

## AFTRA Health Plan At-a-Glance

If you qualify for coverage, you should understand the benefits available to you under the AFTRA Health Plan to help you make the most of this important benefit.

### Understanding the AFTRA Health Plan

This brochure provides an overview of the AFTRA Health Plan benefits available to qualified performers and their dependents. This brochure only provides an overview of benefits, and it is not a complete description of the Health Plan. For a detailed description of Health Plan benefits, refer to the 2011 Health Plan Summary Plan Description (SPD), which is available at [www.aftrahr.com](http://www.aftrahr.com) (“Health Fund” | “Health Plan SPD”) or may be requested by contacting Participant Services at (800) 562-4690. If there is any conflict between the Health Plan SPD and this brochure, the Health Fund SPD shall govern.

### The AFTRA Health Plan: What you need to qualify and how it works

The AFTRA Health Plan includes comprehensive health coverage and added benefits as described in this brochure.

#### Registration is the first step

If you perform AFTRA-covered work, it is important that you become a registered performer by submitting a completed and signed Performer Registration form to AFTRA H&R. Registering is free and allows AFTRA H&R to track your covered earnings and employer contributions made on your behalf. If you do not register, you may not be able to take advantage of benefits for which you otherwise may qualify. You can obtain a Performer Registration Form from [www.aftrahr.com](http://www.aftrahr.com) (“Forms” | “General Forms”) or by calling Participant Services at (800) 562-4690.

If you previously registered with AFTRA H&R and we have your current mailing address on file, we will notify you when you qualify for Health Plan coverage.

#### Earnings requirements and coverage options

Based upon your earnings for AFTRA-covered work, you may qualify to enroll in individual or family coverage under the AFTRA Health Plan.

To qualify for individual coverage under the Health Plan, you must have AFTRA-covered earnings of at least \$10,000 in four consecutive calendar quarters or less.

To qualify for family coverage, you must have AFTRA-covered earnings of at least \$30,000 in four consecutive calendar quarters or less.<sup>1</sup> Performers whose covered earnings only qualify them for individual

coverage may choose to buy-up to the family coverage by paying an additional buy-up premium.

Different rules apply regarding the initial qualification of full-time staff performers, covered roster artists, employees of AFTRA (or its locals) and employees of AFTRA H&R. For more information call Participant Services at (800) 562-4690 or visit [www.aftrahr.com](http://www.aftrahr.com) (“Health Fund” | “Earnings Requirements”).

#### Coverage for Retirees

For those who qualify, the Health Plan offers coverage to retirees through the Early Retiree and Senior Citizen Health Programs. The benefits provided under these programs are generally the same as those provided under active Health Plan coverage, as described in this brochure. However, there are some differences in benefits available under the Early Retiree and Senior Programs when compared to active coverage. For more information, visit [www.aftrahr.com](http://www.aftrahr.com) (“Health Fund” | “Health Plan SPD”) or contact Participant Services at (800) 562-4690.

#### How to enroll

Once you qualify, it's easy to enroll. Simply complete and submit the Performer Enrollment Form, which is available at [www.aftrahr.com](http://www.aftrahr.com) (“Forms” | “Health Forms”), include any documents required to confirm the qualification of dependents you wish to cover (e.g., birth certificate, marriage certificate), and pay your first quarterly Health Plan premium by the required due date. For current premiums, visit [www.aftrahr.com](http://www.aftrahr.com) (“Health Fund” | “Premiums”).

Your AFTRA Health Plan coverage will continue as long as you pay the required quarterly premiums on time and continue to meet the annual earnings requirements outlined previously and the other qualification requirements of the Plan.

<sup>1</sup> If at the end of the same calendar quarter in which you satisfy the \$10,000 minimum required to qualify for individual coverage your reported earnings do not satisfy the \$30,000 minimum required for family coverage, you may only enroll in the Health Plan at the individual level for your initial four-quarter coverage period.

## Benefits Available

The Health Plan provides coverage from network and non-network medical providers, subject to applicable deductibles, copayments and coinsurance. To maximize the benefits payable and reduce out-of-pocket costs, choose hospitals and other health care providers within the Plan's networks with CIGNA, Medco and ValueOptions. Please also note that for major medical benefits, there are different deductibles for services from network providers and those from non-network providers.

## Annual deductibles (calendar Year)

Hospital Benefits	No deductible
<b>Major medical benefits</b>	
■ Individual network	\$200
■ Family network	\$400 (maximum per family)
■ Individual non-network	\$400
■ Family non-network	\$800 (maximum per family)
<b>Prescription drug benefits</b>	
■ Individual (retail only)	\$75
■ Family (retail only)	\$150 (maximum per family)

## Major Medical Coverage

The AFTRA Health Plan's major medical benefit covers a wide range of services provided by network and non-network doctors and other licensed health care practitioners, subject to copayments, coinsurance and out-of-pocket limits.

Network providers	
Copayment	\$10 per office visit.
Annual deductible	\$200 for each individual; \$400 maximum per family.
Provider benefit	90% of the scheduled allowance for each individual's first \$10,000 in covered expenses per year after the deductible; 100% thereafter. Excludes copayment.
Coinsurance	10% of the scheduled allowance for each individual's first \$10,000 in covered expenses per year after the deductible.
Annual out-of-pocket limit	\$1,000 per individual (plus deductible and copayment).
Non-network providers	
Copayment	\$10 per office visit.
Annual deductible	\$400 for each individual; \$800 maximum per family.
Provider benefit	60% of the scheduled allowance for each individual's first \$8,000 in covered expenses per year after the deductible; 100% of the scheduled allowance for covered expenses thereafter. Excludes copayment.
Coinsurance	40% of the scheduled allowance for each individual's first \$8,000 in covered expenses per year after the deductible.
Annual out-of-pocket limit	\$3,200 per individual (plus deductible, copayment, and expenses that exceed the scheduled allowances).

## Hospital Coverage

The Health Plan provides coverage for inpatient and outpatient services from network hospitals and non-network hospitals, subject to copayments, coinsurance and out-of-pocket limits.

Network hospital	Coverage
Copayment	\$100 per inpatient admission.
Inpatient/outpatient benefit	90% of first \$10,000 in covered expenses (excluding the \$100 copayment) for each individual's preauthorized <sup>2</sup> inpatient admission and/or outpatient services per year; 100% thereafter.
Coinsurance	10% of first \$10,000 in covered expenses for each individual's preauthorized inpatient admission and/or outpatient services per year.
Annual out-of-pocket limit	\$1,000 per individual (plus \$100 copayment per inpatient admission <sup>3</sup> ).
Non-network hospital	
Copayment	\$100 per inpatient admission.
Inpatient/outpatient benefit	60% of first \$7,000 in covered expenses (excluding the \$100 copayment) for each individual's preauthorized inpatient admission and/or outpatient services per year; 100% of covered expenses thereafter.
Coinsurance	40% of first \$7,000 in covered expenses for each individual's preauthorized inpatient admission and/or outpatient services per year.
Annual out-of-pocket limit	\$2,800 per individual (plus a \$100 copayment per inpatient admission).

<sup>2</sup> All inpatient hospital admissions must be preauthorized by CIGNA (emergency admissions must be authorized within 72 hours following the admission).

<sup>3</sup> Exception: If you are hospitalized for a single uninterrupted hospitalization spanning two calendar years, you will only be responsible for satisfying the annual network or non-network out-of-pocket maximum once.

## Prescription Drug Coverage

The Health Plan's pharmacy benefits are administered by Medco Health Solutions which offers convenient mail order delivery through Medco Pharmacy and access to specialist pharmacists. The AFTRA Health Plan provides prescription drug coverage with copayments and a separate deductible for retail pharmacy purchases.

<b>Retail pharmacies<sup>4</sup></b>	
<b>Copayments</b>	
Generic drugs up to a 30-day supply	\$10
Brand name drugs up to a 30-day supply	25% of the total prescription cost.
Brand name with generic equivalent up to a 30-day supply	25% of the total prescription cost, plus entire difference in cost between brand name and generic.
<b>Annual deductible</b>	
Retail pharmacy prescription drug purchases	\$75 annual deductible per individual/\$150 maximum per family.
<b>Medco Pharmacy (mail order)</b>	
<b>Copayments</b>	
Generic drugs up to a 90-day supply	\$30
Brand name drugs up to a 90-day supply	25% of the total prescription cost, with a \$150 maximum per prescription.
Brand name drugs with generic equivalent up to a 90-day supply	25% of the total prescription cost, with a \$150 maximum per prescription, plus the entire difference in cost between brand name and generic.
<b>Annual deductible</b>	
Medco Pharmacy (mail order) prescription drug purchases	No annual deductible.
<b>All pharmacies</b>	
Annual out-of-pocket maximum	\$2,000 <sup>5 6</sup> plus deductible.

<sup>4</sup> Purchases from retail pharmacies are only covered for short-term medications and initial purchases of long term or specialty medications.

<sup>5</sup> The difference in cost between brand name drugs and their generic equivalents (when they are available) is considered a non-covered expense. When participants elect to purchase brand names over available generic equivalents they are responsible for the cost difference. Such costs are not included in the out-of-pocket maximum.

<sup>6</sup> Also, if you use a non-network retail pharmacy, you will 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 network retail pharmacy. This difference between network and non-network pharmacy charges is not applied toward or subject to the annual out-of-pocket maximum.

## Wellness Coverage

Keeping healthy is one of the best ways to manage your own health care costs. The Health Plan provides valuable coverage for preventive care recommended by the U.S. Preventive Services Task Force (USPSTF); the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention; and, the Health Resources and Services Administration (HRSA). Covered wellness services include:

- Regular annual comprehensive physical examinations;
- Immunizations; and
- Certain tests to detect health problems.

<b>All providers (network/non-network combined)</b>	<b>Coverage</b>
Copayment	None
Provider benefit	80% of the scheduled allowance for covered expenses
Coinsurance	20% of scheduled allowance for covered expenses, plus 100% of any expenses from non-network providers which exceed the scheduled allowance.

## Mental Health Coverage

The mental health benefit is administered by ValueOptions, which will refer patients to counselors and to other services as appropriate. All inpatient and outpatient treatment for mental health must be preauthorized by ValueOptions, except in the case of emergency treatment which must be authorized within 72 hours of the commitment.

<b>Mental health benefits</b>	
<b>Benefit Details</b>	
Inpatient copayment	\$100 per admission
Outpatient copayment	\$20 per visit
Inpatient hospital benefit	100% of network rate for pre-authorized admissions, excluding the \$100 copayment. Limit of 30 days per individual per year.
Outpatient benefit	100% of network rate for pre-authorized visits, after a \$20-per-visit copayment. Limit of 40 visits per individual per year.

## Chemical Dependency Coverage

The chemical dependency benefit is administered by ValueOptions, which will refer patients to counselors and to other services as appropriate. All inpatient and outpatient treatment for chemical dependency must be preauthorized by ValueOptions, except in the case of emergency treatment which must be authorized within 72 hours of the commitment.

Chemical dependency	
Benefit details	Coverage
<b>Lifetime maximum</b>	Three (3) courses of pre-authorized treatment.
<b>First course of treatment</b>	<b>95% of scheduled allowance for covered expenses</b>
<ul style="list-style-type: none"> <li>■ Coinsurance</li> <li>■ Failure to complete treatment penalty</li> </ul>	<ul style="list-style-type: none"> <li>■ 5% of allowable expenses</li> <li>■ 50% reduction in reimbursement</li> </ul>
<b>Second course of treatment</b>	<b>80% of scheduled allowance for covered expenses</b>
<ul style="list-style-type: none"> <li>■ Coinsurance</li> <li>■ Failure to complete treatment penalty</li> </ul>	<ul style="list-style-type: none"> <li>■ 20% of allowable expenses</li> <li>■ 60% reduction in reimbursement</li> </ul>
<b>Third course of treatment</b>	<b>60% of scheduled allowance for covered expenses limited to emergency admission for detoxification and outpatient treatment only</b>
<ul style="list-style-type: none"> <li>■ Coinsurance</li> <li>■ Failure to complete treatment penalty</li> </ul>	<ul style="list-style-type: none"> <li>■ 40% of allowable expenses</li> <li>■ 70% reduction in reimbursement</li> </ul>

## Preventive Dental Coverage

The Health Plan's preventive dental benefit provides benefits to reduce out-of-pocket expenses for preventive dental services. In most cases, if you have family coverage under the Health Plan, the dental benefit will also cover your dependents' preventive dental expenses.

The Health Fund contracts with The Guardian Life Insurance Company to administer the preventive dental benefit and to provide access to The Guardian's DentalGuard Preferred provider network of dentists.

Benefit	Coverage
Preventive dental services	\$1,000 maximum per participant or covered dependent age 19 or older per year (network or non-network). There is no annual maximum for pediatric (children under age 19) dental services.

## Life Insurance

Participants in active Health Plan coverage — but not their dependents — qualify for the Plan's basic life insurance benefit of \$30,000. This benefit is provided through a group insurance policy issued by Aetna to the Health Fund, which, as policyholder, pays the premiums on the policy.

## Accidental Death and Personal Loss (AD&PL) Benefits

Participants in active Health Plan coverage — but not their dependents — qualify for the Plan's accidental death and personal loss (AD&PL) benefits of up to \$18,000. This benefit is provided through a group insurance policy issued by Aetna to the Health Fund, which, as policyholder, pays the premiums on the policy.

Participants covered under COBRA continuation coverage, the Early Retiree Program or the Senior Citizen Health Program do not qualify for AD&PL benefits from Aetna.

## Loss of Voice Benefit

You are entitled to a \$10,000 loss of voice benefit if, while you are enrolled in active coverage under the Health Plan and qualify for basic life insurance benefits, you suffer complete and permanent loss of your natural voice from an accidental injury or as a direct result of surgery which prevents you from engaging in your usual occupation. This benefit does not provide coverage for the loss of voice due to illness or disease where no accident occurred and no surgery was performed.

Participants covered under COBRA, the Early Retiree Program or the Senior Citizen Health Program and dependents of active participants do not qualify for loss of voice benefits.

## Questions?

For a more detailed description of AFTRA Health Plan benefits, refer to the 2011 Health Plan Summary Plan Description (SPD) (to view online, visit [www.aftrahr.com](http://www.aftrahr.com) ("Health Fund" | "Health Plan SPD") or contact Participant Services at (800) 562-4690.

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