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.
*** <u>Important Welfare Benefit Changes</u> ***

September 2022

To All Participants of the
Indiana Laborers Welfare Fund

SUMMARY OF MODIFICATION TO THE PLAN

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

DENTAL BENEFITS

<u>Preventive Benefits</u>
Effective January 1, 2022, the Plan will cover up to two routine dental exams, bitewings x-rays and cleanings per calendar year at 100% of the Allowed Amount. Prior to this change, these services were covered at 90% of the Allowed Amount. All other preventive services will continue to be covered at 90% of the Allowed Amount.

<u>Restorative Benefits</u>
Effective January 1, 2022, the Plan will cover crowns (porcelain and resin) and bridges at 70% of the Allowed Amount. Prior to this change, crowns and bridges were not a covered benefit.

**All Dental Benefits are limited to $750 per calendar year.*

SPECIALTY DRUG COST SAVINGS PROGRAM

Effective January 24, 2022, the Specialty Drug Program is mandatory for certain specialty medications to (1) ensure that these often high cost medications are being prescribed for an appropriate patient and condition at an acceptable dose and quantity and (2) ensure that the high cost medications are provided through the PBM pricing program only.

Providers that require “medical buy and bill” will not be covered under the Plan. Medical buy and bill is when a provider will not participate in this mandatory program, either by not filing for patient assistance or by not accepting SavRx distribution and pricing. Dispensing certain specialty medications through the Plan’s PBM is the only available option. A list of these certain specialty medications can be provided by calling the PBM directly. Any new or continued specialty medications received on or after this date must use this program.

If you are currently receiving a specialty medication included under this program and your provider will not utilize the SavRx Mandatory Cost Savings Program, you will be temporarily grandfathered for coverage, however, the Plan will only continue covering your current specialty medication through November 30, 2022. This temporary grandfathering provision will allow you time to find a new provider that will utilize the SavRx Mandatory Cost Savings Program. SavRx and the Fund’s Utilization Management vendor, Hines & Associates, will assist you in locating a provider that will comply with this program. If you do not find a new provider, your specialty medication that is included in this program will not be covered by the Plan after November 30, 2022. Please note that this temporary grandfathering provision only applies to certain specialty medication that are included under this program you are currently taking as of January 24, 2022. If your current specialty medication changes and the new specialty medication is included under this program, it will not be covered under this temporary grandfathering provision and must utilize the SavRx Mandatory Cost Savings Program.

Prior to this change, the Mandatory Cost Savings Program was a voluntary program.

Officers-Board of Trustees

Francis J. Gantner
Chairman

David A. Frye
Secretary-Treasurer

Somer Taylor
Administrative Manager

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 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-ofnetwork 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 outof-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 an 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.

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. This Plan's administrative office can be reached in writing at PO Box 1587, Terre Haute, Indiana 47808 or by phone (800) 962-3158.

STATEMENT

Discrimination is Against the Law. Indiana Laborers Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Indiana Laborers Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Indiana Laborers Welfare Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us.
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you believe that Indiana Laborers Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Indiana Laborers Welfare Fund, PO Box 1587, Terre Haute, Indiana 47807. Telephone number: 800-962-3158. You can file a grievance in person or by mail. If you need help filing a grievance, Indiana Laborers Welfare Fund is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD).

Complaint forms are available at http:// www.hhs.gov/ocr/office/file/index.html. Nondiscrimination statement for significant publications and signification communications that are small-size:

Indiana Laborers Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.