
# INDIANA LABORERS WELFARE FUND

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

*** Important Welfare Benefit Changes ***

March 2023

To All Participants of the
Indiana Laborers Welfare Fund

## SUMMARY OF MODIFICATION TO THE PLAN REGARDING SENIOR MEMBER COVERAGE RULES

The Trustees of the Indiana Laborers Welfare Fund wish to announce the following clarification to the Plan's Senior Member Coverage rules:

One of the benefits offered to members of the Indiana Laborers Union is the ability to qualify for health coverage under the Plan after retirement. It is often difficult and very expensive for older Americans to find health care coverage in the years immediately prior to Medicare. The Indiana Laborers Welfare Fund is proud to help fill this gap by offering subsidized health care coverage to qualifying Retirees, as well as those with a Total Disability.

The Board of Trustees would like to remind all Participants and Retirees that the Senior Member Coverage is only designed for those who are fully retired from the construction industry. In the event you return to work in a position in the construction industry anywhere within the United States, your coverage under the Senior Member Coverage Program will terminate. If you plan to return to work in a job that is related to the construction industry, you are encouraged to contact the Fund Office to ensure your Senior Member Coverage will not be at risk.

**Effective April 1, 2023, in the event you have returned to work in a position in the construction industry anywhere within the United States while you have Senior Member coverage with the Indiana Laborers Welfare Fund, your Senior Member coverage will terminate under the Plan.**

## SUMMARY OF MODIFICATION TO THE PLAN

The Trustees of the Indiana Laborers Welfare Fund wish to announce the following changes to the Plan:

**Substance Abuse Benefits**
Effective August 1, 2022, the Plan will remove the limit of full panel drug screenings each plan year and follow Anthem's Clinical Utilization Management Medical Policy Guidelines as follows:

*Presumptive* urine drug testing (UDT) to verify compliance with treatment, identify undisclosed drug use or abuse, or evaluate aberrant* behavior is considered **medically necessary**, beginning at the start of treatment, as part of a monitoring program tailored to the unique needs of Eligible Persons who are:

A. Receiving treatment for chronic pain with prescription opioid or other potentially abused medications; **or**
B. Undergoing treatment for, or monitoring for relapse of, opioid addiction or substance use disorder.

Presumptive *urine drug testing is also considered **medically necessary** for the following:*

A. To assess an Eligible Person when clinical evaluation suggests use of non-prescribed medications or illegal substances; **or**
B. On initial entrance into a pain management program or substance use disorder recovery program.

*Definitive* urine drug testing to verify compliance with treatment, identify undisclosed drug use or abuse, or evaluate aberrant* behavior is considered **medically necessary**, beginning at the start of treatment, as part of a monitoring program tailored to the unique needs of Eligible Persons whose requests meet criteria *both* A and B below:

A. Testing indications- *either* 1 or 2 below must be present:
    1. Receiving treatment for chronic pain with prescription opioid or other potentially abused medications; **or**
    2. Undergoing treatment for, or monitoring for relapse of, opioid addiction or substance use disorder; **and**

B. Testing scenarios- *either* 1 or 2 below have been met:
    1. Definitive testing following prior presumptive testing:
        a. The *presumptive* urine drug testing was done for a medically necessary reason; **and**
        b. The *presumptive* test was positive for an illegal drug (for example, but not limited to methamphetamine or cocaine), positive for a prescription drug with abuse potential which was not prescribed, or negative for prescribed medications; **and**
            i. The specific *definitive* test(s) ordered are supported by documented rationale for each test ordered; **and**
            ii. Clinical documentation reflects how the results of the test(s) will be used to guide clinical care;
            **or**
    2. Definitive testing without prior presumptive testing:
        a. *Presumptive* urine drug tests are not available for the drug in question (examples may include, opioids and their metabolites such as fentanyl, meperidine, tramadol, and tapentadol, muscle relaxants and their metabolites such as carisoprodol, synthetic cannabinoids and their metabolites, as well as cathinones [“Bath Salts”] and their metabolites); **and**
        b. The specific *definitive* test(s) ordered are supported by documented rationale for each test ordered; **and**
        c. Clinical documentation reflects how the results of the test(s) will be used to guide clinical care.

*Aberrant behavior includes, but is not limited to, lost prescriptions, repeated requests for early refills, prescriptions from multiple providers, unauthorized dose escalation, and apparent intoxication.

Prior to this change, full panel drug testing was limited to two per plan year.

Any other exclusion in the plan will remain unless specifically addressed above.

**Smoking Cessation Benefits**

Effective August 1, 2022 smoking cessation benefits will be expanded under the General Medical Benefit and the Prescription Drug Card Benefits as follows:

A. Smoking cessation prescription drugs will be paid under the Schedule of Benefits as follows:

Copayments (Participant pays)

Mail Order Participating Pharmacies (90 day supply)

(see Section 4.12 C for approved walk-in pharmacies that allow a 90 supply)

| | |
|---|---|
| Generic ..... | 15% of drug cost with a $25 minimum and $50 maximum |
| Brand Formulary ..... | 25% of drug cost with a $50 minimum and $100 maximum |
| Brand Non-Formulary ..... | 35% of drug cost with a $100 minimum and $200 maximum |

Retail Participating Pharmacies (up to 30 day supply)

| | |
|---|---|
| Generic ..... | 20% of drug cost with a $10 minimum and $20 maximum |
| Brand Formulary ..... | 30% of drug cost with a $20 minimum and $40 maximum |
| Brand Non-Formulary..... | 40% of drug cost with a $40 minimum and $80 maximum |
| Mail Order Specialty Drugs (up to 30 day supply) | |
| Generic | 15% of drug cost with a $8 minimum and $16 maximum |
| Brand Formulary ..... | 25% of drug cost with a $16 minimum and $33 maximum |
| Brand Non-Formulary..... | 35% of drug cost with a $40 minimum and $80 maximum |

B. Physician office visits will be payable under the Schedule Benefits as any other physician office visit.

**Autism Spectrum Disorder**

Effective August 1, 2022 the Plan will cover services deemed Medically Necessary to treat the diagnosis of Autism Spectrum Disorder, subject to the Medical Care Review program found in Section 8.15 of your Plan Document/Summary Plan Description.

A. Applied Behavior Analysis (ABA) - ABA therapy must be ordered by a qualified physician specialist, such as developmental pediatrician, pediatric neurologist, neuropsychologist, etc. and precertification for Medically Necessity will be required as described in the Medical Care Review program found in Section 8.15 of your Plan Document/Summary Plan Description prior to start of therapy and concurrent reviews are required. ABA therapy must be provided by providers certified with the Behavior Analyst Certification Board (ttps://www.bacb.com).

B. Developmental Therapy: This service must be deemed Medically Necessary and be intended to meet the medical therapy needs of children who require intensive services (those in addition to services available through Early Intervention Programs (IEP) or Individual Educational Plans (IEP). Developmental Therapy services must be ordered by a specialist physician such as a developmental pediatric or pediatric neurologist, and provided by licensed pediatric physical therapists, licensed pediatric occupational therapist, and licensed pediatric speech therapist, which may include feeding therapy and communication. Precertification for Medical Necessity and concurrent review are required.

**Wig Benefit**

Effective January, 1, 2023, the Plan shall pay 75% for the cost of one wig per plan year up to a $2,000 annual maximum for a wig prescribed by a Physician as a prosthetic for hair loss due to the following injuries or diseases, or due to treatment of the following diseases:

- Burns resulting in permanent alopecia;
- Lupus;
- Alopecia areata, alopecia totalis, alopecia universalis;
- Fungal infections not responding to a course of anti-fungal treatment resulting in complete cranial hair loss;
- Chemotherapy;
- Radiation therapy.

A wig or hairpiece for the diagnosis of androgenetic alopecia (male pattern baldness) is not covered on the basis that this is not considered to be a medical diagnosis.

This Benefit is not available for those under Class CP for Senior Member Coverage. Prior to this change, coverage was not provided under the Plan.

**Weight Loss Prescription Program**

Effective January 1, 2023, the Plan will provide coverage for weight loss medications to participants subject to the following:

- Mandatory prior authorization review by Sav-Rx clinical team,
- Mandatory step therapy clinical review,
- Closed formulary of medications under this program include Phentermine, Contrave, Qsymia, Xenical, Saxenda, and Wegovy.
- The individual's body mass index (BMI) must be greater than 30,
- Mandatory clinical management review with prescribing physician and patient on regular intervals set by the Sav-Rx clinical team,
- Copayments will be the same under the current schedule of benefits for other prescription benefits, and
- Corresponding physician office visits regarding compliance and efficacy of the prescribed weight loss medication will be covered as any other physician office visit according the schedule of benefits.

This Benefit is not available for those under Class CP for Senior Member Coverage. Prior to this change, coverage was not provided under the Plan.

**Cologuard Covered as a Routine Preventive Care Benefit**

Effective January 1, 2023, Cologuard has been added under the Routine Preventive Care Benefit as an option for Colorectal Cancer Screening as outlined below.

**Routine Preventive Care Benefit:**

Colorectal Cancer Screening – In-Network Benefits Only:

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|---|---|
| Age 45 and over: 1 sigmoidoscopy every 5 Plan Years | 100%; otherwise under General Medical Benefit |
| Age 45 and over: 1 colonoscopy every 5 Plan Years | 100%; otherwise under General Medical Benefit |
| Age 45 and over: Multi-targeted stool DNA test (Cologuard) every 1-3 years | 100%; otherwise under General Medical Benefit |

The Plan will pay 100% for one of the above routine preventive colorectal cancer screening services within the recommended screening intervals outlined. Any subsequent colorectal cancer screening services or diagnostic services will then be payable under the General Medical Benefit subject to deductible and coinsurance.

This Benefit is not available for those under Class CP for Senior Member Coverage. Prior to this change, Cologuard was only payable under the General Medical Benefit.

**Adult & Dependent Opt-Out Provisions:**

Effective January 1, 2023, the following rules will be applicable to "opt-out" (decline coverage) from the Plan by spouses of active participants, as well as the rules governing removing coverage for adult dependent children.

*Spouse of Active Participant:*

A spouse of an active participant may have other coverage available and desire to opt out of this Plan's coverage. In order for the spouse to opt-out of coverage, the spouse must provide proof of other coverage

other than Medicare and must sign an acknowledgment regarding return to coverage requirements and Medicaid rules.

A spouse who has opted out of coverage under the Plan may return to coverage on December 1 of each year or if the spouse experiences a with a qualifying event. There will also be no reduction to the contribution rate or any applicable self-payments if the spouse of an active participant opts out of the Plan.

*Adult Dependent Child (Age 18-26)*
Effective January 1, 2023, an adult dependent child aged 18-26 can be removed from Plan coverage by the participant ("parent"). The adult dependent child does not have the right to appeal termination of coverage by the participant (parent). It is the participant's (parent) choice to cover the adult dependent child under the Plan. If the parent so chooses to cover the adult dependent child, then the Plan is required to provide coverage up to age 26.

A participant (parent) may remove coverage for an adult dependent child if the Plan is provided with proof of other coverage for the adult dependent child for coverage other than Medicare. The participant (parent) must sign an acknowledgment regarding the return to coverage requirements and Medicaid rules regarding the adult dependent child. The Plan will provide notice of loss of coverage to the adult dependent, but consent from the adult dependent child is not required to be removed from coverage under the Plan.

The participant (parent) can reinstate coverage for the adult dependent child on December 1 each year or in the event the adult dependent child experiences a qualifying event.

Prior to this change, only a spouse of an active participant who had a high deductible health plan (HDHP) through their employer could opt-out of coverage under 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 any questions regarding this notice or any other benefits covered by the Plan, you can contact the Fund Office at (800) 962-3158.

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.

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