SUMMARY OF MATERIAL MODIFICATION AND AMENDMENT #6 TO THE LABORERS LOCAL NO. 754 WELFARE FUND GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2021. These changes are effective as of **November 8, 2023** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

The Nutritional Counseling exclusion is hereby deleted and replaced with the following in the Eligible Medical Expenses section:

Nutritional Counseling: Services related to nutritional counseling for medical and mental health conditions (e.g., eating disorders such as bulimia and anorexia, diabetes mellitus, gastro-intestinal disorders, chronic obstructive pulmonary disease), in which dietary adjustment has a therapeutic role, when furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the Plan. Medically necessary nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

DocuSigned by:
Vincenza Quinlan
0CD64135D554499...

Authorized Signature	Date	Title
Vincenza Quinlan	12/5/2023	12/5/2023 Fund Manager

Witness	Date	Title
[signature]	12/05/2023	12/05/2023 Trustee

Laborers Local No. 754 Welfare Fund
Summary Of Material Modifications

TO: Plan Participants

FROM: Board of Trustees of the Laborers Local No. 754 Welfare Fund

SUBJECT: Expiration of COVID-19 Public Health Emergency and National Emergency

DISTRIBUTION DATE: May 2, 2023

PLAN EIN: 13-1895923
PLAN NUMBER: 501

The federal government has declared that effective May 11, 2023, the COVID-19 Public Health Emergency and the National Emergency will both expire.

As a result of the end of the Public Health Emergency, effective **May 12, 2023**, the following changes will be made to the Laborers Local No. 754 Welfare Fund:

1. **COVID-19 Tests**: COVID-19 diagnostic testing (laboratory, office and/or facility PCR and rapid tests) and test-related services will continue to be covered under the plan. However, normal deductibles and coinsurance will apply. At home COVID-19 tests will no longer be covered under the plan.

2. **COVID-19 Vaccines**: COVID-19 vaccine coverage will be consistent with other vaccines and immunizations under plan rules and covered subject to the Affordable Care Act (ACA).

3. **COVID-19 Treatments:** Eligible expenses for COVID-19 treatment and therapeutics be covered under the prescription plan. Normal deductibles and coinsurance will apply.

Plan Deadlines: During the National Emergency, deadlines for filing claims and appeals, enrolling under a special enrollment period, electing and paying for COBRA, and providing COBRA notices were extended. All of these extensions will end **July 10, 2023**. At that time, all of the previous enrollment periods, provisions, and COBRA deadlines will apply.

If you have any questions about these Plan changes, please contact the Fund Office.

Sincerely,

The Board of Trustees of the Laborers Local No. 754 Welfare Fund

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #5
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2021. These changes are effective as of **February 1, 2023** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *Gene therapy is now added to the Plan's list of services that need to be precertified under the* ***Continuing Care Services (Outpatient and Physician)*** *subsection under the* ***Medical Management Program.***

2. *Gene therapy drugs is now added to the list of drugs that need to be precertified under the* ***Monthly High Cost Drugs that are $2,000 or more*** *subsections under the* ***Medical Management Program****.*

3. *The* ***Recommended List of Items and/or Services for Prenotifcation*** *(added in Amendment #3) under the* ***Medical Management Program*** *section is hereby deleted and replaced with the following:*

MEDICAL MANAGEMENT PROGRAM

Recommended List of Items and/or Services for Prenotification
The below items and/or services, if Covered Expenses under the Plan, should be prenotified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of this document.

- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Dialysis

Prenotification is used to inform the Medical Management program of upcoming services. It is a data-entry process and does not require judgment or interpretation for Medical Necessity. Prenotification is set in motion by a telephone call from you, the patient, or a representative acting on your behalf or on behalf of the patient. There are no reductions of benefits or penalties if prenotification is not performed.

4. *Under the **Medical Schedule of Benefits**, the **eviCore – Embarc Program** benefit (added in Amendment #4) is hereby deleted and replaced, and a benefit for **MinuteClinic** is hereby added alphabetically as follows:*

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
eviCore - Embarc Program **(limited gene therapy drugs)**	100% (Deductible waived)
NOTE: Gene therapy drugs include but are not limited to, Luxturna, Zynteglo, Zolgensma, and Skysona and must be purchased through the eviCore – Embarc Program to be eligible for coverage under the Plan. Any facility charges or administrative costs associated with these drugs will be paid under the regular plan benefits.	
MinuteClinic	100%; Deductible waived

5. *Under **Eligible Medical Expenses**, the **Gene Therapy Drugs (through eviCore – Embarc Program only)** benefit (added in Amendment #4) is hereby deleted and replaced, and a benefit for **MinuteClinic** is hereby added alphabetically as follows:*

ELIGIBLE MEDICAL EXPENSES

(#) **Gene Therapy Drugs (through eviCore – Embarc Program only):** Gene therapy drugs include but are not limited to, Luxturna, Zynteglo, Zolgensma, and Skysona and must be received through the eviCore – Embarc Program to be eligible for coverage under the Plan. Covered services include the cost for the gene therapy product, however, any medical, surgical, and Hospital services directly related to the administration of the gene therapy product will be paid under the regular plan benefits.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(#) **MinuteClinic:** Walk-in clinic health services provided at a MinuteClinic for:

(a) Scheduled and unscheduled visits for minor Illnesses and Injuries;

(b) Routine vaccinations and immunizations administered within the scope of the clinic's license; and

(c) Screening and monitoring services.

Expenses for health examinations needed to go to a school, camp, or sporting event, or to join in a sport or other recreational activity will not be covered under the MinuteClinic benefit but may be payable under other provisions of the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

6. *The following exclusion is hereby added alphabetically to the **General Exclusions and Limitations** section of the Plan:*

GENERAL EXCLUSIONS AND LIMITATIONS

(#) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

7. *The address to which an appeal is submitted as shown under the* ***Internal Review of Initial Adverse Benefit Determination*** *and the* ***External Review of Adverse Benefit Determinations*** *sections under* ***Claim Procedures*** *are hereby deleted and replaced with the following:*

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

[signature]	12/27/2022	Trustee
Authorized Signature	Date	Title
[signature]	12/27/22	Fund Manager
Witness	Date	Title

15566-05

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #4
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2021. These changes are effective as of **August 17, 2022** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The **eviCore – Embarc Program** benefit (added in Amendment #1) in the **Medical Schedule of Benefits** is hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
	MEDICAL BENEFITS	
eviCore - Embarc Program **(for Luxturna, Zolgensma, and Zynteglo gene therapy drugs only)**	100% (Deductible waived)	Not Applicable
NOTE: These 3 gene therapy drugs must be purchased through the eviCore – Embarc Program to be eligible for coverage under the Plan. Any facility charges or administrative costs associated with these drugs will be paid under the regular plan benefits.		

2. *The **Gene Therapy Drugs (through eviCore – Embarc Program only)** benefit (added in Amendment #1) in the **Eligible Medical Expenses** section is hereby deleted and replaced as follows:*

ELIGIBLE MEDICAL EXPENSES

(#) **Gene Therapy Drugs (through eviCore – Embarc Program only):** Luxturna, Zolgensma, and Zynteglo gene therapy drugs must be received through the eviCore – Embarc Program to be eligible for coverage under the Plan. Covered services include the cost for the gene therapy product, however, any medical, surgical, and Hospital services directly related to the administration of the gene therapy product will be paid under the regular plan benefits.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

[signature] 9-15-22	Trustee
Authorized Signature — Date	Title
[signature] 9/15/22	Fund Manager
Witness — Date	Title

AMENDMENT 2022.01 TO THE LABORERS LOCAL NO. 754 WELFARE PLAN SUMMARY PLAN DESCRIPTION

THIS AMENDMENT made by all of the Trustees of the Laborers Local No. 754 Welfare Fund to be effective May 12, 2022:

WITNESSETH:

WHEREAS, in accordance with the Laborers Local No. 754 Welfare Fund Summary Plan Description ("Plan"), the Trustees shall have the right to amend the Plan; and

WHEREAS, the Trustees, as fiduciaries of the Laborers Local No. 754 Welfare Fund, have agreed to amend the Plan;

NOW, THEREFORE, the Trustees hereby amend the Plan as set forth below:

1. The "Training Fund Benefits" section of the Plan is hereby amended as follows:

Training Benefits – Journeymen

The Fund will provide training for its members through a partnership with the Laborers International Union of North America Local 17. Local 754 members are free to choose from over 100 courses offered at Local 17 at no cost to the participant.

Class schedules can be found on the Union website (www.local754.com). They are also posted in the Union office. Members choosing to participate in a class can sign up by contacting the Union office.

Entry Level Driver Training

Effective February 7th, 2022, entry-level drivers who are seeking a Class A or B commercial driver's license ("CDL") for the first time, upgrading to a Class A or B CDL, or obtaining a passenger, school bus or a hazardous material endorsement for the first time, are required to complete Entry Level Driver Training.

Entry-level driver applicants must successfully complete both a mandatory theory (knowledge) course and a behind-the-wheel training course as part of the Entry Level Driver Training. All courses must be conducted by a training provider listed on the Training Provider Registry ("TPR"), which can be found on the Federal Motor Carrier Safety Administration website (https://tpr.fmcsa.dot.gov/).

The Fund will cover the cost of the theory course. However, Local 754 members will be responsible for paying the cost of the behind-the-wheel training course.

CDL Physical Exam & Licensing

When a member chooses to participate in a CDL physical exam, the Fund will reimburse the participant directly via check for the exam and license costs.

IN WITNESS WHEREOF, the undersigned Trustees have executed this Amendment this

18 day of August, 2022.

UNION TRUSTEES	EMPLOYER TRUSTEES
______________________	______________________
______________________	______________________

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SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #3
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2021. These changes are effective as of **July 1, 2022** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The list of **Non-Participating Provider Exceptions** under **General Overview of the Plan** is hereby deleted and replaced with the following:*

GENERAL OVERVIEW OF THE PLAN

Non-Participating Provider Exceptions
Unless otherwise described herein, covered services rendered by a Non-Participating Provider are paid at the Participating Provider level, subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has no choice of a Participating Provider.

(2) Covered Person has an Emergency Medical Condition requiring immediate care.*

(3) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.*

(4) Covered Person receives a COVID-19 vaccine.

***NOTE**: In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

2. *The following **Continuity of Care** section is hereby added under **General Overview of the Plan**:*

GENERAL OVERVIEW OF THE PLAN

Continuity of Care (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

3. *The following 4 items are removed from the required precertification list and moved to a **Recommended List of Items and/or Services for Prenotification** section under the **Medical Management Program**:*

MEDICAL MANAGEMENT PROGRAM

Recommended List of Items and/or Services for Prenotification
The following services on the precertification list will not be subject to the precertification penalty, if applicable, however, its highly recommended that these services are prenotified:

- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Dialysis

4. *The **Ambulance Services** benefit in the **Medical Schedule of Benefits** is hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Ambulance Services	
Emergency Medical Condition	80% after Deductible
Non-Emergency Medical Condition	Not Covered
NOTE: Ambulance services by a Non-Participating Provider for an Emergency Medical Condition will be paid at the Participating Provider level of benefits.	

5. *The **Emergency Room Services** benefit in the **Medical Schedule of Benefits** is hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Emergency Services – Emergency Medical Condition	80% (Deductible waived)
Emergency Room - Non-Emergency Medical Condition	Not Covered

6. *Number **(21) – Emergency Room Services** under **Eligible Medical Expenses** is hereby deleted and replaced with the following:*

ELIGIBLE MEDICAL EXPENSES

(21) **Emergency Services/Emergency Room**: When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

7. *The following **External Review of Adverse Benefit Determinations** and **Effect of External Review Determination** subsections are hereby added to the **Claims Procedures** section of the Plan:*

CLAIM PROCEDURES

External Review of Adverse Benefit Determinations
If you have exhausted the Plan's internal appeal process for claims specifically related to compliance with federal protections for Surprise Billing and associated cost-sharing, you may request an external review of the Plan's final adverse determination.

The Plan will provide for an external review process in accordance with federal law.

(1) You have 4 months following the date you receive notice of the Plan's final internal adverse determination specifically related to Surprise Billing and associated cost-sharing, within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

  (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

  (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

  (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

  (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

  (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

  (f) A statement that judicial review may be available to you; and

  (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

8. *The definition of **Medical Emergency** under **Definitions** is hereby deleted in its entirety and not replaced. All references to Medical Emergency in the Plan are deleted and replaced with Emergency Medical Condition.*

9. *The definitions of **Emergency Medical Condition, Emergency Services, Stabilize** and **Surprise Bill/Surprise Billing** are hereby added alphabetically under the **Definitions** section; and the definition of **Usual and Customary Charge (U&C)** is hereby deleted and replaced with the following:*

DEFINITIONS

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means treatment given in a Hospital's emergency room for an Emergency Medical Condition. This includes evaluation of, and treatment to Stabilize an Emergency Medical Condition.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

Authorized Signature 07/06/2022 Date Trustee Title

Witness 7/6/2022 Date Trustee Title

Laborers Local No. 754 Joint Benefit Funds

215 Old Nyack Turnpike • Chestnut Ridge, NY 10977
Phone (845) 425-0210 • FAX (845) 425-1835

June, 2022

Dear Welfare Participant:

Please be advised effective July 1, 2022 your dental benefits will change. The Cigna DHMO plan will no longer be offered. All eligible participants and their families will be migrated to the Cigna DPPO which offers in network and out of network benefits with a calendar year maximum of $2,500. A schedule of benefits is enclosed.

If you are not already registered, we encourage you to register at www.myCigna.com. You will be able to print ID cards, look up dentists and facilities, etc. If you would like to search for in network dentists without creating a profile, a list of participating dentists can be found at www.cigna.com. Click on **"Find a doctor, dentist, facility"** then click the **"Employer or School"** box, enter your city and state, then click on doctor by type and select **"Dentist."** Pick **"Cigna DPPO Advantage "DPPO".**

If you are happy with your current DHMO dentist, just let them know your coverage has changed.

Please contact the fund office if you have any questions or require any additional information.

Very truly yours,
The Board of Trustees

Cigna Dental Benefit Summary
Laborers Local 754 Welfare Fund
Plan Renewal Date: 07/01/2022

Insured by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Cigna Dental PPO				
Network Options	*In-Network:* **Total Cigna DPPO Network**		*Non-Network:* **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Allowable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II, & III expenses	$2500, Class I Applies		$2500, Class I Applies	
Calendar Year Deductible Individual Family	$250 $500		$250 $500	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Brush Biopsy	80% After Deductible	20% After Deductible	80% After Deductible	20% After Deductible

Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: $2,000	50%	50%	50%	50%

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III and IX services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $500 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program*	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 2 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.

Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Allowable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

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SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #2
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2021. These changes are effective as of **February 1, 2022** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The **Mental Disorders and Substance Use Disorders*** and **Physician's Services** benefits in the **Medical Schedule of Benefits** are hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Mental Disorders and Substance Use Disorders*	
Inpatient	100% (Deductible waived)
Outpatient	$25 Copay then 100% (Deductible waived)
Telemedicine	$25 Copay then 100% (Deductible waived)
* Mental Disorder and Substance Use Disorder benefits will be administered by Lower Hudson Valley EAP. Lower Hudson Valley EAP will not require any precertification beyond that which may be required by the Claims Administrator for a particular service.	
NOTE: Emergency care (ambulance and emergency room) will be paid the same as the benefits for ambulance services and emergency room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits	$25 Copay* then 100% (Deductible waived)
Physician Office Surgery	$25 Copay* then 100% (Deductible waived)
Telemedicine	$25 Copay then 100% (Deductible waived)
Teladoc	100% (Deductible waived)
*Copay applies per visit regardless of what services are rendered.	

2. *In the **Eligible Medical Expenses** section, Item **(f) – Telemedicine** is hereby added under number **(39) – Physician's Services** as shown below:*

ELIGIBLE MEDICAL EXPENSES

(39) **Physician's Services:** Services of a Physician for medical care or Surgery.

(f) Telemedicine: Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

3. *In the **General Exclusions and Limitations** section, number **(2) – Administrative Services** is hereby deleted and replaced as shown below:*

GENERAL EXCLUSIONS AND LIMITATIONS

(2) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Welfare Fund.

[signature] 01/31/2022 Trustee

Authorized Signature | Date | Title

[signature] 1/31/22 Fund Manager

Witness | Date | Title

15566-02

National Vision Administrators, L.L.C. dba NVA Vision Services & Administrators Agency

Your NVA Vision Benefit Summary

Laborers Local No. 754 Welfare Fund

Effective 07/01/2021
Group Number# 1351

Schedule of Vision Benefits

Examination Under 19 Once Every Calendar Year 19 & over Once Every Two Calendar Years	▪ Covered 100% After $25 copay	Reimbursed Amount ▪ Up to $35
Fit/Follow-Up Under 19 Once Every Calendar Year 19 & over Once Every Two Calendar Years		
Standard Daily Wear	▪ Covered 100% after $20 copay	▪ N/A
Standard Extended Wear	▪ Covered 100% after $30 copay	▪ N/A
Specialty Wear	▪ Covered 100% after $50 copay	▪ N/A
Lenses Under 19 Once Every Calendar Year 19 & over Once Every Two Calendar Years ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular **Frame** Under 19 Once Every Calendar Year 19 & over Once Every Two Calendar Years **Contact Lenses**① Under 19 Once Every Calendar Year 19 & over Once Every Two Calendar Years Elective Contact Lenses Medically Necessary*	$100 Retail Maximum Total accumulated throughout the benefit period: ▪ Frame ▪ Eyeglass Lenses ▪ Contact Lenses ▪ Lens Options	$100 Retail Maximum Total accumulated throughout the benefit period: ▪ Frame ▪ Eyeglass Lenses ▪ Contact Lenses ▪ Lens Options

How Your Vision Care Program Works

Eligible dependents under age 19 are entitled to receive a vision examination and contact lens evaluation/fitting once every calendar year and any combination of one (1) pair of lenses, lens options, a frame and contact lenses once every calendar year up to the plan allowance. Eligible members and dependents age 19 & over are entitled to receive a vision examination and contact lens evaluation/fitting once every two calendar years and any combination of one (1) pair of lenses, lens options, a frame and contact lenses once every two calendar years up to the plan allowance.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com, or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 13510001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Pre-approval from NVA required.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations.

Lens options listed below are covered under this program and are included in the $100 plan allowance as are those options excluded from the list. Once the allowance has been met, pricing will be based on the fixed option pricing list below:

- $75 Polarized
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $10 Scratch-Resistant Coating (Standard
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $10 Solid Tint
- $40 AR Coating – Tier 1
- $50 AR Coating – Tier 2
- $65 AR Coating – Tier 3
- 20% discount AR Coating – Tier 5
- $50 Progressive Tier -1
- $80 Progressive – Tier 2
- $100 Progressive – Tier 3
- $120 Progressive – Tier 4
- $140 Progressive – Tier 5
- $165 Progressive – Tier 6
- $190 Progressive – Tier 7
- 20% discount Progressive – Tier 8

Get a Better View

- $12 Ultraviolet Coating $80 AR Coating – Tier 4

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to up to 60% savings at participating provider locations through NationsHearing®

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses $65 Transitions Single Vision Standard
Lenses:	Glass or Plastic	$70 Transitions Multi-Focal Standard $15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price.

Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ App: App Store or Google Play ▫ Toll-Free: 1.800.672.7723
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This document is intended as a program overview only and is not a certified document of the individual plan parameters.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2021. These changes are effective as of **July 1, 2021** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The **eviCore – Embarc Program** benefit is hereby added alphabetically to the **Medical Schedule of Benefits** as follows:*

MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
MEDICAL BENEFITS		
eviCore - Embarc Program **(for Luxturna and Zolgensma gene therapy drugs only)**	100% (Deductible waived)	N/A
NOTE: These 2 gene therapy drugs must be purchased through the eviCore – Embarc Program to be eligible for coverage under the Plan. Any facility charges or administrative costs associated with these drugs will be paid under the regular plan benefits.		

2. *The following **Gene Therapy Drugs (through eviCore – Embarc Program only)** benefit is hereby added alphabetically to the **Eligible Medical Expenses** section:*

ELIGIBLE MEDICAL EXPENSES

(#) **Gene Therapy Drugs (through eviCore – Embarc Program only):** Luxturna and Zolgensma gene therapy drugs must be received through the eviCore – Embarc Program to be eligible for coverage under the Plan. Covered services include the cost for the gene therapy product, however, any medical, surgical, and Hospital services directly related to the administration of the gene therapy product will be paid under the regular plan benefits.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Welfare Fund.

[signature]	6/7/21	Trustee
Authorized Signature	Date	Title
[signature]	6/7/21	Fund Manager
Witness	Date	Title

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #7
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2016. These changes are effective as of **December 11, 2020** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The following item is hereby added numerically to the list of* ***Non-Participating Provider Exceptions*** *under the General Overview of the Plan section*:

GENERAL OVERVIEW OF THE PLAN

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan when a:

(4) Covered Person receives a COVID-19 vaccine.

2. *The* ***Preventive Services and Routine Care*** *benefit under the* ***Medical Schedule of Benefits*** *is hereby deleted and replaced as follows*:

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Preventive Services and Routine Care	
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100% (Deductible waived)
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	
Routine Care (age 22 and over) - including immunizations (except COVID-19 vaccine)	100% (Deductible waived)
Maximum Benefit	1 exam every 12 months

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Well Child Care (up to age 22) - including immunizations	100% (Deductible waived)
Age and frequency limitations: 7 visits up to age 12 months; 3 visits from age 13 months - 24 months; 3 visits from age 25 months - 36 months; 1 visit per 12 month period from 3 years - 22 years **NOTE:** Age and frequency limits do not apply to COVID-19 vaccine.	
COVID-19 Vaccine	100% (Deductible waived)
Routine Gynecological Exam - including routine tests and related lab fees	100% (Deductible waived)
Routine Mammogram (age 40 and over)	100% (Deductible waived)
Routine Digital Rectal Exam / Prostate-specific Antigen Test (PSA) (age 40 and over)	100% (Deductible waived)
Routine Colorectal Cancer Screening (age 50 and over)	100% (Deductible waived)
Routine Hearing Examination	$25 Copay then 100% (Deductible waived)
Maximum Benefit	1 exam every 24 months

3. *Number (33) – **Immunizations** in the **General Exclusions and Limitations** section is hereby deleted and not replaced.*

All other provisions of this Plan shall remain unchanged.

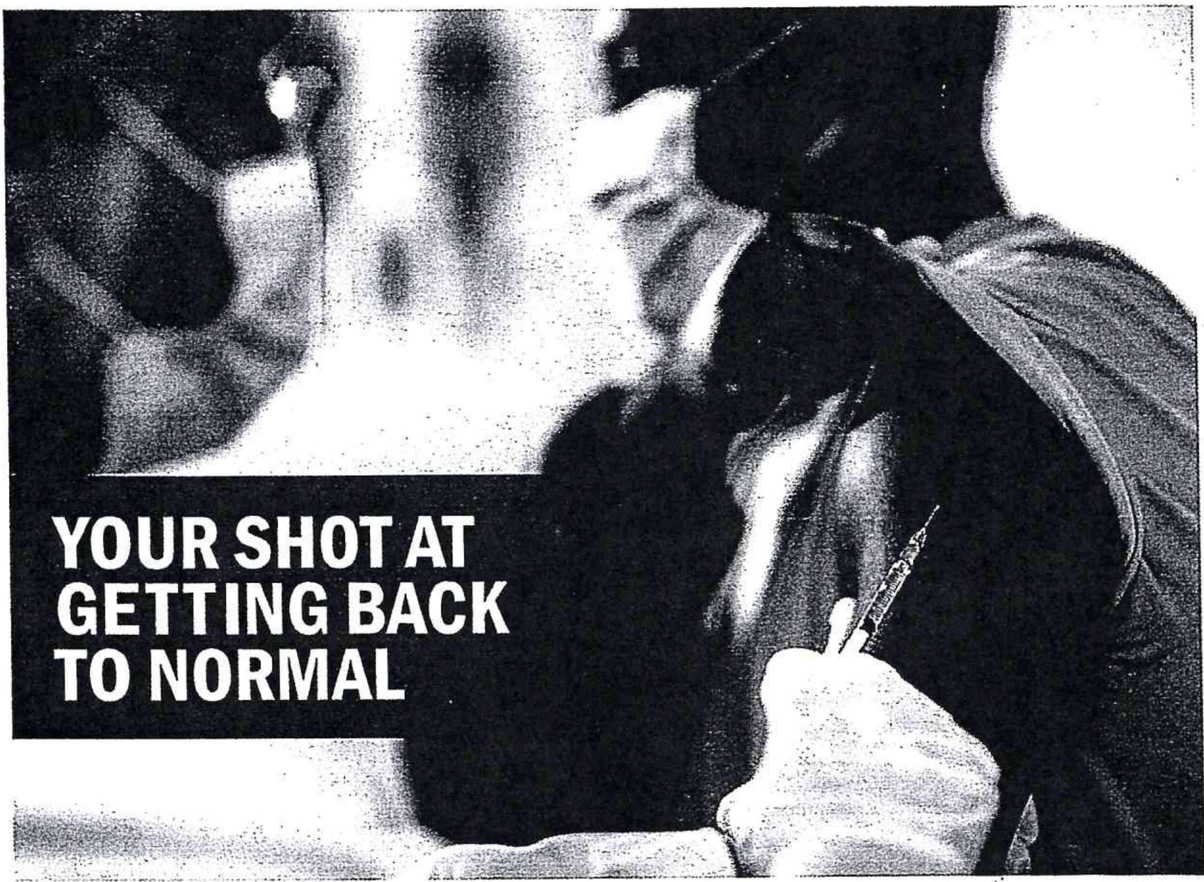
In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

[signature] 12/22/2020 — Trustee

Authorized Signature — Date — Title

[signature] 12/22/20 — Fund Mgr

Witness — Date — Title



Get your COVID-19 vaccine for $0 copay.

Our lives changed pretty drastically due to COVID-19. We changed how we shop, educate our children, and how we think about health care.

But our goal never changed – to make access to that care convenient and affordable.

Now that COVID-19 vaccines are approved by the FDA for emergency use, we're making sure you receive yours as quickly and safely as possible at a local pharmacy. The pharmacy won't charge a copay and it's typically faster than your physician's office. Just make sure you take your member ID card and receive your vaccine from the pharmacy, not the pharmacy's on-site clinic.

$0 copay

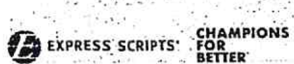
at your local pharmacy

CALL YOUR PHARMACY BEFORE VISITING TO:

- Check if the pharmacy is able to administer the COVID-19 vaccines.
- Make sure they have vaccines available.
- Schedule your appointment, if necessary.

Not available at your local pharmacy? No problem. You can get your vaccine at any pharmacy at no cost to you.

Need more information? Call the Fund Office at 845-425-0210 or e-mail vinnie@local754funds.org.



LiUNA!
Feel the Power
LOCAL 754 JOINT BENEFIT FUNDS
ROCKLAND COUNTY, NY

Image is for representative purposes only and does not depict an actual patient.
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FREQUENTLY ASKED QUESTIONS ABOUT THE COVID-19 VACCINE:

Q. When can I get a COVID-19 vaccine?

A: On December 11, 2020, the U.S. Food & Drug Administration (FDA) issued the first emergency use authorization for the COVID-19 vaccine. It is anticipated that the initial vaccine supply will be limited, and therefore allocated to health care personnel and Long-Term Care (LTC) residents and staff. However, the vaccine supply will increase over time and all adults should be able to be vaccinated in 2021.

Q: How will we know that a COVID-19 vaccine is both safe and effective?

A: Express Scripts looks to the FDA and CDC to determine if the COVID-19 vaccines are safe and effective. Express Scripts will make all FDA-approved COVID-19 vaccines available to members, and we will continue to monitor the latest guidance from leading public health organizations to ensure member safety. You can find helpful videos about vaccine safety and distribution at www.evernorth.com/tag/clinically-speaking-dr-wig or visit the CDC's website for more information.

Q: What are the differences between the leading vaccine candidates?

A: There are three main platforms that vaccine manufacturers are using to develop COVID-19 vaccines. A central theme is that all vaccine candidates are focusing on developing immunity to the "S protein," a component of the COVID-19 virus that is critical to allow itself to attach to receptors within our body and infect our cells. By developing vaccines that promote an immune response in our body against this specific protein, the available clinical trial data has shown encouraging results in preventing significant disease and/or transmission. Another difference between the candidates is differing storage requirements which could vary from simple refrigeration to deep freezing.

Q: Who gets priority access to the vaccine?

A: Priorities will be outlined in state planning documents, but we expect priority will be given to the most vulnerable, such as nursing home residents, along with frontline health care workers. You may periodically check your State Health Department's site for updates on who is eligible to receive the vaccine. The CDC provides a link to accredited State Departments of Health here.

Q: Will I need to get the vaccine every year?

A: At this time, the answer is unclear. Viruses tend to mutate over time, plus we do not yet completely understand how long vaccinations may provide protection from COVID-19 infection. This is a matter that will continue to be studied by the medical and scientific community.

To learn more about COVID-19 vaccinations, visit the CDC website.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #6
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2016. These changes are effective as of **February 1, 2021** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The **Mental Disorders and Substance Use Disorders*** and **Physician's Services** benefits in the **Medical Schedule of Benefits** are hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Mental Disorders and Substance Use Disorders*	
Inpatient	100% (Deductible waived)
Outpatient	$25 Copay then 100% (Deductible waived)
Telemedicine (Effective 1/1/21 – 06/30/21)	$25 Copay then 100% (Deductible waived)
* Mental Disorder and Substance Use Disorder benefits will be administered by Lower Hudson Valley EAP. Lower Hudson Valley EAP will not require any precertification beyond that which may be required by the Claims Administrator for a particular service.	
NOTE: Emergency care (ambulance and emergency room) will be paid the same as the benefits for ambulance services and emergency room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized. **NOTE:** Telemedicine: Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact. Any exclusion regarding telemedicine consultations will not apply during the timeframe listed above for Telemedicine.	
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits	$25 Copay* then 100% (Deductible waived)
Physician Office Surgery	$25 Copay* then 100% (Deductible waived)
Telemedicine (Effective 1/1/21 – 06/30/21)	$25 Copay then 100% (Deductible waived)
Teladoc	100% (Deductible waived)
*Copay applies per visit regardless of what services are rendered.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
NOTE: Telemedicine: Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact. Any exclusion regarding telemedicine consultations will not apply during the timeframe listed above for Telemedicine.	

2. *Letter **(e)** - **Teladoc** is hereby added under number **(39)** - **Physician Services** in the **Eligible Medical Expenses** section of the Plan as follows:*

ELIGIBLE MEDICAL EXPENSES

(39) **Physician Services:** Services of a Physician for medical care or Surgery.

(e) Teladoc: Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc, see the Teladoc contact information under General Plan Information section of the Plan.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone.
- Fast treatment.
- Talk to a Teladoc Physician from anywhere: at home, work, or while traveling.
- Save money by avoiding expensive urgent care or emergency room visits.

Call Teladoc:

- When you need care now.
- If you're considering the emergency room or urgent care center for non-emergency issues.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Teladoc providers treat conditions such as:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections

3. *Number **(2) - Administrative Services** in the **General Exclusions and Limitations** section of the Plan is hereby deleted and replaced as follows:*

GENERAL EXCLUSIONS AND LIMITATIONS

(2) **Administrative Services:** Expenses for completion of claim forms, shipping and handling and telemedicine consultations will not be considered eligible. This exclusion does not apply to telemedicine consultations provided as part of the Teladoc program as described in the Eligible Medical Expenses section of the Plan.

4. *The first paragraph under **Coordination of Benefits with Medicare** in the **Coordination of Benefits** section is deleted and replaced as follows:*

COORDINATION OF BENEFITS

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you or your Dependent(s) are enrolled in the Plan due to your Retiree coverage, and you and/or your Dependent(s) did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

5. *The following **Telemedicine Program Administrator** is hereby added to the **General Plan Information** section of the Plan:*

GENERAL PLAN INFORMATION

Telemedicine Program Administrator:	Teladoc, Inc. 1945 Lakepointe Drive Lewisville, TX 75057 (800) 835-2362 www.teladoc.com

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

[signature] 12-18-20 Trustee
Authorized Signature Date Title

[signature] 12/18/20 Fund Mgr.
Witness Date Title

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #5
TO THE
LABORERS LOCAL NO. 754
WELFARE FUND
GROUP NO. 15566

This Summary of Material Modification and Amendment describes changes to the Laborers Local No. 754 Welfare Fund effective February 1, 2016. These changes are effective as of **February 1, 2020** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Board of Trustees Laborers Local No. 754 Welfare Fund (the "Plan Sponsor") is amending the Laborers Local No. 754 Welfare Fund (the "Plan") as follows:

1. *The **Ambulance Services** benefit in the **Medical Schedule of Benefits** section is hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
MEDICAL BENEFITS	
Ambulance Services	
Medical Emergency Services	80% after Deductible
Non-Medical Emergency Services	Not Covered
NOTE: Non-Participating Providers are paid at Participating Provider level of benefits for a Medical Emergency. Non-Participating Provider air ambulance services are payable up to 300% of Medicare Allowable Rate and not subject to Usual and Customary Charges.	

2. *Item **(b)** under number **(16) - Dental Care** under **Eligible Medical Expenses** is hereby deleted and replaced as follows:*

ELIGIBLE MEDICAL EXPENSES

(16) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(b) Emergency repair due to Injury to sound natural teeth, including the emergency replacement of sound natural teeth.

3. *The first paragraph under **Coordination of Benefits with Medicare** in the **Coordination of Benefits** section is deleted and replaced as follows:*

COORDINATION OF BENEFITS

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

[signature]	03/10/2020	Trustee
Authorized Signature	Date	Title
[signature]	03/10/2020	Trustee
Witness	Date	Title

15566-05

3. *The first paragraph under **Coordination of Benefits with Medicare** in the **Coordination of Benefits** section is deleted and replaced as follows:*

COORDINATION OF BENEFITS

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Board of Trustees Laborers Local No. 754 Welfare Fund has caused this Amendment to take effect, be attached to, and form a part of their Plan.

[signature]	03/10/2020	Trustee
Authorized Signature	Date	Title
[signature]	03/10/2020	Trustee
Witness	Date	Title

WE ARE PLEASED TO ANNOUNCE THAT EFFECTIVE 2/1/21 TELADOC SERVICES ARE AVAILABLE TO YOU AND YOU FAMILIES WITH NO OUT OF POCKET EXPENSE.

MERITAIN℠ HEALTH

An Aetna Company

Reach a doctor 24/7

The Teladoc® solution

Teladoc is the on-demand healthcare solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions.

Benefits of Teladoc

- Saves time and money
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- Great health means peace of mind

With Teladoc, you can talk to a doctor 24/7/365 by phone, online video or mobile app. Use Teladoc for medical advice and care when:

- Your primary care doctor is not open.
- You are at home, traveling or do not want to take time off work to see a doctor.
- You need a prescription or refills*.

**Please note, there is no guarantee you will be prescribed medication.*

Highly qualified, experienced doctors

When you use Teladoc, your medical questions will be answered by a highly qualified doctor. Teladoc doctors are:

- Experienced—with an average of over 10–15 years in practice.
- Progressive—using the latest technology to provide excellent care.
- U.S. board certified and state licensed.
- Specially trained in telemedicine.

There's more than one way to reach a doctor

By phone. Just call **1.800.362.2667.**

Online. Simply request a video consultation online at **www.MyDrConsult.com.**

On the go. You can download the Teladoc mobile app by visiting the App Store or Google Play.

Common conditions treated:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraines
- Eye/ear infection
- Rash/skin infections
- Sinus infections
- Stomachache/ diarrhea
- Urinary tract

Our members love Teladoc

"We had a good experience with the doctor. She called and talked to me, and gave great service. I had no problem picking up my prescription. This is a really good service."

Contact a Teladoc physician at **1.800.362.2667**, or by visiting **www.MyDrConsult.com**.

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How to register for Teladoc

You can use Teladoc anywhere you have Internet access. Just:

1. Visit www.MyDrConsult.com and click *Set Up Account*.
2. Enter your name, date of birth, ZIP code, email address, preferred language and gender and click *Continue*. The system will identify you based on this information. If you're unable to be identified, you'll be directed to Teladoc Customer Service.
3. On the next screen, enter the required information and click *Set up my account*. Your registration is now complete!

Then, you can complete your profile by clicking on *My Medical History*. You can enter your history right after registering or you can come back to finish it later. By finishing it when you register, you'll be ready to request a consultation any time and you won't have to fill out your medical history when you're feeling sick.

If you have any questions, or run into any problems when setting up your account, call Teladoc at **1.800.DOC.CONSULT (1.800.362.2667)**.

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The Teladoc® Mobile App

The mobile app from Teladoc makes access to healthcare even easier. You can download the Teladoc app for your mobile device from the App Store or Google Play. Talk with board-certified doctors 24/7/365—without having to wait for an appointment!

Common conditions treated

When your primary doctor isn't available, Teladoc can provide you with treatment for acute conditions, including:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraines
- Eye/ear infections
- Rash/skin irritations
- Respiratory infections
- Sinus infections
- Stomachache/diarrhea
- Urinary tract infections
- Many other conditions

There's more than one way to contact a doctor

- By calling **1.800.362.2667**
- Online at www.MyDrConsult.com
- Downloading the mobile app from the App Store or Google Play

You can reach a doctor 24/7/365 with the Teladoc mobile app. It works with all Apple® and Android mobile devices. To download, just visit the App Store or Google Play.

Need help? You can contact a Teladoc doctor at 1.800.362.2667, or visit them online at www.MyDrConsult.com.

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