CENTRAL LABORERS' WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

AMENDED PLAN LANGUAGE

On October 19, 2021, 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, 2022:

The Summary Plan Description, specifically the section of the Summary Plan Description entitled "Your Spouse or Dependent Loses a Job or Takes a New Job" is amended to read as follows:

When your spouse or Dependent children loses employer-provided insurance due to the loss of his or her job, you should contact the Fund Office to add your spouse or children to your coverage.
If your spouse takes a new job and your spouse's new employer offers comparable coverage to this Plan or comprehensive insurance, your spouse must enroll in that coverage before this Plan will provide or coordinate benefits for your spouse. Please contact the Fund Office if your spouse accepts a new job.

If your Dependent child obtains new health insurance coverage, you will need to provide the Fund Office with information about the new benefit plan.

The Summary Plan Description, specifically the section of the Summary Plan Description entitled "Coordination of Benefits" will have the following sentence from deleted:

- If an Adult Child or Dependent child has employment-based health coverage and declines such coverage, then this Plan will only pay 20% of any otherwise allowable charges.

The Summary Plan Description, specifically the section of the Summary Plan Description entitled "Coordination of Benefits" will be amended to read as follows:

Coordination of Benefits (Amended January 1, 2022)

The Plan has been designed to help you meet the cost of your health care expenses. It is not intended that you receive greater benefits than your actual health care expenses, so the benefits payable under the Plan will be coordinated with the benefits of other health care plans. The amount of benefits payable under this Plan may be affected when you are covered by any other plan (defined below), determined without regard to any coordination of benefits (COB) rules.

Specifically, in a calendar year, the Plan will pay either its regular benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will equal 100% of allowable expenses incurred by you or your Dependent. When a plan provides payment in the form of services, such as services received from a Health Maintenance Organization (HMO), rather than cash payments, the reasonable cash value of the services will be considered both an allowable expense and a benefit paid.

Coordination of Benefits (COB) provision. When you or your Dependents are covered by more than one plan, the COB rules prevent duplicate payments and provide the rules for the order in which each plan pays benefits.

Allowable expense means a health care service or expense, reduced by this Plan's deductibles, coinsurance or co-payments that is covered in full or in part by the Central Laborers' Welfare Fund Plan of Benefits.

Allowable Expenses do not include:

- any of the exclusions under the Central Laborers' Welfare Fund;
- the difference between a semi-private room in the Hospital and a private room;
- any amount in excess of the lowest negotiated fees;
- in absence of negotiated rates, any amount in excess of this Plan's Usual and Customary Charges; or
- any amount reduced from a primary plan's allowable expenses when that reduction is related to the failure of the plan Participant to comply with the primary plan's utilization review procedures or the Participant's failure to obtain health care service from the primary plan's network providers.

Although payments by this Plan cannot be more than would normally be paid if the COB rules did not exist, your combined reimbursement may exceed the maximum under this Plan, but cumulative payments by this Plan will not exceed the maximum allowed for any benefit defined in this booklet.

"Plan" means any plan providing benefits or services for or by reason of medical, prescription drug, vision, hearing or dental or treatment or healing under:

- group insurance;
- group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis or other group prepayment coverage;
- labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans; or
- governmental programs or coverage required or provided by any statute.

Keep in mind that if your full-time working spouse has coverage offered through his or her employer your spouse must enroll in that coverage to have secondary coverage under this Plan. The COB rules will not apply and your spouse will have no coverage under this Plan if your spouse does not enroll in his or her employer's coverage.

(No coverage of any kind under this Plan shall be afforded to a participant's dependent who has, or has available, medical coverage of any kind under his or her employer's plan unless the employer's plan provides the same maximum benefits to all its employees irrespective of the coverage the employee (or the person of whom he or she is a dependent) may have in another plan.)

To administer the COB rules properly, and to determine whether this Plan will reduce its regular benefits, it is necessary to determine the order in which the various plans will pay benefits. The order in which the plans will be considered to pay benefits is determined by the first of the following rules that apply:

- When another plan does not have coordination of benefits rules (COB rules), that plan must pay benefits first.

- When another plan has COB rules, the first of the following rules that apply determine which plan will pay benefits first:

    - If a plan covers the claimant as an employee, then that plan will pay benefits first.

    - If a plan covers the claimant as a Dependent whose parents are not divorced or separated, the plan of the parent whose birthday anniversary is earlier in the calendar year will pay on allowable expenses incurred first; except if both parents' birthdays are on the same day, the plan covering the parent for the longer period of time will pay first. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.

    - If a plan covers a Dependent whose parents are divorced or separated, then the following rules apply:

        - If a plan covers a Dependent of a parent who is ordered by court decree to provide health coverage, then that plan pays benefits first. If the parent with responsibility has no health care coverage for the Dependent's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;

        - If a court decree charges each parent with equal responsibility to provide health coverage for a Dependent, then the birthday rule will apply so that the parent whose birthday anniversary is earlier in the calendar year pays first; except that if both parents' birthdays are on the same day, the plan covering the parent for the longer period pays first. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.

    - when there is no court decree requiring a parent to provide health coverage for a Dependent, the following rules will apply:

        - when the parent who has custody of the Dependent has not remarried, that parent's plan will pay first; or

        - when the parent who has custody of the Dependent has remarried, benefits will be determined by that parent's plan first, by the stepparent's plan second and by the non-custodial parent's plan third.

    - If a Dependent is covered under this plan, a spouse's plan and/or his/her parents' plan, then the plan that has covered the Dependent for the longest duration will be primary. If two or more plans share the same effective date, the order of coverage will be determined by the policyholder or benefit plan holder's birth month, with the earliest plan holder with the earliest birth month being primary over all others. If a plan does not adhere to the "birthday rule" in determining the order of benefits, then that plan must pay first.
    - If a Participant's Spouse is covered under this plan and/or his/her parents' plan, then the plan that has covered the Spouse for the longest duration will be primary. (Keep in mind that if your full-time working spouse has coverage offered through his or her employer, your spouse must enroll in that coverage to have secondary coverage under this Plan. The COB rules will not apply and your spouse will have no coverage under this Plan if your spouse does not enroll in his or her employer's coverage.)
    - If a Participant, a Participant's Spouse or Dependent is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active

employee or a dependent of an active employee is the primary plan. For purposes of this rule, a person continuing coverage through the use of an hour bank for continued eligibility is considered to be a laid off employee.

- If a Participant, a Participant's Spouse or Dependent is covered under a right of continuation pursuant to federal or state law and is also covered under another plan, the plan that covers the person as an active employee is the primary plan and the plan providing continuation coverage is secondary.

Once the order of payment is determined, the Fund Office will calculate the regular benefits under each plan in the order in which the plans are considered to pay their benefits and compare the amount with the total allowable expenses under this Plan. If payment of regular benefits by the Welfare Fund would result in payment of benefits that exceed allowable expenses, the Welfare Fund will reduce the regular benefit paid to eliminate the excess.

If this Plan is secondary and your primary plan does not pay benefits because you did not comply with that plan's rules, this Plan may deny your benefit claim.

Regardless of the order outlined above, in the event a covered person incurs claims and any no-fault, personal Injury protection ("PIP") and/or medical payments coverage(s) is found to be available, these "First Party" coverages (or Another source(s)) are primary and must be paid out (exhausted) in their entirety before a payment under the Welfare Fund is to be considered eligible.

The Welfare Fund has the right and does not need consent by you, your Dependent or any person to:

- release or obtain any information the Welfare Fund determines to be necessary to implement these rules (in accordance with any applicable legislation);
- make any payments necessary to satisfy the intent of these rules if payments have been made under any other plan that should have been made under the group policy; or
- recover any excess payments to satisfy the intent of these rules.

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.