LOCAL 802 AFM
Musicians Health Fund
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VERY IMPORTANT NOTICE TO PARTICIPANTS OF THE LOCAL 802 MUSICIANS HEALTH FUND
Important Information Regarding Your Health Fund Benefits

Please take the time to read this Notice carefully and keep it with your copy of the Fund's Summary Plan Description ("SPD").
December 1, 2020

This document is being sent to inform you of important changes to the benefits and minimum contribution levels of the Local 802 Musicians Health Fund (the "Fund" or "Plan") and serves as a Summary of Material Modifications/Reductions ("SMM/SMR") to benefits offered by the Fund. You should take the time to read this notice carefully and keep it with the copy of the Summary Plan Description ("SPD") that was provided to you. If you have any questions regarding this notice, please contact the Fund Office at (212) 245-4802.

The Board of Trustees is keenly aware of the severe impact that the COVID-19 pandemic is having on musicians working in the entertainment industry. The pandemic has had a substantial impact on the Health Fund, as contributions to the Fund have fallen precipitously in conjunction with the industry shutdowns. While the Fund has been able to pay for the Plan benefits by drawing upon its reserves, over the last several months it has become abundantly clear that modifications to the Plan are needed to more closely align Fund expenses and income on a going-forward basis, and to allow for the long-term sustainability of the Fund.

To this end, the Board of Trustees conducted a detailed review of the Plan's benefit design and eligibility requirements and considered various options. The Board of Trustees ultimately determined that, at this time, merging Plan A+ and Plan A participants into the newly established "Recovery Plan A" is needed for the Fund to endure the challenges presented by the COVID-19 pandemic. The Trustees are committed to providing valued and sustainable benefits to the largest number of Fund participants possible. Please read below for more detail on the changes adopted by the Trustees.

ELIGIBILITY RULES

Under the Plan's eligibility rules, in order to be eligible for benefits, you must have at least a certain level of contributions made on your behalf during a six-month Contribution Period (January 1-June 30th for coverage for the six-month period beginning September 1st, and July 1st to December 31st for coverage for the six-month period beginning March 1st. Once you meet the minimum contribution level during a six-month Contribution Period, you and your eligible Dependents are eligible for coverage for the corresponding Coverage Period (September 1st to February 28th/29th or March 1st to August 31st), provided you enroll in a timely manner and pay the required participant premium. Once covered by the Fund, you will continue to be eligible for coverage during subsequent Coverage Periods provided that sufficient employer contributions are made on your behalf for the corresponding Contribution Period.

Minimum Contribution Levels

Under the current Plan rules, in order to be eligible for Recovery Plan A benefits for the six-month Coverage Period beginning March 1, 2021, you must have at least $2,000 in contributions made to the Fund on your behalf during the six-month Contribution Period July 1, 2020 to December 31, 2020. For the six-month Coverage Period beginning September 1, 2021, the minimum contribution level for Recovery Plan A will increase to $2,150 for the six-month Contribution Period January 1, 2021 to June 30, 2021.

LEVEL OF BENEFITS

For the six-month Coverage Period that begins March 1, 2021, Plan A and Plan A+ benefits will be replaced with a new Recovery Plan A (as shown in the Schedule of Benefits that begins on page 3 of this notice).

Below is a summary of the Coverage Period for each respective Contribution Period along with the corresponding new Minimum Contribution Requirement:

For the Contribution Period that runs for the Six-Month Period from:	Minimum Contribution Requirement	Eligible for Recovery Plan A for the Six-Month Period from:
July 1, 2020 – December 31, 2020	$2,000	March 1, 2021 – August 31, 2021
January 1, 2021 – June 30, 2021	$2,150	September 1, 2021 – February 28, 2022

The enrollment process for enrolling in the Plan and the applicable participant premiums will not change at this time (see below for a summary of the current premium levels). However, the only medical plan option being offered by the Fund as of March 1, 2021 is **Recovery Plan A.** Dental and vision benefits (Plan B) also will continue to be offered, as described below.

PARTICIPANT PREMIUMS

Participants are required to pay a quarterly premium for coverage under Recovery Plan A. Participants who qualify for this option may also continue to "buy-up" to the Plan B dental and vision benefits by paying an additional premium for the entire six-month Coverage Period. The quarterly participant premiums for individual and family coverage are below.

Remember, if an individual gains eligibility for Recovery Plan A but does not timely enroll and pay the required premium, they will automatically receive Plan B benefits at no cost (but will not be enrolled in Recovery Plan A). Individuals who gain eligibility for Plan B but who do not qualify for Recovery Plan A are automatically enrolled in Plan B and are not required to pay a participant premium for their Plan B coverage.

Quarterly Participant Premiums

Plan Level	Premium
Recovery Plan A $2,000 of employer contributions 7/1/20 – 12/31/2020 $2,150 of employer contributions 1/1/21 – 6/30/2021	$300 Individual $1,200 Family
Plan B $500 level of employer contributions	None
Plan B Dental and Vision "Buy-up" for Recovery Plan A Participants six-month premium (two quarters) paid in advance	$247 Individual $692 Family

Prescription Drug Formulary

Effective March 1, 2021, the Plan will exclude coverage of non-formulary brand name drugs.

As you know, the Plan uses Express Scripts to administer its prescription drug benefits, and uses the Express Scripts National Preferred Formulary for generic and brand name medications. The formulary is a list of commonly prescribed medications. Medications selected for the formulary can safely and effectively treat most medical conditions while helping to keep costs down. Prescription drugs that are not on the formulary are called "non-formulary drugs."

Currently, the Plan provides coverage for both formulary and non-formulary brand name drugs. However, as of March 1, 2021, the Plan will no longer cover drugs that are not on the Express Scripts National Preferred Formulary. If you attempt to fill a prescription that is not on the National Preferred Formulary, the pharmacist will generally let you know and work with the prescribing physician or health care practitioner to find a comparable drug on the formulary as an alternative. If you fill a prescription for a non-formulary drug, you will pay the entire cost for the prescription.

Please note that a drug's placement on the National Preferred Formulary is subject to change. To find out whether a medication is on the formulary, or whether it is a preferred or non-preferred drug, call Express Scripts at the number listed on the back of your Express Scripts ID card, or visit Express Scripts online at www.express-scripts.com.

There may be exceptions for coverage of a non-formulary brand name drug in certain circumstances. Coverage for drugs that are not on the formulary and thus not covered by the Plan must be approved through Express Scripts' exception process. The requests are evaluated by Express Scripts on the basis of medical necessity, the individual's health and safety and the existence of other comparable alternatives. If you or your physician would like to request an exception, your physician must contact Express Scripts directly – the exception process must be initiated by your physician.

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
Deductible (per calendar year) • Unless otherwise indicated, the Deductible must be met prior to benefits being payable. • Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. • The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount	Individual: $750 Per Calendar Year* Family: $1,500 Per Calendar Year*	Individual: $5,000 Per Calendar Year* Family: $12,500 Per Calendar Year*
Out-of-Pocket Payment Limit (per calendar year)* • All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. • Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and Deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. • Pharmacy expenses do not apply towards the Payment Limit. • The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.	Individual: $5,350 Per Calendar Year* Family: $10,700 Per Calendar Year*	None/Not Applicable
*The annual deductible and out-of-pocket payment limits (which apply to in-network services) accumulate on a calendar year basis.		
PREVENTIVE CARE AND WELLNESS: Visit maximums only apply to Preventive Care and Wellness benefits that are payable in full In-Network as required by law to be covered as Preventive Benefits. Other Medically Necessary visits, services or supplies will be covered according to the type of benefit and the place where the service is received.		
Routine Physical Exams		
Performed at a physician's, PCP office	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived
Covered Persons through age 21 Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
Covered persons age 22 and over Maximum one (1) visit per Calendar Year	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived
Preventive screening and counseling services performed in office		
Office visits for: • **Obesity and/or healthy diet counseling:** 26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet related chronic disease).* • **Misuse of alcohol and/or drugs:** Maximum five (5) visits per calendar year.* • **Use of tobacco products:** Maximum eight (8) visits per calendar year.* • **Sexually transmitted infection counseling:** Maximum two (2) visits per calendar year.** • **Genetic risk counseling for breast and ovarian cancer:** Not subject to any age or frequency limits * For purposes of calculating the visit maximums, each session of up to 60 minutes is equal to one visit. ** For purposes of calculating the visit maximums, each session of up to 30 minutes is equal to one visit.	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived
Routine Cancer Screenings (whether performed in office or facility)		
Routine Cancer Screenings: Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card. **Lung Cancer Screening:** Maximum one (1) screening every calendar year for individuals age 55 and over. Other lung cancer screenings covered under Outpatient diagnostic testing.	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
Preventive care immunizations		
Performed in a facility or at a physician's office Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived
Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Maximum one (1) visits per Calendar Year.	Covered at 100% of Negotiated Charge; Deductible waived	Covered at 100% of Recognized Charges; Deductible waived
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
• **Preventive care services only.** See the Maternity and Related Newborn Care sections for more information on coverage levels for maternity care under the Plan. • **Comprehensive Lactation support and counseling services:** Facility or office visits. Counseling services maximum six (6) visits per calendar year in either individual or group setting. • **Breast pump supplies and accessories.** See the Breast feeding durable medical equipment section of the booklet for limitations on breast pump and supplies.	Covered at 100% of Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of the Recognized Charge) per visit
FAMILY PLANNING SERVICES		
Female Contraceptives		
• **Female contraceptive counseling services office visit:** Contraceptive counseling services maximum two (2) visits per Calendar Year either in a group or individual setting • **Female contraceptive device** provided, administered, or removed, by a physician during an office visit • **Female voluntary sterilization:** Inpatient or Outpatient services	Covered at 100% of Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of the Recognized Charge)
Voluntary sterilization for males		
Outpatient Services	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
Abortion		
Outpatient Services	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Treatment of Infertility		
Basic Infertility Services	Covered according to the type of benefit and the place where the service is received	
PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES		
Office Hours Visits to Non-Specialist, including surgical services performed in the physician's office Includes services of an internist, general physician, family practitioner or pediatrician	$30 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit; Deductible waived **Allergy Injections performed at a physician's office when you do not see a physician:** Covered at 100%	50% coinsurance (the Plan pays 50% of Recognized Charges)
Walk-in Clinic Visits (Non-emergency visits) Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic		
Telemedicine/Teledoc Online and telephone based physician consultations	Covered at 100% of Negotiated Charge; Deductible waived	Not covered
Specialist Office Visits, including surgical services performed in the specialist's office	$50 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient surgery/surgeon and physician surgical services	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
EMERGENCY MEDICAL CARE		
Urgent Care Facility (at a non-hospital free standing facility)	$50 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit Visits for Mental Health or Substance Use Disorder services: $30 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit	50% coinsurance (the Plan pays 50% of Recognized Charges)

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
Emergency Room A separate hospital emergency room copayment/payment percentage will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/payment percentage will be waived and your inpatient copayment/payment percentage will apply.	$200 copay per visit then the Plan pays 100% of the balance of the Negotiated Charge; Deductible waived	$200 copay per visit then the Plan pays 100% of the balance of the Recognized Charges; Deductible waived You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill.
Emergency Use of Ambulance Ground, air or water as Medically Necessary	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
HOSPITAL AND OTHER FACILITY CARE		
Inpatient Hospital	$500 then the plan pays 100% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Inpatient Hospital Transplant Facility	$500 then the plan pays 70% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
ALTERNATIVES TO HOSPITAL STAYS		
Outpatient Facility		
Outpatient Facility Charges	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Home Health Care		
Outpatient Home Health Care Limited to 40 visits per calendar year and three (3) intermittent visits per day provided by a participating home health care agency. One (1) visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
Hospice Care		
Inpatient Facility	$500 then the plan pays 70% of the balance of the Negotiated Charge	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Care Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day. Part-time or intermittent home health aide services to care for you up to 8 hours a day	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Skilled Nursing Facility		
Inpatient Facility 60 day maximum days per calendar year	$500 then the plan pays 70% of the balance of the Negotiated Charge	50% coinsurance (the Plan pays 50% of Recognized Charges)
MATERNITY AND RELATED NEWBORN CARE		
Prenatal care services (other than those payable under the Preventive Care Services)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Delivery and postpartum care Services		
Performed in a facility or at a physician's office	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Inpatient Hospital or Birthing Center	$500 then the plan pays 100% of the balance of the Negotiated Charge	50% coinsurance (the Plan pays 50% of Recognized Charges)
MENTAL HEALTH TREATMENT: Coverage is provided under the same terms, conditions as any other illness.		
Inpatient Mental Health Treatment		
Inpatient Mental Health Treatment including Residential Treatment Facility Coverage is provided under the same terms, conditions as any other illness.	$500 then the plan pays 100% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Mental Health Treatment		
Outpatient mental health treatment office visits for: ▪ Physician or behavioral health provider ▪ Telemedicine consultation ▪ Cognitive behavioral therapy consultation	$30 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other outpatient mental health treatment includes: ▪ Skilled behavioral health services in the home ▪ Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) ▪ Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Autism spectrum disorder treatment All other coverage for diagnosis and treatment, including behavioral therapy, will be provided the same as any other illness under this plan.	Covered according to the type of benefit and the place where the service is received	

RECOVERY PLAN A
SCHEDULE OF BENEFITS/AETNA CHOICE® POS II

Plan Features	How Much You Pay:	
	In-Network	**Out-of-Network**
SUBSTANCE USE/RELATED DISORDERS TREATMENT: Coverage is provided under the same terms, conditions as any other illness.		
Inpatient Substance Use Disorder Treatment		
Inpatient: ▪ Substance abuse detoxification during a hospital confinement ▪ Substance abuse rehabilitation during a hospital confinement ▪ Residential treatment facility during a hospital confinement	$500 then the plan pays 100% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Substance Use Disorder Treatment		
Outpatient substance use disorder/abuse office visits for physician or behavioral health provider (includes telemedicine consultation and behavioral therapy consultation)	$30 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other outpatient substance use disorder/abuse services: ▪ Skilled behavioral health services in the home ▪ Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) ▪ Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
OUTPATIENT DIAGNOSTIC PROCEDURES		
Diagnostic Complex Imaging Services		
Outpatient Department of a Hospital	Covered at 100%; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other than Outpatient Department of Hospital	30% coinsurance (the Plan pays 20% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Diagnostic Laboratory Work		
Outpatient Department of a Hospital	Covered at 100%; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other than Outpatient Department of Hospital	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Diagnostic Radiological Services		
Outpatient Department of a Hospital	Covered at 100%	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other than Outpatient Department of Hospital	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)

OTHER SPECIFIC THERAPIES		
Outpatient Infusion Therapy	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	
Radiation Therapy		
Pulmonary Rehabilitation		
Cardiac Rehabilitation		
Clinical trial therapies (Routine Patient Costs)		
SHORT-TERM REHABILITATION SERVICES		
Outpatient Physical Therapy, Spinal Manipulation and Acupuncture Combined 50 visit maximum per calendar year	$50 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Occupational and Speech Therapy		
Habilitation Therapy		
DURABLE MEDICAL EQUIPMENT (DME) AND DEVICES		
Durable Medical Equipment	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Prosthetic Devices		
Orthotic Devices		

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Deductible	**Individual:** $50 Per Calendar Year **Family:** $100 Per Calendar Year	
Prescription Drug Out-of-Pocket Maximum This amount may be adjusted annually in accordance with applicable guidance	**Individual:** $1,300 Per Calendar Year **Family:** $2,600 Per Calendar Year *Does not include copayments incurred for Specialty Drugs eligible for the Saveon SP Copayment Assistance Program for any individuals, whether or not they participate in the program.*	
Type of Drug	**Retail Pharmacy**	**Mail-Order**
Non-Specialty Prescription Drugs		
ACA Required Preventive Medications	$0	$0
Generic	$20 Copay	$40 Copay
Formulary Brand Name Drugs	$35 Copay	$70 Copay
Non-Formulary Brand Name Drugs	Not covered Participant responsible for 100% of Cost	
Supply of Medication	Up to a 30-day supply	Up to a 90-day supply
Specialty Prescription Drugs Only available from Accredo Specialty Pharmacy		
Specialty Drugs not eligible for the SaveonSP Copayment Assistance Program	Not covered	40% Coinsurance ($300 Max per prescription)

Specialty Drugs Eligible for SaveonSP Copayment Assistance Program when Participating in the SaveonSP Program	Not covered	$0 cost share (see www.saveonsp.com/local802afm for applicable copayment amount)
Specialty Drugs Eligible for SaveonSP Copayment Assistance Program when NOT Participating in the SaveonSP Program	Not covered	see www.saveonsp.com/local802afm for applicable copayment amount
Supply of Medication	N/A	Up to a 90-day supply

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As always, if you need assistance or have any questions regarding Fund benefits, 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's benefits and eligibility requirements. 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 and change the Fund's eligibility rules, 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.