>\$346</b>	<b>\$363</b>
<b>Participant and spouse/ Qualified Domestic Partner only</b>	<b>\$525</b>	<b>\$551</b>	<b>\$578</b>	<b>\$606</b>	<b>\$636</b>
<b>Participant and child(ren) only (no spouse/Qualified Domestic Partner)</b>	<b>\$525</b>	<b>\$551</b>	<b>\$578</b>	<b>\$606</b>	<b>\$636</b>
<b>Full Family</b>	<b>\$575</b>	<b>\$603</b>	<b>\$633</b>	<b>\$664</b>	<b>\$697</b>
<b>Senior Citizen retiree only</b>	<b>\$120</b>	<b>\$126</b>	<b>\$132</b>	<b>\$138</b>	<b>\$144</b>
<b>Senior Citizen retiree and spouse/Qualified Domestic Partner</b>	<b>\$345</b>	<b>\$362</b>	<b>\$380</b>	<b>\$399</b>	<b>\$418</b>
<b>Senior Citizen retiree and child(ren) (no spouse/Qualified Domestic Partner)</b>	<b>\$345</b>	<b>\$362</b>	<b>\$380</b>	<b>\$399</b>	<b>\$418</b>
<b>Senior Citizen Full Family</b>	<b>\$395</b>	<b>\$414</b>	<b>\$434</b>	<b>\$455</b>	<b>\$477</b>

Should circumstances require, the Trustees may modify this scheduled increase (up or down), in which case you will be notified.

### **PRESCRIPTION DRUGS**

For a detailed description about the Prescription Drug Program, refer to the January 2005 AFTRA Health Plan SPD booklet, pages 48-49.

Prescription drug costs, and the use of brand name drugs in particular, have been the biggest driver in health care inflation. Nationwide, inflation in prescription drug costs has risen by approximately 14% between 2004 and 2005. For the AFTRA Plan, prescription drug costs exceeded all projections by more than \$1.5 million for 2005.

Beginning January 1, 2007 (regardless of your eligibility cycle), the Prescription Drug Program will be modified according to the chart below. The new schedule is designed to keep participants' costs as low as possible and limit out-of-pocket expenses, but also encourage the use of generics rather than brand names where a generic equivalent is available.

The annual deductible when you purchase drugs at a retail pharmacy has not been changed. Participants are reminded that there is, and continues to be, *no* deductible when you purchase your drugs through the Mail Order Program.

Effective January 1, 2007, for all covered participants (including retirees, under age 65 retirees and COBRA participants), even if they started their Health Plan coverage in an eligibility cycle prior to January 1, 2007, the Prescription Drug Program will include the following changes:

<b>PROGRAM FEATURES</b>	<b>CURRENT PROGRAM</b>	<b>NEW PROGRAM EFFECTIVE 1/1/07</b>
<b>Retail Deductible</b>	<b>\$75 individual/\$150 family</b>	<b>Same</b>
<b>Retail Generic Copayment For up to 30-day supply</b>	<b>Greater of \$3 or 25%</b>	<b>Greater of \$5 or 25%</b>
<b>Retail Brand Name Copayment For up to 30-day supply</b>	<b>Greater of \$15 or 25%</b>	<b>Same</b>
<b>Generic Equivalent Copayment For up to 30-day supply</b>	<b>Greater \$15 or 25%</b>	<b>Greater of \$5 or 25%, plus entire difference in cost between brand and generic</b>
<b>Mail Order Deductible</b>	<b>None</b>	<b>None</b>
<b>Mail Order Generic Copayment For up to 90-day supply</b>	<b>\$6</b>	<b>Greater of \$10 or 20%, \$35 maximum copayment per prescription</b>
<b>Mail Order Brand Copayment For up to 90-day supply</b>	<b>\$25</b>	<b>Greater of \$30 or 20%, \$75 maximum copayment per prescription</b>
<b>Mail Order Brand Name with Generic equivalent For up to 90-day supply</b>	<b>\$25</b>	<b>Greater of \$10 or 20%, \$35 maximum copayment per prescription, plus entire difference in cost between brand and generic</b>
<b>Out-of-Pocket Maximum*</b>	<b>\$1,500 plus applicable deductible</b>	<b>\$2,000 plus applicable deductible</b>

\*The out-of-pocket maximum applies to covered expenses only.

## **CHANGES TO THE AFTRA HEALTH PLAN EFFECTIVE JULY 1, 2007**

On July 1, 2007, the AFTRA Health Plan will be further restructured in terms of benefit offerings, eligibility thresholds, and other changes as described below.

- The Plan will offer four tiers of health coverage.
- The minimum covered earnings requirements to qualify for health care coverage will increase from \$10,000 to \$15,000.
- The Coordination of Benefits feature will be amended.

### **MINIMUM EARNINGS REQUIREMENTS FOR NEW TIERS**

For a detailed description about how the minimum earnings requirements work, refer to the January 2005 AFTRA Health Plan SPD booklet, pages 14-18.

The following chart illustrates the minimum covered earnings required to qualify for each new tier of health coverage. These earnings requirements will be increased approximately 2.75% for each eligibility cycle beginning in 2008 (rounded down to the nearest \$50) until 2010.

<b>NEW LEVELS OF COVERAGE</b>	<b>MINIMUM COVERED EARNINGS REQUIRED FOR ELIGIBILITY FOR EACH TIER</b>			
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
<b>Core</b>	<b>\$15,000</b>	<b>\$15,400</b>	<b>\$15,800</b>	<b>\$16,250</b>
<b>Basic</b>	<b>\$25,000</b>	<b>\$25,650</b>	<b>\$26,350</b>	<b>\$27,100</b>
<b>Standard</b>	<b>\$60,000</b>	<b>\$61,650</b>	<b>\$63,300</b>	<b>\$65,050</b>
<b>Enhanced</b>	<b>\$100,000</b>	<b>\$100,000</b>	<b>\$100,000</b>	<b>\$100,000</b>

Should circumstances require, the Trustees may modify this scheduled increase (up or down), in which case you will be notified.

### **WHEN THE NEW COVERAGE BEGINS**

For a detailed description about when coverage begins, refer to the January 2005 AFTRA Health Plan SPD booklet, pages 16-18.

In general, you will become eligible for the new coverage under the AFTRA Health Plan, as shown in the following chart, on the first day of the second calendar quarter following the quarter in which you meet the new minimum covered earnings requirement (see above).

<b>IF EARNINGS REQUIREMENT IS MET DURING THE PERIOD OUTLINED BELOW:</b>	<b>THEN YOUR 4-QUARTER ELIGIBILITY CYCLE BEGINS:</b>
<b>April 1, 2006 - March 31, 2007</b>	<b>July 1, 2007</b>
<b>July 1, 2006 - June 30, 2007</b>	<b>October 1, 2007</b>
<b>October 1, 2006 - September 30, 2007</b>	<b>January 1, 2008</b>
<b>January 1, 2007 - December 31, 2007</b>	<b>April 1, 2008</b>

However, in order to ensure a smooth transition for participants to the new structure, any coverage you have under the current plan that begins before July 1, 2007, will remain in effect through the end of the four-quarter eligibility cycle. For example, let's assume you earned \$32,000 between October 1, 2005 – September 30, 2006, and enrolled in the Family Plan as it currently exists with an eligibility cycle from January 1, 2007 to December 31, 2007. You will retain that coverage as it currently exists (with the changes in premiums and prescription coverage as described on pages 1-2) throughout your eligibility cycle which ends December 31, 2007, assuming you pay the required quarterly premiums. Assuming further that you qualify for coverage for eligibility beginning January 1, 2008, based on earnings between October 2006 – September 30, 2007, your level of coverage will then be based on the Plan's new earnings requirements for the different tiers.

Remember, as noted on pages 1-2, the changes in the prescription drug coverage and the premiums will go into effect on January 1, 2007, regardless of your eligibility cycle.

As always, in order to enroll and continue coverage, you need to pay any required premiums on a timely basis. If you choose to enroll your spouse, qualified domestic partner or dependents, you must be enrolled in the Plan. If you have questions about payment of premiums through electronic checking or through pre-paid premiums, please call Participant Services at 1-800-562-4690, and ask for information about how to pay premiums through either of these methods.

## **NEW LEVELS OF COVERAGE**

Starting July 1, 2007, the Health Plan will provide four levels of coverage, depending upon covered earnings. If you meet the applicable earnings threshold for a particular level, you will be eligible to purchase coverage based on the premiums described earlier. It is important to keep in mind that if you have sufficient covered earnings to qualify for a higher level of coverage during a calendar quarter within a four-quarter eligibility cycle, you cannot move to a higher level of coverage during that cycle. The additional compensation will be used to determine what level of coverage you qualify for in your next four-quarter eligibility cycle. Further, participants who qualify for the Core and Basic Plans based on their covered earnings may "buy up" (at the beginning of their eligibility cycle) only to the next higher level at true cost, which will be calculated and published in early 2007. The four levels are described as follows:

- **Core Plan** – In order to qualify for this Plan, you must have covered earnings of at least \$15,000 but less than \$25,000 in four consecutive calendar quarters or less. (Covered earnings at the previous threshold of \$10,000 will no longer qualify for coverage.) This new tier provides **catastrophic coverage only for individual medical and hospital benefits. There will be no coverage for life insurance, prescription drugs, dental or accidental death and dismemberment, loss of voice or for dependents.** The annual individual deductible will be \$2,500. After a participant meets the deductible, this Plan will pay 100% of eligible Network Covered Expenses and 80% of the Scheduled Allowance for eligible Non-Network Covered Expenses.

The Core Plan will also provide wellness benefits (to the participant only) as currently provided under the Individual Plan. That is, the Plan will pay 80% of Covered Expenses within the Plan's Scheduled Allowance, up to the annual \$400 individual annual maximum. Further information on the Wellness Program can be found on pages 50-51 of the January 2005 Health Plan SPD. (Please note that the \$10 copayment, as mentioned in the SPD, is incorrect and does not apply to the Wellness Program.) In addition, while there is no coverage under the Prescription Drug Program, this Plan will offer a discount prescription drug card through Medco. Participants will pay the full cost of the prescription drug at the pharmacy, but will be able to receive the same discounted drug prices that all participants in the Fund receive at Network pharmacies.

Finally, participants in this Plan can choose to “buy up” only to the Basic Plan for coverage for themselves with or without their dependents. The buy-up costs will be published in early 2007.

- **Basic Plan** – If you have covered earnings of at least \$25,000 but less than \$60,000 in four consecutive calendar quarters or less, you will qualify for this Plan, which will be the basic level of family health coverage. This Plan will cover the same Covered Expenses as the current Family Plan, but it will have higher copayments and other out-of-pocket expenses (see chart on pages 6-7). It will include the wellness benefit (the same as currently offered under the Family Plan), modified prescription drug coverage as described on page 2, life insurance, accidental death and dismemberment, preventive dental and loss of voice coverage.

Participants in this Plan can choose to “buy up” only to the Standard Plan for coverage for themselves with or without their dependents. The buy-up costs will be published in early 2007.

- **Standard Plan** – If you have covered earnings of at least \$60,000 in four consecutive calendar quarters or less, you will qualify for this Plan. This level of family health coverage is the same as the current Family Plan (see chart on pages 6-7), with the wellness benefit, modified prescription drug coverage as described on page 2, life insurance,

accidental death and dismemberment, preventive dental and loss of voice coverage.

You cannot buy up to a higher Plan unless your covered earnings qualify you as described on page 3 and below.

- Enhanced Plan** –If you have covered earnings of at least \$100,000 in four consecutive calendar quarters or less, you will qualify for this Plan. It is an elective plan, and provides an option for participants to purchase a higher level of coverage for Non-Network providers. The current Family Plan, as well as the new Basic and Standard Plans, pays for Non-Network providers at 60% of the allowance for Covered Expenses. Participants who elect this Plan will have coverage for Non-Network medical and hospital providers at 80% of the allowance for Covered Expenses. There is an additional estimated premium of approximately \$140 per person per quarter, in addition to the regular premium, to elect the Enhanced Plan.

The additional premium will apply for this Plan for the first year only (beginning July 1, 2007). Each year thereafter, that amount may change based on the experience of the Plan in each preceding year. The exact amount of this additional premium will be published in 2007.

The following chart illustrates the copayments and out-of-pocket limits for the Core, Basic, Standard and Enhanced Plans:

<b>BENEFIT</b>	<b>CORE</b>	<b>BASIC</b>	<b>STANDARD (UNCHANGED CURRENT FAMILY PLAN)</b>	<b>ENHANCED</b>
<b>Deductible</b>	<b>\$2,500 (annual total per individual applies to total of both hospital and medical expenses)</b>	<b>\$200/\$400 Network \$400/\$800 Non-Network (Unchanged from current plan. No deductible for any hospital expenses.)</b>	<b>\$200/\$400 Network \$400/\$800 Non-Network (No deductible for any hospital expenses.)</b>	<b>Same as Standard</b>
<b>Inpatient hospital copayment per admission/confinement</b>	<b>None</b>	<b>\$200</b>	<b>\$100</b>	<b>Same as Standard</b>
<b>Network hospital benefit</b>	<b>100% of covered expenses after deductible</b>	<b>80% up to first \$10,000 in covered expenses/yr; 100% thereafter (plus \$200 copayment per confinement)</b>	<b>90% up to first \$10,000 in covered expenses/yr; 100% thereafter (plus \$100 copayment per confinement)</b>	<b>Same as Standard</b>
<b>Network hospital out-of-pocket maximum</b>	<b>None</b>	<b>\$2,000 (or \$10,000 in covered expenses at 20%), plus \$200 copayment per confinement</b>	<b>\$1,000 (or \$10,000 in covered expenses at 10%), plus \$100 copayment per confinement</b>	<b>Same as Standard</b>

<b>BENEFIT</b>	<b>CORE</b>	<b>BASIC</b>	<b>STANDARD (UNCHANGED CURRENT FAMILY PLAN)</b>	<b>ENHANCED</b>
<b>Non-Network hospital benefit</b>	<b>80% of allowable expenses after deductible</b>	<b>60% up to first \$7,000 in allowable expenses/yr; 100% thereafter (plus \$200 copayment per confinement)</b>	<b>60% up to first \$7,000 in allowable expenses/yr; 100% thereafter (plus \$100 copayment per confinement)</b>	<b>80% up to first \$7,000 in allowable expenses/yr; 100% thereafter (plus \$100 copayment per confinement)</b>
<b>Non-Network hospital out-of-pocket maximum</b>	<b>None</b>	<b>\$2,800 (or \$7,000 in allowable expenses at 40%) plus \$200 copayment per confinement</b>	<b>\$2,800 (or \$7,000 in allowable expenses at 40%) plus \$100 copayment per confinement</b>	<b>\$1,400 (or \$7,000 in allowable expenses at 20%) plus \$100 copayment per confinement</b>
<b>Physician/medical specialist copayments</b>	<b>None</b>	<b>\$20</b>	<b>\$10</b>	<b>Same as Standard</b>
<b>Network medical benefit</b>	<b>100% of covered expenses after deductible</b>	<b>80% of first \$10,000 in covered expenses/yr after deductible; 100% thereafter, excluding copayment</b>	<b>90% of first \$10,000/yr after deductible; 100% thereafter, excluding copayment</b>	<b>Same as Standard</b>
<b>Network out-of-pocket maximum</b>	<b>None</b>	<b>\$2,000 (or \$10,000 in covered expenses at 20%) plus deductible and per visit copayment</b>	<b>\$1,000 (or \$10,000 in covered expenses at 10%) plus deductible and per visit copayment</b>	<b>Same as Standard</b>
<b>Non-Network medical benefit</b>	<b>80% of allowable expenses after the deductible</b>	<b>60% of first \$8,000/yr in allowable expenses after deductible; 100% thereafter, excluding copayment</b>	<b>60% of first \$8,000/yr in allowable expenses after deductible; 100% thereafter, excluding copayment</b>	<b>80% of first \$8,000/yr in allowable expenses after deductible; 100% thereafter, excluding copayment</b>
<b>Non-Network medical out-of-pocket maximum</b>	<b>20% of allowable expenses after the deductible</b>	<b>\$3,200 (or \$8,000 in allowable expenses at 40%) plus deductible and copayments</b>	<b>\$3,200 (or \$8,000 in allowable expenses at 40%) plus deductible and copayments</b>	<b>\$1,600 (or \$8,000 in allowable expenses at 20%) plus deductible and copayments</b>
<b>Life Insurance/ Accidental Death and Dismemberment</b>	<b>None</b>	<b>Yes; \$30,000 Life/ \$18,000 AD&amp;D</b>	<b>Yes; \$30,000 Life/ \$18,000 AD&amp;D</b>	<b>Same as Standard</b>
<b>Dental Program</b>	<b>None</b>	<b>Preventive only; same as current plan</b>	<b>Preventive only; same as current plan</b>	<b>Same as Standard</b>
<b>Prescription Drug Program</b>	<b>None; Discount Medco prescription drug card</b>	<b>Yes; see chart page 2 for changes effective 1/1/07</b>	<b>Yes; see chart page 2 for changes effective 1/1/07</b>	<b>Same as Standard</b>
<b>Loss of Voice</b>	<b>None</b>	<b>\$10,000</b>	<b>\$10,000</b>	<b>Same as Standard</b>

## **SENIOR CITIZEN HEALTH PROGRAM**

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For a detailed description of the Senior Citizen Health Program, refer to the 2005 AFTRA Health Plan SPD booklet, pages 59-63.

If you are a participant in the Senior Citizen Health Program as of July 1, 2007, you and your covered dependents will automatically transfer to the Standard Plan, subject to the timely payment of premiums. If you are not yet a participant in the Senior Citizen Health Program, qualifying base years beginning December 1, 2007 will require a minimum of \$15,000 in covered earnings to earn a credit for individual coverage and qualifying family years will require a minimum of \$25,000 in covered earnings to earn a credit for family coverage. (A base year is the twelve-month period beginning December 1 through November 30.) These minimum covered earnings amounts will increase by 2.75% each base year starting December 1, 2008 (rounded down to the nearest \$50) until 2010. Should circumstance require, the Trustees may modify this scheduled increase (up or down) in which case you will be notified. (Generally, current requirements of 15 or more qualifying base years for individual coverage and 20 or more qualifying base years, 15 of which are family qualifying years for family coverage, will continue.)

The following chart illustrates the covered earnings required to earn a credit towards qualifying for individual or family health coverage in the Standard Plan. (For more detailed information about earnings requirements before 2007, refer to page 60 in the Health SPD.)

<b>BASE YEAR BEGINNING</b>	<b>INDIVIDUAL QUALIFYING YEAR COVERED EARNINGS</b>	<b>FAMILY QUALIFYING YEAR COVERED EARNINGS</b>
<b>December 1, 2007</b>	<b>\$15,000</b>	<b>\$25,000</b>
<b>December 1, 2008</b>	<b>\$15,400</b>	<b>\$25,650</b>
<b>December 1, 2009</b>	<b>\$15,800</b>	<b>\$26,350</b>

## **EARLY RETIREE COVERAGE**

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For a detailed description of the Early Retiree coverage, refer to the 2005 AFTRA Health Plan SPD booklet, page 63.

Future early retirees (on or after July 1, 2007) will be offered the plan in which they were last covered prior to their retirement. Current early retirees will continue to be covered as individuals and those who covered their dependents will continue to do so under the new program subject to timely payment of premiums. They will be switched to the Standard Plan as of July 1, 2007.

Early Retiree coverage continues to exclude Life and AD&D insurance, Loss of Voice coverage and dental benefits.

## **COBRA CONTINUATION COVERAGE**

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For more information about COBRA, refer to the 2005 AFTRA Health Plan SPD booklet, pages 23-28.

COBRA continuation coverage is a temporary extension of group health coverage under the Health Plan, under certain circumstances, in the event that a participant or a family member loses coverage as a result of a qualifying event. Those on COBRA under the current Plan design in July 2007 will continue in the Plan at their present level of coverage until their entitlement to COBRA terminates. Qualified beneficiaries who become eligible for COBRA on or after July 1, 2007 will be offered the opportunity to buy coverage based on the new levels. You will receive more information in subsequent communications about the levels of coverage available under COBRA for these individuals.

## **COORDINATION OF BENEFITS RULES AMENDED**

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For more information about Coordination of Benefits, refer to the 2005 AFTRA Health Plan SPD booklet, pages 66-70.

Although this change is not expected to affect many participants and beneficiaries (if any), it is an important aspect of the Plan.

Coordination of benefits operates so that one plan (the “primary plan”) pays benefits as if it provides the participant’s only health coverage while another plan (the “secondary plan”) pays the remainder of the costs (up to certain limits) not covered by the primary plan. The following example illustrates how coordination of benefits works. Let’s assume that a primary plan will pay 80% of allowable expenses and the doctor billed \$3,000. The primary plan accepted the billed amount as allowable expenses. The primary plan would pay \$2,400 (80% of \$3,000), and the secondary plan would pay the balance of \$600. (Both dollar amounts are subject to applicable deductibles.)

Unfortunately, some plans are trying to avoid paying their full share of health expenses, even where they are the primary plan, by adopting a rule that states that where there is a secondary plan involved, the primary plan will impose a special limit on Covered Expenses. In essence, the primary plan is shifting its responsibility onto the secondary plan. Using the preceding example, if the primary plan limits its Covered Expenses to \$1,000 (not the actual bill of \$3,000), and pays 80% (\$800), the secondary plan would then be forced to pay \$2,200, instead of \$600.

In order to avoid this happening to the AFTRA Health Plan when it is the secondary plan, the Trustees have amended the Plan rules as they relate to the amount of Covered Expenses that the Plan will pay from its Major Medical, Hospital, Dental, Mental Health and Chemical Dependency, Wellness and Prescription Drug Programs as follows:

The Covered Expenses that will be paid by the AFTRA Health Plan (whether Network or Non-Network) when it is the secondary plan will be calculated without regard to any provision in the primary plan that reduces the primary plan's expenses when there is a secondary plan. In those cases, the AFTRA Health Plan will *not* pay a greater amount towards a claim than it otherwise would have paid had the primary plan not limited its maximum benefit coverage.

**Please keep this notice of changes together with your January 2005 AFTRA Health Plan Summary Plan Description (SPD) booklet so that you have up-to-date information about the Plan and how it works.**

### **NOTICE OF HIPAA RIGHTS**

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Under the federal privacy law known as HIPAA, the AFTRA Health Fund is legally required to take reasonable steps to protect the privacy of your Protected Health Information (PHI) held by the Fund. To request a Notice of Privacy Practices that describes the permitted and required uses and disclosures of your PHI held by the Fund, you can call Participant Services at 1-800-562-4690, or go to the AFTRA H&R Web site at [www.aftrahr.com](http://www.aftrahr.com).

April 2006

This notice contains important information regarding benefit changes under the AFTRA Health Plan. You should take the time to read it carefully and share it with your family. It is very important that you retain this notice with your copy of the Plan's Summary Plan Description (SPD). If you lost or misplaced your current copy of the Summary Plan Description, please contact the Fund office and we will furnish you with another copy. While every effort has been made to make this description as complete and as accurate as possible, this Summary of Material Modifications (SMM) does not restate those existing terms and provisions of the Plan other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and those remaining existing provisions, or if any point is not discussed in this summary or is only partially discussed, the terms of the SPD will govern in all cases. The Board of Trustees of the AFTRA Health Fund or its duly authorized designee reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or eligibility for such benefits), in whole or in part, at any time and for any reason (including with respect to retirees and with respect to benefits already earned).