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

*** Important Welfare Benefit Changes ***

XXXXXXX 2020

To All Participants of the
Indiana Laborers Welfare Fund

SUMMARY OF MODIFICATION TO THE PLAN

The Trustees of the Indiana Laborers Welfare Fund wish to announce the following change to comply with the No Surprises Act effective December 1, 2022.

Please keep this SMM with your Summary Plan Description (SPD)/Plan Rules and Regulations for easy reference to all Plan provisions. If you have any questions regarding this notice or any other benefits covered by the Plan, you can contact the Fund Office at (800) 962-3158.

The Trustees have made the following changes to the Plan:

The No Surprises Act was signed into law in December 2020 and generally protects patients from "balance billing" for out-of-network emergency services or facilities, out-of-network air ambulance services, and certain non-emergency services performed by a out-of-network provider at a network facility (collectively "No Surprise Services").

As described in more detail below, Participants and Dependents receiving No Surprise Services will generally only be responsible for paying their network cost sharing. You are still encouraged to use network facilities and participating providers whenever possible. Additionally, this SMM describes other changes required by the No Surprises Act, including expanded emergency services and continuity of care provisions.

Consequently, the following changes are made to the Fund's plan of benefits effective December 1, 2022:

EMERGENCY SERVICES
The No Surprises Act requires emergency services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on a out-of-network basis;

2. Without regard to whether the health care provider furnishing the emergency services is an in-network or a out-of-network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on out-of-network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from network provider and network provider emergency facilities;

4. Without imposing cost-sharing requirements on out-of-network emergency services that are greater than the requirements that would apply if the services were provided by an in-network or an in-network emergency facility;

5. By calculating the cost-sharing requirement for out-of-network emergency services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and;

6. By counting cost-sharing payments you make with respect to out-of-network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an in-network.

NON-EMERGENCY SERVICES PERFORMED BY A OUT-OF-NETWORK PROVIDER AT A NETWORK FACILITY
The No Surprises Act requires non-emergency services performed by a out-of-network provider at a network Health Care Facility to be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such network provider were equal to the Recognized Amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an in-network.

Notice and Consent Exception: Non-emergency items or services performed by a out-of-network provider at a network facility will be covered based on your out-of-network coverage (meaning your cost sharing will be based upon the Usual and Customary amounts for out-of-network providers as defined in your Plan) if:

a) 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 provided with a written notice, as required by federal law, that the provider is a out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any network providers at the facility who are able to treat you, and that you may elect to be referred to one of the network providers listed; and

b) You give informed consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary services and items, or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the notice and consent criteria.

PAYMENTS TO OUT-OF-NETWORK PROVIDERS AND FACILITIES
The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at network facilities by out-of-network providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the out-of-network provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

CONTINUITY OF COVERAGE
If you are a Continuing Care Patient, and the contract with your network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and

2. You will be allowed up to ninety (90) days of continued coverage at network cost sharing to allow for a transition of care to an in-network.

INCORRECT PROVIDER INFORMATION
A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a in the network from the Plan or its administrators, the Plan will apply network cost-sharing to your claim, even if the provider was a out-of-network provider at the time the service was rendered.

COMPLAINT PROCESS
If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office at 866-732-1919 or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

EXTERNAL REVIEW OF CERTAIN COVERAGE DETERMINATIONS
If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by a out-of-network provider at a network facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

NEW DEFINITIONS
Due to the nature of the changes required by the No Surprises Act, the Fund has adopted the following definitions, which will assist you in fully understanding the changes required by the No Surprises Act:

Air Ambulance Services means medical transport by helicopter or airplane for patients.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 (i) 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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition, "emergency services" include:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, and
- Further services that are furnished by an out-of-network provider or Out-of-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished)

Independent Freestanding Emergency Department means a health care facility that (i) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) Provides any "Emergency Services" as defined above.

Nonparticipating/Out-of-Network Emergency Facility - An emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

Out-of-Network Rate will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

Qualifying Payment Amount (QPA) generally means, the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

Recognized Amount: For items and services furnished by an out-of-network provider or out-of-network emergency facility, the Recognized Amount will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

Network Health Care Facility – In the context of non-Emergency Services, a network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center (as defined in the Social Security Act.

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

Sincerely,

Board of Trustees

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.

IMPORTANT REMINDER ABOUT YOUR TELEHEALTH BENEFIT

The use of the telehealth option is at NO COST to you. You can access this Telehealth Benefit at www.livehealthonline.com or search for "LiveHealth Online" on a smart phone or tablet to download our app for free.

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.

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 information on the following page is an illustrative example of the types of providers and typical conditions that are treated as well as the average cost of care for each type of medical provider. As you can see if you do not have a true emergent medical condition you can be treated at a much lower cost than the Emergency Room.

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

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 practioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The 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:				
Colds and flu Rashes or skin conditions Sore throats, ear ache, sinus pain Headaches Stomachaches Fever Allergies Acne UTIs and more	Colds and flu Rashes or skin conditions Sore throats, ear ache, sinus pain Minor cuts and burns Pregnancy testing Vaccines	General health issues Preventive care Routine checkups Immunization and screenings	Fever and flu symptoms Minor cuts, sprains, burns, rashes Headaches Lower back pain Joint pain Minor respiratory symptoms UTIs	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.

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:				
$59 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**	$461.50 co-insurance**

* Provided by Anthem Blue Cross and Blue Shield.

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

Perspectives Member Assistance Program (MAP)

The Trustees have implemented a program to provide professional consultations for a variety of problems that may affect your personal well-being and your job performance. There are many services available to you and they are provided at no cost. This program is called Perspectives and is available to all Participants and members of their household.

Accessing the Perspectives MAP Program

To access the Perspectives MAP program, Participants and members of their household may call in by phone or through the internet portal 24 hours a day, seven days a week.

- Using your telephone, call the program's toll-free number at 1-800-456-6327
- For web-based services, visit perspectivesltd.com. The username is: **INLAB** and the password is: **perspectives**

Perspectives Counseling Services

Perspectives Case Managers, all of whom are licensed masters- or doctorate-level behavioral health clinicians, are available to assist with a variety of concerns, including (but not limited to):

- Alcohol/Addictions/Abuse
- Anger
- Budgeting
- Child Custody
- Depression
- Family Issues
- Grief/Loss
- Mood Swings
- Parenting
- Relationship Issues
- Stress
- Work-Life Balance

At the time of the initial call, the Perspectives Case Manager will gather some preliminary information and assess your situation. After the assessment, the Case Manager will then coordinate an appointment for you to meet with a local counselor, who will work with you to develop a solution-focused plan of action. Short-term counseling, **up to eight sessions** per issue, can be provided by the counselor to assist in resolving the problem. If long term or specialized care is indicated during either the assessment or through the course of face-to-face counseling, a referral will be made to a resource or facility that meets your needs. The Perspectives MAP will coordinate with this Plan and make every effort to provide referrals to treatment providers within the PPO network. If these referrals are necessary, the objective is to recommend the most appropriate level of care for your unique situation.

Perspectives Legal and Financial Services

Perspectives Legal and Financial Services provides a cost-effective solution to help Participants and members of their household who have legal concerns. The program provides you with phone access to specialists who can help you understand your options and point you in the right direction for the help you need. If you do require an attorney, you will be given a referral to their network that includes a FREE 30 minute consultation and 25% reduction in attorney fees. The following services are included in the Perspectives Legal and Financial Services program:

- College Planning
- Debt Counseling
- Retirement Planning
- Separation/Divorce
- Tax Consultation
- Will Preparation

Perspectives WorkLife Online

Perspectives WorkLife Online provides Participants and members of their household with online access to services that help with various areas of life and productivity. The following services are included in Perspectives WorkLife Online:

- Career Development/ Training
- Elder Care/ Child Care
- Financial Calculators
- Legal Forms
- Self-Assessments

Perspectives WorkLife Services Perspectives WorkLife Services provides Participants and members of their household with access to the relocation center and FREE phone consultations with specialists who assist families with child and eldercare issues, as well as convenience services. Our national network of pre-screened child and eldercare providers offer a time-saving service for you and the people you care about. The following services are included in Perspectives WorkLife Services:

- Adoption
- Day Care
- Nursing Home Care
- Pet Services
- Summer Camps

Perspectives SPARK Mobile Application
Available on most smart phone and tablet devices, provides Participants and members of their household with mobile access to secure and confidential counseling, as well as helpful resources on a number of wellbeing and productivity-related topics. The application also contains a summary of Indiana Laborers Welfare Fund's MAP, as well as the ability to connect immediately with one of Perspectives' licensed and experienced behavioral health clinicians.