CENTRAL LABORERS' WELFARE FUND BENEFIT GRIDS 2024

CENTRAL LABORERS' WELFARE FUND
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BlueCross/BlueShield PPO Plan for Active Participants Only (Not offered to Retired Participants)

Medical Benefits	Network	Out-of-Network
	Care is received from a Blue Cross/Blue Shield of Illinois PPO Physician or Hospital	Care is received from any qualified health care provider
Deductible Individual Family	 $125 $375	 $1,900 $5,700
Out-of-Pocket Maximum Individual Family	 $9,500 $28,500	 No Limit No Limit
Maximum Calendar Year Benefit	None	
Hospital Benefits Inpatient Outpatient	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Physician Office Visit/Telehealth Visit	$25 co-payment (No Deductible)	Plan pays 50%; You pay 50%
Physician Supervised Weight Loss (Criteria must be met.) **Diet Assessment/Behavioral Counseling**	$25 co-payment (No Deductible) physician visit Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% - applicable to all services
Nutritional Counseling (Criteria must be met.) **Testing and other services**	$25 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% - applicable to all services
X-rays and Labs	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Preventive Care Services Physical Exam Benefit	 $400 at 100%; Then 80% thereafter	 $400 at 100%; Then 80% thereafter
Well Child Benefits	$200 at 100%; Then 80% thereafter	No coverage except at a Public Health Dept
Emergency Room If not Medically Necessary, you pay 100%	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)
Rehabilitation Services Inpatient Outpatient - Up to 60 visits/yr.	 Not covered Plan pays 80%; You pay 20%	 Not covered Plan pays 50%; You pay 50%
Mental Health Treatment Inpatient Outpatient	 Plan pays 80%; You pay 20% $25 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Substance Abuse Services Inpatient Outpatient	 Plan pays 80%; You pay 20% $25 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	 Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Additional Surgical Option	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	Plan pays 50%; You pay 50%
Durable Medical Equipment	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Prosthetic Devices $25,000 MAXIMUM/YEAR	 Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Spinal Manipulation Calendar Year Maximum - $1,000 Up to 60 treatments per calendar year for related therapy	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Home Health Care Up to 40 visits per calendar year	 Plan pays 80%; You pay 20%	 Plan pays 50%; You pay 50%
Podiatry Services Orthotics Calendar Year Maximum - $500	$25 co-payment on physician exams 80% on all other services	Plan pays 50%; You pay 50%
TMJ Treatment Calendar Year Maximum - $500	$25 co-payment on physician exams 80% on all other services	Plan pays 50%; You pay 50%
FOR MORE DETAILS	Refer to your Summary Plan Description	

BlueCross/BlueShield PPO Plan for Retired Participants

Medical Benefits	Network	Out-of-Network
	Care is received from a Blue Cross/Blue Shield of Illinois PPO Physician or Hospital	Care is received from any qualified health care provider
Deductible Individual Family	 $125 $375	N/A
Out-of-Pocket Maximum Individual Family	 $9,500 $28,500	 N/A
Maximum Calendar Year Benefit	None	
Hospital Benefits Inpatient Outpatient	 Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	No Benefits
Physician's Office Visit/Telehealth Visit	$25 co-payment (No Deductible)	No Benefits
Physician Supervised Weight Loss **(Criteria must be met.)** **Diet Assessment/Behavioral Counseling**	$25 co-payment (No Deductible) physician visit Plan pays 80%; You pay 20%	No Benefits
Nutritional Counseling **(Criteria must be met.)** **Testing and other services**	$25 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	No Benefits
X-rays and Labs	Plan pays 80%; You pay 20%	No Benefits
Preventive Care Services Physical Exam Benefit	 $400 at 100%; Then 80% thereafter	 $400 at 100%; Then 80% thereafter
Well Child Benefit	$200 at 100%; Then 80% thereafter	No Benefits
Emergency Room If not Medically Necessary, you pay 100%	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)
Rehabilitation Services Inpatient Outpatient - Up to 60 visits per/yr.	 Not covered Plan pays 80%; You pay 20%	No Benefits
Mental Health Treatment Inpatient Outpatient	 Plan pays 80%; You pay 20% $25 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	No Benefits
Substance Abuse Services Inpatient Outpatient	 Plan pays 80%; You pay 20% $25 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	No Benefits
Additional Surgical Option	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	No Benefits
Durable Medical Equipment	Plan pays 80%; You pay 20%	No Benefits
Prosthetic Devices $25,000 MAXIMUM/YEAR	 Plan pays 80%; You pay 20%	No Benefits
Spinal Manipulation Calendar Year Maximum - $1,000 Up to 60 treatments per calendar year for related therapy	Plan pays 80%; You pay 20%	No Benefits
Home Health Care Up to 40 visits per calendar year	 Plan pays 80%; You pay 20%	No Benefits
Podiatry Services Orthotics Calendar Year Maximum - $500	$25 co-payment on physician exams 80% on all other services	No Benefits
TMJ Treatment Calendar Year Maximum - $500	$25 co-payment on physician exams 80% on all other services	No Benefits
FOR MORE DETAILS	Refer to your Summary Plan Description	

HealthLink Open Access Plan for Active and Retired Participants

Medical Benefits	Network (HMO Provider)	PPO	Out-of-Network
Deductible			
Individual	None	$125	$1,900
Family	None	$375	$5,700
Out-of-Pocket Maximum			
Individual	$9,500	$9,500	No Limit
Family	$28,500	$28,500	No Limit
Maximum Calendar Year Benefit	None		
Hospital Benefits			
Inpatient	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Outpatient	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Physician's Office Visit/Telehealth Visit	$25 co-payment (No Deductible)	$25 co-payment (No Deductible)	Plan pays 50%; You pay 50%
Physician Supervised Weight Loss (Criteria must be met.) Diet Assessment/Behavioral Counseling	$25 co-payment (No Deductible) Plan pays 80%; You pay 20%	$25 co-payment (No Deductible) Plan pays 80%; You pay 20%	Plan pays 50%; You Pay 50% - applicable to all services
Nutritional Counseling (Criteria must be met.) Testing and other services	$25 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	$25 co-payment (No Deductible) for Counseling Service Plan pays 80%; You pay 20%	Plan pays 50%; You Pay 50% - applicable to all services
X-rays and Labs	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Preventive Care Services Physical Exam Benefit	$400 at 100%; Then 80% thereafter		$400 at 100%; Then 80% thereafter
Well Child Benefit	$200 at 100%; Then 80% thereafter		No Coverage except at a Public Health Department
Emergency Room (If not Medically Necessary, you pay 100%)	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)	$155 co-payment on Physician Services (waived if admitted inpatient, not observation)
Rehabilitation Services			
Inpatient	Not covered	Not covered	Not covered
Outpatient – Up to 60 visits per/yr.	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Mental Health Treatment			
Inpatient	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Outpatient	MD Visits 1-3: 100%; then $25 co-payment thereafter Plan pays 80%; You pay 20% on all other services	$25 co-payment on physician exams Plan pays 80%; You pay 20% on all other services	Plan pays 50%; You pay 50%
Substance Abuse Services	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Inpatient	MD Visits 1-3: 100%; then $25 co-payment thereafter	$25 co-payment on physician exams	Plan pays 50%; You pay 50%
Outpatient	Plan pays 80%; You pay 20% on all other services	Plan pays 80%; You pay 20% on all other services	
Additional Surgical Option	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	Plan pays up to $100 per consultation for 2nd & 3rd surgical opinions	Plan pays 50%; You pay 50%
Durable Medical Equipment	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Prosthetic Devices $25,000 MAXIMUM/YEAR	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Spinal Manipulation	$25 co-payment on Physician visit or manipulation services		
Calendar Year Maximum - $1,000	All other services Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Up to 60 treatments per year for related therapy	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Home Health Care	Plan pays 100%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Up to 40 visits per calendar year			
Podiatry Services	$25 co-payment on physician exams	$25 co-payment on physician exams	Plan pays 50%; You pay 50%
Orthotics Calendar Year Maximum - $500	80% on all other services	80% on all other services	
TMJ Treatment	$25 co-payment on physician exams	$25 co-payment on physician exams	Plan pays 50%; You pay 50%
Calendar Year Maximum - $500	80% on all other services	80% on all other services	
FOR MORE DETAILS	Refer to your Summary Plan Description		

Prescription, Vision, Hearing & Dental Benefits for All Active and Retired Participants Regardless of the Network Chosen	
Prescription Drug Benefits	**Network**
Retail Pharmacy CVS/Caremark Generic Drugs Brand Name: No generic/formulary available Generic/formulary available **90-day supply may be purchased for the same co-payments as mail order if the purchase is made at a CVS pharmacy.**	For a 30-day supply, you pay: $15 co-payment $50 co-payment $125 co-payment *plus* the difference in cost between the generic/formulary and brand name drug
Mail Order Service Generic Drugs Brand Name: No generic/formulary available Generic/formulary available	For up to a 90-day supply, you pay: $25 co-payment $100 co-payment $250 co-payment *plus* the difference in cost between the generic/formulary and brand name drug
Patient expenses do not apply to out-of-pocket maximums.	
Vision Care Benefits – for individuals 0 - 18 years of age	
Vision Exam	Paid under the well child benefit of the comprehensive benefit plan with no charge and no deductible up to $200 and a 20% co-insurance on allowable charges thereafter.
Glasses or Contacts	$300 per purchase maximum on eye glasses (lenses and frames) and/or contacts
Vision Care Benefits – for individuals 19 years old and older	
Covered Services	$300 per person per Plan Year
Hearing Care Benefits	
Hearing Exam	Up to $100 per person once every 12-consecutive month period
Hearing Aid	Up to $750 per person once every 60-consecutive month period
Dental Benefits - for individuals 0 -18 years of age	
Dental Exam	Plan pays 80%; You pay 20% (does not apply to the $2,500 Annual Dental Maximum)
All other Covered Services	Plan pays 80%; You pay 20% (does apply to the $2,500 per person Annual Dental Maximum, including orthodontic service charges. See the Orthodontic Benefit information below.)
Dental Benefits – for individuals 19 years old and older	
Covered Services	Plan pays 80%; You pay 20% (including examinations)
Calendar Year Maximum Benefit	$2,500 per person, including orthodontic service charges
Orthodontic Services	Plan pays 50%; You pay 50%
Orthodontic Lifetime Maximum	$1,500
BENEFITS LISTED BELOW ARE OFFERED TO ACTIVE PARTICIPANTS ONLY (NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)	
Loss of Time Benefit (Active Participants Only) (NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)	
Weekly Benefit Amount	$250
Maximum Benefit Period	13 weeks
Payment Starts	1st day after accidental Injury; 8th day of disability due to Illness
Death Benefit (Active Participants Only) (NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)	
Benefit Amount	$10,000
AD&D Benefit (Active Participants Only) (NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)	
Death or Dismemberment	$10,000
Partial Dismemberment	$5,000

CONTACTS

CONTACT	CONTACT PHONE NUMBER	CONTACT WEBSITE/EMAIL
CENTRAL LABORERS' WELFARE FUND	1-800-252-6571 ELIGIBILITY – OPTION 6, OPTION 4 ENROLLMENT – OPTION 5 BENEFITS: MEDICAL – OPTION 6, OPTION 2 DENTAL – OPTION 6, OPTION 5 VISION – OPTION 6, OPTION 2	WEBSITE www.central-laborers.com EMAIL claims@central-laborers.com
BLUECROSS/ BLUESHIELD	1-800-810-2583	WEBSITE www.bcbsil.com
HEALTHLINK	1-800-624-2356	WEBSITE www.healthlink.com
CVS/CAREMARK	1-866-818-6911	WEBSITE www.caremark.com