Summary of Material Modification
Central Laborers' Welfare Fund

As required, the Central Laborers' Welfare Fund Office must inform Plan Participants of any amendments that apply to benefits provided to Participants and their eligible Dependents.

Effective April 1, 2018, the Board of Trustees amended the Welfare Fund's requirements which apply if a claim is denied and the procedures for appealing a denied claim as follows:

Claim Filing and Appeal Information

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

If a Claim is Denied

If your claim is denied (in whole or in part), the Plan will:

- provide you with certain information about your claim; and
- notify you of its denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial of your health care claim (or Loss of Time Benefit claim filed before April 1, 2018), it will provide:

- the specific reason or reasons for the decision;
- reference to the Plan provisions on which the decision was based;
- a description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- a copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
- a copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- a copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

In addition, for Loss of Time Benefit claim filed on and after April 1, 2018, the notice will also include:

- The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

- An explanation of the clinical or scientific judgment for the determination, applying the terms of the plan to your medical circumstances, if the adverse benefit determination was based on medical necessity or other similar exclusions, or a statement that such explanation will be provided free of charge upon request;

- A discussion of the decision, including an explanation of the basis for (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable); (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

- A statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records, and other information to your claim for benefits;

- A statement of your right to present evidence and testimony in support of your claim during the appeal/review process;

- A statement that before the Plan can issue an adverse benefit determination on review of a disability claim, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give you a reasonable opportunity to respond prior to that date; and

- A statement that before the Plan can issue an adverse benefit determination on review of a disability claim based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under the Plan to give you a reasonable opportunity to respond prior to that date;

- A statement of your rights under the Employee Retirement Income Security Act of 1974 ("ERISA") to bring a civil action; and

- If applicable, the notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

Appealing a Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Trustees at the Fund Office as soon as possible. Deadlines for filing written appeals are as follows:

- within 180 days from the date of a decision for **health care** or **Loss of Time Benefit** claims; or

- within 60 days from the date of a decision for **death** or **AD&D benefit** claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- submit additional materials, including comments, statements or documents; and
- request to review all relevant information (free of charge).

In addition, if your claim is for health care or Loss of Time Benefits and is denied based on:

- an internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information; and

- a Medical Necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

You may request a hearing (in person or by representative). If you don't request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, of the date, time and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, within five calendar days after a decision on your appeal is made.

Appeal Timeframes

The Plan's determination on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims as shown below:

- **Health Care Claims**. A determination will be made within 60 days from receipt of your appeal. However, the determination may be made at the Fund's next quarterly meeting if the appeal is received within 30 days of that meeting.

- **Loss of Time Benefit Claims**. A determination will be made within 45 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:

    - make its decision at the next quarterly meeting of the Board of Trustees; or

    - if your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

- **Death and AD&D Benefit Claims**. A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review. However, the Plan may:
    - make its decision at the next quarterly meeting of the Board of Trustees; or
    - if your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

- has appropriate training and experience in the field of medicine involved in the medical judgment; and

- was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity, upon request, of any medical experts consulted in making a determination of your appeal.

Information Requirements

When the Plan notifies you of its determination on your appeal with respect to a health care claim (or Loss of Time Benefit claim filed before April 1, 2018), it will provide:

- the specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;

- a statement notifying you that you have the right to request a free copy of all documents, records and relevant information;

- information relating to any additional voluntary appeal procedures offered by the Plan;
- a statement that you may bring a civil action suit under ERISA;
- a copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- a copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

In addition, for Loss of Time Benefit claims filed on and after April 1, 2018, the notice will include:

- The specific reason(s) for the denial;
- Reference to the specific plan provisions on which the benefit determination is based;
- A statement that you have the right to request a free copy of all documents, records and information relevant to your appeal;
- The specific internal rule, guideline, protocol, standard, or other similar criterion, if any, relied upon in making the determination or alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria does not exist;
- An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation or a statement that such explanation will be provided free of charge upon request;
- An explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable); (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
- That you may bring a civil action suit under the Employee Retirement Income Security Act of 1974 (ERISA);
- Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA Section 502(a) and the specific expiration date for bringing suit; and
- If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

The Trustees' decision on an appeal is final and binding.

The foregoing revisions replace the sections of the Welfare Fund's "Summary Plan Description, Amended April 1, 2017" entitled "If a Claim is Denied" (Page 68) and "Appealing a Denied Claim" (Page 69).

Should you have any questions regarding the foregoing Plan changes, please contact the Fund Office at **800-252-6571.**