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

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SUMMARY OF MATERIAL MODIFICATIONS

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

From: Holly Ubilla, Director of Fund Administration

Date: April 30, 2024

Re: **Important Changes to Your Welfare Fund Provided Benefits**

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" or "Fund"). 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 these changes 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.

The Board of Trustees has carefully monitored the financial health of the Welfare Fund as work has approached pre-Pandemic levels and is pleased to report that circumstances now permit certain benefit improvements and changes to be implemented effective July 1, 2024. Please read this document carefully as it announces plan changes for Active Participants and Non-Medicare-Eligible Early Retirees. There are no changes to the benefits being provided to Medicare-Eligible Retirees.

Active Participants - The Board of Trustees is delighted to announce a return to the tiered benefit structure.

- As described more fully in Section 1 below, Active Participants will be eligible to receive Tier I/BASIC, II or III benefits during a six-month coverage period, depending on their covered earnings (i.e., earnings on which employer contributions are payable to the Fund) during a specified 12-month work period.
- Section 2 describes the key features of each new benefit tier. Please note that the Plan maintains the out-of-network and prescription drug coverage implemented during the Pandemic, as both have proven to provide strong incentives for participants to use in-network providers, avoid high-cost prescriptions when equivalent lower-cost options are available, and generally become better, smarter consumers of healthcare services, all of which will work towards allowing the Welfare Fund to continue to provide valuable health benefits to its members.
- As described in Section 3, the Plan will continue to provide supplemental hospital indemnity coverage to participants receiving Tier I/BASIC or Tier II benefits.
- Section 4 describes the new self-pay premiums that take effect July 1, 2024 for each tier of benefits. You will also be able to buy-up to Tier III coverage.

- Finally, please note that effective July 1, 2024, there will no longer be a grace period for self-pay payments. Please read Section 7 carefully and take steps to ensure that you comply with the new rules to avoid disruption of your benefits.

Medicare-Eligible Retirees - Coverage for Medicare-Eligible Retirees currently covered under the fully-insured, Aetna-managed Medicare Advantage plan has not changed. Self-pay premiums will also remain the same. Section 5 describes changes to the eligibility criteria for those seeking to commence retiree medical benefits on or after July 1, 2024.

Early Retirees (Non-Medicare Eligible) - Beginning July 1, 2024, those currently covered under the Plan as early retirees that are not Medicare-eligible will be placed in one of the new benefit tiers (Tier I, Tier II or Tier III), described in Section 2 below, based on their retirement date. Please see Section 6 for details regarding the tier of benefits for which you qualify and Sections 4 and 7 regarding self-pay premiums payable for such coverage.

1. Tier Eligibility (Active Participants):

Effective July 1, 2024, for each six-month coverage period, the required covered earnings during the appropriate twelve-month period is as follows:

Coverage Tier	Covered Earnings
Tier I	$37,500 - $55,000
Tier II	$55,001 - $85,500
Tier III	$85,501 and up

As a reminder, the applicable coverage periods and work periods are shown below:

Health Coverage Period	Earnings Work Period
January 1 through June 30	October 1 through September 30
July 1 through December 31	April 1 through March 31

2. Following are key features of the benefits for Tiers I, II and III effective July 1, 2024 (Active Participants and Non-Medicare Eligible Early Retirees):

Feature	Tier I/BASIC Coverage	Tier II Coverage	Tier III Coverage
Medical Deductible (7/01/2024-6/30/2025)	In-Network $500 per individual $1,250 per family Out-of-Network $10,000 per individual $20,000 per family	In-Network $300 per individual $750 per family Out-of-Network $10,000 per individual $20,000 per family	In-Network $0 per individual $0 per family Out-of-Network $10,000 per individual $20,000 per family
Office Visits (Physician/Specialist)	In-Network $50/$50 copay, not subject to the deductible Out-of-Network $50 per visit for a primary care physician and $65 per visit for a specialist, plus 50% of the remaining cost, after you have met the out-of-network deductible	In-Network $35/$50 copay, not subject to the deductible Out-of-Network $50 per visit for a primary care physician and $65 per visit for a specialist, plus 50% of the remaining cost, after you have met the out-of-network deductible	In-Network $25/$50 copay Out-of-Network $50 per visit for a primary care physician and $65 per visit for a specialist, plus 50% of the remaining cost, after you have met the out-of-network deductible
Inpatient Hospital	In-Network 70% coverage, after $500 per admission copay and after you have met the in-network deductible Out-of-Network 50% coverage, after $500 per admission copay and after you have met the out-of-network deductible	In-Network 80% coverage, after $250 per admission copay and after you have met the in-network deductible Out-of-Network 50% coverage, after $500 per admission copay and after you have met the out-of-network deductible	In-Network 100% coverage Out-of-Network 50% coverage, after $500 per admission copay and after you have met the out-of-network deductible
Hospital Emergency Room	In-Network 70% coverage, after $200 per visit copay and after you have met the in-network deductible Out-of-Network	In-Network 80% coverage, after $200 per visit copay and after you have met the in-network deductible Out-of-Network	In-Network 100% coverage, after $200 per visit copay Out-of-Network

	A true emergency is covered as if it were in-network*	A true emergency is covered as if it were in-network*	A true emergency is covered as if it were in-network*
Diagnostic Lab Testing and Imaging	<u>In-Network</u> Lab & X-rays: 100% coverage, no deductible or copay Complex Imaging: $50 copay, no deductible <u>Out-of-Network</u> 50% after you meet the out-of-network deductible	<u>In-Network</u> Lab & X-rays: 100% coverage, no deductible or copay Complex Imaging: $50 copay, no deductible <u>Out-of-Network</u> 50% after you meet the out-of-network deductible	<u>In-Network</u> Lab & X-rays: 100% coverage, no deductible or copay Complex Imaging: $50 copay, no deductible <u>Out-of-Network</u> 50% after you meet the out-of-network deductible
Medical Maximum Out-of-Pocket Expenses	<u>In-Network</u> $5,350 per individual $10,700 per family <u>Out-of-Network</u> Unlimited out-of-pocket expenses	<u>In-Network</u> $2,750 per individual $5,500 per family <u>Out-of-Network</u> Unlimited out-of-pocket expenses	<u>In-Network</u> $2,000 per individual $4,000 per family <u>Out-of-Network</u> Unlimited out-of-pocket expenses

* *Note that you may receive a bill for the difference between the full amount billed by a provider and the amount paid by the Plan, which is known as "Balance Billing." "Surprise Billing" is an unexpected Balance Bill that happens when you cannot control who is involved in your care – when you have an emergency, or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network provider. Generally, under the law, you will only be responsible for the in-network cost sharing amount when: (1) You receive covered emergency services from an Out-of-Network provider or Out-of-Network emergency facility; (2) You receive covered non-emergency services from an Out-of-Network provider as part of a visit to an In-Network facility; or (3)You receive a covered air ambulance service provided by an Out-of-Network provider. There are various special rules and exceptions to this general rule, so you should carefully review the SMM "Changes to Medical Benefits Pursuant to the No Surprises Act" effective July 1, 2022 for more information.*

3. **<u>Supplemental Hospital Indemnity Coverage</u>**: Participants receiving Tier I/BASIC or Tier II coverage will continue to be automatically enrolled for supplemental hospital indemnity coverage through Aetna. This supplemental coverage pays cash benefits directly to participants for covered hospital stays as follows:

   - Hospital Admission: $1,000 (once per participant, per plan year)
   - Hospital Daily Stay: $50 (including substance abuse or mental disorder)
   - ICU Daily Stay: $100
   - Rehabilitation Daily Stay: $25
   - Nursery admission (non-Nicu): $100

   Daily Stay benefits begin on day 2 and pay up to a maximum of 15 days (per type of stay) per participant for the Plan Year (July 1 through June 30).

   Due to the lower Tier III cost-sharing, participants receiving Tier III coverage will no longer be enrolled for supplemental hospital indemnity coverage.

4. Self-Pay Premiums (Active Participants and Early Retirees (Non-Medicare)):

Effective July 1, 2024, the quarterly self-pay rates for medical coverage under the Welfare Plan will be revised as follows:

Self-Pay Premium Rates for Active Participants

Class	Coverage	Quarterly Rates 7/01/2024 to 6/31/2025
Basic*	Participant Only Participant + 1 Family	$270 $1,233 $2,156
Tier I	Participant Only Participant + 1 Family	$270 $338 $405
Tier II	Participant Only Participant + 1 Family	$354 $442 $530
Tier III	Participant Only Participant + 1 Family	$556 $695 $834
Buy-up from Tier I to Tier III**	Participant Only Participant + 1 Family	$1,841 $2,843 $4,274
Buy-Up from Tier II to Tier III**	Participant Only Participant + 1 Family	$748 $969 $1,286

*Tier I BASIC only applies to new Participants who have met the earnings requirement but have not satisfied their 3 consecutive eligible years yet.

** Includes the self-pay premium for Tier III coverage

Self-Pay Premium Rates for Early Retirees (non-Medicare)

Category	Coverage	Monthly Rates 7/01/24 to 6/30/25
Formerly Eligible for Tier I Coverage		
Age 60 through Age 64	Retiree Only	$52
	Retiree + 1	$101
	Family	$141
Age Under 60	Retiree Only	$91
	Retiree + 1	$166
	Family	$240
Formerly Eligible for Tier II Coverage		
Age 60 through Age 64	Retiree Only	$67
	Retiree + 1	$130
	Family	$182
Age Under 60	Retiree Only	$118
	Retiree + 1	$214
	Family	$311
Formerly Eligible for Tier III Coverage		
Age 60 through Age 64	Retiree Only	$106
	Retiree + 1	$206
	Family	$288
Age Under 60	Retiree Only	$186
	Retiree + 1	$343
	Family	$501

5. **<u>Eligibility for Retiree Medical Benefits:</u>** Transitioning from the Recovery Tier back to a multi-tiered plan of benefits requires adjustment to the criteria for qualifying for retiree medical benefits. For those retiring on or after July 1, 2024, a participant and their eligible family members (as defined in Section II.C of the Summary Plan Description) will be eligible for Fund benefits, provided that the participant meets all of the following criteria upon their retirement:

   - The participant had **fewer than twelve (12)** Pension Credits **as of January 1, 2008**, and at least **twenty-five (25)** Pension Credits at retirement.

     - OR -

     Had **twelve (12)** or more Pension Credits **as of January 1, 2008**, and at least **twenty (20)** Pension Credits at retirement.
   - The participant is eligible to receive a pension from the Pension Fund of Local No. One IATSE, **and**
   - The participant has earned a pension credit in at least three of the five Plan Years immediately preceding the year in which they retire.

If the participant does not meet all of the above requirements upon retirement, coverage under the Plan will terminate when their active coverage terminates. The participant and their family members may, however, be eligible for COBRA continuation coverage.

6. **Determination of Early Retiree Tier:** If you are **not** eligible to enroll in Medicare upon your retirement, you will receive the Fund's Tier I, II or III benefits based on your retirement date as follows:

   - If you retired prior to July 1, 2020, you and your eligible family members will return to the tier of benefits you had prior to July 1, 2020.
   - If you retired between July 1, 2020 and June 30, 2024, you and your family members will receive Tier III benefits, as there were no tiers in place at that the time of your retirement.
   - If you are retiring on or after July 1, 2024, the tier of benefits you and your eligible family members will receive will be the highest tier in which you were covered (based on covered earnings or earnings plus buy-up) in two of the last four open enrollment periods immediately preceding your retirement. Note that for open enrollments between July 1, 2020 and June 30, 2024, $37,500 will be considered the covered earnings requirement for Tier III Early Retiree benefits, as there were no Tiers in place at that time.

   After retirement, you will continue to receive that tier of benefits (assuming you continue to meet all other Fund requirements) until the earliest date you are eligible to enroll in Medicare, at which point you will receive the Fund's Medicare-Eligible benefits.

7. **Elimination of Grace Period for Self-Pay Payments (Active Participants and Early Retirees (Non-Medicare)):** Self-pay premiums will continue to be billed every quarter and payment is due on or before July 1, October 1, January 1, and April 1 of each Plan Year. If your payment is not received in the Fund Office by the due date (or the next business day following the due date if it falls on a weekend or bank holiday), **your coverage will be terminated**, and you will not have another opportunity to enroll for coverage until the next Open Enrollment Period (for either January 1 or July 1 effective date of coverage).

   As part of the transition away from a grace period, effective July 1, 2024, the Fund will provide each participant with one once-in-a-lifetime allowance to pay late, without regard to whether the participant has paid late in the past. In other words, a participant who has failed to make the self-pay premium payment by the quarterly deadline will be allowed, once in his/her lifetime, to remit that payment by the end of the following month of the quarter and medical and pharmacy coverage will be provided retroactive to the beginning of the quarter, even if that individual had used their allowance prior to July 1, 2024.

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.