INDIANA LABORERS WELFARE FUND
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www.indianalaborers.org

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

*** Important Welfare Benefit Changes ***

June 2024

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 changes to the Plan:

I. LIFE EVENTS AND REGISTRATION OF NEW DEPENDENTS:

There are several significant events that may occur while you are covered under the Plan. Remember to contact the Fund Office in writing if:

1. Your address or telephone number changes.
2. You marry, divorce or obtain a legal separation from your spouse. You must also submit the appropriate legal documents (for example: marriage certificate, divorce decree, custody agreement). See timely registration requirements below.
3. You change your beneficiary.
4. The status of a dependent changes.
5. You become a parent. You must also submit the child's state-certified birth certificate, decree of adoption or a qualified medical child support order. See timely registration requirements below.
6. You go into or return from military service.
7. You are injured on the job.
8. You are injured in an accident.
9. You become eligible for Medicare.
10. You retire.
11. You change your enrollment status in a Medicare prescription drug plan.
12. You perform work for a non-signatory employer.
13. You perform work at a different trade within the construction industry for a signatory or non-signatory employer.

Timely Registration Requirements for Employees:
An Employee has 30 days after a life event (marriage, adoption, etc.) to add a Dependent, unless the life event is the birth of a child. If an Employee has a child, that child must be added as a Dependent within 60 days of the child's birth. If the new Dependent is added in a timely manner, the new Dependent will be eligible retroactively to the date of the life event.

If a Dependent of an Employee is not added in a timely manner (more than 30 days after the life event or more than 60 days after birth), the new Dependent will be eligible beginning with the first of the month after the receipt of all documented proof of dependency.

Officers-Board of Trustees

James O. McDonald, II
Chairman

Brian C. Short
Secretary-Treasurer

Somer Taylor
Administrative Manager

Employee Example 1:
John and Jane's child is born on June 12, 2024. They must file all required documentation regarding the birth of their child no later than August 11, 2024 to the Fund Office. However, August 11, 2024 is a Sunday, therefore, they have until August 12, 2024 in order for any services incurred for the period on or after June 12, 2024 to be eligible for payment by the plan. John submits the required paperwork on June 30, 2024. All services incurred for the child will be paid by the Plan since all required documentation was received within the 60-day timeline.

If they did not submit all required documentation regarding the birth of their child until August 20, 2024, no services will be paid by the Plan for any services prior to September 1, 2024, which means that all services related to the newborn child would be denied by the Plan until coverage begins September 1, 2024.

Employee Example 2:
Mark and Mary get married on June 12, 2024. They must file all required documentation regarding their marriage no later than July 12, 2024 to the Fund Office. However, they forgot to submit the required documentation until August 7, 2024 and Mary had a hospital stay on July 20, 2024. Since all required documentation was not received until August 7, 2024, the Plan will deny all services incurred by Mary through August 7, 2024. Due to untimely filing, coverage for Mary will not begin until September 1, 2024.

Timely Registration Requirements for Retirees:
A Retiree, after a one-time election for Retiree benefit coverage, has 30 days after a life event (marriage, adoption, etc.) to add a Dependent, unless the life event is the birth of a child. If a Retiree has a child, that child must be added as a Dependent within 60 days of the child's birth. If the new Dependent is added in a timely manner, the new Dependent will be eligible retroactively to the date of the life event. The Retiree may also change the benefit coverage type as long as it is received by the Fund Office within the timeframes noted above.

If a Dependent of a Retiree is not added in a timely manner (more than 30 days after the life event or more than 60 days after birth) and a request to change the benefit coverage type is also not received within the same timeframes noted above, the new Dependent will not be covered under the Plan and the benefit coverage type will not be changed.

Retiree Example 1:
Roger is a Retiree and has Class AS single coverage. Roger marries Rachel on June 12, 2024. They must file all required documentation regarding their marriage no later than July 12, 2024 to the Fund Office. However, they forgot to submit the required documentation until August 7, 2024 and Rachel had a hospital stay on July 20, 2024. Since all required documentation was not received until August 7, 2024, the Plan will deny all services incurred by Rachel, the benefit coverage type will remain as AS single coverage for Roger, and Rachel will not be eligible for any benefits under the Plan.

Retiree Example 2:
Paul is a Retiree. He is married to Penny and they have AS family coverage. Paul and Penny's child is born on June 12, 2024. They must file all required documentation regarding the birth of their child no later than August 11, 2024 to the Fund Office. However, August 11, 2024 is a Sunday, therefore, they have until August 12, 2024 in order for any services incurred for the period on or after June 12, 2024 to be eligible for payment by the Plan. John and Penny submit the required paperwork on June 30, 2024. All services incurred for the child will be paid by the Plan since all required documentation was received within the 60-day timeline.

However, if they did not submit all required documentation regarding the birth of their child until August 20, 2024, no services for the child will be paid by the Plan for the child and the child will not be covered under the Plan.

II. WORK FOR A DELINQUENT EMPLOYER

Employers have a legal obligation to make contributions for work performed by LIUNA members. However, there will be occasions when an Employer may become delinquent with contributions and the Plan must take legal action to collect the monies due. Currently, an Employee impacted by a delinquency is only guaranteed to receive two (2) months of credits in the Welfare Fund when payments are not received.

Effective as of **July 1, 2024**, Employees will be granted credit for all work performed for a delinquent Employer. Credit will continue to be provided during the delinquency unless the Board of Trustees provides advance notice to the affected Employees that this practice will stop. If notice is provided by the Board, then the affected Employees will need to decide whether to continue working for the delinquent Employer, and may be required to make self-payments to continue coverage.

III. SELF-PAYMENTS TO MAINTAIN ELIGIBILITY

Article III of the Summary Plan Description (SPD) explains the requirements to maintain eligibility for coverage. In some cases, if a Participant has not worked enough hours in a Qualification Period, the Participant may elect to make Total or Partial Self-Payments to continue coverage. Effective as of **August 1, 2024**, the Self-Payment options described in the SPD will only be available under the following conditions:

Total Self-Payments- In addition to the other requirements outlined in the SPD, a person must be working under a collective bargaining agreement (CBA) **or** be available and actively seeking work under a CBA.

Partial Self-Payments- In addition to the other requirements outlined in the SPD, a person must be working under a CBA or be available and actively seeking work under a collective bargaining agreement. The Participant must have also worked at least 320 hours under a collective bargaining agreement in the prior twelve months.

Example #1- Assume Bob has no hours reported and otherwise qualifies to make a Total Self-Payment to maintain coverage. If the Board of Trustees learns that Bob is not actively seeking CBA employment, or has turned down CBA employment opportunities, then his Self-Payment rights will terminate.

Example #2- Assume Jack has worked only limited hours in the past twelve months and would like to make a Partial Self-Payment to maintain coverage. If Jack has not worked at least 320 hours in the past year, he will not be eligible to make the self-payment. Additionally, if it is determined that he is not actively seeking CBA employment, or has turned down CBA employment opportunities, then he cannot make partial Self- Payments.
This change is being made to ensure the Self-Payment provisions are only available to those Participants who are actively engaged in the industry and working or seeking to work for a contributing employer. Continued coverage for those who are not actively engaged in the industry may be available through COBRA.

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 (812) 238-2551.

If you have any questions regarding these changes, please contact the Fund Office at 1-812-238-2551. 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.