SUMMARY OF MATERIAL MODIFICATION
FOR THE CENTRAL LABORERS' WELFARE FUND

To:	Participants and Beneficiaries
From:	Board of Trustees
Re:	Plan Changes Regarding (1) Transition to a Single Network, (2) Vision Care Benefit Increase, (3) Hearing Benefit Opt Out

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.

TRANSITION TO A SINGLE NETWORK PROVIDER

Effective January 1, 2026, the Central Laborers' Welfare Fund will only have one network: the BlueCross BlueShield Blue Choice Options Preferred Provider Organization (BCO PPO). This means that if you currently receive health and welfare benefits through either the HealthLink provider network or the BlueCross BlueShield of Illinois PPO, you will be transitioned to the BCO PPO. In other words, all active and retired Participants will be transitioned to the BCO PPO. The BCO PPO single network has three components/tiers, the Blue Choice Options (BCO) component/tier, the Preferred Provider Organization (PPO) component/tier, and an out-of-network component/tier. Under the BCO tier, there is no deductible if you receive medical services from a BCO provider. Similar as before, the PPO tier provides you with flexibility in seeing providers; however, a deducible of $160 per person and $480 per family will apply. Finally, there is an out-of-network component to the BCO PPO with improved, but still limited, out-of-network benefits that will allow you to see out-of-network providers, if desired. Please note, there is a higher deductible for out-of-network providers ($2,400 per person/$7,200 per family), no out-of-pocket maximum for medical services received, and coinsurance of only 50% of the Allowable Charge, which will be lower than the billed charge from the out-of-network provider.

The transition to the BCO PPO provides the best of both worlds as Participants who previously accessed the HealthLink provider network will still have access to Physicians and other providers without having to pay a deductible and active and retired Participants who previously accessed the BlueCross BlueShield of Illinois PPO will now have out-of-network benefits under the BCO PPO. Best of all, you will not need a separate card to access either BCO providers or PPO providers. You can see a list of BCO and PPO in-network providers at bcbsil.com by selecting Providers, navigating to the Provider directory, selecting your search preference by either logging in or continuing as a guest, clicking on Employer Plans, selecting the PPO tab, and then choosing the Blue Choice Options (BCO) tab.

The enclosed 2026 Schedule of Benefits lists the benefits under the three (3) tiers (that is, the BCO tier, the PPO tier, and Out-of-Network tier). In general, the underlying benefit structure is remaining the same for 2026; the Fund is simply transitioning to one comprehensive network. With the transition to the BCO PPO, active and retired Participants will now get the benefit of a three-tiered plan similar to what existed under HealthLink through the BlueCross BlueShield BCO PPO.

Below is an example showing the practical differences between the three (3) tiers. The example assumes that no deductibles or out-of-pockets have been met and that the services received are not subject to the No Surprises Act. Please note, this is only an example, and the processing of actual claims could result in different outcomes:

BCO Example		**PPO Example**		**Out-of-Network Example**	
Charge from BCO Provider	$40,000	Charge from PPO Provider	$40,000	Charge from OON Provider	$40,000
Repriced pursuant to network contract	($20,000)	Repriced pursuant to network contract	($20,000)	Repriced to Allowable Charge	($20,000)
Allowable Charge	$20,000	Allowable Charge	$20,000	Allowable Charge for OON	$20,000
Deductible	$0.00	Deductible	$160	Deductible	$2,400
Subtotal after Deductible	$20,000	Subtotal after Deductible	$19,840	Subtotal after Deductible	$17,600
Less 80% coinsurance	($16,000)	Less 80% coinsurance	($15,872)	Less 50% coinsurance	($8,800)
Remaining amount owed by you after coinsurance (subject to out-of-pocket maximum of $9,500 for individuals & $28,500 for families)	$4,000	Remaining amount owed by you after coinsurance (subject to out-of-pocket maximum of $9,500 for individuals & $28,500 for families)	$3,968	Remaining amount owed by you after coinsurance (no out-of-pocket maximum)	$8,800
Total Amount Owed	**$4,000**	**Total Amount Owed**	**$4,128** ($160 deductible + $3,968 coinsurance)	**Total Amount Owed if OON Provider balance bills**	**$31,200** ($2,400 deductible + $8,800 coinsurance + $20,000 if balance billed)

All active and retired Participants will receive a new BCO PPO medical card in December 2025. If you have not received a new medical card by the last week of December, please contact the Fund Office. Please note, you also have the option of logging in at bcbsil.com and printing off a temporary medical card.

VISION CARE BENEFIT INCREASE

Effective January 1, 2026, the Board of Trustees increased the Vision Care Benefit for individuals 19 years and older from $300 per calendar year to $600 per calendar year. Please note, the Vision Care Benefit for Children ages 0-19 remains the same.

HEARING BENEFIT OPT OUT

If you wish, you may elect to cease coverage for the Hearing Care Benefit under the Welfare Fund for yourself or your Dependents at any time by providing written notice to the Fund Office of your intention to cease hearing coverage. If you or your Dependents desire to opt out of these limited scope benefits, please contact the Fund Office.

If you have any questions about these changes, or require more information, please contact the Fund Office.

Sincerely,

Board of Trustees

Enclosures

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, CHRISTY BRAKE, 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 WEBSITE HAS A TABLE SUMMARIZING WHICH PROTECTIONS DO AND DO NOT APPLY.