

**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").
May 2021

This document is being sent to inform you of important changes to the benefits of the Local 802 Musicians Health Fund "Plan" and serves as a Summary of Material Modifications ("SMM") to benefits offered through the Plan. 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 pleased to announce a number of benefit enhancements that are outlined in this Notice. In addition, this notice will serve to provide clarifications to the December 2020 SMM that pertained to the newly established "Recovery Plan A" effective March 1, 2021.

MEDICAL BENEFITS (AETNA)

TELEDOC Program

The Plan covers telemedicine through its TELEDOC Program. Effective March 1, 2021, dermatology and mental health care are being added to this program as detailed below. As a reminder, in order to access the TELEDOC program for any type of visit, you should download the app and go online. You can also call TELEDOC to set up your account or for help logging in. As part of the process, you will be asked to complete or update a brief medical history.

Dermatology

Dermatology visits are now covered under the TELEDOC Program with a \$50 copayment per visit. You can receive treatment for many common skin conditions including acne, eczema, raised moles, rashes, rosacea and others. Once you have registered and logged into the TELEDOC Program, you can upload images on the app or website. Included with this charge is the ability to ask follow-up questions for up to seven days after you receive your custom diagnosis and treatment plan.

Mental Health Care

You can receive confidential therapy by phone or video under the TELEDOC Program with a \$30 copayment per visit. You can talk to a therapist or psychiatrist seven days a week (7 a.m. to 9 p.m. local time) from wherever you are for such mental health conditions as anxiety, depression, not feeling like yourself, marital issues, and stress. Once you have registered with TELEDOC, you can schedule an appointment with the therapist or psychiatrist of your choosing.

Existing TELEDOC Services

Please note that a \$30 or \$50 copayment (depending on the type of service) applies to all other TELEDOC services. Telemedicine visits received from any participating provider who offers such services (outside of the TELEDOC program) are also covered for medical and behavioral health services at the applicable Plan copayment. Telemedicine visits to out-of-network providers are covered subject to the applicable out-of-network cost sharing.

COVID-19 Testing Reminder

The Fund covers the following services that pertain to COVID-19 testing when received from either an in-network or out-of-network provider with no cost-sharing (for example, no copayments, deductibles or coinsurance).

- Diagnostic tests to detect the virus that causes COVID-19, including the administration of such tests, for the following types of tests:
 - Tests to detect the virus that are approved, cleared or authorized by certain sections of the Federal Food, Drug, and Cosmetic Act (the Drug Act);
 - Tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied);
 - Tests developed in and authorized by a state that has notified the United States Department of Health and Human Services (“HHS”) of its intention to review tests to diagnose COVID-19; and
 - Tests determined appropriate by HHS.
- Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, one of the tests described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

These services will also be provided without any need for prior authorization or medical management. This means that you do not have to get precertification/prior authorization to have the tests or those visits covered.

The above Plan provisions are effective through the end of the National Public Health Emergency due to COVID-19.

Payment for the treatment of COVID-19, including but not limited to hospital, transportation and pharmacy services will be covered in accordance with the terms and conditions set forth in the Summary Plan Description (SPD) and will still be subject to applicable cost-sharing.

MinuteClinic

As of March 1, 2021, you are able to access all covered MinuteClinic® services at no cost to you. MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores and is the largest provider of retail health care in the United States, making it easy to access care in your neighborhood. MinuteClinic offers a broad range of services to keep you and your family healthy and to treat and diagnose a variety of illnesses, injuries and conditions. MinuteClinics can also write prescriptions, when medically appropriate.

MinuteClinics are open 7 days a week, including evenings and weekends and you can walk in or schedule appointments online beforehand. For even more convenience, you can pick up your prescription on-site. For your best health, you are encouraged to have a relationship with a primary care physician or other doctor and should tell them about your visit to MinuteClinic. You can also have the MinuteClinic send a summary of your visit directly to your doctor.

PRESCRIPTION DRUG BENEFITS (ESI)

Vaccine Program

Effective February 4, 2021, the Plan covers routine adult immunizations and immunization vaccines for children from birth to age 18 who meet the age and gender requirements and who meet the CDC medical criteria for recommendation at no cost when such immunizations are obtained from a participating pharmacy. This benefit includes services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as required under the Affordable Care Act and listed below. Please note that not all participating pharmacies will be able to give all covered vaccines at all times. You should contact the participating retail pharmacy regarding vaccine availability and times for administration by a pharmacist. Preventive immunizations are also covered under the Fund's Aetna medical benefits. Contact Aetna at the number on your ID card for information.

The following vaccines are available from pharmacists at participating retail pharmacies:

- COVID-19
- Flu (seasonal influenza)
- Tetanus, diphtheria, pertussis
- Hepatitis
- Human papillomavirus (HPV)
- Meningitis
- Pneumonia
- Shingles/zoster
- Travel vaccines (rabies, typhoid, yellow fever, etc.)
- Childhood vaccines (MMR, etc.)

COVID-19 Vaccine

To promote access to COVID-19 vaccines and preventive services, the Plan has adopted the following provisions as they pertain to the COVID-19 vaccines and preventive services effective January 1, 2021:

- The Fund will cover a preventive service within 15 business days of the date it becomes a Qualifying Coronavirus Preventive Service on an in-network basis under both the Medical and Prescription Drug benefits, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements.
- From January 1, 2021 through the end of the COVID-19 Public Health Emergency, the Plan will cover a preventive service within 15 business days of the date it becomes a Qualifying Coronavirus Preventive Service on an out-of-network basis, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements.

The Plan will reimburse an out-of-network provider for the item or service in an amount that the Plan determines is reasonable, as determined in comparison to prevailing market rates for such services. A reasonable amount shall include the amount that the provider would be paid under Medicare for the item or service.

Qualifying Coronavirus Preventive Service means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease (COVID-19) and that is, with respect to the

individual involved:

- a) An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force, or
- b) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC, which has been adopted by the Director of the CDC. This provision is in effect regardless of whether the immunization is recommended for routine use.

COVID-19 Public Health Emergency: COVID-19 Public Health Emergency means the emergency period defined in the Social Security, as determined by the Secretary of Health and Human Services pursuant to authority under the Public Health Service Act. The Public Health Emergency was initially declared as of January 27, 2020, and has been extended thereafter.

CLARIFICATIONS TO ESI PRESCRIPTION DRUG BENEFITS

Out of Pocket Limit

Eligible out-of-pocket prescription drug expenses that you incurred during the period October 1, 2020 through December 31, 2020 will be added to those you incur in calendar year 2021 to determine when you have met the Out-of-Pocket Limit of \$1,300 per individual and \$2,600 per family that applies for prescription drugs. This means that all eligible out-of-pocket expenses that are incurred during the 15-month period will apply toward the limit. The eligible out-of-pocket expenses that have been applied to these limits will reset on January 1, 2022 and on every January 1 thereafter.

Deductible

Effective March 1, 2021, the Plan will require an annual prescription drug deductible of \$50 per individual and \$100 per family per year (prorated for Calendar Year 2021 to \$41 per individual and \$83 per family).

Please note that participants are responsible for paying the deductible until they reach the Out-of-Pocket Limit. Once the Out-of-Pocket limit is met, the Fund will pay 100% of covered prescription drug expenses even if the full deductible has not been met at that time.

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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

<p>This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan's benefits. 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.</p> <p>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</p>
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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.

