SUMMARY OF MATERIAL MODIFICATIONS

CENTRAL LABORERS' WELFARE FUND

Effective November 2, 2018, the Trustees of the Central Laborers' Welfare Fund adopted the following changes to the Fund's Plan provisions and definitions:

The section of the Summary Plan Description entitled "Adding a Child by Birth or Adoption" was amended to read as follows:

Adding a Dependent Child or Adult Dependent by Birth, Adoption or Open Enrollment

Generally, the Plan covers natural born children, adopted children (including placement for adoption), stepchildren and children for whom you are the legal guardian subject to the following requirements:

- For initial enrollment of ***natural born, adopted children (including placement for adoption), stepchildren and children for whom you are the legal guardian***, you must notify the Fund Office and provide the required documentation within 31 days of the qualifying event (i.e., adoption, placement for adoption, legal guardianship or marriage for addition of stepchildren) for coverage to begin as of the date of the qualifying event.

- For initial enrollment of ***natural born children, being added due to birth***, you must notify the Fund Office and provide the required documentation within 90 days of the qualifying event (i.e., the birth) for coverage to begin as of the date of birth. If you notify the Fund Office or delay providing required documentation for a period greater than 31 days (90 days in the case of a birth), coverage will begin on the first day of the month following the month in which the Fund Office receives notification and all required documentation.

If you adopt a child or have a child placed with you for legal guardianship or adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage. Stepchildren are eligible for coverage on the date of your marriage, provided your spouse is required to maintain medical and/or dental coverage. All children need to meet the Plan's definition of a Dependent described in the definitions section of this Summary Plan Description.

You may add a Dependent without a qualifying event during the Plan's annual Open Enrollment process. If adding your Dependent during Open Enrollment and that enrollment is not due to a qualifying event, your Dependent's eligibility will be effective, the first day of the plan year for which you are enrolling, the first day of the participant's eligibility, if after the start of a plan year, or the first day of the month following receipt of the Open Enrollment form and all required documents if they are submitted after the Open Enrollment deadline date, whichever is later.

Please remember that your Dependent(s)' eligibility may be subject to verification and may require additional documentation such as a birth certificate(s), divorce decree(s), marriage license, death certificate(s) or other information necessary to confirm a Dependent's relationship and eligibility for benefits. Some of the documentation can be completed by you or your Dependent. However, some forms must be completed by a Dependent's insurance carrier or Dependent's employer, if applicable. If the required documentation is not received on a timely basis, then your Dependent's eligibility may be delayed as provided above.

The section of the Summary Plan Description entitled "Child Losing Eligibility" was amended to read as follows:

Dependent Child or Adult Dependent Losing Eligibility

In general, your dependent child or adult dependent is no longer eligible for coverage when he or she no longer meets the definition of Dependent as described in this Summary Plan Description. You should notify the Fund Office immediately when your dependent child or adult dependent is no longer eligible for coverage. See the definition of Dependent in the Definitions section of the Summary Plan Description.

Your Dependent may consider applying for COBRA Continuation Coverage as he or she nears the age of 26 or otherwise loses eligibility as a result of no longer being a Dependent under the Plan. Generally, your Dependent may elect COBRA Continuation Coverage for up to 36 months when his or her Plan coverage ends provided you notify the Fund Office within 60 days of your Dependent losing eligibility for Plan coverage.

The definition of "Dependent" in the Definitions section of the Summary Plan Description is hereby amended to read as follows:

Dependent means:

- Your lawful spouse; and
- Your child (including a natural child, legally adopted child, child formally placed for adoption, stepchild, and a child under legal guardianship) prior to the last day of the month of the child's 26th birthday.
- An unmarried child who is over age 26 who:
  - continues to be incapable of self-sustaining employment by reason of any handicap condition;
  - otherwise meets the criteria previously described;
  - is chiefly dependent upon you for lifetime care and supervision; and
  - who was considered to be handicapped upon reaching age 26.

    Upon request of the Plan, proof of such incapacity and dependency is to be furnished from time to time, but in no event more frequently than once a year. The child must maintain a principal residence with you for more than one-half of the calendar year and must be dependent on you for more than one-half of his or her support for the calendar year.

  - An unmarried disabled child who has reached age 26, is covered as a Dependent if the child does not live with you, provided that:
  - The child's parents:
    - Are divorced or legally separated under a decree or separate maintenance;
    - Live apart at all times during the last six (6) months of the calendar year;
    - Provide over one-half of the child's support for the calendar year;
  - The child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
  - The child is the qualifying child or qualifying relative, as defined in the Tax code, of one of the parents.
- Your child who is under age 26 and is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) approved by the Board of Trustees or a National Medical Support Notice issued by an authoritative agency within the state where the child, custodial parent or Participant resides.
- Notwithstanding anything contained in this Plan to the contrary, you or your Dependent has the affirmative duty to inform the Plan if and when an individual cease to be a Dependent within sixty (60) days of such event.

Effective May 21, 2019, the Trustees of the Central Laborers' Welfare Fund adopted the following changes to the Fund's Plan provisions and definitions:

The section of the Summary Plan Description Definition, specifically the definition titled "Experimental or investigative…", page 84, is amended and the new definition is added and will read as follows:

Experimental and/or Investigational and/or Unproven means:

Any charge, expenses, service, supply or device that is deemed to be Experimental and/or Investigational and/or Unproven. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

The fact that an Experimental or Investigational or Unproven charge, expense, service, supply, or device regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A charge, expense, service, supply or device will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the charge, expense, service, supply or device was performed or provided or at the time the charge, expenses, service, supply or device was considered for Precertification, any of the following conditions were present with respect to one or more essential provisions of the charge, expense, service, supply or device:**

1. The charge, expense, service, supply or device is described as an alternative to more conventional therapies in the protocols or consent document of the Physician, Hospital or health care provider that performs the service or prescribes the charge, expense, service, supply or device;
2. The prescribed charge, expense, service, supply or device may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts classify the charge, expense, service, supply or device as experimental and/or investigational or unproven or indicate that more research is required before the charge, expense, service, supply or device could be classified as equally or more effective than conventional therapies;
4. With respect to any charge, expense, service, supply or device regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the charge, expense, service, supply or device to be lawfully marketed and it has not been granted at the time the charge, expense, service, supply or device is prescribed or provided or a current investigational new drug or new device application has been submitted and filed with the FDA.

In determining if a charge, expense, service, supply or device is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the charge, expense, service, supply or device was performed, provided or considered:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed charge, expense, service, supply or device;
3. Protocols of the Physician, Hospital or health care provider that renders, or if applicable, prescribes the charge, expense, service, supply or device;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed charge, expense, service, supply or device for the treatment of the covered person's diagnosis, including, but not limited to "United States

Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";

5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the U.S. such as Aetna, Anthem, CIGNA, or Unitedhealthcare (UHC), Tufts or MCG Care Guidelines, formerly Milliman Care Guidelines, or the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines or, the clinical decision support resource titled "UpToDate," McKesson Interqual criteria or Trilogy Claims Administrative Handbook, or the American Dental Association (ADA) with respect to a dental charge, expense, service, supply or device.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed charge, expense, service, supply or device.
7. The latest edition of "The Medicare National Coverage Determinations Manual" or Medicare "Local Coverage Determinations" (LCDs).

The section of the Summary Plan Description titled Medical Benefit Exclusions, specifically the exclusion No. 41, page 43, is amended and will read as follows:

41. Any charge, expense, service, supply or device that is deemed to be Experimental and/or Investigational and/or Unproven as defined on Page 84.

The section of the Summary Plan Description titled Dental Exclusions, specifically the exclusion No. 12, page 53, is amended and will read as follows:

12. Any charge, expense, service, supply or device that is deemed to be Experimental and/or Investigational and/or Unproven as defined on Page 84.

The section of the Summary Plan Description titled Prescription Drug Exclusions, specifically the exclusion No. 6, page 46, is amended and will read as follows:

6. Any charge, expense, service, supply, drug or device that is deemed to be Experimental and/or Investigational and/or Unproven as defined on Page 84.

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.