**Musicians Health Fund**
322 West 48th Street, New York, NY 10036
Phone: 212-245-4802 • Fax: 212-245-2304
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**VERY IMPORTANT NOTICE TO PARTICIPANTS OF THE LOCAL 802 MUSICIANS HEALTH FUND**

# Important Information Regarding Your Health Fund Benefits

*This document is a Summary of Material Modifications ("SMM") intended to notify you of changes to the plan of benefits (the "Plan") of the Local 802 Musicians Health Fund (the "Fund"). This document also includes some important reminders about the Plan's benefit program. You should take the time to read this SMM carefully and keep it with the copy of the summary plan description ("SPD") that was previously provided to you. If you have any questions regarding this notice, please contact the Fund Office at (212) 245-4802.*

June 28, 2019

Dear Participant and Family,

Below is a description of important changes to the Plan's medical benefits, including elimination of the Empire Blue Cross HMO buy-up option, as well as a few reminders about the Plan's benefit program.

## I. MEDICAL BENEFIT CHANGES

### UPDATES TO THE FUND'S *PLAN A* MEDICAL BENEFITS

### *What Is Changing?*

Starting September 1, 2019, the following benefits provided by the Fund are changing:

| Benefit | Current | Change |
|---|---|---|
| Teladoc® | $30 copay | No copay |
| Physical Therapy, Chiropractic & Acupuncture Services ($50 Copay for visits) | No visit limit | 50 visit limit per calendar year (combined limit for all services) |
| Out-of-Network Provider Annual Deductible | $750 Individual<br>$1,500 Family | $2,500 Individual<br>$6,250 Family |
| Out of Network Provider Reimbursement Rate | 75th Percentile of FAIR Health[1] | 150% of Medicare |

[1] Health plans are required to choose a method for determining the "allowable amount" for services that are provided by out-of-network providers, since those providers do not have contractually agreed-upon rates with the plan or claims administrator (as is the case for in-network providers). The Fund currently uses the FAIR Health database for determining a reasonable "allowable amount." Effective as of September 1, 2019, the Fund will use Medicare reimbursement rates to determine the "allowable amount" for out-of-network claims; the "allowable amount" will be 150% of the Medicare reimbursement rate.

***What Is the Out-of-Network Provider Reimbursement Rate?***

As you know, the Plan's coverage varies depending on whether you use doctors and hospitals that are "in-network" or "out-of-network." It is important for you to understand how much the Plan pays for your out-of-network care.

If you receive services from a doctor or hospital that is not part of Aetna's Choice POS II network (i.e., an out-of-network provider), the Plan pays a portion of the provider's bill, but there is a limit on the amount the Plan will pay. Most of the time, you will pay a lot more from your own pocket if you use an out-of-network provider instead of an in-network provider.

The limit on the amount the Plan will pay for out-of-network care is called the "recognized" or "allowed" amount. **The way that this amount is calculated is changing on September 1, 2019. Specifically, going forward this amount will be calculated based on 150% of Medicare instead of the 75$^{th}$ Percentile of FAIR Health. If you use out-of-network providers on or after September 1, your share of your medical costs usually will increase.**

***How Does This Change Affect Me?***

Beginning September 1, 2019, you will pay more out of your pocket if you continue to use out-of-network providers as a result of the change in the way we will calculate the "allowed amount."

Below is an example of how this change could affect future claims for physical therapy services. *The billed and allowed amounts shown in the example are solely for illustrative purposes and are not actual costs, which will vary depending on the provider you use and other factors.*

**30 PHYSICAL THERAPY VISITS:**

| **PLAN A** | **IN-NETWORK** | **CURRENT OUT-OF-NETWORK** | **OUT OF NETWORK** **EFFECTIVE 9/1/19** |
|---|---|---|---|
| **AMOUNT BILLED BY PROVIDER** | $1,800 (30 x $60)<br>*30 visits at $60/visit* | $7,500 (30 x $250)<br>*30 visits at $250/visit* | $7,500 (30 x $250)<br>*30 visits at $250/visit* |
| * **PLAN ALLOWED AMOUNT** | **$1,800** | **$4,500** | **$2,250** |
| **YOUR SHARE OF THE ALLOWED AMOUNT**<br>*(Copayments, deductibles and coinsurance paid by the patient)* | $1,500<br>*30 visits at $50 copayment/visit* | $2,625<br>Deductible: $750<br>50% Coinsurance: $1,875<br>*(50% of $3,750 = $1,875)* | $2,250<br>Deductible: $2,250<br>*(applied toward the $2,500 annual deductible* |

| | | | |
|---|---|---|---|
| **POTENTIAL PROVIDER BALANCE BILL** *(amount billed by provider over and above the "Plan Allowed Amount")* | $0 | $3,000 | $5,250 |
| **YOUR TOTAL POTENTIAL COST** "Your Share of the Allowed Amount"+ "Potential Provider Balance Bill" = maximum amount that the provider may bill you | **$1,500** | **$5,625** | **$7,500** |

*"Plan Allowed Amount" is the maximum amount the health plan will pay for a covered health service. Deductibles are applied to the plan allowed amount before coinsurance is calculated.

### *How Can I Avoid These Extra Costs?*

You can avoid these extra costs by getting your care from a provider that is in Aetna's Choice POS II network of health care providers. Go to www.aetna.com and click on "Find a Doctor". If you are already a member, sign on to your Aetna navigator® member site.

## UPDATES TO THE FUND'S *PLAN A+* MEDICAL BENEFITS

### *What Is Changing?*

Starting September 1, 2019, the following benefits are changing:

| Benefit | Current | Change |
|---|---|---|
| Teladoc® | $20 | No copay |
| Primary Care Physician Copay | $20 | $25 |
| Specialist Physician Copay | $20 | $40 |
| ER Copay | $0 | $150 |
| Physical Therapy, Chiropractic & Acupuncture Services Visit Limits ($25 Copay for visits) | No visit limit | 50 visit limit per calendar year (combined limit for all services) |
| Out-of-Network Provider Annual Deductible | $500 Individual<br>$1,000 Family | $1,500 Individual<br>$3,750 Family |
| Out of Network Provider Reimbursement Rate | 75th Percentile of FAIR Health[2] | 150% of Medicare |

[2] Health plans are required to choose a method for determining the "allowable amount" for services that are provided by out-of-network providers, since those providers do not have contractually agreed-upon rates with the plan or claims administrator (as is the case for in-network providers). The Fund currently uses the FAIR Health database for determining a reasonable "allowable amount." FAIR Health is an independent nonprofit organization that collects data for and manages the nation's largest database of health insurance claims. Effective as of September 1, 2019, the Fund will use Medicare reimbursement rates to determine the "allowable amount" for out-of-network claims.

***What Is the Out-of-Network Provider Reimbursement Rate?***

As you know, the Plan's coverage varies depending on whether you use doctors and hospitals that are "in-network" or "out-of-network." It is important for you to understand how much the Plan pays for your out-of-network care.

If you receive services from a doctor or hospital that is not part of Aetna's Choice POS II network (i.e., an out-of-network provider), the Plan pays a portion of the provider's bill, but there is a limit on the amount the Plan will pay. Most of the time, you will pay a lot more from your own pocket if you use an out-of-network provider instead of an in-network provider.

The limit on the amount the Plan will pay for out-of-network care is called the "recognized" or "allowed" amount. **The way that this amount is calculated is changing on September 1, 2019. Specifically, going forward this amount will be calculated based on 150% of Medicare instead of the 75th Percentile of FAIR Health. If you use out-of-network providers on or after September 1, your share of your medical costs usually will increase.**

***How Does This Change Affect Me?***

Beginning September 1, 2019, you will pay more out of your pocket if you continue to use out-of-network providers as a result of the change in the way we will calculate the "allowed amount."

Below is an example of how this change could affect future claims for physical therapy services. *The billed and allowed amounts shown in the example are solely for illustrative purposes and are not actual costs, which will vary depending on the provider you use and other factors.*

**30 PHYSICAL THERAPY VISITS:**

| **PLAN A+** | **IN-NETWORK** | **CURRENT OUT-OF-NETWORK** | **OUT OF NETWORK** **EFFECTIVE 9/1/19** |
|---|---|---|---|
| **AMOUNT BILLED BY PROVIDERT** | $1,800 (30 x $60) *30 visits at $60/visit* | $7,500 (30 x $250) *30 visits at $250/visit* | $7,500 (30 x $250) *30 visits at $250/visit* |
| ***PLAN ALLOWED AMOUNT** | **$1,800** | **$4,500** | **$2,250** |
| **YOUR SHARE OF THE ALLOWED AMOUNT** *(Copayments, deductibles and coinsurance paid by the patient)* | **$750** *30 visits at $25 copayment/visit* | **$1,700** Deductible: $500 30% Coinsurance: $1200 *(30% of $4,000 = $1,200)* | **$1,725** Deductible: $1,500 Coinsurance: $225 *(30% of $750 = $225)* |
| **POTENTIAL PROVIDER BALANCE BILL** *(amount billed by provider over and above the "Plan Allowed Amount")* | $0 | $3,000 | $5,250 |

| | | | |
|---|---|---|---|
| **YOUR TOTAL POTENTIAL COST**<br>"Your Share of the Allowed Amount"+ "Potential Provider Balance Bill" = maximum amount that the provider may bill you | **$750** | **$4,700** | **$6,975** |

*"Plan Allowed Amount" is the maximum amount the health plan will pay for a covered health service. Deductibles are applied to the plan allowed amount before coinsurance is calculated.

***How Can I Avoid These Extra Costs?***

You can avoid these extra costs by getting your care from a provider that is in Aetna's Choice POS II network of health care providers.

Go to www.aetna.com and click on "Find a Doctor". If you are already a member, sign on to your Aetna navigator® member site.

***What's Next?***

- Aetna and Fund representatives will be available to answer questions at the following date & time:

**WEDNESDAY, JULY 31, 2019 – 5:30 P.M.**
**LOCAL 802 CLUBROOM**
**322 West 48th Street**
**New York, NY 10036**

- You will receive a new ID card from Aetna by September 1, 2019. Be sure to present your new ID card for care after this date. For additional contemporary ID cards: Visit www.aetna.com through the secure member website. If you're on the go, you can access your card through Aetna's mobile app.

***Questions?***

If you have questions, please contact Aetna at 1-877-843-8498 or the Fund Office at 212-245-4802.

## II. TERMINATION OF THE FUND'S EMPIRE BLUE CROSS HMO BUY-UP OPTION

Effective September 1, 2019, the Fund will no longer offer the Empire Blue Cross HMO as an option to Fund participants. (As a reminder, the HMO option has been phased-out over the last few years, *and was closed to new participants as of 2014*.)

HMO Participants who are eligible for Plan A or Plan A+ as of September 1, 2019 may enroll in the applicable option (Plan A or Plan A+) by timely remitting the required participant premium for coverage beginning as of September 1st. As a reminder, participant contributions for each Plan option are due on a quarterly basis within 30 days of the date of the invoice sent by the Fund Office, and eligible participants also may elect and pay for Plan B (dental and vision) benefits.

*If you are currently covered by the HMO, you will receive a separate notice from Empire Blue Cross explaining that you have the opportunity to purchase an individual HMO plan directly from Empire Blue Cross. Please be aware that the individual HMO coverage is not offered or administered by the Fund.* Plan details can be viewed at www.Empireblue.com. Also note that the individual plan of benefits will not be identical to the HMO coverage currently offered by the Fund and likely will not be as generous.

## III. IMPORTANT REMINDERS ABOUT THE FUND'S BENEFIT PROGRAM

Need care for a minor illness when your doctor's office is closed? You have plenty of options. You may visit retail, walk-in, or urgent care clinics to give you alternatives to the emergency room at a lower cost and less wait time too! The sites are staffed with nurse practitioners and physician assistants with evening and weekend hours available, no appointments needed.

In addition, as a reminder, the Fund provides you with access to Teladoc®, which gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Now at no cost to you. For more information about Teladoc® or other options, contact Aetna at 1-877-843-8498 or the Fund Office at 1-212-245-4802.

The Fund also offers programs that let you speak with an Aetna nurse to help you get answers to your health questions. If a time comes when you're dealing with more complex health challenges, you can be assigned a nurse to work with you by telephone on an ongoing basis. Or if you have an ongoing health concern, a nurse may call to check in from time to time. Your conversations are completely confidential. Aetna does not share this information with the Fund, and they keep all information confidential as required by law. For more information about this program, contact Aetna at 1-877-843-8498 or the Fund Office at 1-212-245-4802.

## IV. NEW SPD LANGUAGE ABOUT RECOVERY OF OVERPAYMENTS

(SPD at page 85 - "Important Information You Should Know")

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party claims administrator – Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to the same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

## V. NOTICE TO BROADWAY MUSICIANS CONCERNING THE IMPUTED CREDIT

Under your new Collective Bargaining Agreement, the employers' contributions to the Local 802 Musicians Health Fund increased by 15%, from $222 to $255 per week, effective March 4, 2019. As a result, fewer performances will be required for eligibility for each tier of benefits under the Fund.

Since 2007 when the Health Fund and Sick Pay Fund merged, Broadway musicians have received an imputed credit that was designed to assure that musicians playing 5.7 performances per week would meet the Fund's eligibility threshold for Plan A+. In effect the imputed credit deemed the employer contribution to the Health Fund to be higher than the amount actually contributed by the employer in accordance with the collective bargaining agreement. The imputed credit involved no cash outlay by the Fund, although its effect was to lower the dollar eligibility thresholds required for Plans A and A+. Under the new Collective Bargaining Agreement, due to the 15% increase in employer contributions, playing 5.7 performances per week significantly exceeds the eligibility threshold for Plan A+. Accordingly, the Fund has determined that the imputed credit is no longer necessary and will terminate on June 30, 2019. The last contribution period for which the credit will apply is the current contribution period (January 1 – June 30, 2019), which determines coverage effective September 1, 2019.

## VI. BOARD OF TRUSTEES AND PROFESSIONAL ADVISORS

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As always, if you need assistance or have any questions regarding any of the issues described in this notice, please contact the Fund Office at (212) 245-4802.

Sincerely,

Board of Trustees
Local 802 Musicians Health Fund

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan. A full description of benefits available from the Fund is set out in the SPD (as amended by prior SMMs), except to the extent that this SMM explicitly modifies the SPD.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the SPD and the Agreement and Declaration of Trust establishing the Fund (the "Trust Agreement"). The Trust Agreement and the SPD are available at the Fund Office and may be inspected by you free of charge during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. 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 Plan and decide all matters, legal and/or factual, arising under the Plan.