Recovery Basic Tier Benefit Summary (07/01/2022 - 12/31/2022)

The following chart summarizes the benefits the Welfare Plan will provide for all the eligible participants who are receiving Basic Coverage. It is not intended to interpret, extend or change in any way the provisions of the Summary Plan Description, the carrier's benefit descriptions, or the other official plan documents. In the event of a conflict or inconsistency, the Summary Plan Description, the carrier's benefit descriptions, or other official plan documents will govern in all cases.

Feature	Recovery Tier Coverage	Notes
Medical Deductible	In-Network $750 for individuals/ $1,500 for families Out-of-Network $10,000 for individuals/ $20,000 for families	The deductible is the amount you pay for covered health care services before the Plan starts to pay. **Note that In-Network office visits (primary care and specialist) and diagnostic testing are NOT subject to the deductible.** Deductibles will accumulate by Plan Year (7/01-6/30). If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Office Visits (Physician/ Specialist)	In-Network $50/$50 copay Out-of-Network $50/$65 per visit deductible, then 50% after plan deductible	The copay is the amount you pay at the time of a covered service. It is counted towards your maximum out-of-pocket expenses. **Note that Out-of-Network office visits are subject to the deductible ($10,000/$20,000), after which you are responsible for 50% of the covered charge.**
Inpatient Hospital	In-Network 70% coverage, after $500 per admission copay and plan deductible Out-of-Network 50% coverage, after $500 per admission deductible and plan deductible	Coinsurance is the percentage of covered charges you are responsible for after the admission copay and your deductible. For an In-Network hospitalization, there is a $500 per admission copay, after which you will be responsible for 30% of the covered charges **up to your Maximum Out-of-Pocket limits (see below for details)**. **For Out-of-Network, you will be responsible for 50% of those covered charges after the Out-of-Network deductible ($10,000/$20,000); maximum Out-of-Pocket does not apply.**
Hospital Emergency Room	In-Network $200 per visit copay, then 70% after plan deductible Out-of-Network $200 per visit deductible, then 70% after plan deductible	Note that if you visit an emergency room for a true emergency and are subsequently admitted to the hospital, the $200 copay is waived. Also, if you visit an Out-of-Network emergency room for a true emergency, the services will be covered the same as an In-Network emergency room.
Diagnostic Lab Testing and Imaging	In-Network Lab & X-rays: 100% Complex Imaging: $50 copay Out-of-Network 50% after deductible	Charges for radiology and lab services are covered at 100%, except that complex diagnostic imaging (e.g. CAT, MRI, PET) requires a $50 copay. **Note that Out-of-Network diagnostic testing charges are subject to the deductible, after which you will be responsible for 50% of charges.**
Medical Maximum Out-of-Pocket Expenses	In-Network $5,350 per individual $10,700 per family Out-of-Network Unlimited out-of-pocket	**The Maximum Out-of-Pocket limit is the most you have to pay for covered services during the Plan Year, after which the Plan pays 100%.** Medical deductibles, copays, and coinsurance are applied against Out-of-Pocket Maximums, which accumulate by Plan Year. **Note that there is NO Maximum Out-of-Pocket protection for Out-of-Network expenses.**
Prescription Drugs	Retail purchase at a participating pharmacy: **Generic Drugs**: $5 copay (No Brand Name or Non-formulary Drugs) Express Scripts Mail Order Copays (3 mos): $10	Note that Recovery Basic Tier coverage only covers generic drugs. Brand name and non-formulary drugs are NOT covered.
Prescription Maximum Out-of-Pocket Expenses	In-Network $1,000 per individual $2,000 per family Out-of-Network Unlimited Out-of-Pocket	**The Maximum Out-of-Pocket limit is the most you have to pay for covered services during the Plan Year, after which the Plan pays 100%.** Prescription deductibles and copays are applied against Out-of-Pocket maximums, which accumulate by Plan Year. **Note that there is NO Maximum Out-of-Pocket protection for Out-of-Network expenses.**

PARTICIPANTS REQUESTING SPOUSAL COVERAGE

➤ PLEASE NOTE ➤

You are required to provide prompt notice to the Fund Office if you and your spouse legally separate or divorce.

If you fail to inform the Fund Office of such legal separation or divorce, the Fund may hold you responsible for ALL COSTS associated with extending coverage to your spouse after your legal separation or divorce became final. This may include the full premium expense for such coverage, or any claims expense incurred after the legal separation or divorce.

FAILURE TO REMOVE A FORMER SPOUSE FROM YOUR HEALTH INSURANCE COVERAGE IS ENROLLMENT FRAUD. As such, the Trustees also reserve the right to terminate your Fund coverage and that of your covered family members for failure to provide timely notice of a legal separation or divorce from a covered spouse.

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 MODIFICATION

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

From: Scott Cool, Director of Fund Administration

Date: May 10, 2022

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"). Please 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 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.

The Board of Trustees has made the following changes to the Welfare Fund plan of benefits:

1. **Expansion of Eligibility Rules for the Six-Month Coverage Period July 1, 2022 Through December 31, 2022**:
   As previously announced on April 8, 2022, you will be eligible for Welfare Fund benefits for this period, if you had at least $18,750 in Covered Earnings during the six-month period October 1, 2021 through March 31, 2022.

   The Board of Trustees has determined to further expand eligibility for this period to those who had at least $37,500 in Covered Earnings during the twelve-month period April 1, 2021 through March 31, 2022.

2. **Special Disability Crediting Rules for the Six-Month Coverage Period July 1, 2022 Through December 31, 2022:**

   In determining eligibility for benefits for this period, the following Special Eligibility Rules relating to disability crediting will apply to disabilities occurring between 3/16/2020 and 4/01/2022:

   (a) You will be credited with deemed earnings equal to 1/52nd of the covered earnings attributed to you during the 52-week period 3/01/19 to 2/28/20 if that amount is higher than the amount calculated using the 52-week period immediately preceding the week in which your disability commenced.

   (b) If you are unable to provide proof of short-term disability, you may alternatively submit a certification from your treating physician on a form provided by the Fund Office.

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.