

**SUMMARY OF MATERIAL MODIFICATION  
AND  
AMENDMENT #8  
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 **January 1, 2025** 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.

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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 **Medical Schedule of Benefits** is hereby deleted and replaced as shown in **Exhibit A**.*
2. *Under **Eligible Medical Expenses** section of the Plan, **Gene Therapy Drugs (through eviCore – Embarc Program only)** benefit (added in Amendment #4) is hereby deleted and replaced as follows:*

**ELIGIBLE MEDICAL EXPENSES**

**(##) Gene Therapy Drugs Available Through eviCore – Embarc Program Only:** Gene therapy drugs include but are not limited to, Luxturna, Zyntegro, Zolgensma, Hemgenix, Skysona, Roctavian, Lyfgenia, Casgevy, and Lenmeldy and received through the eviCore – Embarc Program. 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. The list of eligible gene therapy drugs is subject to change by the eviCore – Embarc Program.

**All Other Gene Therapy Drugs Not Available Through eviCore – Embarc Program:** Gene therapy products and services directly related to their administration when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

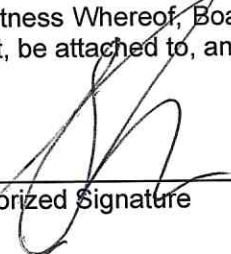
- (a) Replacing a disease-causing gene with a healthy copy of the gene;
- (b) Inactivating a disease-causing gene that may not be functioning properly; or
- (c) Introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. The Plan determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, professional and facility services directly related to administration of the gene therapy product.

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

3/4/2025  
Date

Trustee  
Title

  
\_\_\_\_\_  
Witness

3/4/2025  
Date

Fund Manager  
Title

## EXHIBIT A

### MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited
<b>CALENDAR YEAR MAXIMUM BENEFIT</b>	Unlimited
<b>CALENDAR YEAR DEDUCTIBLE</b>	
Single	\$500
Family	\$1,000
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</b> (excludes Deductible)	
Single	\$3,000
Family	\$6,000
MEDICAL BENEFITS	
<b>Allergy Injections</b>	90% after Deductible
<b>Allergy Testing</b>	\$25 Copay then 100% (Deductible waived)
<b>Ambulance Services</b>	
Emergency Medical Condition	90% after Deductible
Non-Emergency Medical Condition	Not Covered
<b>NOTE:</b> Ambulance services by a Non-Participating Provider for an Emergency Medical Condition will be paid at the Participating Provider level of benefits.	
<b>Ambulatory Surgical Center</b>	90% after Deductible
<b>Cardiac Rehab (Outpatient)</b>	90% after Deductible
Maximum Benefit	36 sessions in a 12-week period
<b>Chiropractic Care/Spinal Manipulation</b>	\$25 Copay then 100% (Deductible waived)
<b>Contraceptive Medication and Devices</b> (not obtainable at a Pharmacy) – includes office visits	90% after Deductible
<b>NOTE:</b> Includes any item or service not otherwise covered under the preventive services provision.	
<b>Dental (Accidental Injury)</b>	90% after Deductible
<b>Diagnostic Testing, X-Ray and Lab Services (Outpatient)*</b>	90% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	90% after Deductible
*If rendered as part of a Physician office visit and billed by the Physician, benefits are covered subject to the applicable Physician's office visit cost sharing.	
<b>Durable Medical Equipment (DME)</b>	90% after Deductible
<b>Emergency Services – Emergency Medical Condition</b>	90% (Deductible waived)
<b>Emergency Room - Non-Emergency Medical Condition</b>	Not Covered

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
<b>eviCore - Embarc Program (limited gene therapy drugs)</b>	100%; Deductible waived
<b>NOTE:</b> Eligible gene therapy drugs available but are not limited to, Luxturna, Zynteglo, Zolgensma, Hemgenix, Skysona, Roctavian, Lyfgenia, Casgevy, and Lenmeldy 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. The list of eligible gene therapy drugs is subject to change by the eviCore – Embarc Program.	
<b>Home Health Care</b>	90% after Deductible
Calendar Year Maximum Benefit	120 visits (3 visits per day maximum)
<b>Hospice Care</b>	
Inpatient	90% after Deductible
Inpatient Lifetime Maximum Benefit	30 days
Outpatient	90% after Deductible
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>	
Inpatient	90% after Deductible
Room and Board Allowance	*Semi-Private Room Rate
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Service and Supplies	90% after Deductible
Outpatient	90% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
<b>Maternity (non-facility charges)*</b>	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)
Lactation Consultations	100% (Deductible waived)
All Other Prenatal and Postnatal Care	100% (Deductible waived)
Delivery	90% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
<b>Mental Disorders and Substance Use Disorders*</b>	
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.	
<b>NOTE:</b> 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.	
<b>MinuteClinic</b>	100%; Deductible waived
<b>Outpatient Therapies</b> (physical, speech/hearing, occupational)	\$25 Copay then 100% (Deductible waived)
Combined Calendar Year Maximum Benefit	60 visits

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
<b>Physician's Services</b>	
Inpatient/Outpatient Services	90% 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.	
<b>Preventive Services and Routine Care</b>	
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
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. 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
<b>Private Duty Nursing</b>	90% after Deductible
Calendar Year Maximum Benefit	70 - 8 hour shifts
<b>Prosthetics</b>	90% after Deductible
<b>Respiratory/Pulmonary Therapy (Outpatient)</b>	90% after Deductible
Maximum Benefit	36 hours or a 6-week period
<b>Skilled Nursing Facility and Rehabilitation Facility</b>	90% after Deductible
Combined Calendar Year Maximum Benefit	60 days

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
<b>Transplants</b>	90% after Deductible (Aetna IOE program)*  Not Covered (All Other Network Providers)
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.	
<b>NOTE:</b> Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other illness.	
<b>Urgent Care Clinic</b>	
Medical Emergency Services	90% (Deductible waived)
Non-Medical Emergency Services	90% after Deductible
<b>Vision Care</b>	
Routine Eye Examination	\$25 Copay then 100% (Deductible waived)
Maximum Benefit	1 exam every 24 months
Glasses or Contact Lenses – Age 19 and Over	100% (Deductible waived)
Maximum Benefit	1 pair every 24 months up to \$100 maximum
Glasses – Up to age 19	100% (Deductible waived)
Maximum Benefit	1 pair every 12 months
Vision Therapy/Orthoptic Training (treatment of convergence insufficiency only)	100% (Deductible waived)
Lifetime Maximum Benefit	12 vision therapy visits or sessions
<b>NOTE:</b> Includes any item or service not otherwise covered under the preventive services provision.	
<b>NOTE:</b> Disposable contacts will will not be subject to the “one pair of lenses” maximum.	
<b>Walk-In Clinic</b>	\$25 Copay then 100% (Deductible waived)
<b>Wig (see Eligible Medical Expenses)</b>	90% after Deductible
<b>All Other Eligible Medical Expenses</b>	90% after Deductible