LOCAL 802 AFM

Musicians Health Fund

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IMPORTANT BENEFIT PLAN CHANGES EFFECTIVE OCTOBER 1, 2014

Date: March 31, 2014

To: Fund Participants

From: The Board of Trustees

The Board of Trustees continuously reviews with the Fund's consultants the various benefits offered by the Fund and the financial health of the Fund. The Board also focuses on how the Fund's financial position might look in the future (based on projections provided by the Fund's consultants), including the impact of the Affordable Care Act (the "ACA"), and how to better meet the changing needs of the Fund's Participants in light of the new insurance alternatives available under the ACA.

As a result of this review, the Board has determined, based on advice from the Fund's consultants, that benefit changes are required in order to protect the Fund's long-term financial viability and to accommodate the needs of the Fund' s Participants and their families. In addition, since the Fund's consultants have determined that the Fund's benefit costs are higher than the contributions that the Fund receives from contributing employers and Participants (and the income earned on such amounts), the Board is increasing the Fund's contribution requirements.

Accordingly, effective October 1, 2014, the Fund will offer the following three benefit plans (instead of the current plans):

- A "high option" plan (*new* Plan A+) that will provide comprehensive medical, hospital and prescription drug benefits. This plan's coverage will exceed the ACA's "minimum value" standard and will be equivalent to a "gold" plan in the Marketplace.

- A "base option" plan (*new* Plan A) that will also provide comprehensive benefits, but somewhat less than those of new Plan A+, and will also meet the ACA's "minimum value" standard. Plan A will be equivalent to a "silver" plan in the Marketplace.

- An "ancillary benefits" plan (*new* Plan B) that will provide dental and vision coverage for Participants for whom only a small amount of employer contributions is made to the Fund. (Participants eligible for new Plan A+ and Plan A will also have the opportunity to purchase these benefits.)

The following pages include three charts that summarize the Fund's *current* and *new* benefit plans, including the amount of employer contributions required for eligibility for each plan and the new Participant contribution requirements. We also have enclosed summaries of the benefits provided by each of the new plans.

	CURRENT PLAN		NEW PLAN (effective 10/1/14)
Plan A+	***With* Hospitalization:** medical, hospital and prescription drug coverage, with a $2 million annual limit on medical benefits.	***Without* Hospitalization:** medical and prescription drug coverage, with a $2 million annual limit on medical benefits.	Medical, hospital and prescription drug coverage, with no annual limit. Participants can also buy Plan B dental and vision benefits. Participants who do not pay the required contributions for Plan A+ will be eligible for Plan B benefits *at no cost*.
Required Employer Contributions (per 6-month eligibility period)	At least $4,300 in employer contributions.	At least $3,200 in employer contributions.	At least $4,500 in employer contributions.
Required Participant Contributions**	$0 for individual coverage/$200 per month for family coverage (or $100 per month without hospitalization coverage). *HMO Buy-Up Cost (as of 5/1/14)*: $60 per month for individual/$220 per month for family.	$0 for individual coverage/$200 per month for family coverage. *HMO Buy-Up Cost (as of 5/1/14)*: $125 per month for individual/$450 per month for family.	$100 per month for individual coverage/$400 per month for family coverage, payable quarterly at $300 per quarter for individual and $1,200 per quarter for family coverage. *HMO Buy-Up Cost*: $60 per month for individual/$220 per month for family. *Additional Cost to Buy Plan B Benefits*: $42.00 per month for individual/$116.00 per month for family, payable for six months in advance at $247.00 for individual coverage and $692.00 for family coverage.
Does the Coverage Meet the Minimum Value Standard under the ACA?	Yes. Note that this is the *only* current plan option that meets the ACA's minimum value standard.	No.	Yes, and it is equivalent to a "gold" plan in the Marketplace. We anticipate that this option will be less expensive for Fund Participants than similar coverage available in the Marketplace.

*** The Board will review the Participant contribution amounts on a periodic basis and will implement increases as the Board deems necessary, in its sole and absolute discretion, from time to time.*

	CURRENT PLAN	NEW PLAN (effective 10/1/14)
Plan A	Medical and prescription drug coverage, with a $50,000 annual limit on medical benefits.	Medical, hospital and prescription drug coverage, with no annual limit. Higher deductibles, copayments and coinsurance than new Plan A+. Participants can also buy Plan B dental and vision benefits. Participants who do not pay the required contributions for Plan A will be eligible for Plan B benefits *at no cost*.
Required Employer Contributions (per 6-month eligibility period)	At least $1,400 in employer contributions.	At least $2,000 in employer contributions.
Required Participant Contributions**	$25 per month for individual coverage/$135 per month for family coverage *HMO Buy-Up Cost (as of 5/1/14)*: $350 per month for individual/$900 per month for family.	$100 per month for individual coverage/$400 per month for family coverage, payable quarterly at $300 per quarter for individual coverage and $1,200 per quarter for family coverage. *HMO Buy-Up Cost*: $225 per month for individual/$450 per month for family. *Additional Cost to Buy Plan B Benefits*: $42.00 per month for individual/$116.00 per month for family, payable for six months in advance at $247.00 for individual and $692.00 for family.
Does the Coverage Meet the Minimum Value Standard under the ACA?	No.	Yes, and it is equivalent to a "silver" plan in the Marketplace. We anticipate that this option will be less expensive for Fund Participants than similar coverage available in the Marketplace.

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	CURRENT PLAN	NEW PLAN (effective 10/1/14)
Plan B	Medical coverage, with a $5,000 annual limit.	Dental and vision coverage.
Required Employer Contributions (per 6-month eligibility period)	At least $500 in employer contributions.	At least $500 in employer contributions.
Required Participant Contributions**	None. *HMO Buy-Up Cost (as of 5/1/14)*: $535 per month for individual/$1,370 per month for family.	None. No HMO buy-up. Note: If an individual is eligible for Plan A+ or Plan A but does not pay the required Participant contributions, (s)he will automatically receive these benefits at no cost unless (s)he opts out.
Does the Coverage Meet the Minimum Value Standard under the ACA?	No.	No. These are "excepted benefits" that do not qualify as "minimum essential coverage" under the ACA. As a result, eligibility for this option will not preclude an individual from qualifying for the federal premium subsidy to purchase insurance in the Marketplace, if (s)he satisfies the ACA's family income requirements.

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Change in the Fund's Six-Month Coverage Periods

As you know, under the Fund's current rules, the amount of employer contributions made to the Fund for work performed by a Participant during the period from *January through June* determines eligibility for coverage for the period *October through March*, and contributions for work performed during the period from *July through December* determines eligibility for coverage for the period *April through September*. In order to comply with the ACA, the six-month Coverage Periods will start and end *one month earlier (running from September – February and March – August)*, as described in detail in the following chart. In order for the Fund to transition to this new format, the first Coverage Period will begin when the plan design changes become effective on October 1, 2014 (rather than on September 1) and it will therefore last for five (rather than six) months, ending on February 28, 2015.

	CURRENT RULE	NEW RULE (effective 10/1/14)
January through June Eligibility Period	The amount of Employer Contributions made to the Fund for work performed during the 6-month Eligibility Period from *January 1 through June* 30 determines the Participant's eligibility for coverage for the 6-month Coverage Period from *October 1 through March 31.*	*The Fund's 6-Month Eligibility Period will remain the same, but the 6-Month Coverage Period will start and end one month earlier.* Accordingly, the amount of Employer Contributions made to the Fund for work performed during the 6-month Eligibility Period from ***January 1 through June 30*** will determine the Participant's eligibility for the 6-month Coverage Period from ***September 1 through February 28/29 (except for the first year of implementation, when the Coverage Period will start on October 1, 2014 and end on February 28, 2015).***
July through December Eligibility Period	The amount of Employer Contributions made to the Fund for work performed during the 6-month Eligibility Period from *July 1 through December 31* determines the Participant's eligibility for coverage for the 6-month Coverage Period from *April 1 through September 30.*	*The Fund's 6-Month Eligibility Period will remain the same, but the 6-Month Coverage Period will start and end one month earlier.* Accordingly, the amount of Employer Contributions made to the Fund for work performed during the 6-month Eligibility Period from ***July 1 through December 31*** will determine the Participant's eligibility for the 6-month Coverage Period from ***March 1 through August 31.***

Transition Rule: Temporary Option to Buy-Up to a Higher Level of Coverage

In order to lessen the impact of the changes in plan design and eligibility requirements, the Board of Trustees has adopted a transitional rule pursuant to which an eligible Participant will have a temporary option to purchase a higher level of coverage than (s)he otherwise qualifies for, as follows:

1. Buy-Up to Plan A+. A Participant who has at least $4,300 (but less than $4,500) of employer contributions during the 6-month eligibility period ending June 30, 2014 or December 31, 2014 will be eligible to buy up to Plan A+ for the corresponding coverage periods by contributing the shortfall (*i.e.*, $200 or less) to the Fund. *This option applies solely to the eligibility periods ending June 30, 2014 (for coverage October 1, 2014 – February 28, 2015) and December 31, 2014 (for coverage March 1, 2015 – August 31, 2015).*

2. Buy-Up to Plan A. A Participant who has at least $1,400 (but less than $2,000) of employer contributions during the 6-month eligibility period ending June 30, 2014 or December 31, 2014 will be eligible to buy up to Plan A for the corresponding coverage periods by contributing the shortfall (*i.e.*, $600 or less) to the Fund. *This option applies solely to the eligibility periods ending June 30, 2014 (for coverage October 1, 2014 – February 28, 2015) and December 31, 2014 (for coverage March 1, 2015 – August 31, 2015).*

Rules Applicable to the Temporary Buy-Up Option

- The Board of Trustees reserves the right, in its sole and absolute discretion, to discontinue the buy-up option after the first eligibility period (ending June 30, 2014) in order to maintain or improve the overall financial status of the Fund.

- The buy-up payment is *in addition to* the required Participant contributions described in the *New Plan* portions of the charts shown above.

- The election to purchase the higher level of coverage must be made by the applicable due date communicated by the Fund Office.

Change to the Current Empire Blue Cross HMO Buy-Up Option

Effective as of October 1, 2014, Participants who are eligible for the new Plan A+ or new Plan A will be eligible to buy up to the Fund's HMO coverage by paying the amounts set forth in the *New Plan* portions of the charts shown above. Participants eligible for new Plan B are not permitted to buy up to the HMO.

As you may recall from prior communications from the Fund, the HMO coverage meets the ACA's "minimum value" standard. Since Plan B participants will not have the option to purchase this coverage as of October 1, 2014, they will not be considered to have an offer of

"minimum value" coverage from the Fund for purposes of determining their eligibility for the federal government's premium subsidy for coverage purchased in the Marketplace.

Discontinuance of the Fund's Current Waiver/Opt-Out Premium Reimbursement Policy

Effective as of October 1, 2014, the Fund will no longer reimburse individuals for premiums they pay for alternative or additional medical or hospitalization coverage, even if the Participant opts out of the Fund's coverage (including by not paying the required Participant contribution for coverage under the Fund). This change applies to health coverage purchased for periods beginning on or after October 1, 2014.

New Enrollment Rules

Effective October 1, 2014, eligible individuals will no longer be automatically enrolled for coverage under the Fund (unless the individual qualifies only for Plan B coverage).

The enrollment process will be as follows:

- In August and February of each year, the Fund Office will notify Participants of any change in their eligibility based on their coverage in the prior 6-month Coverage Period. ***Remember, the Fund's new 6-Month Coverage Periods will be September – February and March – August (except that a 5-Month Coverage Period will apply for the first Coverage Period beginning on the effective date of the new program -- October 1, 2014 – February 28, 2015).***

- If there is no change in a Participant's eligibility, the Fund Office will simply send the Participant an invoice for the required contributions to be paid by the Participant by the stated deadline.

- If, however, there is a change in the Participant's eligibility, the Fund Office will notify the Participant of the plan option for which (s)he will be eligible for the upcoming 6-month Coverage Period and provide the Participant with an invoice and Enrollment Form, which must be returned to the Fund Office by the stated deadline.

- Participant contributions for each Plan option will be due on a quarterly basis within 30 days of the date of each quarterly invoice; HMO Buy-Up amounts will continue to be due on a monthly basis; and the Plan B self-pay contributions for eligible and enrolled New Plan A+ and Plan A Participants will be due on a semi-annual basis.

New Plan A+ and New Plan A -- Individuals eligible for Plan A+ and Plan A will be required to complete the Enrollment Form and submit it to the Fund Office along with the required Participant contribution for the applicable plan option. As noted, these Participants may also elect to purchase the Plan B dental and vision benefits. If an individual decides *not* to pay for the plan option for which (s)he is eligible (either Plan A+ or Plan A), (s)he will automatically be

enrolled in Plan B coverage (at no cost), but must complete and submit an Enrollment Form in a timely manner in order for his/her eligible dependents to be covered by Plan B. *Remember that if you do not have <u>any</u> health coverage from any source, you may be subject to ACA penalties for not having coverage under what is known as the "individual mandate." Plan B dental and vision benefits do not count as health coverage for this purpose.*

<u>New Plan B</u> – Individuals eligible for Plan B are automatically enrolled in these benefits. (This includes Participants who have only $500 - $1,999 in employer contributions during the 6-month eligibility period, as well as individuals who are eligible for Plan A+ or Plan A but decide not to pay for that coverage.) Pursuant to the ACA, these individuals may opt out of Plan B coverage by submitting to the Fund Office the required waiver form, but if you do opt out of Plan B, you will not receive any of the employer contributions paid (or required to be paid) to the Fund on your behalf, even if you have other health coverage from another source. (*See* paragraph above describing discontinuance of the Fund's premium reimbursement policy.) Remember, as noted above, coverage under Plan B alone does not satisfy the ACA's individual mandate because Plan B only provides "excepted" benefits.

<u>Important note regarding the Fund's Grandfathered Status under the ACA</u>

Please be advised that the Fund believes that, due to the changes being made to the Plan, the Plan will no longer be a "grandfathered" health plan under the ACA, effective as of October 1, 2014. Being a grandfathered health plan meant that the Plan was not required to include certain consumer protections of the ACA that apply to non-grandfathered plans. Now that the Plan will not be grandfathered, the Plan's benefits are being modified to ensure compliance with all of the ACA's requirements for non-grandfathered plans. For example, the new Plan A+ and Plan A options will cover certain preventive services at no charge to you, will offer new protections when you appeal claims and coverage denials, and will provide enhanced emergency care benefits, as described in more detail in the Summary of Material Modifications that will be sent to you.

* * * *

We will provide you with additional communications describing the new plan options and rules in more detail, including an updated Summary Plan Description ("SPD") and new Summaries of Benefits and Coverage ("SBCs").

With regard to the future beyond October 2014, as you are aware, the delivery of health care benefits has become more complicated and costly, particularly in light of the ACA's numerous requirements and fees. As a result, the coming years may continue to be unpredictable and require changes to the Fund's benefits and rules. The Board will continue to do its best to provide the Fund's Participants and their families with comprehensive and valuable benefits.

If you have any questions regarding the above or the enclosed materials, feel free to contact the Fund Administrator, Gloria McCormick, at the Fund Office.

Sincerely,

The Board of Trustees

Enclosure (Benefit Summary)

This Notice is intended to provide you with an easy-to-understand description of some changes that are being made to the Fund's benefits. While every effort has been made to make this description as complete and accurate as possible, this Notice, of course, cannot contain a full restatement of the terms and provisions of the plan. For a full description of your rights under the Fund, please refer to the full SPD and any prior amendments, and any insurance contracts (collectively, the plan documents). If any conflict should arise between this Notice and the plan documents, or if any point is not discussed in this Notice or is only partially discussed, the terms of the plan documents (including the SPD) will govern in all cases.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Fund, or any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the amendment procedures established under the trust agreement establishing the plan. The plan documents and trust agreement are available at the Fund Office and may be inspected by you during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Fund's plan documents, make any promises to you about benefits under the Fund, or to change any provision of the Fund's plan of benefits. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Fund's plan and decide all matters arising under the plan.

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Plans A+ & A
Medical and Hospitalization
Effective 10/1/2014

	NEW Plan A+		New Plan A	
	In Network	Out of Network	In Network	Out of Network
Deductible	$0	$500	$250	$750
Coinsurance	80%	70% (80% Facility)	70%	50%
Out of Pocket Maximum	$6,350		$6,350	
Inpatient Stay	80%	20% Coins	$500 Copay	Ded & Coins
Mental Health	80%	20% Coins	$500 Copay	Ded & Coins
Substance Abuse	80%	20% Coins	$500 Copay	Ded & Coins
Outpatient Facility	80%	20% Coins	Ded & Coins	Ded & Coins
Outpatient Surgery Phys/Surg Services	$20 Copay	Ded & Coins	Ded & Coins	Ded & Coins
Outpatient Mental Health	$20 Copay	Ded & Coins	$50 Copay	Ded & Coins
Outpatient Substance Abuse	$20 Copay	Ded & Coins	$50 Copay	Ded & Coins
Imaging	80%	Ded & Coins	Ded & Coins	Ded & Coins
Rehab Speech Therapy	$20 Copay	Ded & Coins	Ded & Coins	Ded & Coins
Rehab Occupational & Physical Therapy	$20 Copay	Ded & Coins	Ded & Coins	Ded & Coins
Lab OP & Professional Services	$20 Copay	Ded & Coins	Ded & Coins	Ded & Coins
Xray& Diagnostic	80%	Ded & Coins	Ded & Coins	Ded & Coins
Emergency Room	100%	100%	$150 Copay	Ded & Coins
Primary Care Visit	$20 Copay	Ded & Coins	$30 Copay	Ded & Coins
Specialist Care Visit	$20 Copay	Ded & Coins	$50 Copay	Ded & Coins
Preventive/Immunizations	100%	100%	100%	100%
Skilled Nursing Facility	80%	100%	Ded & Coins	Ded & Coins
DME, Chiro, Home Health	$20 Copay	Ded & Coins	Ded & Coins	Ded & Coins
Ambulance	100%	Ded & Coins	Ded & Coins	Ded & Coins
Prescription Drugs				
Retail				
Generic	$20 copay		$20 copay	
Formulary	$35 copay		$35 copay	
Non-Formulary	40% with minimum $50, max $75		40% with minimum $50, max $75	
Mail Order				
Generic	$40 copay		$40 copay	
Formulary	$70 copay		$70 copay	
Non-Formulary	40% with minimum $100, max $150		40% with minimum $100, max $150	

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PLAN B
Dental and Vision
EFFECTIVE 10/1/2014

DENTAL COVERAGE	BENEFIT LEVEL
Annual Deductible	$50.00
Annual Maximum Benefit	$1,500
Services through a Network Provider	
Diagnostic Services	100%
Preventive Services	100%
Basic Restorative Services	80%
Major Restorative Services	50%
Services through a Non-Network Provider	Paid at Network Allowance
Orthodontia	50% to $1,500 Maximum

OPTICAL COVERAGE	BENEFIT LEVEL
Exam	Every 12 Months
Lenses/Contacts	Every 12 Months
Frames	Every 24 Months
Exam Copay	$10.00 Copay
Frame Allowance	$130 Allowance, 20% above Allowance
Standard Plastic Lenses	$20 Copay
Lens Options	
UV Treatment	$15 Copay
Tinting	$15 Copay
Scratch Resistant Coating	$15 Copay
Poly Coating	$40 Copay

Dental and Optical benefits will be provided on an insured basis.

Information about specific insurance company will be provided to you at a later date.