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

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SUMMARY OF MATERIAL MODIFICATIONS TO
THE ANNUITY FUND OF LOCAL NO. ONE, I.A.T.S.E.

To: All Participants in the Annuity Fund of Local No. One, I.A.T.S.E.

From: Scott Cool, Director of Fund Administration

Date: December 12, 2018

Re: Updates to Provisions Related to Disability Claims

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to the Annuity Fund of Local No. One, I.A.T.S.E. (the "Plan"). You should take the time to read this SMM carefully and keep it with the copy of the 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, telephone number (212) 247-5225, or visit our web site at www.FundOneIATSE.com.

Effective April 1, 2018, the Board of Trustees determined to amend the Plan with respect how disability is determined for purposes of receiving certain benefits. Those Plan changes require updates to the following provisions of the 2013 SPD:

Section V.G, Distributions for Temporary Disability, appearing on page 12 of the 2013 SPD, is revised to read as follows:

G. <u>Temporary Disability</u>

If you become temporarily disabled, you will be eligible to request a distribution from the Plan. You will be considered to be temporarily disabled if your physician certifies, on a form provided by the Fund, (a) that you are unable, as a result of bodily injury or by reason of disease, to engage in any gainful employment with an employer for a period of at least 45 days, and (b) that he/she is treating you for such temporary disability. The Fund may periodically require you to provide an updated physician's certification. The amount of your distribution, should you be determined to be temporarily disabled, would be limited to the lesser of: (1) $50,000; or (2) 50% of your Individual Account as of the most recent Valuation Date (i.e., the last business day), less any outstanding loans.

Section V.H, Distributions for Total and Permanent Disability, appearing on page 12 of the 2013 SPD, is revised to read as follows:

H. Total and Permanent Disability

If you become totally and permanently disabled, the value of your Individual Account will be payable to you. You will be considered to be totally and permanently disabled only if:

- you have received a Social Security Disability Award reflecting that you are totally and permanently disabled, and
- such disability has lasted for at least five months and is expected to continue for at least an additional seven months.

A new Section V.L, Distributions for Caregiver Leave is added to read as follows:

L. Caregiver Leave

If you cease work in covered employment for a period of 45 days or more to serve as the primary caregiver to an immediate family member (Spouse, child or parent), suffering from a life-threatening illness or severe disability, and you have not returned to covered employment you may apply for a distribution from your Individual Account. You must submit a completed certification, on a form provided by the Fund Office, from your immediate family member's treating physician certifying the physician is treating your immediate family member for such condition. The Fund may periodically require you to provide an updated physician's certification. The amount available for distribution on this basis, would be limited to the lesser of: (1) $50,000; or (2) 50% of your Individual Account as of the most recent Valuation Date (i.e., the last business day), less any outstanding loans.

Section IX, Claims & Appeals Procedures, appearing on pages 20-24 of the 2013 SPD is revised to read as follows:

SECTION IX
Claims & Appeals Procedures

A. Claims and Review Procedure

To obtain Plan benefits, you (or your beneficiary) must file a written application with the Fund Office (sent to the attention of the Director of Fund Administration). You will be notified of the acceptance or denial of your claim for benefits within 90 days from the date your claim is filed. In some cases, your request may take more time to review and an additional processing period of up to 90 days may be required due to circumstances outside of the Plan's control. If this happens, you will be notified in writing before the end of the initial 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the extension is needed because you did not submit the information necessary to decide your claim, the time period in which your claim must be decided will be tolled from the date the extension notice is sent to you until you supply the necessary information.

If your claim is denied in whole or in part, you will be notified in writing of the reason(s) for the denial and the specific references to Plan provisions on which the denial is based. This notice also will explain any additional information needed to perfect the claim and the reason(s) why such information is necessary, together with an explanation of the Plan's appeal procedure and the time limits applicable to those procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA upon an adverse decision on appeal.

B. Appeal Procedure

If your claim has been denied, you can:

- request, in writing, within 60 days of receipt of the claim denial notice, a review of your claim by the Trustees,
- review all documents relating to the denial (upon reasonable notice) and request that the Plan provide you, free of charge, copies of all documents, records or other information relevant to your claim, and
- submit all issues and comments in writing.

The Trustees (or a committee designated by the Trustees which will not be the persons who initially denied your claim or subordinates to such persons) will make a decision at their next regularly scheduled meeting if your request for review is filed with the Trustees at least 30 days before such meeting. If your request is filed less than 30 days before the next regularly scheduled meeting, the Trustees will make a decision at the second regularly scheduled meeting following their receipt of your request for review. If special circumstances require an extension of time for making a decision on your request for review, the Trustees will make a decision at the third meeting following their receipt of your request for review. You will be notified prior to the beginning of the extension period if there is a need for such an extension of time, of the special circumstances that exist and when the Trustees expect to render a decision. If the extension is needed because you did not submit the information necessary to decide your claim, the time period in which your claim must be decided will be tolled from the date the extension notice is sent to you until you supply the necessary information.

The Trustees will consider your appeal and give you its decision after reviewing all necessary and relevant evidence. The Trustees will give you a full and fair review of the decision denying your application (known as an “adverse benefit decision”), based upon all comments, documents, records and other information that you submit, without regard to whether that information was submitted or considered in connection with the initial benefit determination.

If your claim is denied on appeal, in whole or in part, the Trustees will furnish a written notice of denial to you that includes the following information:

- the specific reason or reasons for the denial, written in a way that is readily understandable,
- a reference to the specific Plan provisions on which the denial is based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, and
- a statement describing your rights to obtain additional information about the Plan’s appeal process and your right to bring a civil action under Section 502(a) of ERISA upon the adverse decision on appeal.

You will be notified of the decision of the Trustees (or their committee) no later than 5 days after the decision is made.

C. Rules Applicable to All Claims and Appeals

The decision of the Trustees (or their committee) concerning an appeal shall be final and binding on all parties. A claimant must exhaust these claims and appeals procedures before he or she may bring a legal action seeking payment of benefits under the Plan. Under no circumstances may any legal action be commenced or maintained against the Plan, the Fund, the Trustees, or any Contributing Employer or representative of the Plan or Fund more than one year following the earlier of: (i) the date that the one-year period of limitations would commence under applicable law, (ii) the date upon which the claimant knew or should have known that the claimant did not receive an amount due under the Plan, or (iii) the date on which the claimant fully exhausted the Plan's administrative remedies. Any legal or equitable action for benefits under the Plan must be brought in the United States District Court for the Southern District of New York.

If you have any questions about the claims or appeals process, please contact the Fund Office.

This SMM is intended to provide you with an easy-to-understand description of certain changes 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.