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 2025

This Summary of Material Reduction in Covered Benefits is intended to notify you of important changes being made to the benefits provided by the Local 802 Musicians Health Fund (the "Fund" or "Plan") as well as changes to the Fund's eligibility and contributions rules. You should take the time to read this notice carefully and keep it with the copy of the Summary Plan Description ("SPD") (and prior notices) previously provided to you by the Fund. If you have any questions regarding this notice, 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. The Fund is facing financial challenges as health care costs continue to rise and the Trustees have determined that the changes described in this notice are necessary to support the sustainability of the Fund. The additional contributions that some employers and the Union have bargained have limited the extent of these changes.

CHANGES TO THE FUND'S ELIGIBILITY AND CONTRIBUTIONS RULES

Background

Under the Plan's 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 the preceding six-month Contribution Period. Currently, your employer(s) must contribute at least $3,000 on your behalf in a Contribution Period for you to be eligible for coverage under Plan A in the next Coverage Period. As a reminder, contributions from January 1- June 30 earn coverage for the six-month period beginning the following September 1 and contributions from July 1 - December 31 earn coverage for the six-month period beginning March 1. For example, contributions in the January 1, 2026 to June 30, 2026 Contribution Period determine eligibility for the September 1, 2026 to February 28, 2027 Coverage Period.

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. .

Eligibility Threshold: Increase to Minimum Employer Contribution Levels

Starting with the six-month Contribution Period of January 1, 2026 to June 30, 2026 (for coverage September 1, 2026 to February 28, 2027), the minimum contribution level for Plan A eligibility will increase from $3,000 to $3,250.

Starting with the six-month Contribution Period of January 1, 2028 to June 30, 2028 (for coverage September 1, 2028 to February 28, 2029), the minimum contribution level for Plan A eligibility will increase from $3,250 to $3,500.

The above changes do not affect eligibility for coverage for the March 1, 2026 to August 31, 2026 Coverage Period (which is based on contributions made to the Fund during the period July 1, 2025 to December 31, 2025).

The level of employer contributions required for Plan B (dental and vision coverage) is currently $500 and is not changing at this time.

Elimination of Bank/Excess Contributions Rule

The current Plan rules allow for excess employer contributions above the threshold amount to be carried forward into the following Contribution Period to maintain continued eligibility under Plan A.

Starting with the six-month Contribution Period of January 1, 2026 to June 30, 2026 (for coverage September 1, 2026 to February 28, 2029), employer contributions may no longer be carried forward from previous Contribution Periods. Accordingly, the minimum employer contribution level must be met in each Contribution Period to remain eligible.

Elimination of LS-1 Contracts

Starting with the six-month Contribution Period of January 1, 2026 to June 30, 2026 (for coverage September 1, 2026 to February 28, 2027), contributions from LS-1 Contracts will no longer be accepted by the Fund for credit towards the minimum employer contribution level required for eligibility.

CHANGES TO MEDICAL BENEFIT COST-SHARING

Effective March 1, 2026, the following changes are being made to the Fund's benefits:

Benefit	Current	Effective March 1, 2026
	In-Network Provider	**In-Network Provider**
Primary care visit to treat an injury or illness (PCP)	$30 copay/visit; deductible does not apply	**$40** copay/visit; deductible does not apply
Specialist visit	$50 copay/visit; deductible does not apply	**$75** copay/visit; deductible does not apply
Diagnostic test (x-ray, blood work)	Office and free-standing facility: 30% coinsurance after deductible; Hospital outpatient: No charge	Office and free-standing facility: 30% coinsurance after deductible; **Hospital outpatient: 30% coinsurance after deductible**
Imaging (CT/PET scans, MRIs)	Office and free-standing facility: 30% coinsurance after deductible; Hospital outpatient: No charge	Office and free-standing facility: 30% coinsurance after deductible; **Hospital outpatient: 30% coinsurance after deductible**

As set forth in the above chart, starting March 1, 2026, after your deductible is met, you will pay 30% of the allowed amount for diagnostic tests and imaging at an in-network hospital and the Fund will pay the rest. This is already the rule for diagnostic tests received at an in-network non-hospital free-standing facility, so this change makes the cost-sharing the same for tests administered at in-network hospitals. Please keep in mind, however, that even with the same cost-sharing, using a stand-alone facility instead of a hospital for tests and imaging will generally be less expensive for you because the overall cost is usually so much lower at a free-standing facility.

As also noted in the chart, primary care and specialist visits currently have a $30 and $50 copay, respectively. Starting March 1, 2026, the copays will increase to $40 and $75.

There are no changes to the Plan's out-of-network cost sharing requirements at this time. As a reminder, the cost of out-of-network services is generally substantially higher for participants (and also more costly for the Fund) than in-network services.

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 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), except to the extent that this notice 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.