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 ***

October 2023

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 the Plan:

Coordination of Benefits
Effective April 1, 2023, the combination Plan and SPD was amended with new Coordination of Benefits provisions. Coordination of Benefits refers to the order in which benefits are paid when a Participant, Retiree, or Dependent has health coverage through this Plan and another plan or insurance policy. The following is the exact language that can be found in Section 8.11 of the combination Plan and SPD.

Section 8.11 – Coordination Of Benefits
These Coordination of Benefits provisions do not apply to benefits provided under the MAPD plan for Class CP retirees. If you and your eligible Dependents are covered under the MAPD plan, benefits will not be coordinated between the fully insured MAPD policies. See Appendix A for more details.

The Coordination of Benefits provisions provided for in this Section 8.11 apply to an Eligible Person who is covered by more than one group health plan (this Plan and another plan (or plans)), or an insurance policy which provides for the payment of medical benefits. If this applies to you or your Dependents, please read this Section carefully to understand how Benefits will be paid. You may contact the Fund Office with any questions.

Coordination with Other Group Plans
All Benefits payable under this Plan shall be coordinated with benefits payable under any Other Group Plan if the Covered Expenses are for a Participant, Retiree or Dependent.

If a Participant, Retiree or Dependent is covered by an Other Group Plan, the Benefits under this Plan and the Other Group Plan shall be coordinated. This means that one plan pays its full benefits first, then the other plan pays up to its full benefit; provided, however, that total benefits from this Plan and the Other Group Plan(s) shall not be more than 100% of Covered Expenses incurred.

Benefits paid under this Section shall be paid in the following order:

A) If the Other Group Plan does not have a coordination of benefits provision, the Other Group Plan shall pay its benefits first.

B) When the Other Group Plan does have a coordination of benefits provision, the following rules shall be applied:

1. The plan which covers the person as an employee, member or nondependent shall pay its benefits first.

2. If the rule described in subparagraph 1 above is not determinative because one or more plans cover the person as an employee, the plan which covers the person as an active worker at the time the expense is incurred shall pay its benefits first.

3. If the rule described in subparagraph 1 above does not apply, the plan which covers the person as a dependent of the parent whose birthday falls earlier in a year will pay its benefits before the plan of the parent whose birthday falls later in the year, except as described under the rule explained in subparagraph 4 below involving a Benefit Claim for a dependent child of divorced or separated parents or the rule described in subparagraph 5 below involving a Benefit Claim for a dependent child that is covered under an Other Group Plan as a result of their spouse's employment. If both parents have the same birthday, the benefits of the plan which covered the parent longer are paid before those of the plan which covered the parent for a shorter period of time. The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

4. If a Benefit Claim is made for a dependent child of divorced or separated parents, the plan which covers a child as a dependent of a parent who by court decree must provide for health care shall pay its benefits first.

   If there is no court decree which requires a parent to provide for health care for a dependent child:

   a. The plan covering the parent that is not remarried and who has custody of the child shall pay its benefits first.

   b. If a parent who has custody of the child has remarried; such parent's plan will pay its benefits first; the stepparent's plan shall pay its benefits next; and the plan of the parent without custody shall pay its benefits third.

   If a court decree requires both parents to provide for health care for a dependent child, the birthday rule, as described in subparagraph 3 above, will be used to determine primary and secondary coverage. If the parent with custody has remarried, the plan of the stepparent with custody shall pay its benefits next; and the plan of the stepparent without custody shall pay its benefits last.

5. If a Benefit Claim is made for a dependent child who is covered under an Other Group Plan as a result of their spouse's employment, benefits will be paid in the following order:

a. If the dependent child is covered under an Other Group Plan as an employee, that Other Group Plan shall pay its benefits first.

b. If the dependent child is married and is covered under an Other Group Plan through the spouse's employment, that Other Group Plan will pay its benefits second.

c. After applying the rules in subparagraphs 5a and 5b, then the rules in subparagraphs 3 or 4, as applicable, shall apply to determine the order of remaining plans.

6. If a person whose coverage is provided under a right of continuation pursuant to federal law (COBRA) or state law is also covered under any Other Group Plan, the plan which covers the person as an employee or member (or as that person's Dependent) shall pay its benefits first and the plan which provides benefits under the continuation coverage shall pay its benefits second.

7. If none of the preceding rules in subparagraphs 1 through 6 apply, the plan which has covered the person for a longer period of time shall pay its benefits first.

Where part of an Other Group Plan coordinates benefits and part does not, each part shall be treated like a separate plan.

Notwithstanding the order listed above, when the Other Group Plan is an insured product (such as certain vision benefits) provided by this Plan, the Other Group Plan shall pay its benefits first.

If benefits which this Plan should have paid are instead paid by an Other Group Plan, this Plan may reimburse the Other Group Plan. Amounts so reimbursed shall be treated like any other Plan benefits in satisfying this Plan's obligations.

If this Plan pays more for a Covered Expense than is required by this Section, then this Plan may recover such excess payment from –

A. any person to whom the payment was made; or

B. any insurance company, service plan or any other organization which should have made payment.

Coordination with Insurance

A homeowners', event, premises, or automobile policy of insurance which provides for the payment of medical benefits (such as no-fault, personal injury protection, or medical payments coverage) shall always pay on a primary basis before the Plan.

Definitions Related to Coordination of Benefits

For purposes of this Section, the following terms shall have the following meanings –

Other Group Plan

The term "Other Group Plan" means programs which provide benefit payments or services to a Participant, Retiree or covered Dependents for hospital, medical, surgical, dental, prescription drug, vision, hearing or any other health care under –

- group insurance;
- group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including Health Maintenance Organizations;
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans;
- coverage under government programs and any other coverages required by law;
- other arrangements of insured or self-insured group coverage; or
- COBRA coverage.

Provided, however, that –

- individually purchased health insurance plans are not treated as an "Other Group Plan" for coordination of benefits purposes; and
- where both the Employee and one or more of his Dependents are eligible to participate because of employment with an Employer, this Plan shall also be treated as an "Other Group Plan" for coordination of benefits purposes.
- In the event this Plan provides an insured product in addition to noninsured coverage, the insured product shall also be treated as an "Other Group Plan" for coordination of benefits purposes.

Benefit Claim Period
The term "Benefit Claim Period" means part or all of a Calendar Year during which the Participant, Retiree or covered Dependent is eligible for benefits under the Plan.

Covered Expense
The term "Covered Expense" means any Usual, Customary and Reasonable expense incurred which is covered by at least one Other Group Plan during a Benefit Claim Period and where an Other Group Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Benefit Claim Period shall also be considered a Covered Expense.

Subrogation
Effective April 1, 2023, the combination Plan and SPD was amended with new Subrogation provisions. Subrogation refers to when the Plan "takes the place of" an Eligible Person to recover medical expenses that were paid out for injuries caused by an accident for which a third-party may be liable The following is the exact language that can be found in Section 8.13 of the combination Plan and SPD.

Section 8.13 – Subrogation
These Subrogation provisions do not apply to benefits provided under the MAPD plan for Class CP retirees. Class CP retirees should refer to Appendix A for the applicable Subrogation provisions.

The Subrogation provisions provided for in this Section 8.13 apply to an Eligible Person who receives treatment or services due to an accident or injury that someone else may be liable. If this applies to you or your Dependents, please read this Section carefully to understand how Benefits will be paid. Also, there is specific paperwork that you must fill out and return to the Fund Office prior to any Benefits being paid. You may contact the Fund Office with any questions.

If an Eligible Person is injured in an accident for which someone else may be liable, that person or an insurer may be responsible for paying the related medical expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these Injuries may be difficult; recovery from a third party may take a long time (you may have to go to court), and your creditors may not wait patiently. Because of this, as a service to the Participant, the Plan will advance Benefit payments related to such an accident based on the Plan's rights of restitution and subrogation. This means the Participant must reimburse the Plan if recovery is obtained from any person or entity.

The Plan will receive restitution for all Benefit payments made as the result of the Injuries or Sicknesses which are caused by the actions of a third party and which give rise to a court ordered financial award or out-of-court settlement to the Eligible Person from a third party tort-feasor, person or entity. This Plan will provide Benefits otherwise not payable under this Plan, to or on behalf of the Eligible Person, only on the following terms and conditions:

A) In the event of any payment under this Plan, the Plan shall be subrogated to all of the Eligible Person's rights of recovery against any person or organization.

   This means that the Plan has an independent right to bring an action in connection with such Injury or Sickness in the Eligible Person's name and also has a right to intervene in any such action brought by the Eligible Person, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

B) Consistent with the Plan's rights set forth in this Section, if the Eligible Person submits Benefit Claims for or receives any Benefit Claims payments from the Plan for an Injury or Sickness that may give rise to any claim against any third-party, the Eligible Person's representative will be required to execute a "Subrogation Assignment of Rights, and Restitution Agreement" affirming the Plan's rights of restitution and subrogation with respect to such Benefit Claims payments and claims. This form will assist the Plan in recovering Benefit Claims paid from a third party who was responsible for the Injuries giving rise to the Benefit Claims. This Agreement must also be executed by the Eligible Person's attorney, if applicable.

   Because Benefit Claims payments are not payable unless you sign a Subrogation Agreement, the Eligible Person's Benefit Claims will not be paid until the fully signed Agreement is received by the Plan.
   This means that if an Eligible Person files a Benefit Claim and a Subrogation Agreement is not received promptly, the Benefit Claim will not be paid.

C) The Eligible Person shall do whatever is necessary to secure the Plan's subrogation rights and shall do nothing after the loss to prejudice such rights. The Eligible Person must do nothing to impair or prejudice the Plan's rights. For example, if the Eligible Person chooses not to pursue the liability of a third party, the Eligible Person may not waive any rights covering any conditions under which any recovery could be received. Where the Eligible Person chooses not to pursue the liability of a third party, the acceptance of Benefit Claims from the Plan authorizes the Plan to litigate or settle your claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of Benefit Claims obligates the Eligible Person (and their attorney, if applicable) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the accident.

D) The Eligible Person shall agree to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident. Failure to execute the necessary forms will result in no Benefit Claims being paid.

E) The Plan is also granted a right of restitution from the proceeds of any settlement, judgment or other payment obtained by the Eligible Person. This right of restitution is cumulative with and not exclusive of the subrogation right granted in paragraph A above, but only to the extent of the Benefit Claims paid by the Plan.

F) The Plan's rights of restitution and subrogation provide the Plan with first priority to any and all recovery in connection with the Injury or Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under the Eligible Person's own uninsured motorist insurance, underinsured motorist insurance, or any medical pay or no-fault benefits payable.

   This right of subrogation is specifically and unequivocally pro tanto subrogation, that is, subrogation from the first dollar received by the Eligible Person, and the pro tanto subrogation is to take effect before the entire debt is paid to the Eligible Person. In addition to its pro tanto rights, the Plan is entitled to restitution of the full amount of Benefits paid, regardless of whether the Eligible Person is made whole by the third party for all damages.

G) The Plan's rights of restitution and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Sickness, and regardless of whether the Eligible Person actually obtains the full amount of such judgment, award, settlement, compromise, insurance or order.

   The Plan, by payment of any proceeds, is granted an equitable lien on the proceeds of any settlement, judgment or other payment received by the Eligible Person, and the Eligible Person consents to said lien and agrees to take all steps necessary to help the Board of Trustees secure such lien.

   The Plan shall have a lien on any amount received by the Eligible Person or a representative of the Eligible Person (including your attorney) that is due to the Plan under this Section, and any such amount shall be deemed to be held in trust by the Eligible Person for the Benefit of the Plan until paid in full to the Plan.

H) The subrogation and restitution rights and liens apply to any recoveries made by the Eligible Person as a result of the Injuries sustained or Sickness suffered, including but not limited to the following:

   1. Payments made directly by the third party tort-feasor or any insurance company on behalf of the third party tort-feasor or any other payments on behalf of the third party tort-feasor.

   2. Any payments, settlements, judgments or arbitration awards paid by any insurance company under an uninsured, underinsured motorist policy or medical pay provisions on the insured's behalf.

3. Any payments from any source designed or intended to compensate an insured for Sickness, Injury, disease or Disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

4. Any payments from an employer or worker's compensation insurer.

5. Any payments or donations due made by or through a charitable organization or online fundraising, social media, or crowdfunding platform (for example, GoFundMe).

I) It is the obligation of the Eligible Person to:

1. Notify the Plan within ten days of any accident or Injury for which someone else may be liable;

2. Notify the Plan in writing of any Injury, Sickness, disease or Disability for which the Plan has paid medical expenses on behalf of the Eligible Person that may be attributable to the wrongful or negligent acts of another person;

3. Notify the Plan in writing if the Eligible Person retains services of an attorney, and of any demand made or lawsuit filed on behalf of the Eligible Person, and of any offer, proposed settlement, acceptance settlement, judgment or arbitration award;

4. The Eligible Person must notify the Plan before accepting any payment prior to the initiation of a lawsuit. If the Eligible Person does not notify the Plan and accepts payment that is less than the full amount of the Benefits that the Plan has advanced, the Eligible Person will still be required to repay the Plan, in full, for any Benefits it has paid on the Eligible Person's behalf;

5. The Eligible Person must notify the Plan within ten days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the Plan's claims;

6. Provide the Plan or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information and cooperate with the Plan or its agents in defining, verifying or protecting its right of subrogation and restitution; and

7. Promptly provide restitution to the Plan for Benefits paid on behalf of the Eligible Person attributable to Sickness, Injury, disease or Disability, once the Eligible Person has obtained money through settlement, judgment, award or other payment.

J) The Eligible Person will not make any settlement which specifically excludes or attempts to exclude the medical expenses paid by the Plan.

K) The Plan‘s right of recovery shall be a prior lien against any proceeds recovered by the Eligible Person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

L) The Eligible Person shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights, specifically, no court costs nor attorney's fees may be deducted from the Plan's recovery without the prior expressed written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or any other such doctrine purporting to reduce the Plan's recovery amount.

M) If the Eligible Person fails to notify the Plan, as required herein, then upon recovery made, whether by suit, judgment, settlement, compromise or otherwise, by the Eligible Person, the Plan shall be entitled to restitution to the extent of the Benefits paid by the Plan, immediately upon demand, and shall have the right to recovery thereof, by suit or otherwise.

N) If the Eligible Person refuses to provide restitution to the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or restitution rights, the Plan has the right to recover the full amount of all Benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against the Eligible Person's future Benefit payments under the Plan or contributions made to the Plan by, or on behalf of, the Eligible Person. "Non-cooperation" includes, but is not limited to, the failure to execute a Subrogation, Assignment of Rights, and Restitution Agreement and the failure of any party to respond to the Plan's inquiries concerning the status of any claim or any other Injury relating to the Plan's rights of restitution and subrogation.

O) If the Eligible Person is compensated for their Injury or Sickness, the Eligible Person is responsible for any and all future medical benefits that are a result of this Injury or Sickness, unless the Trustees, in their sole discretion, approve the payment of such benefits.

Failure to comply with any of these requirements may result in:

A) The Plan's withholding payment of future Benefits;

B) An obligation by the Eligible Person to pay costs, attorney's fees and other expenses incurred by the Plan in obtaining the required information or restitution.

This restitution and subrogation program is a service to the Eligible Person. It provides for the early payment of Benefit Claims and also saves the Plan money (which saves you money too) by making sure that the responsible party pays for the Injuries.

Fund Service Providers
Effective June 1, 2022, Legal Counsel for the Fund is Ledbetter Parisi, LLC.

Additional Fluoride Treatment
Effective for services incurred on or after June 7, 2023, the Plan will cover two topical fluoride applications for patients under age 15 in any Calendar Year as part of your Dental Benefits. Prior to this change, the Plan covered one topical fluoride application per Calendar Year for patients under age 15.

Board of Trustees

The following Trustee roster has been updated effective September 2023

Employer Trustees

Jeremy Ayres
Jeffrey Chapman
Mike Ferrara
William Hasse III
Butch McAreavy
James McDonald
Dave Podlogar

Employee Trustees

Andrew Angel
James Daniels
Murray Miller
Kevin Roach
Brian Short
Danny Stults
James Terry

Description of Benefits, Class A

Effective October 1, 2023, the combination Plan and SPD, Article IV - Description of Benefits was amended with new Exclusions provisions. The following is the exact language that can be found in Section 4.14 Substance Abuse Benefit of the combination Plan and SPD.

Section 4.14 – Substance Abuse Benefit

Substance Abuse Benefits will not be paid for:

1. Medical and surgical expenses incurred from or occurring during an attempt to commit or the commission of a misdemeanor or felony or the willful participation in a public disturbance or riot and as a direct result of driving while legally impaired.

Benefit Exclusions & Limitations

Effective October 1, 2023, the combination Plan and SPD, Article V – Benefit Exclusions & Limitations was amended. The following is the exact language that can be found in Article V, Paragraph 37 of the combination Plan and SPD.

Article V – Benefit Exclusions & Limitations, Paragraph 37

37. Injury, Sickness, treatment or expenses incurred from or occurring during an attempt to commit or the commission of a misdemeanor or felony or the willful participation in a public disturbance or riot and as a direct result of driving while legally impaired, whether or not court-ordered. Notwithstanding the foregoing, inpatient or outpatient treatment at a Hospital or Substance Abuse Treatment Center may be covered provided the services are medically necessary for the treatment of alcoholism, chemical dependency or substance abuse and would otherwise be covered under the Plan's Section 4.14- Substance Abuse Benefit.

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,

Indiana Laborers Welfare Fund
Board of Trustees

****IMPORTANT NOTICE CONCERNING YOUR HEALTH & WELFARE BENEFITS****

Over the past three years, group health plans, like the Indiana Laborers Welfare Fund ("the Fund") were required to provide enhanced coverage and administrative relief to participants and beneficiaries in response to the COVID-19 pandemic. As you may be aware, the National Emergency declaration relating to the COVID-19 pandemic ended on April 10, 2023 and the Public Emergency declaration ended on May 11, 2023. Below is an explanation of how this may affect your rights and benefits available under the Fund.

COVID-19 Testing

In response to the COVID-19 pandemic and a desire to make COVID-19 testing more widely available to the public, the federal government required group health plans, like the Fund, to provide diagnostic services, such as COVID-19 diagnostic tests, without cost-sharing, prior authorization, or other medical management restrictions. In addition, since January 15, 2022, plan participants were able to purchase FDA authorized at-home over-the-counter COVID-19 rapid diagnostic tests without any cost sharing as required by federal law. With the Public Health Emergency and National Emergency ending, group health plans are no longer required to reimburse participants for purchases of over-the-counter COVID-19 rapid diagnostic tests. Accordingly, the Fund will no longer reimburse plan participants and beneficiaries for at-home over-the-counter COVID-19 rapid diagnostic tests as of May 11, 2023. The Fund will continue to cover COVID-19 diagnostic tests provided during health care provider visits.

COVID-19 Vaccinations for Grandfathered plans

In addition to COVID-19 diagnostic testing, a Grandfathered group health plan, like the Fund, is not required to provide COVID-19 preventive items, services and immunizations without cost-sharing, however, the Fund covers routine childhood and adult immunizations if recommended by a physician at 100% when provided in-network. Accordingly, the Plan will cover COVID-19 immunizations in the same manner as other routine immunizations covered by the Plan.

Administrative Relief: Claims Related Extension to Expire

Participants and beneficiaries were granted administrative relief for certain claims related deadlines, such as extensions during the Outbreak Period for filing claims for benefits, appealing adverse benefit determinations and filing or perfecting a request for external review, if applicable. In light of the Public Health and National Emergency declarations ending, the extensions for claims related deadlines will soon expire. This Notice is to inform you that the Plan will treat July 10, 2023 as the end of the Outbreak Period. If you have any questions about how this may affect your rights and obligations under the Plan, please contact the Fund Office.

Administrative Relief: COBRA Related Extension to Expire

In addition to extensions for claims related matters, participants and beneficiaries were also granted extensions for COBRA deadlines. In light of the National Emergency declaration ending on April 10, 2023, the extensions for COBRA deadlines will soon expire. This Notice is to also inform you that the Plan will treat July 10, 2023 as the end of the Outbreak Period. Accordingly, if you or your dependents are entitled to elect COBRA continuation coverage but have not yet elected COBRA continuation coverage or you have not paid your initial premium because of the extensions allowed for COBRA deadlines, please be aware of the July 10, 2023 date. Please contact the Fund Office if you have any questions regarding when you must elect COBRA continuation coverage or submit your initial premium for COBRA continuation coverage.

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 Post Office Box 1587, Terre Haute, Indiana 47808-1587, or by phone (800) 962-3158.

INDIANA LABORERS WELFARE FUND
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