aftra H&R

BENEFITS UPDATE

Inside this issue

This *Benefits Update* includes important information about your AFTRA Health and Retirement Plan benefits. Please keep this *Benefits Update* with your AFTRA Health and Retirement Plan documents and share this information with your family.

Retroactive pension benefit increase effective Dec. 1, 2014

The Board of Trustees is pleased to announce that it has enacted a retroactive pension benefit improvement for Retirement Plan participants.

Previously, as announced in the August 2013 *Benefits Update*, effective Dec. 1, 2013, the AFTRA Retirement Plan was amended to increase the benefit accrual rate to 7% of AFTRA H&R covered contributions (up from the current 4.86%) solely with respect to covered contributions credited for the period May 1, 2009 through Nov. 30, 2012.[1]

New Plan change effective Dec. 1, 2014

Effective Dec. 1, 2014, the Plan has now been amended to increase the benefit accrual rate to 7.55% of AFTRA H&R covered contributions (up from the current 4.86%) solely with respect to covered contributions credited for the period Dec. 1, 2012 through Nov. 30, 2014 (the "period"). For participants on whose behalf contributions were due only to the Retirement Fund — and not to the Health Fund — during this period, the benefit accrual rate is 21.57% of the covered contributions.

Updated accrual examples under the revised accrual formula

To help you better understand the pension benefit accrual formula following the Dec. 1, 2014 benefit improvement, please refer to the table on the following page, which is an updated version of the table at the top of page 27 of the May 2013 edition of the Retirement Plan SPD.

continued on next page

If you (and/or your dependents) have Medicare or will become eligible for Medicare within the next 12 months, a federal law gives you more choices about your prescription drug coverage. If you are a participant in the Senior Citizen Health Program, please see the notice on page 8 for more details. It is vital that you review this information before enrolling in a Medicare Part D plan, which would exclude you from receiving prescription drug coverage under the Senior Program.

[1] For participants on whose behalf contributions were due only to the Retirement Fund – and not the Health Fund – during that period, the formula for that period was 20% of the covered contributions.

Annual Benefit Accruals under the Retirement Plan over a 20-year Period *(following benefit improvement effective Dec. 1, 2014)*				
Period Beginning	**Period Ending**	**Annual Covered Earnings**	**Annual Contributions**	**Accrual During Period**
Dec. 1, 1998[2]	Nov. 30, 2008	$60,000.00	$7,800.00	$14,840.00[3]
Dec. 1, 2008	Nov. 30, 2009	$60,000.00	$7,800.00	$783.00[4]
Dec. 1, 2009	Nov. 30, 2012	$60,000.00	$7,800.00	$1,638.00[5]
Dec. 1, 2012	Nov. 30, 2014	$60,000.00	$7,800.00	$1,177.80[6]
Dec. 1, 2014	Nov. 30, 2018	$60,000.00	$7,800.00	$1,516.32[7]
Total				**$19,955.12**

Note: The total annual benefit accrual in this example would have been $19,535.48 (as compared to $19,955.12) without the Dec. 1, 2014 benefit improvement, because the accrued benefit for contributions credited for the period Dec. 1, 2012 to Nov. 30, 2014 would have been calculated at the 4.86% rate.

continued on next page

[2] For purposes of this example, the base year Dec. 1, 2002 to Nov. 30, 2003, covered earnings were assumed to be $30,000 for the first six months and $30,000 for the second six months of the period.

[3] The $14,840 figure represents the cumulative benefit accrued from Dec. 1, 1998 through Nov. 30, 2008, based on the accrual rates in the table on page 25 of the May 2013 Retirement Plan SPD and constant covered earnings of $60,000 per year.

[4] For the base year Dec. 1, 2008 to Nov. 30, 2009, covered earnings were assumed to be $30,000 for the first five months and $30,000 for the next seven months and contributions were assumed to be $3,900 for each of those periods. Therefore, the amounts of the annual benefits were calculated as follows:

Dec. 1, 2008 to April 30, 2009 - $30,000 covered earnings x 1.70% = $510

May 1, 2009 to Nov. 30, 2009 - $3,900 contributions x 7.00% = $273

Total annual benefit for Dec. 1, 2008 to Nov. 30, 2009 = $510 + $273 = $783

[5] The $1,638 figure represents the cumulative benefit accrued during the three-year period from Dec. 1, 2009 to Nov. 30, 2012 under the improved 7.00% contributions formula adopted effective Dec. 1, 2013, assuming constant contributions of $7,800 per year. In other words, $7,800 x 7.00% = $546 per year, or $1,638 for the three-year period.

[6] The $1,177.80 figure represents the cumulative benefit accrued during the two-year period from Dec. 1, 2012 to Nov. 30, 2014 under the improved 7.55% contributions formula effective Dec. 1, 2014, assuming constant contributions of $7,800 per year. In other words, $7,800 x 7.55% = $588.90 per year, or $1,177.80 for the two-year period.

[7] The $1,516.32 figure represents the cumulative benefit accrued during the four-year period from Dec. 1, 2014 to Nov. 30, 2018 under the 4.86% contributions formula, assuming constant contributions of $7,800 per year, calculated as follows: $7,800 x 4.86% = $379.08, or $1,516.32 for the four-year period.

How Retirement Plan participants will be affected under the change

- **Current retirees who worked during the period Dec. 1, 2012 to Nov. 30, 2014** — Retirees currently receiving a pension from the Retirement Plan that includes benefits accrued after Dec. 1, 2012 will receive a letter about the pension increase by June 2015. A one-time retroactive pension payment will be issued to most retirees who had covered employment on and after Dec. 1, 2012 sufficient to earn a pension credit, and all subsequent monthly benefit payments will reflect the increased benefit. Retirees who were already receiving the maximum benefit under the AFTRA Retirement Fund will not receive the retroactive pension payment, nor increased future payments. Retirees who were receiving the minimum benefit will not receive the retroactive pension payment, nor increased future payments if the increase still does not bring their monthly benefit above the minimum amount. Retirees who worked but did not have sufficient earnings to accrue a pension credit[8] during the period will receive neither an adjusted payment nor increased future payments.

- **Current retirees who did not work during the period Dec. 1, 2012 to Nov. 30, 2014** — Participants who are currently receiving a pension from the AFTRA Retirement Fund, but who did not have covered contributions credited on or after Dec. 1, 2012 are unaffected by this change.

- **Active performers (not retired) who worked during the period Dec. 1, 2012 to Nov. 30, 2014** — Participants who are not yet receiving a pension from the AFTRA Retirement Fund, but who worked and accrued an AFTRA Retirement Fund pension credit[9] during this time period, will receive the retroactive accrual adjustments for covered contributions credited for Dec. 1, 2012 through Nov. 30, 2014.

- **Beneficiaries of participants described above** — If a deceased participant described above would have received a retroactive adjustment had he or she lived, the participant's beneficiary will receive a retroactive adjustment based on the type of survivor benefit the beneficiary receives.

Participants with questions about the pension benefit increase or those wishing to request a pension analysis should call Participant Services at (800) 562-4690 (Option 3).

No increases to active and Senior Program Health Plan premiums for 2015

The Board of Trustees is pleased to announce that the AFTRA Health Plan premiums for active coverage and Senior Program coverage, which were scheduled to increase as of January 1, 2015, will not increase, remaining at the 2014 levels for the 2015 calendar year. 2014/2015 premiums are outlined in the tables below:

2014/2015 premiums for performers who qualify for FAMILY coverage:

Type of coverage	Quarterly premiums for 2014 and 2015
Participant only (active coverage)	$420
Participant plus legal spouse or same-sex domestic partner (active coverage)	$736
Participant and children (active coverage)	$736
Full family (active coverage)	$807
Retiree only (Senior Program)	$166
Retiree plus legal spouse or same-sex domestic partner (Senior Program)	$484
Retiree plus children (Senior Program)	$484
Full family (Senior Program)	$552
Full family (Early Retiree Program)	$5,112[10]

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[8,9] In order to accrue a pension credit, a participant must have had covered earnings of $7,500 or more during the base year Dec. 1, 2008–Nov. 30, 2009 and $15,000 or more during the base years beginning Dec. 1, 2009 and later.

[10] Early Retiree premiums quoted are for 2014 and first quarter 2015 only. It is expected that Early Retiree Premiums will increase April 1, 2015.

2014/2015 premiums for performers who qualify for INDIVIDUAL coverage only:			
Type of coverage	**Quarterly premiums for 2014 and 2015**	**Quarterly buy-up premium effective April 1, 2014[11]**	**Total quarterly premium through Mar. 1, 2015 (individual premium plus buy-up premium, if applicable)**
Participant only (active coverage)	$420	n/a	$420
Participant plus one dependent (active coverage)	$420	$2,567	$2,987
Participant and plus two or more dependents (active coverage)	$420	$4,889	$5,309
Retiree only (Senior Program)	$166	n/a	$166
Retiree plus one dependent (Senior Program)	$166	$2,567	$2,733
Retiree plus two or more dependents (Senior Program)	$166	$4,889	$5,055
Retiree only (Early Retiree Program)	$2,494[12]	n/a	$2,494

Buy-up, COBRA and early retiree premiums expected to increase in April

Though there will be no increase in regular Health Plan premiums for active and Senior Program coverage for 2015, please note that premiums for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), premiums for early retiree coverage and buy-up premiums (for performers who qualify only for individual coverage to buy-up to family coverage) are expected to increase on April 1, 2015 as they typically do each year. Any such increases in buy-up, COBRA and early retiree premiums will be announced in early 2015.

As a reminder to Health Plan participants, AFTRA H&R must receive your Health Plan premium payment before each quarterly due date, or you risk losing coverage. If you think you may have difficulty making your next premium payment due to financial hardship, please visit *www.aftrahr.com* ("Health Fund" | "Premiums" | "Financial assistance and resources") to view links to available resources that may be of assistance.

Late premium payments now accepted online

If you miss the payment deadline for your quarterly AFTRA Health Plan premium, you may now submit your payment online at *www.aftrahr.com* ("Pay premiums") within 30 days of the invoice due date.

It is important, however, to make every effort to pay premiums on time, because payments made online after the due date may result in a lapse in coverage. However, coverage will be retroactively reinstated if the full payment amount is received in full within 30 days of the invoice due date.

As a reminder, certain types of invoices, including premiums for most self-pay plans, may not be paid online and must be paid by check.

[11] Participants who qualify only for individual coverage based upon earnings must pay an additional buy-up premium in order to receive family coverage. It is expected that buy-up premiums will increase April 1, 2015. For more information regarding the buy-up option, refer to page 20 of the 2011 Health Plan SPD, which is available at *www.aftrahr.com* ("Health Fund" | "Health Plan SPD").

[12] Early retiree premiums quoted are for 2014 and first quarter 2015 only. It is expected that Early Retiree Premiums will increase April 1, 2015.

Updated Express Scripts National Preferred Formulary is effective Jan. 1, 2015

As announced in the January 2014 *Benefits Update*, effective April 1, 2014, the Health Plan adopted Express Scripts' National Preferred Formulary for prescription drugs. Because it is a closed formulary, medications that are not included in the Express Scripts National Preferred Formulary are not covered by the AFTRA Health Plan, unless an exception is approved for coverage of a non-formulary medication as described below.

Express Scripts has published its National Preferred Formulary for 2015. The 2015 formulary will not cover certain previously covered medications as of Jan. 1, 2015.

The updated 2015 formulary excludes 66 medications. You will pay the full cost of any excluded prescriptions after the formulary effective date of Jan. 1, 2015, unless an exception is approved.

Please take a moment to review the list of excluded drugs inserted into this Benefits Update, or visit *www.express-scripts.com* to log in to view the list. Please keep in mind that, while the insert lists the drugs excluded as of Jan. 1, 2015, this list will change over time, and so you should view the list at *www.express-scripts.com* or call Express Scripts at (800) 903-8343 for the most up-to-date information to confirm a drug's formulary status.

About ESI's National Preferred Formulary

Developed by Express Scripts, the National Preferred Formulary includes covered medications across all therapeutic classes. If a medication is excluded from the formulary, at least one covered alternative medication will be available. While a covered alternative medication won't be identical to an excluded drug, Express Scripts' Pharmacy and Therapeutics Committee[13] has evaluated these covered alternatives and determined that they are at least as effective at treating the same medical conditions as the excluded drugs for the same disease or condition. If you are taking one of the excluded drugs, speak with your doctor about transitioning to one of the covered alternatives.

Express Scripts should contact affected participants and their physicians

If you are taking one of the prescription drugs that will be newly excluded as of Jan. 1, 2015, Express Scripts should contact you in the coming weeks. This communication will identify the drug(s) you're taking that will soon be excluded and will also provide a list of covered alternatives, allowing you and your doctor to discuss your options and consider changing to a covered alternative medication. Express Scripts' communications to physicians will also generally encourage the providers to advise you of your options under the new formulary and amended benefit.

Express Scripts' exception process

Exceptions may be made in limited circumstances if continued use of an excluded drug is approved through Express Scripts' formulary exception process. Exception requests are evaluated on the basis that use of the excluded drug is medically necessary and essential to the covered individual's health and safety, and/or that all formulary drugs comparable to the excluded drug have been previously tried by the patient and are not effective. If your physician's request is approved through that process, your applicable copayment for the approved drug would be the same as for any other drug covered by the formulary.

If you are covered under the Health Plan and believe that an excluded drug meets the requirements described above, discuss this with your physician. If you and your physician decide to request an exception review by Express Scripts, your physician should call Express Scripts at (800) 753-2851 to request an exception review. All requests for formulary exceptions must be initiated by a physician.

AFTRA H&R appeals process

If you complete the formulary exception process and your request for an exception is denied by Express Scripts, you have a right to appeal under the Health Plan. To be considered an appeal, all requests for review must be made in writing and must be sent to:

AFTRA Health Fund
Appeals Department
P.O. Box 1806, Murray Hill Station
New York, NY 10156-1806

Your request should be sent within 180 days of your receipt of the denial from Express Scripts that you are appealing and should state the reason(s) for your appeal. For additional information relating to your right to appeal or regarding your prescription drug benefits, refer to the Health Plan SPD, which is available at *www.aftrahr.com* ("Health Fund" | "Health Plan SPD").

[13] The Express Scripts National Pharmacy & Therapeutics Committee consists of 15 non-employee physician members and one pharmacist member from the active community and academic-based practices, and the committee represents a broad range of medical specialties.

Maximize your hearing aid benefit by purchasing devices from HearPO

Participants and covered dependents who utilize the Health Plan's hearing aid benefit now have an opportunity to save money on devices they purchase and get the most out of the benefit available to them under the Health Plan.

Through its relationship with Cigna, the AFTRA Health Plan is pleased to offer its enrollees discounted prices on all digital and digitally programmable hearing aids purchased through HearPO on or after Sept. 1, 2014. Cigna is notifying audiologists and ear nose and throat (ENT) physicians in its networks to make them aware of the new offering.

Before ordering a new hearing aid device, your health care professional will verify your Health Plan benefit and eligibility information and complete a disclosure form that outlines your hearing aid benefit and any cost sharing (if the cost of the device is greater than the benefit). Since this is a new offering for the AFTRA Health Plan, you may need to remind your doctor or care provider that because the Plan uses the Cigna network you are eligible for discounted devices from HearPO.

As a reminder, the Health Plan's hearing aid benefit covers only traditional behind the ear (BTE) or in the ear (ITE) hearing aid devices, payable up to a maximum of $1,000 per BTE or ITE device for each covered individual. If you choose a device that is more costly than the benefit allows, you will be responsible for the difference in cost. The benefit is also limited to one device per ear every three years per covered individual.

The hearing aid benefit is payable only if the hearing aid is medically necessary and prescribed by a licensed physician or other medical provider acting within the scope of his or her license or certification. No benefits are provided for hearing aid repair or battery replacement.

If you have any questions about the hearing aid benefit or to submit a claim, please contact Participant Services at (800) 562-4690.

Expanded eligibility for coverage of adult dependent children effective Dec. 1, 2014

Effective Dec. 1, 2014, children (as defined by the Health Plan) of qualified participants will be eligible for dependent coverage up until the end of the calendar quarter in which they reach age 26, regardless of whether they qualify for other employer-sponsored coverage. This provision is subject to payment of the appropriate premiums to include dependent coverage (premiums for family coverage or individual coverage with the buy-up option).

Under the terms of the Health Plan, a participant's children (including biological children, legally adopted children, children placed for adoption during the waiting period before the adoption becomes final, stepchildren and foster children) may be covered under the participant's Health Plan enrollment until the end of the calendar quarter in which the children reach the age of 26. In accordance with the Affordable Care Act, the Health Plan currently provides that dependent coverage is not available for an adult child who qualified for other employer-sponsored coverage (other than a group health plan of the other parent), as described on page 84 of the 2011 Health Plan SPD. However, the new Health Plan change eliminates this restriction related to other employer-sponsored coverage after Dec. 1.

If you have questions about this change or other questions about eligibility or coverage, contact Participant Services at (800) 562-4690.

Learn more about the AFTRA Health Plan's mental health and chemical dependency benefits, which were improved in late 2013

Through an agreement with its behavioral health benefits partner, ValueOptions, the AFTRA Health Plan provides benefits for mental health and chemical dependency treatment on par with its medical benefits. Both prescribed medication therapies and counseling services are covered. As a reminder, the AFTRA Health Plan's mental health and chemical dependency benefits were improved with several changes effective Dec. 1, 2013. Participants and their families are encouraged to familiarize themselves with these expanded benefits and seek help when it is needed.

To learn more, review the benefits charts on the mental health and chemical dependency pages at *www.aftrahr.com* ("Health Fund" | "Health Plan at-a-glance"). For complete information, refer to the 2011 Health Plan SPD as modified by the September 2013 *Benefits Update*; both documents can also be viewed at *www.aftrahr.com* ("Health Fund" | "Health Plan SPD").

For questions about your mental health or chemical dependency benefits, call AFTRA H&R's Participant Services at (800) 562-4690. If you need help selecting a behavioral health provider or other assistance, contact ValueOptions at (800) 704-1421.

Summary Annual Report for the AFTRA Health Plan

This is a summary of the annual report of the AFTRA Health Plan, EIN 13-3467049, Plan No. 502, for period Dec. 01, 2012 through Nov. 30, 2013 (the Plan Year). The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance information

The Health Plan has contracts with The Guardian Life Insurance Company, Aetna Life Insurance Company and Union Security Life Insurance Company of New York to pay dental, life insurance, long-term disability and accidental death and personal loss claims incurred under the terms of the Plan. The total premiums paid for the Plan Year ending Nov. 30, 2013 were $717,094. All other benefits are self-insured, with the Board of Trustees of the AFTRA Health Fund committing that the AFTRA Health Plan will itself pay all claims other than dental, life insurance, long-term disability and accidental death and personal loss claims incurred under the terms of the Health Plan.

Basic financial statement

The value of Plan assets, after subtracting liabilities of the Health Plan, was $211,046,287 as of Nov. 30, 2013, compared to $211,754,529 as of Dec. 1, 2012. During the "Plan Year" the Health Plan experienced a decrease in its net assets of $708,242. This decrease includes unrealized appreciation and depreciation in the value of Plan assets; that is, the difference between the value of the Health 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 Health Plan had total income of $117,241,125, including employer contributions of $87,343,878, participant contributions of $21,620,843, realized gains of $3,301,824 from the sale of assets, earnings from investments of $4,922,800 and other income of $51,780.

Plan expenses were $117,949,367. These expenses included $18,630,851 in administrative expenses, and $99,318,516 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:

- an accountant's report;
- financial information;
- information on payments to service providers;
- assets held for investment;
- fiduciary information, including non-exempt transactions between the plan and parties-in-interest (persons who have certain relationships with the Plan);
- loans or other obligations in default or classified as uncollectible;
- leases in default or classified as uncollectible;
- transactions in excess of 5% of the Plan assets;
- insurance information, including sales commissions paid by insurance carriers;
- information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the Plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Board of Trustees, AFTRA Health Fund at 261 Madison Ave., 7th Floor, New York, NY 10016-2312, or by telephone at (212) 499-4800. The charge to cover copying costs will be $8.28 for the full annual report of the AFTRA Health Plan and $16.83 for the AFTRA Retirement Fund, or $.09 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 Health Plan and accompanying notes, or 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 above does not include a charge for the copying costs of these portions of the reports because these portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the Health Plan (Board of Trustees, AFTRA Health Fund, 261 Madison Ave., 7th 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.

Important Notice About Your Prescription Drug Coverage and Medicare — Medicare Part D Notice of Creditable Coverage

Please review this important notice from the AFTRA Health Plan for Medicare-eligible participants, spouses and dependents regarding your prescription drug coverage, other AFTRA Health Plan coverage and Medicare.

The annual enrollment period for Medicare's prescription drug coverage — Medicare Part D — is from Oct. 15 through Dec. 7, 2014. Therefore, it is time for you to consider whether you want to make any changes in your current prescription drug plan coverage.

During the upcoming enrollment period, you have the opportunity to enroll in a Medicare Part D prescription drug plan, or to keep your AFTRA Health Plan coverage (provided you pay your AFTRA Health Plan premiums on time and, if you are an active participant, provided you remain qualified for coverage under the AFTRA Health Plan).

It is important to note that if you choose to enroll in a Medicare prescription drug plan, the AFTRA Health Plan's Senior Citizen Health Program cannot provide you with prescription drug coverage.

Please read this Notice of Creditable Coverage carefully before you make your decision, and keep the notice where you can find it. This notice contains important information about the Medicare prescription drug coverage and the current prescription drug coverage offered under the AFTRA Health Plan. This information can help you decide whether or not you want to join a Medicare drug plan. This notice also provides you with some of the sources where you may find more information about the Medicare program and the options that are available to you. If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is contained in this notice.

It is important to note that if you choose to enroll in a Medicare prescription drug plan, the AFTRA Health Plan's Senior Citizen Health Program will not provide you with prescription drug coverage. However, it will continue to provide your other hospital and medical benefits in accordance with the Senior Program benefits under the Health Plan. Therefore, if you qualify for the Senior Program under the AFTRA Health Plan and want prescription drug coverage under the Senior Program, you must not enroll in a Medicare Part D plan. If you are currently enrolled in a Medicare Part D plan, in order for you to receive prescription drug coverage under the Senior Program effective Jan. 1, 2015, you must terminate your enrollment in your Medicare Part D plan at the end of the calendar year by contacting your current plan or by calling (800) 633-4227 (800-MEDICARE).

Medicare Part D prescription drug plans

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- In 2006, Medicare prescription drug (Part D) coverage became available to everyone with Medicare. You can get Medicare Part D coverage if you join a Medicare prescription drug plan or a Medicare Advantage Plan (Part C) (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. (Some plans might also offer more coverage for a higher monthly premium.)

- The AFTRA Health Plan has determined that its prescription drug coverage provides "creditable coverage." That means the AFTRA Health Plan is, on average for all Plan participants, expected to pay out as much as, or even more than, the standard Medicare prescription drug coverage will pay. Because this Plan's coverage is "creditable coverage," if you are satisfied with the AFTRA Health Plan coverage, you may choose to keep your AFTRA Health Plan coverage and not enroll in a Medicare prescription drug plan at this time. If you later decide to join a Medicare drug plan, you will not pay a higher premium (a penalty).

continued on next page

When can you join a Medicare prescription drug plan?

People can enroll in a Medicare prescription drug plan when they first become eligible and during this year's annual open enrollment period from Oct. 15, 2014 through Dec. 7, 2014. If you decide to enroll in Medicare prescription drug coverage in a future year, you may do so during any subsequent Medicare Part D annual open enrollment period from Oct. 15 through Dec. 7 each year going forward. Also, if you lose your current creditable prescription drug coverage under the AFTRA Health Plan through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan. **But remember, as stated above, the AFTRA Health Plan's Senior Citizen Health Program will not provide prescription drug coverage if you enroll in a Medicare prescription drug plan.**

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

Remember, your current AFTRA Health Plan coverage pays for health expenses, in addition to prescription drugs, some of which may not be covered by Medicare.

If you are covered under the AFTRA Health Plan's Senior Citizen Health Program and choose to enroll in a Medicare Part D Plan, you will no longer have prescription drug coverage through the AFTRA Health Plan effective Jan. 1, 2015. Medicare will provide your sole prescription drug coverage, although you will maintain the AFTRA Health Plan medical and hospital coverage. **The premium under the AFTRA Health Plan will not be reduced to reflect the termination of the prescription drug coverage.** If you decide to join a Medicare prescription drug plan and you lose your prescription drug coverage under the Senior Program, be aware that you and your dependents will be able to get your prescription drug coverage back (at the beginning of any future calendar year) once you drop your Medicare Part D coverage. In addition, if you decide to join a Medicare prescription drug plan and you drop your Senior Program coverage entirely, you will be eligible to re-enroll in the Senior Program effective Jan. 1 of any year provided you pay the required premium.

continued on next page

Medicare Advantage (Part C) and the AFTRA Health Plan's Senior Citizen Health Program

As you may know, the federal Medicare program is divided into four parts:

- ***Part A*** is free to eligible recipients and helps to pay for inpatient hospital care;
- ***Part B*** is optional, requires premium payments and helps pay for outpatient medical care (e.g., doctors' bills, X-rays, lab tests, etc.);
- ***Part D*** is optional and, if elected, requires premium payments for prescription drug coverage; and
- ***Part C***, called Medicare Advantage, is an option that Medicare beneficiaries can choose as an alternative to Parts A and B (and sometimes Part D). Under Medicare Advantage, private health insurance companies contract with the federal government to offer Medicare benefits – and sometimes additional benefits — through their own policies. These include:
  - managed care plans such as health maintenance organizations (HMOs);
  - preferred provider organizations (PPOs); and
  - fee-for-service plans.

If you enroll or are enrolled in a Medicare Advantage Plan, you cannot enroll in, nor receive coverage under the AFTRA Health Plan's Senior Citizen Health Program. If you join a Medicare Advantage Plan, you can choose to terminate your coverage under the Medicare Advantage Plan at any time for any reason.

If you decide to drop coverage in a Medicare Advantage Plan, you can enroll in the AFTRA Health Plan's Senior Citizen Health Program for the first time or re-enroll effective Jan. 1, 2014 or any Jan. 1 thereafter provided that:

- you meet all the qualification requirements for eligibility under the Senior Program;
- the Eligibility Department in the AFTRA H&R New York office receives your properly completed Senior Citizen Health Program Enrollment Form prior to Jan. 1; and
- you pay the required premium for coverage under the Senior Program by the due date specified on your invoice.

To learn more about qualification for the Senior Citizen Health Program and benefits available under the Health Plan, review the AFTRA Health Plan Summary Plan Description, visit ***www.aftrahr.com*** or contact Participant Services at (800) 562-4690.

If you are not covered under the Senior Citizen Health Program but you are covered as an active participant under the AFTRA Health Plan and you choose to enroll in a Medicare Part D plan, your coverage under the AFTRA Health Plan will not be affected. For participants with active coverage under the Health Plan, the Plan, by law, will always pay before Medicare. Therefore, if you elect a Medicare Part D plan in addition to the AFTRA Health Plan, you will have to pay the Medicare Part D plan premium in addition to the AFTRA Heath Plan premium, though it is unlikely that there will be any benefits payable by the Medicare Plan, because it will always be secondary to the AFTRA Health Plan. As an alternative, you may drop AFTRA Health Plan coverage entirely, enroll in a Medicare Part D plan and rely solely on your Medicare health benefits and your Medicare Part D plan's prescription drug benefits. (However, you should note that included with active coverage under the Health Plan are other benefits – such as preventive dental benefits, a life insurance benefit, accidental death & personal loss benefits and a loss of voice benefit — which Medicare does not provide.)

If you are a participant with active coverage under the AFTRA Health Plan and you elect to drop your coverage under the Health Plan (or you no longer qualify for coverage), you will be able to re-enroll in the AFTRA Health Plan as of the beginning of your next coverage period, but only if you once again meet the Health Plan's earnings requirements and pay the required premium.

When will you pay a higher premium (penalty) to join a Medicare prescription drug plan?

You should also know that if you drop or lose coverage under the AFTRA Health Plan and don't enroll in a Medicare prescription drug plan within 63 continuous days after your AFTRA Health Plan coverage ends, you may be required to pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later on.

If your AFTRA Health Plan coverage ends and you go 63 continuous days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's), you will pay more to enroll in Medicare prescription drug coverage. Your monthly premium for Medicare Part D coverage may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% (1% x 19 months) higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) for as long as you have Medicare prescription drug coverage. Finally, you may have to wait until the following October to enroll in another Medicare Part D plan.

For more information about your Medicare prescription drug plan options

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You should receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. More information about Medicare prescription drug plans can be found on the following websites:

- *www.medicare.gov*
- *www.aarp.org*

Important contact information:

- **AFTRA H&R Participant Services: (800) 562-4690 or *www.aftrahr.com***
- **Cigna HealthCare: (800) 768-4695 or *www.cignasharedadministration.com***
- **Cigna's 24-hour Nurseline: (800) 768-4695**
- **ValueOptions: (800) 704-1421**

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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 2011 Health Plan SPD and 2013 Retirement Plan SPD. 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 Plans other than the specific terms and provisions it is modifying. If any conflict should arise between this summary and the terms of the SPDs (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 SPDs 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 Plans. The Board also reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plans or any benefits provided under the Plans (or qualification 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).

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 the Director of Benefits at (212) 499-4800. 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 website 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.*

EXPRESS SCRIPTS®

2015 Preferred Drug List Exclusions

The excluded medications shown below are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Take action to avoid paying full price. If you are currently using one of the excluded medications, please ask your doctor to consider writing a new prescription for one of the following preferred alternatives.

Drug Class	Excluded Medications	Preferred Alternatives
AUTONOMIC & CENTRAL NERVOUS SYSTEM Interferon Beta Medications for Multiple Sclerosis	Betaseron	Avonex, Extavia, Rebif
Long-Acting Opioid Oral Analgesics	Kadian, Zohydro ER	morphine sulfate ER, oxymorphone ER, Nucynta ER, Opana ER, Oxycontin
Transmucosal Fentanyl Analgesics	Abstral, Fentora, Subsys	fentanyl citrate, Lazanda
Triptans	Axert, Frova	rizatriptan, sumatriptan, zolmitriptan, Relpax
CARDIOVASCULAR Angiotensin II Receptor Antagonists + Diuretic Combinations	Edarbi/Edarbyclor, Teveten HCT	candesartan/HCTZ, irbesartan/HCTZ, losartan/HCTZ, valsartan/HCTZ, Benicar/HCT
DERMATOLOGICAL Topical Acne/Antibiotic Combinations	BenzaClin Gel Pump, Veltin	clindamycin/benzoyl peroxide, clindamycin PLUS tretinoin, Acanya, Ziana
DIABETES Blood Glucose Meters & Strips	Abbott (FreeStyle, Precision), Bayer (Breeze, Contour), Nipro (TRUEtest, TRUEtrack), Roche (Accu-Chek)	LifeScan (OneTouch)
Dipeptidyl Peptidase-4 Inhibitors & Combinations	Jentadueto, Kazano, Nesina, Tradjenta	Janumet, Janumet XR, Januvia, Kombiglyze XR, Onglyza
Glucagon-Like Peptide-1 Agonists	Tanzeum, Victoza	Bydureon, Byetta
Insulins	Novolin	Humulin
	Apidra, NovoLog	Humalog
EAR/NOSE Nasal Steroids	Beconase AQ, Omnaris, Veramyst, Zetonna	flunisolide, fluticasone propionate, triamcinolone acetonide, Nasonex, Qnasl
Otic Fluoroquinolone Antibiotics	Cetraxal	ciprofloxacin otic solution, Ciprodex
ENDOCRINE (OTHER) Growth Hormones	Nutropin/Nutropin AQ, Omnitrope, Saizen, Tev-Tropin	Genotropin, Humatrope, Norditropin
Topical Testosterone Products	Fortesta, Testim, Testosterone Gel, Vogelxo	AndroGel, Axiron
GASTROINTESTINAL Anti-Inflammatory/Anti-Ulcer Agents	Duexis, Vimovo	famotidine PLUS ibuprofen, omeprazole PLUS naproxen
Pancreatic Enzymes	Pancreaze, Pertzye, Ultresa	pancrelipase DR, Creon, Zenpep
HEMATOLOGICAL Erythropoiesis-Stimulating Agents	Aranesp, Epogen	Procrit

Continue on back ❯❯

Continued

Drug Class	Excluded Medications	Preferred Alternatives
HEPATITIS Protease Inhibitors	Incivek	Olysio, Victrelis
Other Direct-Acting Antivirals (example: Sovaldi)	*To be determined after FDA approval*	*To be determined after FDA approval*
Pegylated Interferons	PegIntron	Pegasys
INFLAMMATORY CONDITIONS Tumor Necrosis Factor Antagonists and Other Drugs for Inflammatory Conditions	Cimzia, Simponi, Xeljanz	Enbrel, Humira, Stelara
OBSTETRICAL & GYNECOLOGICAL Ovulatory Stimulants (Follitropins)	Bravelle, Follistim AQ	Gonal-f, Gonal-f RFF
OPHTHALMIC Antiglaucoma Drugs (Ophthalmic Prostaglandins)	Zioptan	Iatanoprost ophthalmic solution, travoprost ophthalmic solution, Lumigan, Travatan Z
OSTEOARTHRITIS Hyaluronic Acid Derivatives	Euflexxa, Gel-One, Hyalgan, Supartz	Monovisc, Orthovisc, Synvisc, Synvisc-One
RESPIRATORY Pulmonary Anti-Inflammatory Inhalers	Alvesco, Flovent Diskus/HFA	Asmanex Twisthaler/HFA, Pulmicort Flexhaler, QVAR
Pulmonary Anti-Inflammatory/ Beta Agonist Combination Inhalers	Breo Ellipta	Dulera, Symbicort
Short-Acting Beta-2 Adrenergic Inhalers	Proventil HFA, Xopenex HFA	ProAir HFA, Ventolin HFA
UROLOGICAL Erectile Dysfunction Oral Agents	Levitra, Staxyn, Stendra	Cialis, Viagra

Additional covered alternatives may be available. Costs for covered alternatives may vary. Log on to ***Express-Scripts.com/covered*** *to compare drug prices. Other prescription benefit considerations may apply.*

Excluded Medications/Products at a Glance

Abbott (FreeStyle, Precision)
Abstral*
Alvesco
Apidra
Aranesp*
Axert*
Bayer (Breeze, Contour)
Beconase AQ
BenzaClin Gel Pump*
Betaseron
Bravelle
Breo Ellipta
Cetraxal*
Cimzia
Duexis*
Edarbi/Edarbyclor
Epogen*
Euflexxa*
Fentora*
Flovent Diskus/HFA
Follistim AQ
Fortesta
Frova*
Gel-One*
Hyalgan*
Incivek*
Jentadueto
Kadian
Kazano
Levitra
Nesina
Nipro (TRUEtest, TRUEtrack)
Novolin
NovoLog
Nutropin/Nutropin AQ
Omnaris
Omnitrope
Pancreaze*
PegIntron
Pertzye*
Proventil HFA
Roche (Accu-Chek)
Saizen
Simponi
Staxyn
Stendra*
Subsys*
Supartz*
Tanzeum*
Testim
Testosterone Gel*
Teveten HCT
Tev-Tropin
Tradjenta
Ultresa*
Veltin*
Veramyst
Victoza
Vimovo*
Vogelxo*
Xeljanz
Xopenex HFA
Zetonna
Zioptan
Zohydro ER*

* New exclusion as of Jan. 1, 2015

Express Scripts manages your prescription benefit for your employer, plan sponsor or health plan.
These changes apply to most Express Scripts national drug lists; does not apply to Medicare plans.