INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
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BOARD OF TRUSTEES
INDIANA LABORERS WELFARE FUND
413 SWAN STREET
TERRE HAUTE, IN 47807

Summary Annual Report for the INDIANA LABORERS WELFARE FUND

This is the summary annual report for the INDIANA LABORERS WELFARE FUND, EIN 35-0923209, Plan number 501 for the period December 1, 2017 to November 30, 2018. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $221,408,617 as of November 30, 2018, compared to $228,608,206 as of December 1, 2017. During the plan year the plan experienced a decrease in its net assets of ($7,199,589). This decrease includes unrealized appreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $91,235,734 including employer contributions of $78,360,387, employee contributions of $7,685,373, realized gains of $6,911,569 from the sale of assets, losses from investments of ($3,380,833), and other income of $1,659,238.

Plan expenses were $98,435,323. These expenses included $10,581,113 in administrative expenses, $87,854,210 in benefits paid to participants and beneficiaries, and $0 in other expenses.

Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- An accountant's report

- Financial information and information on payments to service providers

- Assets held for investment

- Insurance information including sales commissions paid by insurance carriers

- Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates

To obtain a copy of the full annual report, or any part thereof, write or call the office of BOARD OF TRUSTEES INDIANA LABORERS WELFARE FUND, who is the plan administrator, 413 SWAN STREET, TERRE HAUTE, IN, 47807, 812-238-2551. These portions of the report are furnished without charge.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

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Plan Sponsor
413 SWAN STREET
TERRE HAUTE, IN 47807
35-0923209

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

U.S. Department of Labor
Employee Benefits Security Administration
Public Disclosure Room
200 Constitution Avenue, N.W.
Room N-1513
Washington, DC 20210

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.

WOMEN'S HEALTH & CANCER RIGHTS

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your plan administrator for more information. The Plan's administrative office can be reached in writing at PO Box 1587, Terre Haute, Indiana 47807-1587, or by phone (800) 962-3158.

Indiana Laborers Health Care Fund: Classes A, AS and S

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (800) 962-3158. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (800) 962-3158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $300/individual or $600/family Out-of-Network: $600/individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health, Prescription and Dental Benefits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Emergency Room -$70/visit, Dental Care - $25/individual or $75/family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network- $3,000/individual or $6,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for prescription drugs, LiveHealth Online Doctor Visit, premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbs.com or call the Fund Office at (800) 962-3158 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	50% coinsurance	LiveHealth Online Doctor Visit - no copayment, deductible or coinsurance. LiveHealth Online Doctor Visit is an In-network benefit only – no coverage for a telemedicine program other than LiveHealth Online.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization	No Charge for specific covered services except for Routine Physical Exam which is paid up to $300 per year, then 25% coinsurance; all non-specified preventive services covered at 25% coinsurance	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For specific benefits and limitations, see Plan Document Section 4.13*
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com or by calling (800) 228-3108.	Generic drugs	Retail – 20% ($10 min/ $20 max) Mail Order & Approved 90 day Retail – 15% ($25 min/ $50 max)	Not covered	No deductible on Prescription Benefits. Copayment does not apply to deductible or out-of-pocket limit. Present Prescription Drug Card at time of retail purchase. If Card is not presented, may submit receipt for reimbursement. Retail is 30-day supply. Mail Order & Approved Retail is 90-day supply. If generic equivalent is available; you will pay the applicable copayment plus the difference between the generic drug and the brand name drug. See the Plan at Section 4.12 E) for Prescription Exclusions*
	Formulary brand drugs	Retail – 30% ($20 min/ $40 max) Mail Order & Approved 90 day Retail – 25% ($50 min/ $100 max)		
	Non-formulary brand drugs	Retail–40% ($40 min/ $80 max) Mail Order & Approved 90 day Retail–35% ($100 min/$200 max)		

*For more information about limitations and exceptions, see summary plan description (SPD).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Mail Order Only – Generic: 15% ($8 min/ $16 max) Formulary brand: 25% ($16 min/ $33 max) Non-formulary brand: 35% ($40 min/ $80 max)	Not covered	Precertification is required for Specialty Drugs over $2,000. Specialty Mail Order is up to 30 day supply. If generic equivalent is available; you will be required to pay the applicable copayment plus the price difference between the generic drug and the formulary brand name drug. See the Plan at Section 4.12 E) for Prescription Exclusions*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Precertification is required.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	25% coinsurance	50% coinsurance	$70 deductible per person per visit unless life threatening sickness, accident, or inpatient admission.
	Emergency medical transportation			----------none----------
	Urgent care			LiveHealth Online Doctor Visit - no copayment, deductible or coinsurance. LiveHealth Online Doctor Visit is an In-network benefit only – no coverage for a telemedicine program other than LiveHealth Online.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	No Friday or Saturday admissions unless emergency, scheduled surgery within 24 hours, or Medically Necessary per doctor. Precertification is required.
	Physician/surgeon fees			Precertification is required.

*For more information about limitations and exceptions, see summary plan description (SPD).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	In-patient treatment must be received at an In-Network facility. In-patient treatment is not covered at an Out-of-Network facility unless approved by Medicare. Must be supervised/ performed by MD. Precertification is required.
	Inpatient services		Not covered	
If you are pregnant	Office visits	25% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Benefits limited to female Employee or dependent spouse only.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient stay of at least 48 hours for the mother & newborn child following a vaginal delivery or at least 96 hours for the mother & newborn child following a cesarean section delivery. Benefits limited to female Employee or dependent spouse only. Precertification is required.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Precertification is required.
	Rehabilitation services			
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	25% coinsurance	Not Covered	Precertification is required.
	Durable medical equipment		50% coinsurance	Precertification is required for wheelchairs and pneumatic compression devices.
	Hospice services			Precertification is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge up to $35	Limited to 1 exam every 12 months.
	Children's glasses	Frames: In-Network (private practice) - No charge up to $50 wholesale price In-Network (retail providers) – No charge up to $130 retail price Lenses: Single vision, lined bifocal or trifocal – No charge	Frames: Reimbursement up to $80 retail price Lenses: Single – Reimbursement up to $55 Bifocal – Reimbursement up to $80 Trifocal – Reimbursement up to $105	Lenses & Frames **or** Contact Lenses once every 24 months.
	Children's dental check-up	10% coinsurance		Not subject to Dental deductible. Limit two dental check-ups per person per Calendar Year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (unless used as an anesthetic for covered surgery)
- Bariatric surgery
- Cosmetic surgery (unless medically necessary)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (up to $1,000 per Plan Year)
- Dental care (adult)
- Hearing aids
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Fund Office at (800) 962-3158 or the Department of Labor's Employee Benefits Security Administration at (866) EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al (800) 962-3158.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist *coinsurance*	**25%**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,100**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$300**
Specialist *coinsurance*	**25%**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$300**
Specialist *coinsurance*	**25%**
Hospital (facility) *coinsurance*	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$370
Copayments	$0
Coinsurance	$480
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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