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").
November 1, 2022

This notice is being sent to inform you of important changes to the minimum level of employer contributions required for eligibility for coverage under the Local 802 Musicians Health Fund (the "Fund" or "Plan), as well as changes to the Fund's rules regarding excess ("banked") employer contributions and the amount of participant contributions (premiums) required for coverage under the Fund.

This notice also describes a new utilization and clinical management program that applies to the Fund's prescription drug coverage, which is provided through Express Scripts, and clarifies language in the Fund's Summary Pan Description ("SPD") regarding covered drugs.

You should take the time to read this notice 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 these changes to the Plan, please contact the Fund Office at (212) 245-4802.

The Board of Trustees is committed to providing valuable and sustainable benefits to the largest number of Fund participants as possible. As we all know the Covid-19 pandemic had a devastating effect on our industry and the Health Fund in particular. Those effects are still unfolding and, like much of the world, the Fund is continuing to adjust to the financial impact of the pandemic. The Trustees are carefully and continuously monitoring the financial condition of the Plan, and have determined that changes are necessary in order to work toward sustaining the Plan over the long-term and to protect the Fund in the event of another industry downturn in the short term. With that in mind, the Trustees have determined that the changes described in this notice are necessary at this time. Of course, continued uncertainty in the industry and the financial markets, as well as rising healthcare costs, may make additional changes necessary in the future in order to improve the Fund's financial condition and enable the Fund to continue to provide health coverage for as many musicians as possible.

Please read below for an explanation of the changes adopted by the Trustees.

Background

Under the Plan's eligibility rules, in order to be eligible for benefits, the Fund must have received at least a certain amount of employer contributions made on your behalf during each six-month Contribution Period. Currently, your employer(s) must contribute at least $2,150 on your behalf in a Contribution Period for you to be eligible for coverage under current Plan A (formerly called Recovery Plan A) in the next Coverage Period (January 1- June 30 for coverage for the six-month period beginning September 1st, and July 1 - December 31 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, 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 (and allowing for the use of any available "banked" contributions, as described below).

Minimum Employer Contribution Levels

As noted, under the current Plan rules, in order to be eligible for Plan A benefits, you must have at least $2,150 in employer contributions made to the Fund on your behalf during the Contribution Period. ***Starting with the six-month Contribution Period of January 1, 2023 to June 30, 2023 (for coverage beginning September 1, 2023), the minimum contribution level for Plan A will increase to $3,000.*** The level of employer contributions required for Plan B (dental and vision coverage) is currently $500 and is not changing at this time.

Participant Contributions/Premiums

Participants are required to pay a quarterly premium for coverage under Plan A. Participants who qualify for this option may also "buy-up" to the Plan B dental and vision benefits by paying an additional premium.

Effective for the Coverage Period beginning September 1, 2023, the quarterly participant premiums will increase from $300 to $600 for individual coverage and from $1,200 to $1,800 for family coverage.

The quarterly participant premiums for the Coverage Period beginning **September 1, 2023** for all Plan options are as follows:

Plan Level	Participant Premiums (payable quarterly in advance)
Plan A $3,000 of employer contributions 1/1/23 – 6/30/2023	$600/quarter Individual $1,800/quarter Family
Plan B $500 of employer contributions 1/1/23 – 6/30/2023	None
Plan B Dental and Vision "Buy-up" for Plan A Participants	$247/quarter Individual $692/quarter Family

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

Excess Contributions (Bank)

The current Plan rule allows for excess employer contribution amounts to be carried forward from the previous two Contribution Periods to maintain continued eligibility under Plan A, and the maximum amount of "credit" that may be carried forward is equal to the total amount of the contributions required for the previous 12-month period.

Beginning with the January to June 2023 Contribution Period, if you have employer contributions that exceed the minimum required for Plan A (i.e., over $3,000), the excess amount can be carried forward for *one* Contribution Period to maintain continued eligibility. Your "account" will be charged with the amount of contributions required for eligibility and the excess, if any, will be carried forward and applied to the next Contribution Period. The maximum amount of credit that may be carried forward is equal to the total amount of the employer contributions required for the preceding 6-month period.

This change means that excess contribution amounts will expire after six months rather than the current twelve months.

Prescription Drug Utilization and Clinical Management Program

The Plan currently uses Express Scripts' Advanced Utilization Management (AUM) program whereby medications may be managed through prior authorization requirements, step therapy, and drug quantity management programs. Effective December 1, 2022, the Plan has adopted Express Scripts' *Ultimate* Advanced Utilization Management (UAUM) program, which uses the same utilization management tools as the AUM program but expands the number of drugs to which prior authorization, step therapy and drug quantity management programs apply. Express Scripts will contact you if you are affected by the implementation of the UAUM program.

While the new UAUM program is effective December 1, 2022, participants who are actively filling medications that would be subject to the program (and aren't already subject to the current AUM program) will be grandfathered until January 1, 2023, and therefore will not be subject to the UAUM program criteria for prescriptions filled on or before December 31, 2022.

The list of medications that require prior authorization or step therapy, or that are subject to dosage and/or quantity limits, are determined by Express Scripts and will change from time to time. Accordingly, you should contact Express Scripts (at the number listed on the back of your Express Scripts ID card) if you have questions about whether any of these requirements apply to your medications. If you go to a participating pharmacy, medications affected by these programs will be identified by Express Scripts when you present the prescription. If you receive a prescription for one of the medications, you should consult with your physician or pharmacist to have them reach out to Express Scripts at (877) 621-8824 to discuss any applicable requirements. If you fill a prescription without the required authorization or approval, your medication will not be covered by the Fund.

Prescription Drug Benefit Clarification

The following language in the current SPD (listed as an exclusion and not covered by the Plan) is deleted, effective January 1, 2021:

> **Prescription Drug Benefits: Prescription Drugs Not Covered**
> "FDA-approved drugs used for purposes other than those approved by the FDA"

The Plan covers a wide range of federal legend prescription drugs that are within the Plan's formulary, unless otherwise specifically excluded from coverage, when medically necessary and prescribed by an authorized provider. This may include coverage of FDA approved medications for purposes other than the FDA approved indication if the drug is otherwise covered. Please keep in mind that drug coverage is first subject to the Plan's elected drug coverage inclusions/exclusions and then may be subject to clinical management programs, including formulary management, prior authorization, and/or step therapy criteria for approval, as described above. Approval of coverage through clinical management program criteria can only be completed by your provider.

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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 notice serves as a Summary of Material Modifications ("SMM") and is intended to provide you with an easy-to-understand description of certain changes to the Plan's eligibility requirements and rules. A full description of the benefits available from the Fund and the Plan's rules 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 and other 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.