



INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587

Telephone (812) 238-2551 Toll Free 1-800-962-3158

Fax (812) 238-2553 www.indianalaborers.org

This letter serves as a summary of material modifications of the Plan.
Please keep this with your Summary Plan Description.

*** Important Welfare Benefit Changes ***

July 2018

To All Participants of the
Indiana Laborers Welfare Fund

The Trustees have amended the Plan to make the following changes:

Full Drug Screening Panels related to Substance Abuse Benefits

For claims related to Substance Abuse Benefits that occur on or after December 1, 2017, after the initial baseline test, the Plan will only cover two full drug screening panels each Plan Year. Previously, there were no limits on the number of full drug screening panels under the Substance Abuse Benefit that would be covered under the Plan.

Appeals Associated with Work-Related Injuries

Effective December 1, 2017, if you have received a benefit denial from the Plan within the last 36 months for a claim for treatment related to a work-related injury, you will have up to 36 months from the claim denial date to appeal that benefit denial. The 36 months is counted from the date of the claim denial. Previously, if you had a work-related injury claim that was denied by the Plan, you would have to appeal the denial within 180 days.

Important note: This change will benefit you if you have had a work-related injury that was denied by the Plan because the injury was work-related but the claim was subsequently denied by Workers' Compensation. If your claim was denied by the Plan within the 36 months prior to December 1, 2017, you are now eligible to appeal the claim denial on the basis that the claim was denied by Workers' Compensation.

Termination of Eligibility for working for non-signatory employer or in a different trade

The Plan section on termination of eligibility was amended so that if you begin working for a non-signatory employer or begin working at a different trade in the construction industry, coverage for you and any covered family members will cease on the day after the Trustees become aware of such activity. Prior to this change, your eligibility was terminated retroactive to the first day of the coverage period when you began working in either of these situations.

If the Plan made any benefit payments on behalf of you or your Dependents during such period, the Plan may seek to recover any such payments from you. The Trustees reserve the right to create equitable exceptions to this rule in cases where the exception would not run contrary to the purposes and intent of providing benefits under this Plan.

Officers-Board of Trustees

Francis J. Gantner
Chairman

David A. Frye
Secretary-Treasurer

Somer Taylor
Administrative Manager

Copay for LiveHealth Online reduced from \$20 to \$0

Effective March 20, 2018, the copay for LiveHealth Online, as explained below, was reduced from \$20 to \$0. There is no cost to you for this online doctor visit.

Disability Benefit Claims and Appeals Procedures

The Plan was amended to comply with the new claims and appeals regulations effective for Disability Benefit Claims filed on or after April 1, 2018. These rules ensure that the Plan is compliant to new Department Of Labor regulations and includes the following requirements regarding claims and appeals for Disability Benefits:

1. The Plan must include a discussion of any initial denial or denial on appeal, including an explanation of why the Plan disagrees or does not follow:
 - the opinion of your treating health care professionals and vocational professionals, or
 - the opinion of medical or vocational experts whose advice was obtained on behalf of the Plan, or
 - the disability determination regarding the claimant by the SSA.
2. Explanations of denials that are based on a medical necessity or experimental treatment.
3. Copies of any internal plan rules relied on in making a benefit denial, or a statement that such rules do not exist if there are no such rules.
4. Before the Plan can issue a denial on appeal based on new or additional evidence or a new or additional rationale, you must be freely provided the evidence or rationale in advance of a denial so you may respond.
5. If more than 10% of individuals residing in your county speak the same non-English language, the Plan must provide its services in a culturally and linguistically appropriate manner. This means the Plan would need to provide language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language; provide, upon request, a notice in any applicable non-English language; and must include in the English versions of all claims and appeals notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.
6. General requirements against bias in claims decision-making.

Self-pay for Totally Disabled Participants and Annual Exam Requirements

Effective July 1, 2018, Totally Disabled Participants who previously made total self-payments under the Active rate will be moved to the Senior Program and make payments under that group's rate. Totally Disabled Participants will also be required to have an annual exam to qualify to continue to be Totally Disabled.

Payment levels

Effective July 1, 2018, only services received at an In-Network Provider will be paid at the In-Network level and any services received by an Out-of-Network Provider will be based on the Fair Health Relative Value at the 85th percentile. Prior to this date, some services received at an

Out-of-Network Provider could be paid at an In-Network level if the claim was repriced by a third-party service.

Statement Regarding Status as a Grandfathered Health Plan

This group health plan believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 1-800-962-3158. You may also contact the Participant Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions regarding these changes, please contact the Fund Office at 1-800-962-3158.

Sincerely,
Board of Trustees

IMPORTANT REMINDER ABOUT YOUR TELEHEALTH BENEFIT

The Fund has partnered with Anthem to offer a new feature called LiveHealth Online. The LiveHealth Online program gives covered non-Medicare persons the capability to speak with a certified physician online (with a webcam) or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical situation. This online doctor visit benefit is available 24 hours a day, 7 days a week and can be accessed at www.livehealthonline.com. There is no cost to you for the online doctor visit.

THERE IS NO COST TO YOU FOR THE ONLINE DOCTOR VISIT

Medicare Retirees and their Eligible Dependents will need to pay the full cost of the visit using a credit card through the website of smartphone application at the time of service. You can then submit a claim to the Fund Office for a full reimbursement of the fee. The Trustees hope this benefit will help reduce the cost of non-urgent ER visits for both you and the Fund.

A GUIDE FOR WHERE TO GO WHEN YOU NEED MEDICAL CARE*

Lower Costs

Higher Costs

Telehealth LiveHealth Online	Nurse Practitioner Retail Clinic	Doctor's Office	Urgent Care Center	Emergency Room
Average Cost per Visit Charged to the Indiana Laborers Welfare Plan:				
\$49 per visit*	\$82 per visit*	\$105 per visit*	\$147 per visit*	\$1,636 per visit*
Your Cost after Health and Welfare Fund Payment (assuming In Network provider and your deductible is met):				
\$0 copayment	\$20.50 co-insurance**	\$26.25 co-insurance**	\$36.75 co-insurance**	\$446.50 co-insurance**

* provided by Anthem Blue Cross and Blue Shield.

** This represents the average cost of each visit and will vary by provider.

Telehealth LiveHealth Online	Nurse Practitioner Retail Clinic	Doctor's Office	Urgent Care Center	Emergency Room
Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when, where, and how it works best for you. Go to the following website www.livehealthonline.com or call toll-free at (888) 548-3432.	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room. "Freestanding" emergency room (ER) locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed at a much higher cost than at other health care facilities
Typical Conditions Treated:				
<ul style="list-style-type: none"> • Colds and flu • Rashes or skin conditions • Sore throats, ear ache, sinus pain • Headaches • Stomachaches • Fever • Allergies • Acne • UTIs and more 	<ul style="list-style-type: none"> • Colds and flu • Rashes or skin conditions • Sore throats, ear ache, sinus pain • Minor cuts and burns • Pregnancy testing • Vaccines 	<ul style="list-style-type: none"> • General health issues • Preventive care • Routine checkups • Immunization and screenings 	<ul style="list-style-type: none"> • Fever and flu symptoms • Minor cuts, sprains, burns, rashes • Headaches • Lower back pain • Joint pain • Minor respiratory symptoms • UTIs 	<ul style="list-style-type: none"> • Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose • Broken bones
Your Time:				
No need to leave home or work. Use of mobile device, tablet or computer for virtual visit. Typically answered within minutes.	No appointment needed.	Appointment times required. Shorter wait times than an emergency room.	Walk in scheduling. No appointments taken and wait time will vary.	No appointments taken and wait times can be long and be up to many hours before you are seen.

*The information provided here is intended to be general information on how you can get the most out of your plan and your health care dollars. It is not intended as medical advice. You should consider all relevant factors and to consult with your treating doctor when selecting a health care professional or facility for care. During a medical emergency, go to the nearest hospital or call 911.