CENTRAL LABORERS' WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

IMPORTANT INFORMATION REGARDING YOUR 2025 BENEFITS

CENTRAL LABORERS' WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

This document is a Summary of Material Modification ("SMM") intended to notify you of important plan changes to the plan of benefits for the Central Laborers' Welfare Fund ("Fund" or "Plan"). This summary is intended to satisfy the requirements for issuance of a SMM under the Employee Retirement Income Security Act of 1974, as amended. You should take the time to read this SMM carefully and keep it with the Summary Plan Description ("SPD"). This SMM does not contain a full restatement of the terms of the Plan. If you need another copy of the SPD, or if you have any questions regarding the changes described herein, please contact the Fund Office at: 201 N. Main St., P.O. Box 1267, Jacksonville, IL 62651-1267, telephone number: (800) 252-6571.

CHANGES TO YOUR MEDICAL DEDUCTIBLE, OFFICE VISIT COPAY, and EMERGENCY ROOM COPAY

Effective January 1, 2025, the Board of Trustees amended the Plan's SPD to increase the in-network, medical deductible for all individuals covered by the Plan (*i.e.*, Active Participants, Retired Participants, and Dependents) from $125 per year to $160 per year; the in-network, medical deductible for families will also increase from $375 per year to $480 per year.

Effective January 1, 2025, the Board of Trustees further amended the Plan's SPD to increase the out-of-network, medical deductible for all individuals covered by the Plan from $1,900 per year to $2,400 per year; the out-of-network, medical deductible for families will also increase from $5,700 per year to $7,200 per year.

As a part of the changes made by the Trustees that are effective January 1, 2025, the copay for office visits is increasing from $25 to $30, and the copay for emergency room visits is increasing from $155 to $200. However, the copay for an emergency room visit is waived in the event the individual is admitted to the hospital.

Enclosed herein please find an updated Schedule of Benefits (effective January 1, 2025)

CHANGES TO YOUR PRESCRIPTION DRUG COPAYS

Effective January 1, 2025, the Board of Trustees amended the Plan's SPD to provide an updated prescription drug copay schedule for all individuals covered by the Plan as follows:

Prescription Drug Category	Current Copay	New Copay (Effective 1/1/25)
Retail – Brand Formulary	$50	$65
Retail – Brand Non-Formulary	$125	$160
Mail Order – Generic	$25	$30
Mail Order – Brand Formulary	$100	$130
Mail Order – Brand Non-Formulary	$250	$325

Please note, the $15 copay for retail generic drugs will remain the same.

SPOUSAL COVERAGE EXCEPTION

The Plan currently provides that if your spouse's employer offers comparable medical coverage to the Plan or offers

comprehensive insurance, your spouse must enroll in that coverage before the Plan will provide benefits to your spouse. Effective January 1, 2025, the foregoing rule has been modified to create an exception. The exception provides as follows:

> ***Notwithstanding the foregoing rule, the Plan will deem comparable coverage to <u>not</u> exist in the event the monthly cost to your spouse of obtaining/maintaining medical coverage or insurance through his or her employer exceeds the Plan's current self-payment rate on a monthly basis. In such an event, your spouse will not be required to enroll in his or her employer's medical coverage or insurance, but you and your spouse must <u>annually</u> verify the cost to your spouse of obtaining/maintaining medical coverage through his or her employer on a form prescribed by the Fund Office in order to receive coverage under the Plan.***

In other words, if there is a costs associated with your spouse obtaining/maintaining medical coverage or insurance through his or her employer, and that costs exceeds the Plan's current self-payment rate, which is subject to change, on a monthly basis, your spouse will not have to enroll in his or her employer's medical coverage/insurance in order to be covered as a Dependent by the Plan. However, this exception must be verified every year by the Fund on a form that you and your spouse submit to the Fund Office.

ADDITION OF DISPOSABLE INSULIN PUMPS

Effective July 16, 2024, the Board of Trustees amended the Plan's SPD to provide coverage for disposable insulin pumps, such as Omnipod insulin pumps, and the supplies thereto, such as the Dexcom G6 and G7 or other compatible continuous glucose monitors.

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, SUCH AS, 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, SUCH AS, 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.

BlueCross/BlueShield PPO Plan for Active Participants Only (Not offered to Retired Participants)

Medical Benefits	Network	Out-of-Network
	Care is received from a Blue Cross/Blue Shield PPO Physician or Hospital	Care is received from any qualified health care provider
Deductible Individual Family	 $160 $480	 $2,400 $7,200
Out-of-Pocket Maximum Individual Family	 $9,500 $28,500	 No Limit No Limit
Maximum Calendar Year Benefit	None	
Hospital Benefits Inpatient Outpatient	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Physician Office Visit/Telehealth Visit	$30 co-payment (No Deductible)	Plan pays 50%; You pay 50%
Physician Supervised Weight Loss (Criteria must be met.) **Diet Assessment/Behavioral Counseling**	$30 co-payment (No Deductible) physician visit Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% - applicable to all services
Nutritional Counseling (Criteria must be met.) **Testing and other services**	$30 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% - applicable to all services
X-rays and Labs	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Preventive Care Services Physical Exam Benefit	$400 at 100%; Then 80% thereafter	$400 at 100%; Then 80% thereafter
Well Child Benefits	$200 at 100%; Then 80% thereafter	No coverage except at a Public Health Department
Emergency Room If not Medically Necessary, you pay 100%	$200 co-payment on physician services (waived if admitted inpatient, not observation)	$200 co-payment on physician services (waived if admitted inpatient, not observation)
Rehabilitation Services Inpatient Outpatient - Up to 60 visits per calendar year	 Not covered Plan pays 80%; You pay 20%	 Not covered Plan pays 50%; You pay 50%
Mental Health Treatment Inpatient Outpatient	 Plan pays 80%; You pay 20% $30 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Substance Abuse Services Inpatient Outpatient	 Plan pays 80%; You pay 20% $30 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Additional Surgical Option	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	Plan pays 50%; You pay 50%
Durable Medical Equipment	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Prosthetic Devices $25,000 maximum per calendar year	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Spinal Manipulation Calendar Year Maximum - $1,000 Up to 60 treatments per calendar year for related therapy	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Home Health Care Up to 40 visits per calendar year	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Podiatry Services Orthotics Calendar Year Maximum - $500	$30 co-payment on physician exams 80% on all other services	Plan pays 50%; You pay 50%
TMJ Treatment Calendar Year Maximum - $500	$30 co-payment on physician exams 80% on all other services	Plan pays 50%; You pay 50%
FOR MORE DETAILS	Refer to your Summary Plan Description	

BlueCross/BlueShield PPO Plan for Retired Participants

Medical Benefits	Network	Out-of-Network
	Care is received from a Blue Cross/Blue Shield PPO Physician or Hospital	Care is received from any qualified health care provider
Deductible Individual Family	 $160 $480	 N/A
Out-of-Pocket Maximum Individual Family	 $9,500 $28,500	 N/A
Maximum Calendar Year Benefit	None	
Hospital Benefits Inpatient Outpatient	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 No Benefits
Physician's Office Visit/Telehealth Visit	$30 co-payment (No Deductible)	No Benefits
Physician Supervised Weight Loss (Criteria must be met.) **Diet Assessment/Behavioral Counseling**	$30 co-payment (No Deductible) physician visit Plan pays 80%; You pay 20%	No Benefits
Nutritional Counseling (Criteria must be met.) **Testing and other services**	$30 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	No Benefits
X-rays and Labs	Plan pays 80%; You pay 20%	No Benefits
Preventive Care Services Physical Exam Benefit Well Child Benefit	 $400 at 100%; Then 80% thereafter $200 at 100%; Then 80% thereafter	 $400 at 100%; Then 80% thereafter No coverage except at a Public Health Department
Emergency Room If not Medically Necessary, you pay 100%	$200 co-payment on physician services (waived if admitted inpatient, not observation)	$200 co-payment on physician services (waived if admitted inpatient, not observation)
Rehabilitation Services Inpatient Outpatient - Up to 60 visits per calendar year	 Not covered Plan pays 80%; You pay 20%	 No Benefits
Mental Health Treatment Inpatient Outpatient	 Plan pays 80%; You pay 20% $30 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	No Benefits
Substance Abuse Services Inpatient Outpatient	 Plan pays 80%; You pay 20% $30 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	No Benefits
Additional Surgical Option	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	No Benefits
Durable Medical Equipment	Plan pays 80%; You pay 20%	No Benefits
Prosthetic Devices $25,000 maximum per calendar year	Plan pays 80%; You pay 20%	No Benefits
Spinal Manipulation Calendar Year Maximum - $1,000 Up to 60 treatments per calendar year for related therapy	Plan pays 80%; You pay 20%	No Benefits
Home Health Care Up to 40 visits per calendar year	Plan pays 80%; You pay 20%	No Benefits
Podiatry Services Orthotics Calendar Year Maximum - $500	$30 co-payment on physician exams 80% on all other services	No Benefits
TMJ Treatment Calendar Year Maximum - $500	$30 co-payment on physician exams 80% on all other services	No Benefits
FOR MORE DETAILS	Refer to your Summary Plan Description	

HealthLink Open Access Plan for Active and Retired Participants

Medical Benefits	Network (HMO Provider)	PPO	Out-of-Network
Deductible Individual Family	 None None	 $160 $480	 $2,400 $7,200
Out-of-Pocket Maximum Individual Family	 $9,500 $28,500	 $9,500 $28,500	 No Limit No Limit
Maximum Calendar Year Benefit	None		
Hospital Benefits Inpatient Outpatient	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Physician's Office Visit/Telehealth Visit	$30 co-payment (No Deductible)	$30 co-payment (No Deductible)	Plan pays 50%; You pay 50%
Physician Supervised Weight Loss **(Criteria must be met.)** **Diet Assessment/Behavioral Counseling**	$30 co-payment (No Deductible) Plan pays 80%; You pay 20%	$30 co-payment (No Deductible) Plan pays 80%; You pay 20%	Plan pays 50%; You Pay 50% - applicable to all services
Nutritional Counseling **(Criteria must be met.)** **Testing and other services**	$30 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	$30 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	Plan pays 50%; You Pay 50% - applicable to all services
X-rays and Labs	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Preventive Care Services Physical Exam Benefit	$400 at 100%; Then 80% thereafter	$400 at 100%; Then 80% thereafter	
Well Child Benefit	$200 at 100%; Then 80% thereafter	No Coverage except at a Public Health Department	
Emergency Room **(**If not Medically Necessary, you pay 100%)	$200 co-payment on physician services (waived if admitted inpatient, not observation)	$200 co-payment on physician services (waived if admitted inpatient, not observation)	$200 co-payment on physician services (waived if admitted inpatient, not observation)
Rehabilitation Services Inpatient Outpatient – Up to 60 visits per calendar year	 Not covered Plan pays 80%; You pay 20%	 Not covered Plan pays 80%; You pay 20%	 Not covered Plan pays 50%; You pay 50%
Mental Health Treatment Inpatient Outpatient	 Plan pays 80%; You pay 20% MD Visits 1-3: 100%; then $30 co-payment thereafter Plan pays 80%; You pay 20% on all other services	 Plan pays 80%; You pay 20% $30 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Substance Abuse Services Inpatient Outpatient	Plan pays 80%; You pay 20% MD Visits 1-3: 100%; then $30 co-payment thereafter Plan pays 80%; You pay 20% on all other services	Plan pays 80%; You pay 20% $30 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Additional Surgical Option	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	Plan pays 50%; You pay 50%
Durable Medical Equipment	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Prosthetic Devices $25,000 maximum per calendar year	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Spinal Manipulation Calendar Year Maximum - $1,000 Up to 60 treatments per year for related therapy	$30 co-payment on physician visit or manipulation services All other services Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Home Health Care Up to 40 visits per calendar year	Plan pays 100%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Podiatry Services Orthotics Calendar Year Maximum - $500	$30 co-payment on physician exams 80% on all other services	$30 co-payment on physician exams 80% on all other services	Plan pays 50%; You pay 50%
TMJ Treatment Calendar Year Maximum - $500	$30 co-payment on physician exams 80% on all other services	$30 co-payment on physician exams 80% on all other services	Plan pays 50%; You pay 50%
FOR MORE DETAILS	Refer to your Summary Plan Description		

Prescription, Vision, Hearing & Dental Benefits for All Active and Retired Participants Regardless of the Network Chosen	
Prescription Drug Benefits	**Network**
Retail Pharmacy CVS/Caremark Generic Drugs Brand Name: No generic/formulary available Generic/formulary available **90-day supply may be purchased for the same co-payments as mail order if the purchase is made at a CVS Pharmacy.**	For a 30-day supply, you pay: $15 co-payment $65 co-payment $160 co-payment *plus* the difference in cost between the generic/formulary and brand name drug
Mail Order Service Generic Drugs Brand Name: No generic/formulary available Generic/formulary available	For up to a 90-day supply, you pay: $30 co-payment $130 co-payment $325 co-payment *plus* the difference in cost between the generic/formulary and brand name drug
Patient expenses do not apply to out-of-pocket maximums.	
Vision Care Benefits – for individuals 0 - 18 years of age	
Vision Exam	Paid under the well child benefit of the comprehensive benefit plan with no charge and no deductible up to $200 and a 20% co-insurance on allowable charges thereafter.
Glasses or Contacts	$300 per purchase maximum on eyeglasses (lenses and frames) and/or contacts
Vision Care Benefits – for individuals 19 years old and older	
Covered Services	$300 per person per Plan Year
Hearing Care Benefits	
Hearing Exam	Up to $100 per person once every 12-consecutive month period
Hearing Aid	Up to $750 per person once every 60-consecutive month period
Dental Benefits - for individuals 0 -18 years of age	
Dental Exam	Plan pays 80%; You pay 20% (does not apply to the $2,500 Annual Dental Maximum)
All other Covered Services	Plan pays 80%; You pay 20% (does apply to the $2,500 per person Annual Dental Maximum, including orthodontic service charges. See the Orthodontic Benefit information below).
Dental Benefits – for individuals 19 years old and older	
Covered Services	Plan pays 80%; You pay 20% (including examinations)
Calendar Year Maximum Benefit	$2,500 per person, including orthodontic service charges
Orthodontic Services	Plan pays 50%; You pay 50%
Orthodontic Lifetime Maximum	$1,500
BENEFITS LISTED BELOW ARE OFFERED TO ACTIVE PARTICIPANTS ONLY **(NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)**	
Loss of Time Benefit (Active Participants Only) **(NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)**	
Weekly Benefit Amount	$250
Maximum Benefit Period	13 weeks
Payment Starts	1st day after accidental Injury; 8th day of disability due to Illness
Death Benefit (Active Participants Only) **(NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)**	
Benefit Amount	$10,000
AD&D Benefit (Active Participants Only) **(NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)**	
Death or Dismemberment	$10,000
Partial Dismemberment	$5,000