Welfare Fund
of Local No. One, I.A.T.S.E.

320 West 46th Street, 6th Floor ● New York, NY 10036 ● Tel (212)247-5225 ● Fax (212)247-5227 ● www.fundoneiatse.com

SUMMARY OF MATERIAL MODIFICATIONS

To: Medicare Participants in the Welfare Fund of Local No. One, IATSE

From: Scott Cool, Director of Fund Administration

Date: October 23, 2020

Re: **Important Changes to Your Welfare Fund Provided Benefits**
Effective January 1, 2021

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to the Welfare Fund of Local No. One, IATSE ("the Plan"). Please read this SMM carefully and keep it with the copy of the 2016 Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding this change to the Plan, please contact the Fund Office during normal business hours at 320 West 46th Street, 6th Floor, New York, New York, 10036, (212) 247-5225.

Due to concerns regarding the financial health of the Welfare Plan resulting from the COVID-19 pandemic, and in an effort to continue providing our Medicare retirees with quality supplemental medical and pharmacy insurance, the Board of Trustees has determined to move your Welfare Fund provided coverages to an Aetna managed Medicare Advantage plan effective January 1, 2021. This fully insured insurance plan has been designed specifically for Local One Medicare retirees to be similar to your current coverage, although there are some important differences.

The following chart compares the key features of your current coverage with the new Medicare Advantage program which will become effective January 1, 2021:

Feature	Current Coverage through 12/31/2020	NEW Medicare Advantage Coverage effective 1/01/2021
Annual Deductible (The amount you have to pay out of pocket before the plan will pay its share of your covered services.**)**	**$500** Individual **$1,500** Family	**$0** – No Deductible
Office Visits (Primary Care and Specialists)	**$0** copay for both primary care and specialist visits **$0** for wellness exams and covered screenings and immunizations	**$20** copay for both primary care and specialist visits **$0** for wellness exams and covered screenings and immunizations

Feature	Current Coverage through 12/31/2020	NEW Medicare Advantage Coverage effective 1/01/2021
Hospital Care (Inpatient and Outpatient)	**$0** copay per inpatient stay **$0** outpatient care copay	**$250** copay per inpatient stay Up to **14 meals** following an inpatient stay, if authorized. **$0** outpatient care copay
Urgent and Emergency Care	**$0** Urgent Care copay **$0** Emergency Care copay	**$20** Urgent Care copay **$90** Emergency Care copay (waived if admitted)
Diagnostic Procedures	**$0** copay for outpatient lab, x-ray and complex imaging	**$20** copay for outpatient lab, x-ray and complex imaging
Hearing Services	**$3,000** reimbursement for hearing aids once **every 36 months**	**$3,000** reimbursement for hearing aids once **every 36 months**; hearing exam not covered
Skilled Nursing Facility Care	**$0** copay, 120 day maximum	**$0** copay per day for days 1-20 **$75** copay per day for days 21-100
Ambulance and non-Emergency Transportation	**$0** copay for ambulance	**$20** copay for ambulance **$0** copay for non-emergency transportation with limit of 24 trips and 60 miles per trip

Prescription Drugs	**$0** Deductible **30-Day/90-Day Copays**: Generic Drugs: **$5/$10** Preferred Brand: **$25/$50** Non-Preferred Brand: **Not Covered**	**$0** Deductible **30-Day/90-Day Copays**: Generic Drugs: **$5/$10** Preferred Brand: **$25/$50** Non-Preferred Brand: **$35/$70** **Medicare Coverage Gap**: You will generally continue to pay the same amount for covered drugs during the coverage gap. **Catastrophic Coverage**: After $6,550 true out-of-pocket costs are incurred, your share of the cost for a covered drug will be 5% but not greater than the cost share amounts listed above.
Maximum Out-of-Pocket Expenses (The most you have to pay for covered services during the Plan Year, after which the Plan pays 100%.)	**MEDICAL** **$2,000** per individual per year **$6,000** per family per year **PHARMACY** **$500** per individual per year **$1,500** per family per year	**MEDICAL** **$6,700** per individual per year (excluding hearing aids and prescription drug expenses)

This SMM is intended to provide you with an easy-to-understand description of certain changes and/or clarifications to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, 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 Plan (the "Trust Agreement"). The Trust Agreement is 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 arising under the Plan.

Welfare, Pension and Annuity Funds
of Local No. One, I.A.T.S.E.

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NOTICE OF NON-DISCRIMINATION

The Local One Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Local One Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age disability, or sex.

The Local One Welfare Fund

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you believe that the Local One Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (212)247-5225.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (212)247-5225.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (212)247-5225.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (212)247-5225.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(212)247-5225 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (212)247-5225.

1- אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (212)247-5225.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১(212)247-5225.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (212)247-5225.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 12(212)247-5225 (رقم هاتف الصم والبكم: (212)247-5225)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (212)247-5225.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (212)247-5225

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (212)247-5225.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (212)247-5225.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (212)247-5225.