SUMMARY OF MATERIAL MODIFICATION TO THE
GREATER ST. LOUIS CONSTRUCTION LABORERS' WELFARE FUND

The following is a summary of recent changes to the Greater St. Louis Construction Laborers' Welfare Fund (the "Plan"). Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult the SPD booklet.

Effective Janaury 1, 2022, the definition of Geographic Area in Section 1.B. of the SPD is revised to read as follows:

Geographic Area – the Greater St. Louis Metropolitan area and any area within a 450-mile radius of Covered Individual's residence.

If you have any questions, please contact the Benefit Office at (314) 644-2777, or toll free (800) 489-0228, ext. 2, or send an e-mail to benefits@stllaborers.com.

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Effective January 15, 2022, the following NOTE is added to the end of the **Schedule of Benefits** in Section 6.A:

NOTE: Effective January 15, 2022 and through the end of the COVID-19 Public Health Emergency as declared by the U.S. Department of Health and Human Services, the Plan will reimburse Covered Individuals for the cost of up to eight over-the-counter COVID tests per 30-day period. In order to receive reimbursement, the Covered Individual must submit such documentation as required by the Benefit Office. COVID tests purchased for employment purposes are not eligible for reimbursement.

If you have any questions or wish to request a reimbursement form, please contact the Benefit Office at (314) 644-2777, or toll free (800) 489-0228, ext. 2, or send an e-mail to benefits@stllaborers.com.

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Effective December 1, 2021, Section 13C.1 of the SPD is revised to read as follows:

1. the Disabilities are due to totally unrelated causes, and (a) you have returned to active work for at least five consecutive days, excluding Saturdays and Sundays, between periods of Disability or (b) you have not yet been released to return to work by the licensed doctor, nurse practitioner or physician assistant who certified your initial period of Disability.

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Effective April 1, 2022, the provision of Section 13.A of the SPD which provides the benefit amount shall be revised to read as follows:

Benefit Amount: $300 per week ($60 per day, excluding Saturdays and Sundays, for any incomplete week of Disability).

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Effective July 1, 2022, the provisions of the SPD are revised in the following manner

1. The definition of **Covered Charges** in Section 1.B is revised by adding the following to the end of item 3:

   However, Emergency Services, air ambulance services and those services described in Section 6.E.5.b and c, will be covered at the Recognized Amount if such amount is greater than the Usual and Reasonable Charge.

2. The definition of **Emergency** in Section 1.B is deleted and replaced with the following:

   Emergency Medical Condition – A medical condition, including a mental health condition or substance use disorder, manifesting itself in 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 serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily function or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

3. Section 1.B is further revised by the addition of the following definitions:

   Ancillary Services –
   1. Services and supplies related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;
   2. Services and supplies provided by assistant surgeons, hospitalists and intensivists;
   3. Diagnostic services, including radiology and laboratory services; and
   4. Services and supplies provided by an Out-of-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

Continuing Care Patient – An individual who, with respect to a provider or facility is:

1. Undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. Undergoing a course of institutional or inpatient care from the provider or facility;
3. Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;
4. Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Determined to be terminally ill (as determined under Section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Emergency Services – With respect to an Emergency Medical Condition:

1. An appropriate medical screening-examination that is within the emergency department of a Hospital or of an Independent Freestanding Emergency Department as applicable, including Ancillary Services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available to the Hospital or Independent Freestanding Emergency Department to stabilize the patient;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished); and
3. With respect to Out-of-Network Providers and facilities, post-stabilization services until the patient is determined by the provider or facility to be able to travel using nonmedical transportation to nonemergency medical transportation. At such time, the patient may give informed consent to continued treatment by the Out-of-Network Provider which treatment shall not be considered Emergency Services. Such consent must acknowledge that the patient understands that continued treatment by the Out-of-Network Provider may result in greater cost to the patient and may only be given after the patient is provided with a written notice, as required by federal law, stating (1) that the provider is an Out-of-Network Provider with respect to the Plan, (2) the estimated charges for treatment and any advance limitations that the Plan may apply to treatment, (3) the names of any Network Providers at the facility who are able to treat the patient, and (4) that the patient may elect to be referred to one of the Network Providers listed.

Independent Freestanding Emergency Department – A public or private facility, licensed and operated according to the law, which is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services.

Qualifying Payment Amount – The amount calculated using the methodology described in 29 CFR 716-6(c) which is generally the contracted rates of the Plan for the service or supply in the geographic region, with certain exceptions.

Recognized Amount – For services or supplies furnished by an Out-of-Network Provider:

1. An amount determined by an applicable All-Payer Model Agreement;
2. If there is not applicable All-Payer Model Agreement, an amount determined by a specified state law;
3. If there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

For air ambulance services, the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

4. Section 2.B is revised by adding the following to the end of the first paragraph:

   The list on the website will be updated at least every ninety days. If you receive inaccurate information from the list on the website (or in response to an inquiry to the medical network or the Benefit Office) indicating that a provider is a Network Provider, services and supplies provided by that Out-of-Network Provider will be covered as if the provider was a Network Provider.

5. Section 2.B is further revised by adding the following to the end of the second paragraph:

   The only exception to the Usual and Reasonable Charge limitation is in the case of Emergency Services, air ambulance services and those services described in Section 6.E.5.b and c, which will be covered at the Recognized Amount if such amount is greater than the Usual and Reasonable Charge.

6. Section 2.B is further revised by adding the following to the end of the fourth paragraph:

   Benefits for services performed by a Tier 2-Out-of-Network Provider will be paid at the Tier 2-Out-of-Network benefit level even if you were referred to that Out-of-Network Provider by a Network Provider except in the case of Emergency Services, air ambulance services, and such services as provided in Section 6.E.5.

7. The third paragraph in Section 6.A is revised to read as follows:

   To receive Network benefits, all covered services, except for Emergency Services, air ambulance services and such services as provided in Section 6.E.5., must be performed or referred by a participating Network Provider or authorized in advance by the Plan.

8. The Schedule of Benefits in Section 6.A is revised by deleting Item 6 and replacing it with the following:

6.	**Emergency Services** Coverage is provided for worldwide Emergency Services as defined in this Booklet.	$75 Co-pay per visit, then Tier 1 Deductible. After Tier 1 Deductible is met, 10% Co-insurance applies. Co-pay is waived if admitted to hospital.

9. The Schedule of Benefits in Section 6.A is further revised by deleting the Benefits and Services description in Item 7 and replacing it with the following:

   Ambulance Services
   Coverage is provided for ambulance services related to an Emergency Medical Condition as defined in this Booklet. Please refer to Section 6.F.3.b. below.

   Air ambulance services related to an Emergency Medical Condition are covered at the Tier 1 Network benefit level regardless of whether the provider is a Network Provider or an Out-of-Network Provider.

10. Section 6.C is revised by adding the following to the end of the third paragraph:

    The only exception to the Usual and Reasonable Charge limitation is in the case of Emergency Services, air ambulance services and those services described in Section 6.E.5.b and c, which will be covered at the Recognized Amount if such amount is greater than the Usual and Reasonable Charge.

11. Section 6.D.2 is revised to read as follows:

    Such care is for an Emergency Medical Condition requiring immediate attention (see Section 1.B.for a definition of Emergency Medical Condition);

12. The second sentence of Section 6.E.3 is revised to read as follows:

    For all benefits, it requires you to cost-share 10% (for Tier 1 – Network benefits) or 40% (for Tier 2 – Out-of-Network benefits other than Emergency Services, which is 10%).

13. Section 6.E.5 is revised to read as follows:

    5. Network Benefits for Out-of-Network Providers

       a. Benefits for ambulance services related to an Emergency Medical Condition (other than air ambulance services) and provided by an Out-of-Network

provider will be payable based on the tier of the facility where the Covered Individual is transported. If the facility is a Tier 1 Network facility, the ambulance services are paid at the Tier 1 Network benefit level (10% Co-insurance). For an Out-of-Network facility, the ambulance services are paid at the Tier 2 Out-of-Network benefit level (40% Co-insurance). Air ambulance services related to an Emergency Medical Condition and provided by an Out-of-Network Provider will be payable at the Tier 1 Network benefit level.

b. With regard to non-emergency services or supplies that are otherwise covered by the Plan, if such services or supplies are provided by or performed by an Out-of-Network Provider at a Network facility, the services or supplies are covered by the Plan:

- With a cost-sharing requirement that is not greater than the cost-sharing requirement that would apply if the services or supplies had been furnished by a Network Provider;
- By calculating the cost-sharing requirement as if the total amount that would have been charged for the services or supplies by a Network Provider were equal to the Recognized Amount for the services and supplies; and
- By counting cost-sharing payments you make with respect to Out-of-Network non-emergency services or supplies toward your Network deductible and Network out-of-pocket maximum.

Notice and Consent Exception: Non-emergency services or supplies performed by an Out-of-Network Provider at a Network facility will be covered based on your Out-of-Network coverage if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are given written notice by the provider, as required by federal law, stating (1) that the provider is an Out-of-Network Provider with respect to the Plan, (2) the estimated charges for your treatment and any advance limitations that the Plan may apply to your treatment, (3) the names of any Network Providers at the facility who are able to treat you, and (4) that you may elect to be referred to one of the Network Providers listed; and
- You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that such continued treatment may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and services or supplies furnished as a result of unforeseen, urgent medical needs that may arise at the time a service or supply is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

c. If you are a Continuing Care Patient and your provider's status changes from Network to Out-of-Network, the Plan will notify you in a timely manner of your right to elect continued transitional care from the provider for a period of up to 90 days at Network cost sharing levels.

14. Section 6.G.4 is revised by adding the following to the end thereof:

    However, charges for Emergency Services, air ambulance services and those services described in Section 6.E.5.b and c, will be covered at the Recognized Amount if such amount is greater than the Usual and Reasonable Charge.

15. The first sentence of Section 18.E.1 is revised to read as follows:

    If the claimant receives notice of an adverse benefit determination or final adverse internal appeal determination involving medical judgement, a recission of coverage or the Plan's compliance with the surprise billing and cost-sharing protections of the No Surprises Act with respect to Emergency Services, Non-Emergency Services provided by an Out-of-Network Provider at a Network facility, and/or air ambulance services, the claimant may file a request for an external review within 4 months after the date the claimant receives notice of the adverse benefit determination or final adverse internal appeal determination.

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Effective July 1, 2022, Section 14.D of the SPD is revised to read as follows:

D. RESUMPTION OF COVERED EMPLOYMENT

1. If a Retired Eligible Employee who is covered by the Retiree Coverage of the Plan returns to work in Covered Employment, the Retired Eligible Employee's coverage under the Plan may be continued at the Retiree Coverage premium rates established by the Trustees until the Retired Eligible Employee meets the requirements of Section 3. for Active Employee coverage under the Plan. When the Eligible Employee ceases to be eligible for Active Employee coverage, the coverage options will be determined by whether his pension benefit has been suspended as set forth below:

    a. If the eligible Employee's pension benefit has been suspended, the Eligible Employee will be entitled to elect continued coverage through self-payment and COBRA as provided in Sections 3. and 5. of this Booklet. When the Eligible Employee's pension benefits resume, the Eligible Employee's Active Employee self-payment or COBRA continuation coverage will cease, and the Eligible Employee may resume the Eligible Employee's coverage under the Retiree Coverage of the Plan.

    b. If the Eligible Employee's pension benefit has not been suspended, the Eligible Employee may resume the Eligible Employee's coverage under the Retiree Coverage of the Plan.

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The SPD is revised as follows to clarify that mammogram screenings are covered on an annual basis and to expand the coverage of colonoscopies as preventive care effective May 1, 2022:

1. The Schedule of Benefits in Section 6.A is revised by adding the following sentence to the end of Item 3. Physician Office Visit – Preventive Care:

   In addition to the foregoing, the following services shall also be considered preventive care:

   - annual mammogram screenings; and
   - colonoscopies performed due to a family history of colorectal cancer.

2. Item (2) of Section 6.F.4.L is revised to read as follows:

   (2) routine annual mammograms;

3. Item (10) of Section 6.F.4.L is revised to read as follows:

   (10) routine colonoscopies (including colonoscopies performed due to a family history of colorectal cancer); and

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The SPD is revised as follows effective October 1, 2022:

1. Section 3.B.1.a. is revised to read as follows:

    a. the natural child of an Eligible Employee (in order for a child of an unmarried Eligible Employee to be eligible for coverage under the Plan, the Eligible Employee must be shown as the parent of the child on the child's birth certificate or provide proof of parentage. A copy of the birth certificate or proof of parentage must be submitted to the Benefit Office before that child will be added to the Plan. The Welfare Plan Director will have discretion on the proof of parentage documents).

2. Section 7.K.1. is revised to read as follows:

    1. therapeutic devices or appliances covered under the Plan's medical benefit

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The following new Section 8.E. is added to the SPD effective March 1, 2023:

E. Laborers' Escaping Addiction Now (LEAN STL) Program

The LEAN STL Program offers assistance to participants of the Plan in accessing resources for the treatment and management of alcohol dependence and substance use disorder and for recovery support. The LEAN STL Program also provides assistance to participants in accessing resources for the treatment and management of behavioral health concerns. The LEAN STL Program provides participants with access to a Laborers' Recovery Specialist. The Specialist will work with the Plan's Member Assistance Program (MAP) and its Behavioral Health plan to offer resources and education to participants and their families.

The Laborers' Recovery Specialist is a primary point of contact for participants and their families in need of recovery-related services and will be available to assist participants and their families in locating recovery and behavioral health facilities. The Specialist will be available by phone 24/7 to provide this assistance. The Laborers' Recovery Specialist will also assist in the education of laborers on job sites regarding this Plan's substance use disorder and behavioral health benefits.

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1. Effective July 1, 2022, the following new subsection q is added to Section 6.F.4 of the SPD:

    q. Cooling System Treatments

    Charges for services and supplies necessary for the administration of FDA approved cooling system treatments to prevent hair loss due to chemotherapy are covered up to $600.00 in a Covered Individual's lifetime.

2. Effective May 12, 2023, the second and third Notes at the end of Section 6.A of the SPD regarding coverage related to COVID-19 is deleted.

3. Effective May 12, 2023, the Note in Section 7.G of the SPD regarding coverage related to COVID-19 is deleted.

4. Effective August 11, 2023, the first Note at the end of Section 6.A. of the SPD regarding coverage related to COVID-19 is deleted.

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Effective March 1, 2023, the provisions of the SPD are revised in the following manner:

1. The following new item 28 is added to the Schedule of Benefits in Section 6.A of the SPD:

28.	**Bariatric Surgery** Bariatric Surgery Benefits are provided for covered services rendered at a Network Facility by a Network Provider. Excluded from annual Out-of-Pocket Maximum. Coverage is limited to one surgery per lifetime for any eligible individual with a $50,000 maximum benefit including any charges incurred as a result of complications from surgery. No coverage for dependent children.	After Deductible is met, 10% Co-insurance applies.	Not covered.

2. The following new subsection q is added to Section 6.F.4 of the SPD:

   r. Charges for bariatric surgery for the treatment of morbid obesity will be covered for you or your spouse if the requested surgical procedure has been evaluated and determined to be medically necessary by the Plan's Medical Management provider. Coverage is limited to surgery provided by a Network provider at a Network facility. Bariatric surgery coverage is not provided for dependent children.

Charges for bariatric surgery are excluded from the annual Out-of-Pocket maximum. Coverage is limited to one surgery per lifetime for any eligible individual with a $50,000 maximum benefit, including any charges incurred as a result of complications from the surgery.

3. Item 21 of Section 6.G of the SPD is revised to read as follows:

21. charges for weight loss treatment or surgery unless specifically set forth as a Covered Charge in Section 6 of this Booklet;

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Effective March 1, 2024, item p of Section 6.F.4 of the SPD is revised to read as follows:

p. Nutritional Counseling/Dietician Services

Nutritional counseling/dietician services will be provided without limitation for the following medical conditions:

(1) Childhood and adult obesity;
(2) Cardiovascular disease risk factors in overweight adults including hypertension, dyslipidemia, impaired fasting glucose or metabolic syndrome; and
(3) Chronic disease states such as diabetes mellitus, eating disorders, gastrointestinal disorders, kidney disease, seizures and other conditions in which diet adjustments may play a role in improvement.

Nutritional counseling/dietician services for such medical conditions are deemed medically necessary. Services provided for all other conditions and disease states shall be considered experimental and investigational and will not be covered.

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Effective January 1, 2024, the following new sentence is added to the end of Section 8.C.3 of the SPD:

> These benefits include coverage for family therapy when a) a Covered Individual has been given a mental health diagnosis for which there is a consensus among the clinical community that family therapy can be a Medically Necessary and appropriate treatment and b) a physician or other appropriate provider has prescribed family therapy with or without the Covered Individual being present during the therapy session.

If you have any questions, please contact the Benefit Office at (314) 644-2777, or toll free (800) 489-0228, ext. 2, or send an e-mail to benefits@stllaborers.com.

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Effective January 1, 2026, Section 10.A.3 of the SPD is revised to read as follows:

3. Maximum Dental Benefits Per Covered Individual

For all covered sealants, Type B charges and Type C charges (except TMJ)	$2,000 per calendar year**
For all covered TMJ charges	$3,000 lifetime
For all covered Type D (Orthodontic) charges	$2,000 lifetime

**Charges for examinations, cleanings, x-rays and fluoride treatments do not apply towards your annual maximum.

Please note the Plan's claims limitation periods in Section 18.

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Effective January 1, 2024, the trustee list in Section 19.D of the SPD is revised to read as follows:

As of January 1, 2024, the Trustees are:

Union Trustees

Matt Andrews
Brian Watson
Laborers' Local 42
301 South Ewing Avenue
St. Louis, Missouri 63103

Brandon Flinn
Laborers' Local 42/MKLDC
951 Corporate Parkway
Wentzville, Missouri 63385

Jose Gomez
Rob Reed
Brad Wilfong
Laborers' Local 110
4532 South Lindbergh Blvd.
St. Louis, Missouri 63127

Management Trustees

Bradley Grant
Grant Contracting
777 Rudder Road
Fenton, Missouri 63026

David A. Gillick
Mason Contractors Association
1429 South Big Bend
St. Louis, Missouri 63117

Robert Bieg, Jr.
Bieg Plumbing Co., Inc.
2015 Lemay Ferry Road
St. Louis, Missouri 63125

Mike Shepard
SITE Improvement Assoc.
2071 Exchange Drive
St. Charles, Missouri 63303

Corey Black
McCarthy Building Co.
1341 North Rock Hill Road
St. Louis, Missouri 63124

Michael Lutz
Ben Hur Construction
2191 Lemay Ferry Rd. Ste. 200
St. Louis, Missouri 63125

If you have any questions, please contact the Benefit Office at (314) 644-2777, or toll free (800) 489-0228, ext. 2, or send an e-mail to benefits@stllaborers.com.

SUMMARY OF MATERIAL MODIFICATION TO THE GREATER ST. LOUIS CONSTRUCTION LABORERS' WELFARE FUND

The following is a summary of recent changes to the Greater St. Louis Construction Laborers' Welfare Fund (the "Plan"). Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult the SPD booklet.

Effective October 1, 2025, the following sentence is added to the Note at the end of Section 14.B.3 of the SPD:

> An additional exception shall be made in the case of a marriage, occurring after the date of retirement, of a Retired Medicare Eligible Employee who is covered by one of the Plan's Medicare Advantage options. The new Medicare eligible dependent spouse of such Retired Medicare Eligible Employee may be covered under one of the Plan's Medicare Advantage options in accordance with the enrollment requirements of Section 3.B.4.a.

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