aftraH&R

BENEFITS UPDATE

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Health care reform and the AFTRA Health Plan

Introduction

Earlier this year, Congress passed comprehensive national health care reform legislation. This legislation was signed into law by President Obama in late March 2010.

Detailed regulations are being written and issued by federal agencies to implement the new law. Some regulations have been issued, but more are yet to come, and so while some required Health Plan changes are now known, others have yet to be determined pending further guidance from governmental agencies.

This *Benefits Update* outlines the AFTRA Health Plan changes that will become effective Dec. 1, 2010 in order to comply with the new health care reform law. AFTRA H&R's Trustees, staff and consultants will continue to review the law and the regulations as they are issued to identify what other Health Plan changes are required and establish a timeline for implementing these changes. Look for *Benefits Updates* and other notifications from AFTRA H&R for information about these or any other changes to the Health Plan. We also encourage you to visit the new blog "Health care reform and the AFTRA Health Plan" at *www.aftrahr.com* for the most up-to-date information on health care reform as it affects the AFTRA Health Plan.

Participants should know that the AFTRA Health Plan already meets some of the most significant and immediate requirements of the new health care reform law.

For plan years after Sept. 23, 2010, no group health plan may impose pre-existing condition exclusions for children under 19 and, in coming years, pre-existing condition exclusions will not be allowed at any age. The AFTRA Health Plan does not have pre-existing condition exclusions for participants or dependents of any age.

In addition, for plan years after Sept. 23, 2010, certain plans must permit a pediatrician to serve as a child's primary care physician and must allow women to choose an obstetrician or gynecologist without a referral. The AFTRA Health Plan does not require individuals to designate a primary care physician or obtain referrals, and so these requirements do not apply.

Definition of dependent revised to include children up to age 26

Effective Dec. 1, 2010, children of AFTRA Health Plan participants may be covered as dependents under the participant's Health Plan enrollment until the end of the calendar quarter in which they reach age 26. This new provision will apply to all biological children, adopted children, children placed for adoption, stepchildren and foster children of participants, regardless of the child's marital status, place of residence, student status or financial dependency status. However, adult children under age 26 who are eligible to enroll in an employer-sponsored health plan (other than a group health plan of a parent) will not qualify for coverage as a dependent under the AFTRA Health Plan.

Accordingly, effective Dec. 1, 2010, the definition of "Dependents" (found on pages 7-8 of the 2005 Health Plan Summary Plan Description (SPD) and subsequently amended by *Benefits Updates*), is amended to include dependents newly qualified as a result of the plan change described above.

Who qualifies as a dependent?

Effective Dec. 1, 2010, the following individuals qualify as dependents under the AFTRA Health Plan:

- any legally-married spouse[1] of the participant (no change from current rules)
- children of the participant (see the "How does the AFTRA Health Plan define children?" section below), until the end of the calendar quarter in which they reach the age of 26, provided that an adult child is not eligible to enroll in an employer-sponsored health plan (other than a group health plan of a parent);
- unmarried children of the participant age 26 or older who otherwise would lose coverage because of the Plan's age limitation but continue to be dependent on a participant due to an inability to engage in any substantial gainful activity by reason of a physical or mental impairment. Such impairment must meet two conditions. First, the impairment must be expected to result in death or last (or be expected to last) for a continuous period of at least 12 months. Second, the impairment must be certified by the dependent's treating physician. **Participants must provide proof of the child's impairment to AFTRA H&R prior to the date that the dependent's coverage would otherwise terminate due to age in order for coverage to continue.**

How does the AFTRA Health Plan define "children?"

Effective Dec. 1, 2010, the term "children" refers to biological children, legally adopted children (including a child placed for adoption during the waiting period before an adoption becomes final), stepchildren and foster children. Participants are required to provide proof of their relationship to the child (including, but not limited to birth certificates; adoption papers; marriage certificates showing a legal marriage to the parent of a stepchild) or proof that a child was officially placed under your supervision as a foster child by a governing authority.

Any adult child who is eligible to enroll in an employer-sponsored health plan (other than a group health plan of a parent), whether or not the child is enrolled in that plan, does not qualify for dependent coverage under the AFTRA Health Plan.

[1] Refer to page 8 of the 2005 Health Plan SPD for information concerning dependent coverage of domestic partners.

30-day special enrollment period for newly qualified children under age 26 and certain participants

Children of participants who previously were denied or not offered coverage, but now qualify for coverage as a result of the Plan change described above, may be added as dependent children to participants' AFTRA Health Plan coverage during a 30-day special enrollment period. This special enrollment period begins Sept. 25, 2010 and ends Oct. 25, 2010. Such coverage will be effective Dec. 1, 2010. In addition, qualified performers who are not currently enrolled in the Health Plan – and who have a child who newly meets the definition of "dependent," as a result of the Plan change described above – may enroll in the AFTRA Health Plan during this special enrollment period effective as of Dec. 1, 2010, but only if the performer is otherwise qualified to enroll in the AFTRA Health Plan on Dec. 1, 2010 and both the performer and his or her newly qualified adult dependent child enrolls in coverage; additional dependents (other than those who newly meet the definition of "dependent" as a result of the Plan change) may not enroll during the special enrollment period. Coverage for all participants and/or newly qualified dependent children who enroll during the special enrollment period will be effective Dec. 1, 2010 (subject to payment of the required premiums by the due date) and will continue through the end of the participant's current Coverage Period.

AFTRA H&R will send a separate notice to all affected enrolled participants and qualified performers with newly qualified adult child dependents concerning this special enrollment period, as well as instructions as to how to enroll. If you have any questions, please contact Participant Services at (800) 562-4690.

After turning age 26

On the last day of the calendar quarter in which a dependent child reaches age 26, the child's coverage under the AFTRA Health Plan will end. However, the child may be eligible to continue AFTRA Health Plan coverage under terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) for up to 36 months by paying the required COBRA premium in-full and on time. Visit *www.aftrahr.com* ("Health Fund" | "Premiums and buy-up rates") for current COBRA premiums and additional information, including the SPD's provisions on COBRA.

Pay your AFTRA Health Plan premiums online at *www.aftrahr.com*

Online premium payment is fast, convenient and secure. Visa, MasterCard and Discover credit cards are accepted, along with Visa- and MasterCard-branded debit cards.

[2] Refer to the "Eligibility Requirements" section beginning on page 14 of the 2005 Health Plan SPD or visit *www.aftrahr.com* ("Health Fund" | "Earnings requirements" for details about qualification for coverage).

[3] The Coverage Period is the four consecutive calendar quarters that an enrolled participant qualifies for coverage under the Health Plan. The beginning and ending dates for participants' respective Coverage Periods varies depending on the quarter in which they first meet the minimum earnings requirement for qualification. At the end of the initial Coverage Period, coverage for participants and any dependents will continue for an additional four consecutive calendar quarters if they again meet the earnings requirements and pay the required premiums. For additional information, refer to pages 14 and 19-20 of the 2005 Health Plan SPD.

Elimination of lifetime benefit maximums

Overall lifetime benefit maximums to be eliminated

The AFTRA Health Plan currently has an overall lifetime benefit maximum of $1 million for combined hospital and prescription drug benefits (described on page 32 of the 2005 Health Plan SPD) and a separate $1 million overall lifetime benefit maximum for combined major medical and mental health/chemical dependency benefits (described on page 39 of the 2005 Health Plan SPD). Effective Dec. 1, 2010, both of these overall lifetime benefit maximums will be eliminated.

Notice of Grandfathered Health Plan status

The AFTRA Health Plan believes that it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the AFTRA Health Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Associate Director of Benefits Lauretta Davis at (212) 499-4852. You may also contact the US Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or *www.dol.gov/ebsa/healthreform*. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the US Department of Health and Human Services at *www.healthreform.gov.*

Prescription drug program changes provide cost savings, convenience and additional resources to participants

Effective Jan. 1, 2011, participants will be required to use Medco Pharmacy for long-term medications and Accredo Health Group specialty pharmacy for specialty drugs

Two prescription drug program changes will encourage Health Plan participants to take advantage of the cost savings, added convenience, delivery efficiencies and service available when they use Medco Pharmacy and Medco's Accredo Health Group specialty pharmacy. Effective Jan. 1, 2011, prescriptions for long-term medications (medications taken for three months or more, such as those used to treat high blood pressure or high cholesterol) must be filled through Medco Pharmacy. Also, effective Jan. 1, 2011, participants must fill prescriptions for "specialty medications" (drugs used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized patient support) through Accredo Health Group specialty pharmacy. Both Medco Pharmacy and Accredo ship prescription medications directly to participants.

Long-term medications from Medco Pharmacy

On and after Jan. 1, 2011, if you are already taking one or more long-term medications, or if you receive a new prescription for a long-term medication, you may fill each of your prescription twice at a network retail pharmacy, subject to the applicable Health Plan retail copayment. All subsequent prescriptions for each long-term medication, however, must be filled through Medco Pharmacy. **If you continue to purchase a long-term medication at a network retail pharmacy after the first two refills at the retail pharmacy, you will pay the entire cost of those drugs.**

All short-term prescriptions, such as antibiotics, should continue to be filled at a network retail pharmacy. Also, certain compound medications cannot be delivered through the mail, and therefore cannot be filled through Medco Pharmacy. If a long-term drug is not available from Medco Pharmacy, the prescription may continue to be filled at a network retail pharmacy, subject to the applicable Health Plan retail co-payment. If you have any questions concerning whether your medications are "long-term drugs" subject to these requirements, please contact Medco toll-free at (800) 903-8343.

How do I fill a prescription through Medco Pharmacy?

For any medications to be taken for three months or longer, ask your physician to write a 90-day prescription (plus refills up to one year, if appropriate). You may fill this prescription in one of two ways:

- Mail a completed mail order form, which will be included in an introductory mailing from Medco later this year and also is available at *www.medco.com* (after registering with the site, under the "Prescriptions & benefits" heading on the left menu, select "Forms & cards" and then "Print a mail order form by clicking here"); or
- Provide your physician with your H&R Funds No. (labeled as ID No. on your Prescription Drug ID card) and ask him or her to call Medco at (888) 327-9791 for faxing instructions.

Your medication will usually arrive within eight days after Medco receives your order, and you will be billed later.

What will it cost to fill prescriptions through Medco Pharmacy, and how do I pay?

Co-payments for Medco Pharmacy, which remain unchanged, are as follows:

- For generic drugs (up to a 90-day supply) ... $30
- For brand name drugs without a generic equivalent available (up to a 90-day supply) ... 25% of the total cost, with a $150 maximum per prescription
- For brand name drugs with a generic equivalent available (up to a 90-day supply) ... 25% of the total cost, with a maximum of $150 per prescription, plus the entire difference in cost between the brand name and generic drug.

Prescription drug copayments may be paid to Medco Pharmacy online with a credit card or by mail with a check or money order. There is no additional charge for standard shipping.

How will I receive my medications?

Up to a 90-day supply of your medication will be sent directly to you by the mail.

How do I request refills?

E-mail reminders are sent by Medco to participants (who provide an e-mail address when registering with Medco's site) before a refill is due. Participants may refill maintenance medications by mail order form or at *www.medco.com* (one-time registration at the site is required). Refills can also be requested by calling (800) 473-3455 (800 4REFILL).

Why Medco Pharmacy?

The Health Plan's Trustees made this change because of the savings available to the Plan and its participants, and to encourage more participants to utilize Medco Pharmacy. Prescription drugs obtained through Medco Pharmacy are generally less expensive than the same drugs obtained at retail.

Medco Pharmacy is also convenient for participants. Up to a 90-day supply of a long-term drug can be mailed directly to participants' homes, eliminating separate trips to a retail pharmacy. Prescriptions may be refilled by mail, over the phone or online at *www.medco.com* 24 hours a day, seven days a week.

With Medco Pharmacy, participants also have access to additional services and resources, including:

- Registered pharmacists accessible by phone or online 24 / 7.
- Access to specialist pharmacists, privately by phone at no extra cost.
- Information on possible alternative medications, which may meet the participant's therapeutic needs at a lower cost.
- Automatic screening for potential drug interactions, and a state-of-the-art dispensing process to help ensure safety and accuracy.

Specialty medications from Medco's Accredo Specialty Pharmacy

On and after Jan. 1, 2011, if you are already taking one or more specialty medications or you receive a new prescription for a specialty medication, you may fill each of your specialty medication prescriptions once (up to a 30-day supply) at a network retail pharmacy and pay the applicable Health Plan retail co-payment. **All subsequent prescriptions for each specialty medication, however, must be filled through Accredo Specialty Pharmacy. If you continue to purchase the specialty medications at a retail pharmacy, you will pay the entire cost of the drugs.**

What drugs are classified as "specialty" medications?

Specialty medications are defined as high cost pharmaceutical products with special administration, handling and/or clinical support requirements. Specialty medications are typically prescribed for complex chronic conditions such as multiple sclerosis and rheumatoid arthritis, rare diseases such as hemophilia or pulmonary arterial hypertension, and diseases more prevalent in the general population, such as cancer. If you have any questions concerning whether your medication is considered a "specialty medication" subject to these requirements, contact Accredo at (800) 501-7210 or visit *www.medco.com*.

How do I fill a prescription through Accredo Specialty Pharmacy?

Upon receiving a prescription for a specialty medication, simply call Accredo toll-free at (800) 501-7210 between 8 a.m. and 8 p.m. ET Monday through Friday to speak with an intake representative. Or you may provide your physician with your H&R Funds number (labeled as the ID No. on your Prescription Drug ID card) and ask him or her to call Accredo at (800) 987-4904.

Accredo pharmacists will provide counseling to you (and/or consult with your physician) by telephone to explain the medication and its storage requirements, precautions, potential adverse effects, dosing parameters and instructions for use. This support helps ensure a smooth transition, so that you can continue receiving the medications you need. Accredo pharmacists may contact you throughout the duration of therapy to work with you and/or your doctor to ensure proper use of the medication and help manage any possible side effects.

How will I receive my medications?

To ensure the quality of your specialty medication, you may choose a convenient time and place for your delivery from Accredo, whether it is your home or office, your doctor's office or an outpatient clinic (where permitted by law). Accredo will work with you to arrange for expedited delivery and protective packaging for medications that are sensitive to extreme heat or cold.

Why Accredo Specialty Pharmacy?

The Trustees made this change because cost trends for specialty medications are increasing rapidly due to rising prices, increased utilization and increasing numbers of specialty drugs available on the market. The cost for a single specialty medication can range from $6,000 to $350,000 per year. More participants are being prescribed specialty medications for a broader variety of diseases. Specialty medications were once used primarily as therapies for rare conditions, but many newer drugs target diseases such as asthma, osteoporosis and psoriasis that afflict far larger patient populations. Participants using specialty medications also need education and counseling that may not always be available through retail pharmacies.

Accredo, a Medco company, is focused on creating a better model of care for patients with chronic and complex conditions. Teams of registered pharmacists, registered nurses, pharmacy technicians, patient care representatives and reimbursement specialists are available to work with you and your physician throughout the duration of therapy. Accredo also offers efficiencies such as the free scheduled delivery of your medications, refill reminder calls, up to a 90-day supply of medication compared with the 30-day supply you typically get at a network retail pharmacy and free supplies, such as needles and syringes.

Additional resources

Participants with questions about the prescription drug program changes effective Jan. 1, 2011 are encouraged to view the additional information at *www.aftrahr.com* ("FAQs" | "Medco pharmacy FAQs" and "Specialty pharmacy FAQs") or call Participant Services at (800) 562-4690.

CIGNA to provide single nationwide PPO network for Health Plan

Anthem Blue Cross no longer available as PPO network effective Jan. 1, 2011

Effective Jan 1, 2011, CIGNA HealthCare will provide a nationwide PPO health care provider network for Health Plan participants. Participants currently use the CIGNA Shared Administration PPO network to choose network health care providers in 49 of 50 states, and soon they will use the same PPO network for California health care providers. The Health Plan will no longer use Anthem BlueCross' PPO network for dates of service after Dec. 31, 2010. **Therefore, claims for services rendered by Anthem Blue Cross PPO network health care providers for dates of service on or after Jan. 1, 2011 will be treated as non-network and subject to non-network benefits if that provider does not participate in the CIGNA Shared Administration PPO network.**

This change, which was announced in early August at *www.aftrahr.com* and in a *Health Plan News Update* included with the recently mailed premium invoices, offers simplicity for both participants and health care providers (particularly providers who operate in multiple states). This change also allows AFTRA H&R to streamline administration and better manage certain Health Plan costs. Before AFTRA H&R's Trustees decided to make this change, research was conducted to confirm that CIGNA has a broad network of providers throughout California, and the network includes the major California hospital systems most utilized by AFTRA Health Plan participants. AFTRA H&R's Trustees, staff and consultants also considered proposals from several leading PPO providers before selecting CIGNA based upon its broad networks, strong discounts and comprehensive care management services.

It is important to note that the network change in California does not impact the Health Plan's benefits or features. This change also does not affect any other vendors that provide administration services for other Health Plan benefits, including prescription drug benefits (Medco), mental health and chemical dependency benefits (ValueOptions), dental benefits (The Guardian) and life insurance benefits (Aetna).

Watch the mail for your new Health Plan ID card

As a result of the network change, all Health Plan participants will receive new Plan ID cards later this year. Additional instructions and information will be included with the ID card mailing. The cards will not be active until Jan. 1, 2011, but on that date all participants should begin using their new ID cards and destroy the old ID cards.

Confirm network status of California providers

AFTRA Health Plan participants should confirm that their California providers participate in the CIGNA Shared Administration PPO network and plan ahead (for maternity care, elective surgeries, etc.) to maintain continuous in-network care both before and after the transition of PPO networks from Anthem Blue Cross to CIGNA. To identify providers in the CIGNA network, visit *www.aftrahr.com* ("Find a provider") and search CIGNA's Shared Administration PPO Network or call (800) 768-4695.

If you learn that one of your health care providers is not in the CIGNA Shared Administration PPO network, you can nominate your provider to become a member of the network. Visit *www.aftrahr.com* ("Find a provider") and select "Nominate a provider to participate in CIGNA HealthCare's PPO network" to complete a provider nomination form. Please be aware that the submission of the provider nomination form in no way guarantees that the health care provider will be added to CIGNA's network, and covered services from non-network providers are reimbursed at a lower level of benefits.

Additional resources

Participants with questions about the PPO transition in California are encouraged to view the additional information at *www.aftrahr.com* ("FAQs" | "PPO transition FAQs") or call Participant Services at (800) 562-4690.

CIGNA lifestyle management programs available to Health Plan participants in 2011

Beginning Jan. 1, 2011, all Health Plan participants will have access to three new lifestyle management programs through CIGNA and CareAllies:

- *The Quit Today® Tobacco Cessation Program* will offer one regimen – an eight-week supply of nicotine patches, a 12-week supply of nicotine gum or an eight-week behavior change program – at no cost to participants. Each participant taking advantage of this program will develop a personal quit plan and have access to support online or via telephone.
- *The Healthy Steps to Weight Loss® Weight Management Program* will offer participants a self-paced personalized program available online or by telephone (11 coaching sessions over a 12-24 week period) for weight loss. Participants in this program will develop a personal healthy living plan with support from their coach.
- *The Strength and Resilience® Stress Management Program* will help participants manage personal stresses with up to six coaching sessions over an eight-week period. The program will be self-paced and available online or via telephone.

Additional information about the CIGNA lifestyle management programs available Jan. 1, 2011 will be provided to participants in the coming weeks.

Complete a free, secure Health Assessment at the new *MyCareAllies.com*

What steps can you take to improve your health? New online tools from AFTRA H&R and partners CIGNA/CareAllies can help. A free comprehensive online Health Assessment is now available to AFTRA Health Plan participants and their spouses and adult dependents at *MyCareAllies.com* (password "aftra"). The Health Assessment can help determine an individual's risk for certain medical conditions. All information provided in response to Health Assessment questions is handled securely and confidentially, and the assessment only takes a few minutes to complete.

The redesigned *MyCareAllies.com* Web site also includes links to other resources, including the WebMD Personal Health Manager, a MyCareAllies' Health Information Knowledgebase and discounts on health and wellness products and services.

Retirement Plan and Health Plan appeals process amended effective Nov. 1, 2010

The AFTRA Retirement Plan's "Your Right to Appeal a Decision Denying Benefits" and "Appeal Procedure for other Fund Decisions" sections (starting on page 32 of the 2006 AFTRA Retirement Plan SPD) and the AFTRA Health Plan's "Claims and Appeals Procedures" (starting on page 73 of the 2005 AFTRA Health Plan SPD) have been amended. If an appeal of a claim for Retirement Fund or Health Fund benefits is denied in whole or in part, or if any other adverse benefit determination is made as a result of the appeal, the participant (or his or her authorized representative) may, to the extent provided by law, file suit in a court of appropriate jurisdiction challenging the denial or benefit determination. Effective for denials and other adverse benefit determinations made on or after November 1, 2010, however, any such lawsuit must be filed within one year from the date of AFTRA H&R's notice of denial of the appeal or other final adverse benefit determination, and also within any statute of limitations which may be applicable.

Health Plan premiums to increase 5% Jan. 1, 2011

Beginning Jan. 1, 2011, the current quarterly premiums will be increased 5%. The following chart provides the current and new premium amounts if you are qualified to enroll or are already an enrolled participant in the AFTRA Health Plan as of Jan. 1, 2011.

Type of coverage	Current quarterly premium	New quarterly premium effective Jan. 1, 2011
Participant only	$346	$363
Participant and spouse/ domestic partner only	$606	$636
Participant and child(ren) only	$606	$636
Full family	$664	$697
Senior Citizen retiree only	$138	$144
Senior Citizen retiree and spouse/ domestic partner only	$399	$418
Senior Citizen retiree and child(ren) only	$399	$418
Senior Citizen full family	$455	$477

Also note that the rates for "buy-up" coverage, as well as premiums for COBRA continuation coverage and Early Retiree coverage, typically are adjusted annually each April.

Summary Annual Report for the AFTRA Health Plan (for the year ended Nov. 30, 2009)

The Trustees are pleased to present the Summary Annual Report of the AFTRA Health Fund (Federal Employer Identification No. 13-3467049, Plan No. 502) for the fiscal year ended Nov. 30, 2009. The annual report has been filed with the Department of Labor Employee Benefits Security Administration, as required by the Employee Retirement Income Security Act of 1974 (ERISA).

General

The Board of Trustees of the AFTRA Health Fund has committed itself to pay hospital, major medical, prescription drug, mental health and chemical dependency, wellness, dental and loss of voice claims incurred under the terms of the Plan.

Insurance information

The Plan has contracts with Aetna Life Insurance Company to pay life insurance and accidental death and dismemberment claims incurred under the terms of the Plan. The total premiums paid for the Plan Year ending Nov. 30, 2009 were $576,701.

Basic financial statement

The value of Plan assets, after subtracting liabilities of the Plan, was $122,593,486 as of Nov. 30, 2009, compared to $100,270,639 as of Dec. 1, 2008. During the Plan year the Plan experienced an increase in its net assets of $22,322,847. This increase includes unrealized appreciation and depreciation in the value of Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the Plan year, the Plan had total income of $114,616,786 including employer contributions of $72,106,931, participant contributions of $19,052,383, realized gains of $5,345,865 from the sale of assets, and earnings from investments of $18,030,819.

Plan expenses were $92,293,939. These expenses included $14,813,670 in administrative expenses and $77,480,269 in benefits paid to participants and beneficiaries.

Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. an accountant's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. loans or other obligations in default or classified as uncollectible;
5. transactions in excess of 5% of the plan assets; and
6. insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write Board of Trustees, AFTRA Health Fund, 261 Madison Ave., 8th Floor, New York, NY 10016-2312 or call AFTRA H&R at (212) 499-4800. The charge to cover copying costs will be $11.50 for the full annual report of the AFTRA Health Fund and $20.20 for the AFTRA Retirement Fund, $0.10 for any page thereof. You also have the right to receive from the Plan administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Board of Trustees, AFTRA Health Fund, 261 Madison Ave., 8th floor, New York, NY 10016-2312) and at the US Department of Labor in Washington, D.C., or to obtain a copy from the US Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, the Health Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve a symmetrical appearance between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedemas). This coverage is subject to all AFTRA H&R's rules regarding benefits, including but not limited to the annual deductibles and coinsurance applicable to other medical and surgical benefits provided by the AFTRA Health Plan, as well as the Plan's definitions, limitations and exclusions. If you would like more information on WHCRA benefits, call Participant Services at (800) 562-4690.

Two new Producer Trustees join AFTRA H&R Board

AFTRA H&R is pleased to welcome two new Trustees to its Board of Trustees.

Mr. Stephen Mirante works for CBS as Senior Vice President of Human Resources Specialty Services for CBS Corporation. Mr. Ron Wilcox comes to the Board from Warner Music Group, where he serves as Executive Counsel, Business Affairs, Strategic and Digital Initiatives. Both Mr. Mirante and Mr. Wilcox will serve as Producer (Employer) Trustees for AFTRA H&R.

James F. Sirmons retires from AFTRA H&R Board

James Sirmons, a longtime CBS employee and executive, retired from the AFTRA H&R Board of Trustees in June 2010 following 42 years of distinguished service to the AFTRA H&R Board.

After joining the AFTRA H&R Board in the spring of 1968, Mr. Sirmons served as Chair of the Employer Trustees from 1972 through 2003. He was known as a leader who helped create and maintain collegial and effective working relationships between the Employer and Union Trustees, as well as between the Board and the AFTRA H&R staff. Throughout his career, Mr. Sirmons negotiated and helped to administer over 200 labor agreements with AFTRA, the Screen Actors Guild, the Directors Guild, the Writers Guild and the American Federation of Musicians.

Important contact information

- AFTRA H&R Participant Services, (800) 562-4690, *www.aftrahr.com*
- CIGNA HealthCare, (800) 768-4695, *www.cignasharedadministration.com*
- CIGNA's 24-hour Nurseline, (800) 768-4695

AFTRA Health Fund Board of Trustees

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Important information

You should take the time to read this Benefits Update carefully and share it with your family. It is very important that you retain this notice, which is intended to serve as a Summary of Material Modification (SMM), with the Health Plan SPD booklet. While every effort has been made to make this SMM as complete and as accurate as possible, it does not restate the existing terms and provisions of the Plan other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPD (other than with respect to the specific terms and provisions this summary is modifying), or if any point is not discussed in this summary or is only partially discussed, the terms of the SPD will govern in all cases. The Board of Trustees of the AFTRA Health and Retirement Funds or its duly authorized designee reserves the right, in its sole and absolute discretion, to interpret and decide all matters under the Plan. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan or any benefits provided under the Plan (or eligibility for such benefits), in whole or in part, at any time and for any reason (including with respect to retirees and with respect to benefits already earned).