CENTRAL LABORERS' WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

AMENDED PLAN LANGUAGE

On May 24, 2022, the Trustees of the Central Laborers' Welfare Fund adopted the following changes to the Fund's Plan provisions, with an effective date of January 1, 2021:

The Summary Plan Description, specifically the section of the Summary Plan Description entitled "Medical Expense Benefit (For All Participants)":

When you or your eligible Dependents incur expenses as a result of a non-occupational Illness or Injury, the Medical Expense Benefit Plan reimburses you or your provider for a portion of the Covered Charges. You or your eligible Dependent must first satisfy the deductible or make a required co-payment as shown in the *Schedule of Benefits* in the back pocket of this booklet. After the deductible is met, the Plan pays the percentage of the Usual and Customary Charges shown in the *Schedule of Benefits*. Once you have met the out-of-pocket maximum, the Plan may pay up to 100% of Covered Charges incurred for the remainder of the calendar year up to the calendar year benefit maximum. At the end of each calendar year, during the Open Enrollment Period, you will have the opportunity to choose your benefit coverage for the upcoming year through the:

- Participating Provider Option (PPO) Plan;
- Point of Service (POS) Plan; or
- Three-Tiered Plan.

For Retirees, you have the opportunity to choose your benefit coverage from the:

- Point of Service (POS) Plan;
- Health Maintenance Organization (HMO) Plan; or
- Three-Tiered Plan.

- **Precertification is required for hospitalizations and partial hospitalization services, including those prescribed for medical, mental health and substance abuse treatment. Please ask your provider(s) to obtain precertification in advance, if possible. Failure to obtain precertification, when precertification is required, will result in a denial of benefits on the service(s) provided.**
- **The Fund recommends that you ask your provider to obtain precertification for any other service, expense, procedure, supply or device to verify such service, expense, procedure, supply or device is a Covered Charge.**

The benefit design of each of the Plans offered by the Welfare Fund is outlined in the *Schedule of Benefits* located in the back pocket of this booklet. Please call the Fund Office if you have questions about the coverage offered under any of the options. Health care coverage is a very personal decision, so you must decide which option is right for you and your eligible Dependents.

It is important to remember that the Medical Expense Benefit is not designed to cover every health care expense. The Plan pays Covered Charges for services and treatments that are allowed under this Plan to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician – not the Plan. The Plan determines how much will be paid. You and your Physician must decide what medical care is best for you.

Preferred Provider Organization/Point of Service/HMO

The Welfare Fund has joined with several health care networks made up of Physicians, Hospitals and medical professionals that have agreed to provide discounted rates for some services that you or your eligible Dependents receive from them. After your deductible or a specified co-payment is satisfied, the Plan pays a higher percentage of Covered Charges when services are received from a network Hospital or Physician. Contact the plan network administrator to determine if your provider participates in the network.

- ***Save money.*** You save money by using a network provider:
- ***First,*** you save money because the cost of the services provided is discounted.
- ***Second,*** the Plan pays a greater percentage of the cost of network services.

The Summary Plan Description, specifically the section of the Summary Plan Description entitled "Substance Abuse Treatment":

Substance Abuse Treatment

Substance abuse includes alcohol and drug abuse treatment as follows:

- ***inpatient*** treatment for confinement in a licensed Treatment Facility for Substance Abuse or Hospital for care.
- ***outpatient*** treatment for the treatment and care of alcohol and drug abuse in a licensed, non-residential Treatment Facility for Substance Abuse, a certified non-residential treatment program or Hospital.

A Doctor of Medicine (MD), psychiatrist, psychologist or certified addictions counselor will recommend the course of treatment. You may receive substance abuse treatment on an inpatient, outpatient or a combination of inpatient and outpatient basis.

Benefits for the Substance Abuse Treatment Benefits are *not* payable for the following services:

1) An admitting fee or deposit.
2) Treatment that is payable under any other benefit from the Plan.
3) Treatment involving the family of the person for whom a claim is submitted when they are part of the therapy.

The Summary Plan Description, specifically the section of the Summary Plan Description entitled "Mental Health Treatment":

Mental Health Treatment

You and your eligible Dependents are entitled to benefits for Covered Charges incurred for treatment of mental health, including mental and nervous disorders. Benefits for inpatient and outpatient treatment are paid at the levels shown in the *Schedule of Benefits*. Covered mental health treatment services include services furnished by a licensed or accredited Hospital and outpatient services.

The Summary Plan Description, specifically the section of the Summary Plan Description page 30:

Maximum Benefits

The maximum amount payable with respect to all Illnesses or Injuries of any one individual during any calendar year will be the amount shown in the *Schedule of Benefits* in the back pocket of this booklet or specific areas within this booklet that describe particular benefits.

Mental Health Parity and Equity Act

This Plan is designed to be fully compliant with the parity requirements set forth under the Mental Health Parity and Addiction Equity Act ("MHPAEA"). Accordingly, all of the Plan's mental health and substance abuse dependency benefits, as written and in operation, including review and appeal components are designed and applied in full parity across each respective benefit classification under which medical-surgical benefits are provided for under the Plan.

The Central Laborers' Welfare Fund's online Summary Plan Description has been updated with the amended language above. You may request a hard copy of the Summary Plan Description by contacting the Fund Office at 1-800-252-6571.

GRANDFATHERED PLAN NOTICE

THE CENTRAL LABORERS' WELFARE FUND ("FUND") BELIEVES THAT IT IS A "GRANDFATHERED HEALTH PLAN" UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT). AS PERMITTED BY THE AFFORDABLE CARE ACT, A GRANDFATHERED HEALTH PLAN CAN PRESERVE CERTAIN BASIC HEALTH COVERAGE THAT WAS ALREADY IN EFFECT WHEN THAT LAW WAS ENACTED. BEING A GRANDFATHERED HEALTH PLAN MEANS THAT THE FUND MAY NOT INCLUDE CERTAIN CONSUMER PROTECTIONS OF THE AFFORDABLE CARE ACT THAT APPLY TO OTHER PLANS, FOR EXAMPLE, THE REQUIREMENT FOR THE PROVISION OF PREVENTIVE HEALTH SERVICES WITHOUT ANY COST SHARING. HOWEVER, GRANDFATHERED HEALTH PLANS MUST COMPLY WITH CERTAIN OTHER CONSUMER PROTECTIONS IN THE AFFORDABLE CARE ACT, FOR EXAMPLE, THE ELIMINATION OF LIFETIME LIMITS ON BENEFITS. THE FUND WILL NOTIFY YOU WHEN CERTAIN OTHER CONSUMER PROTECTIONS ARE ADOPTED.

QUESTIONS REGARDING WHICH PROTECTIONS APPLY AND WHICH PROTECTIONS DO NOT APPLY TO A GRANDFATHERED HEALTH PLAN AND WHAT MIGHT CAUSE A PLAN TO CHANGE FROM GRANDFATHERED HEALTH PLAN STATUS CAN BE DIRECTED TO THE WELFARE FUND DIRECTOR, CYNTHIA SMITH-BRANNAN, AT 1-800-252-6571. YOU MAY ALSO CONTACT THE EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEPARTMENT OF LABOR AT 1-866-444-3272 OR WWW.DOL.GOV/EBSA/HEALTHREFORM. THE WEB SITE HAS A TABLE SUMMARIZING WHICH PROTECTIONS DO AND DO NOT APPLY TO GRANDFATHERED HEALTH PLANS.