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

January 17, 2025

This document is a Summary of Material Modifications ("SMM") intended to notify you of a new benefit provided by the Local 802 Musicians Health Fund (the "Fund" or "Plan") and additional prescription drugs eligible for copayment assistance through the Fund's program with SaveonSP, as well as updates to the Fund's summary plan description ("SPD"). You should take the time to read this SMM carefully and keep it with the copy of the SPD (and prior SMMs) previously provided to you. If you have any questions regarding this notice or any changes to the Plan, please contact the Fund Office at (212) 245-4802.

New Omnipod Coverage

Effective June 1, 2024, the Plan's coverage of diabetes equipment includes Omnipod products, as a pharmacy benefit.

As part of your coverage with the Fund, the Plan covers diabetic equipment, supplies and self-management education as recommended or prescribed by a licensed Physician or Provider legally authorized to prescribe tools to help manage chronic conditions. These items are covered before you meet your Deductible, based on a provision of the Affordable Care Act (ACA).

Effective June 1, 2024, Omnipod products are included in the Fund's coverage under the Plan's prescription drug benefit.

Omnipod is an FDA-approved, tubeless, disposable insulin delivery system. It consists of a wearable Pod with built-in technology to manage glucose levels, and can be fully controlled by a compatible smart phone. Participants without a compatible smart phone can use the wireless touchscreen controller provided in the intro kit.

Omnipod is covered as a Preferred Brand Name Drug with the following cost sharing:

Type of Drug	Retail Pharmacy	Mail-Order
Non-Specialty Prescription Drugs		
Preferred Brand Name Drugs	$35 Copay	$70 Copay

Please contact Express Scripts at (866) 544-2926 for information on Omnipod products.

More Drugs Eligible for SaveonSP Copay Assistance Program

The Fund offers a copay assistance program through SaveonSP, which identifies high cost specialty drugs for which manufacturers offer copay assistance and helps participants take advantage of the available assistance. Under this program, the cost of the specialty drug is completely covered, with no cost to the participant. If you decline to participate, you will be responsible for a higher copay (rather than the Plan's usual copay).

Effective January 1, 2025, the following drugs, prescribed for treatment of HIV, will now be included in the SaveonSP program:

- Genvoya
- Triumeq
- Biktarvy

A complete list of drugs in the SaveonSP program can be found at www.saveonsp.com/local802afm or obtained upon request to the Fund Office.

Anthem Medical Benefits Administration

As we previously informed Fund participants, the Fund changed its medical benefits administrator from Aetna to Anthem (formerly Empire), as of April 1, 2023. Below are the changes to the Fund's SPD in connection with the transition to Anthem:

1. The Quick Reference Chart on pages 10-11 of the SPD is updated to reflect the following:

Anthem Blue Access PPO **Medical Plan Benefits** • ID Cards/Eligibility for benefits • Medical Network Provider Directory • Additions/Deletions of Providers • Out-of-Network Claims • Plan Benefit Information • Claims questions • First and Second Level Appeals of Medical claims determinations • Coordination of Benefits • Subrogation **Medical Management Program** • Precertification • Case Management	Anthem Member Services P.O. Box 1407, Church Street Station New York, NY 10008 Telephone: 1-844-995-1737 www.anthem.com

2. The section titled "Aetna Choice POS II Plan Medical Benefits," beginning on page 34 of the SPD, is replaced in its entirety with the following:

Anthem PPO Medical Benefits

If you are eligible for Plan A, you are eligible for comprehensive medical benefits administered by Anthem. This section describes the coverage under Plan A. The Plan A Schedule of Benefits outlines the applicable cost-sharing.

How this Plan Works

The Fund provides you with comprehensive medical benefits through Anthem's Blue Access PPO network. The Plan provides coverage for Medically Necessary eligible healthcare services from either in-network or out-of-network providers. You may obtain healthcare services from in-network or out-of-network providers, but your out-of-pocket expenses differ depending on

whether you use in-network or out-of-network providers. There are different cost-sharing provisions for in-network and out-of-network providers that are described in general in this section and outlined in the Schedule of Benefits.

In-Network Providers

If you receive covered services or supplies from a provider that is contracted with Anthem through the Blue Access PPO network (i.e. are in-network), you will typically pay less money out of your pocket. This means that the portion of expenses that you are expected to pay (e.g., cost-sharing that includes Deductibles, copayments, and coinsurance) will generally be lower when you use in-network providers and facilities. The Plan reimburses eligible healthcare services for in-network services based on rates established in an agreement between the provider and Anthem.

It is generally less expensive to both the Fund and to you to use an in-network provider and we strongly encourage you to use in-network providers, although the choice is generally yours as to what type of provider to use.

Looking for an in-network Anthem provider?
You can log onto their website at www.anthem.com, or you can call 1-844-995-1737.

Physicians and other healthcare Providers who participate in the Blue Access PPO network are added and deleted during the year. Anthem is required to confirm the list of in-network providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Provider was in-network on a particular claim, then you will only be liable for in-network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your in-network cost-shares will be calculated based upon the Negotiated Charge.

Out-of-Network Providers

If you receive covered services or supplies from providers who are not part of the Blue Access PPO network, you will typically pay more money out of your pocket than if you use an in-network provider. This means that the portion of expenses that you are expected to pay (e.g., cost-sharing that includes your Deductibles, copayments, and coinsurance percentage) will generally be higher when you use out-of-network providers and facilities. In addition, you will have to pay the entire amount due for services at the time that they are provided and submit a claim for reimbursement.

For out-of-network expenses, the Plan reimburses eligible healthcare services up to the Recognized Charge. Out-of-network providers are generally free to set their own charges for the services or supplies that they provide and are allowed to bill you for charges in excess of what Anthem determines to be the Recognized Charge. This is known as “balance billing” and the Plan is not responsible for any balance bills. As a result, when you use an out-of-network provider, you are responsible for any applicable cost-sharing and any charges that the out-of-network provider may balance bill you. This amount could be considerable.

You will be responsible only for any *in-network* cost-sharing that would apply to the covered services if you receive covered services from a non-Participating Provider in the following situations:

- The provider is listed as a participating provider in the Anthem online provider directory;

- Anthem's paper provider directory listing the provider as a participating provider is incorrect as of the date of publication;
- Anthem gives you written notice that the provider is a participating provider in response to your telephone request for network status information about the provider; or
- Anthem does not provide you with a written notice within one (1) business day of your telephone request for network status information.

In these situations, if a provider bills you for more than your cost-sharing and you pay the bill, you are entitled to a refund from the provider, plus interest.

Inter-Plan Programs

Out-of-Area Services. Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the Anthem Service Area, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") don't contract with the Host Blue.

BlueCard® Program. Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem Service Area and the claim is processed through the BlueCard® Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available.

Negotiated (non-BlueCard Program) Arrangements. With respect to one or more Host Blues, instead of using the BlueCard® Program, Anthem may process your claims for covered services through Negotiated Arrangements for National Accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under the BlueCard® Program description above) made available to Anthem by the Host Blue.

Special Cases: Value-Based Programs. BlueCard® Program. If you receive covered services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value Based Programs: Negotiated (non-BlueCard Program) Arrangements. If Anthem has entered into a negotiated arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

Inter-Plan and Intra-Plan Programs: Federal/State Taxes/Surcharges/Fees. Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, any such surcharge, tax or other fee that is part of the inter-plan or intra-plan claim charge passed on to you.

Non-Participating Providers Outside the Anthem Service Area.

a) **Recognized Charge and Member Liability Calculation.** When covered services are provided outside of Anthem's Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that Recognized Charge. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment made for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

b) **Exceptions.** In certain situations, the Plan may use other pricing methods, such as billed charges, the pricing applicable if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by non-participating providers. In these situations, you may be responsible for the difference between the amount that the non-participating provider bills and the payment made for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core® Program. If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date Anthem ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact Anthem for precertification. Keep in mind, if you need Emergency Medical Care, go to the nearest hospital. There is no need to call before you receive emergency care.

How Claims Are Paid With Blue Cross Blue Shield Global Core®. In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply. You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms, you can get international claim forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

3. The subsection titled “Appropriate Claims Administrators,” beginning on page 105 of the SPD, is updated to reflect the following:

Benefit Type and Appropriate Claims Administrator	Types of Claims Processed
Medical Benefits Anthem Member Services P.O. Box 1407, Church Street Station New York, NY 10008 Telephone: 1-844-995-1737 www.anthem.com	• Pre-Service Claims • Urgent Care Claims and Concurrent claims for precertification and medical management techniques • Post-Service Claims

4. The definition of “Recognized Charge” (on page 152 of the SPD) is revised to read as follows:

Recognized Charge

The Recognized Charge for Non-Participating Providers in the Service Area will be determined as follows:

Facilities. For Facilities, the Recognized Charge will be the average amounts paid by Anthem for comparable services to Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.

All Other Providers. For all other Providers, the Recognized Charge is 150% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type, unadjusted for geographic locality.

See the Inter-Plan Programs section of this SPD for a description of how the Recognized Charge is determined for Non-Participating Providers outside the Anthem Service Area.

Any charges of a Non-Participating Provider that are in excess of the Recognized Charge do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider’s charge that exceeds the Recognized Charge.

The Recognized Charge is not based on UCR. The Non-Participating Provider’s actual charge may exceed the Recognized Charge. You must pay the difference between the Recognized Charge and the Non-Participating Provider’s charge. Contact Anthem at the number on your ID card or visit www.anthem.com for information on your financial responsibility when you receive services from a Non-Participating Provider.

Anthem reserves the right to negotiate a lower rate with Non-Participating Providers or to pay another Host Plan’s rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

See the No Surprises Act section of the SPD for the Recognized Charge for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Booklet for the Recognized Charge for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

5. The definition of “Directory” (on page 146 of the SPD) is replaced in its entirety as follows:

Directory

The list of network providers for your plan. To find a provider in Anthem’s Blue Access Network, you can follow these steps:

1. Go to www.anthem.com/find-care or select the “Find Care” button on the top-right of the anthem.com homepage.
2. On the next screen, scroll down and click on “Basic Search as Guest”.
3. On the next screen, complete the following fields:
   a. Select the type of plan or network - Select “Medical Plan or Network”
   b. Select the state where the plan or network is offered - Select “New York”
   c. Select how you get health insurance – Select “Medical Networks”
   d. Select a plan or network – Select “Blue Access (Employer Sponsored)”

6. All other references to “Aetna” in the SPD are replaced with “Anthem.”

As always, if you need assistance or have any questions regarding Fund benefits, please contact the Fund Office at (212) 245-4802.

Sincerely,

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Local 802 Musicians Health Fund

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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 terms. 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 Plan and the Agreement and Declaration of Trust establishing the Fund (the "Trust Agreement"). The Trust Agreement and the SPD/Plan 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.