

Glossary

Active coverage – Coverage under the Health Plan for performers who meet covered earnings requirements and/or special qualification requirements for covered roster artists, staff performers, employees of AFTRA (or its locals) or employees of AFTRA H&R.

Adverse benefit determination – The denial, reduction, termination or failure to pay (in whole or in part) a benefit under the Plan. An adverse determination can include a decision based on a person’s qualification for the Plan, a benefit not being covered, a Plan exclusion, a service being considered experimental or not medically necessary, a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time) or the cancellation of coverage if a participant no longer qualifies for coverage or fails to pay the required premium on time.

Base year – The 12-month period from December 1 through November 30 that the Health Plan uses to measure covered earnings in determining qualification for the Senior Citizen Health Program.

Buy-up premium – The additional premium that performers who qualify only for individual coverage must pay if they want to “buy-up” to provide coverage for one or more dependents.

Calendar quarter – Any one of four three-month periods throughout the calendar year which are defined as January 1 – March 31; April 1 – June 30; July 1 – September 30; and October 1 – December 31. The Health Plan uses time periods based upon calendar quarters to determine qualification for coverage and the purchase and continuation of coverage, with premium payments due quarterly.

Claim – A request for a plan benefit made in accordance with the Health Plan’s procedures for filing medical treatment, services or supplies claims.

Coinsurance – The percentage of covered expenses that you must pay, in addition to the deductible and any copayment. For example, if the Plan pays 90% of covered expenses from a network provider, the 10% of covered expenses you have to pay is your coinsurance.

Contributing employers – 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 AFTRA H&R.

Copayment – A fixed dollar amount you pay when you receive covered services before you pay your deductible and coinsurance.

Coverage period – The four consecutive calendar quarter-period during which a performer is qualified for the Health Plan and may enroll in coverage by completing the enrollment process and paying the required quarterly premiums on time.

Covered earnings – Earnings paid to you and reported to the AFTRA Health Fund by a contributing employer for covered work performed under a collective bargaining agreement that requires the employer to make contributions to the AFTRA Health Fund on your behalf with respect to those earnings.

Covered expenses – The allowable costs of covered services that the Health Plan will pay in full or in part. The allowable cost generally is the lesser of the provider’s charge, the scheduled allowance or a fixed dollar amount specified by the Plan.

Covered roster artist – A vocal recording artist whose qualification for coverage is based on the artist’s exclusive recording agreement with a record label under the applicable Covered Roster Artists side letter agreement to the AFTRA National Code of Fair Practice for Sound Recordings.

Covered services – Services that the AFTRA Health Plan provides benefits for as described in this SPD.

Custodial care – Supplies and services, including room and board, provided primarily to assist a covered individual in the activities of daily living, regardless of the practitioner or provider who prescribes, recommends or performs the services.

Deductible – The 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 Health Plan.

Dependent – An individual who may be covered under a participant’s Health Plan enrollment based upon his or her relationship with the participant, including:

- Legal spouses, including legally married same-sex spouses;
- Qualified same-sex domestic partners, as defined in this SPD (see Glossary);
- Children (including biological children, legally adopted children, children placed for adoption during the waiting period before the adoption becomes final, stepchildren and foster children) until the end of the calendar quarter in which they reach the age of 26;
- Unmarried children of any age who would otherwise lose coverage because of the Health Plan’s age limitations, but continue to be dependent on the

participant due to an inability to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment;

- Children who meet the requirements above but are not chiefly dependent on the participant 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 AFTRA Health Plan.

Developmental disorder – A severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the individual attains age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency); and
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized support or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Infants and young children, from birth to age 9 who have substantial developmental delays or specific congenital or acquired conditions may be considered to have a developmental disability without meeting three or more of the criteria described above if those individuals, without services and supports, have a high probability of meeting those criteria later in life.

Domestic partner – A person of the same sex who has an exclusive relationship with an unmarried covered performer over the age of 18 and who meets the following criteria:

- Is at least 18 years old;
- Is unmarried;
- Has shared a principal residence with the covered performer for at least six months prior to enrollment and is committed to do so indefinitely;
- Shares responsibility with the covered performer for each other's living expenses;
- Is not related to the other
- Is the sole domestic partner of the other and neither has any other domestic partner;

- Does not have a spouse or other domestic partner in the last six months who is still living; and
- 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 under the Consolidated Omnibus Budget Reconciliation Act (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 as outlined above are met, coverage will begin on the first day of the month following receipt by the AFTRA H&R 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 AFTRA H&R office, must be paid at the same time you pay the premium for coverage to become effective. For additional information, contact AFTRA H&R at (800) 562-4690.

Earnings cycle – A cycle spanning four consecutive calendar quarters which is established once a performer initially meets the minimum covered earnings requirement for individual or family coverage. The performer must continue to meet the annual covered earnings requirements in each consecutive four-quarter earnings cycle to remain qualified for coverage.

Experimental treatment – A medical treatment, service or procedure which meets the following criteria:

- 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;
- Techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
- Procedures which are not proven in an objective way to have therapeutic value or benefit; and
- Any procedure or treatment whose effectiveness is medically questionable.

Family qualifying year – A qualifying year during which a performer had covered earnings equal or greater than the amount required to qualify for active family coverage under the Health Plan.

Individual qualifying year – A base year during which a performer had sufficient covered earnings to qualify for active individual coverage under the Health Plan, but not enough to qualify for family coverage.

Family qualifying year – A qualifying year during which a performer had covered earnings equal or greater than the amount required to qualify for active family coverage under the Health Plan.

Individual qualifying year – A base year during which a performer had sufficient covered earnings to qualify for active individual coverage under the Health Plan, but not enough to qualify for family coverage.

H&R Funds Number – An identification number assigned to registered performers by AFTRA H&R. For AFTRA Health Plan participants, this number is located directly above your name on your AFTRA Health Plan ID card.

Hospital – An institution that:

- 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;
- Maintains clinical records on all patients;
- Has by-laws in effect with respect to its staff of physicians;
- Has a requirement that every patient be under the care of a physician; provides 24 hour nursing service rendered or supervised by a registered nurse;
- Has in effect a hospital utilization review plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and
- 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 – A sickness, disorder, disease or condition (includes pregnancy).

Injury – Accidental bodily injury which is sustained directly and which is independent of all other causes.

Medical emergency – The sudden and unexpected onset of an injury or illness that is acute and that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, permanent impairment to bodily functions or permanent dysfunction of a body part

in the absence of immediate medical attention. Examples of medical emergencies include (but are not limited to) uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones.

Medical provider – A licensed or board-certified provider of medical services, including (but not limited to) physicians, nurses, physiotherapists, speech therapists, dentists, pharmacists, chiropractors, acupuncturists, mid-wives, podiatrists and optometrists who act within the scope of their license or certification and perform services that are medical necessary.

Medically necessary service – Any service, supply, treatment or hospital confinement, or part of a hospital confinement which is:

- Effective and essential to the treatment of the injury or illness for which it is prescribed or performed;
- Based on valid medical need according to accepted standards of medical practice and meets generally accepted standards of medical practice;
- 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;
- 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
- 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 – 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.

Minimum qualifying years requirement – A qualification requirement for the Senior Citizen Health Program (one of several) which is based upon career earnings and the number of qualifying years and/or family qualifying years accrued. Surviving dependents of deceased participants who met this requirement also have additional extended coverage opportunities following the death of a participant.

Network provider – A medical provider that participates in the preferred health care provider network designated for specific benefits under the Health Plan.

Non-network provider – A medical provider that does not participate in the preferred health care provider network designated for specific benefits under the Health Plan.

Participant – A qualified performer who is enrolled in the Health Plan.

Performer – An individual who performs AFTRA-covered work on whose behalf contributions to the Health Fund are required to be made by one or more employers under terms of a collective bargaining agreement or who works as an employee of AFTRA (or its locals) or of AFTRA H&R.⁵⁴

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

Post-service claims – Post-service claims are all claims (including those for which pre-authorization has been obtained) after medical treatment, services or supplies have been provided.

Preferred Provider Organization (PPO) – A health care organization comprised of physicians, hospitals, or other providers who agree to provide health care services at a reduced fee.

Prescription drugs – Medications which 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.

Pre-service claims – Claims that require you to obtain pre-authorization, that is, approval in advance of obtaining medical treatment, services or supplies.

Qualified dependent – A dependent of a participant who meets the qualification requirements for dependent coverage.

Qualified performer – A registered performer who becomes qualified for the Health Plan. Qualified performers may or may not choose to enroll in coverage by completing the enrollment process and paying the required quarterly premiums.

Qualifying year – A base year during which a performer had covered earnings equal to or greater than the amount required to qualify for active individual or family coverage under the Health Plan.

Registered performer – A performer who submits a completed Performer Registration Form to AFTRA H&R and is assigned an H&R Funds Number. Registering with AFTRA H&R allows AFTRA H&R to track a performer's AFTRA-covered earnings and employer contributions in order to notify the performer if or when he or she qualifies for benefits.

Scheduled allowance – The maximum dollar amount of a medical provider's fee for a particular service in a particular geographic area (prior to application of any deductible, coinsurance or maximum) considered when determining benefits payable under the Plan. In the case of a fee billed by a network provider, the scheduled allowance shall be deemed equal to the negotiated rate. 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 for similar services. Amounts above a scheduled allowance are not covered expenses.

Staff performer – A performer whose initial qualification for coverage is based on his or her status as a full-time staff employee of a radio or television station or network.

Urgent care claims – A pre-service claim for medical treatment, services or supplies where the application of the time periods for making pre-service determinations could seriously jeopardize the life, health or well-being of the patient as described on page 93.

Waiting period – The required one-quarter period after the end of the quarter in which a participant initially meets the minimum covered earnings requirement but before the start of the participant's coverage period, which is the earliest that coverage may begin.

⁵⁴ A shareholder of a corporation that is a contributing employer may be considered a performer if the corporation is duly organized and operating under applicable U.S. and state laws and the shareholder is employed by the corporation to render services pursuant to a collective bargaining agreement. However, a sole proprietor or a partner of a partnership will not be considered a performer."