CENTRAL LABORERS' WELFARE FUND BENEFIT GRIDS 2024



CENTRAL LABORERS' WELFARE FUND 201 N MAIN ST PO BOX 1267 JACKSONVILLE, IL 62651-1267 PH 800-252-6571 FAX 217-243-8619 EMAIL claims@central-laborers.com

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

BlueCross/BlueShield PPO Plan for Retired Participants

Medical Benefits	Network	Out-of-Network
	Care is received from a Blue Cross/Blue Shield	Care is received from any qualified health care
	of Illinois PPO Physician or Hospital	provider
Deductible		N/A
Individual	\$125	
Family	\$375	
Out-of-Pocket Maximum		
Individual	\$9,500	N/A
Family	\$28,500	
Maximum Calendar Year Benefit	None	
Hospital Benefits		No Benefits
Inpatient	Plan pays 80%; You pay 20%	
Outpatient	Plan pays 80%; You pay 20%	
Physician's Office Visit/Telehealth Visit	\$25 co-payment (No Deductible)	No Benefits
Physician Supervised Weight Loss	\$25 co-payment (No Deductible) physician visit	No Benefits
(Criteria must be met.)		
Diet Assessment/Behavioral Counseling	Plan pays 80%; You pay 20%	
Nutritional Counseling	\$25 co-payment (No Deductible) for	No Benefits
(Criteria must be met.)	Counseling Service	
Testing and other services	Plan pays 80%; You pay 20%	
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
	\$200 at 100%; Then 80% thereafter	No Benefits
Well Child Benefit		
Emergency Room	\$155 co-payment on Physician Services	\$155 co-payment on Physician Services
If not Medically Necessary, you pay 100%	(waived if admitted inpatient, not observation)	(waived if admitted inpatient, not observation)
Rehabilitation Services		No Benefits
Inpatient	Not covered	
Outpatient - Up to 60 visits per/yr.	Plan pays 80%; You pay 20%	
Mental Health Treatment		No Benefits
Inpatient	Plan pays 80%; You pay 20%	
Outpatient	\$25 co-payment on physician exams	
	Plan pays 80%; You pay 20% on all other	
	services	
Substance Abuse Services		No Benefits
Inpatient	Plan pays 80%; You pay 20%	
Outpatient	\$25 co-payment on physician exams	
oupuion	Plan pays 80%; You pay 20% on all other	
	services	
Additional Surgical Option	Plan pays up to \$100 per consultation for 2 nd &	No Benefits
	3 rd surgical opinions	
Durable Medical Equipment	Plan pays 80%; You pay 20%	No Benefits
Durable medical Equipment	1 iaii pays 00 /0, 100 pay 20 /0	
Prosthetic Devices		No Benefits
\$25,000 MAXIMUM/YEAR	Plan pays 80%; You pay 20%	
	1 iaii pays 00 /0, 100 pay 20 /0	No Benefits
Spinal Manipulation Calendar Year Maximum - \$1,000	Plan nave 80% You nov 20%	
	Plan pays 80%; You pay 20%	
Up to 60 treatments per calendar year for related therapy		
related therapy		
Home Health Care		No Benefits
Up to 40 visits per calendar year	Plan pays 80%; You pay 20%	
Podiatry Services	\$25 co-payment on physician exams	No Benefits
Orthotics Calendar Year Maximum - \$500	80% on all other services	
TMJ Treatment	\$25 co-payment on physician exams	No Benefits
Calendar Year Maximum - \$500	80% on all other services	
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-o	f-Network
Deductible		_			
Individual	None		\$125 \$275	\$1,900 \$5,700	
Family Out-of-Pocket Maximum	None		\$375	\$5,700	J
Individual	\$9,500		\$9,500	No Lin	nit
Family	\$28,500		\$28,500 \$28,500	No Lin	
Maximum Calendar Year Benefit	None		<i>¥20,000</i>		in the second seco
Hospital Benefits					
Inpatient	Plan pays 80%; You pay 20%	Plan pa	ays 80%; `	You pay 20%	Plan pays 50%; You pay 50%
Outpatient	Plan pays 80%; You pay 20%	Plan p	ays 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)		. ,	
Physician Supervised Weight Loss	\$25 co-payment (No	\$25 co	-payment	(No Deductible)	
(Criteria must be met.)	Deductible)		000/	()	applicable to all services
Diet Assessment/Behavioral Counseling	Plan pays 80%; You pay 20%	Plan pa	Plan pays 80%; You pay 20%		
Nutritional Counseling	\$25 co-payment (No	\$25 co	-payment	(No Deductible)	Plan pays 50%; You Pay 50% -
(Criteria must be met.)	Deductible)	for Cou	unseling S	ervice	applicable to all services
Testing and other services	for Counseling Service	Plan pa	ays 80%; `	You pay 20%	
×	Plan pays 80%; You pay 20%			/	
X-rays and Labs	Plan pays 80%; You pay 20%			You pay 20%	Plan pays 50%; You pay 50%
Preventive Care Services Physical Exam Benefit	\$400 at 100%; Then 80% therea				Then 80% thereafter
Well Child Benefit	\$200 at 100%; Then 80% therea	-		C C	cept at a Public Health Department
Emergency Room				t on Physician	\$155 co-payment on Physician Services
(If not Medically Necessary, you pay 100%)	Services	Service		d innotiont not	(waived if admitted inpatient, not
	(waived if admitted inpatient, not observation)	observ		eu inpalient, not	observation)
Rehabilitation Services		000010	auonj		1
Inpatient	Not covered	Not co	vered		Not covered
Outpatient – Up to 60 visits per/yr.	Plan pays 80%; You pay 20%			You pay 20%	Plan pays 50%; You pay 50%
Mental Health Treatment					
Inpatient	Plan pays 80%; You pay 20%			You pay 20%	Plan pays 50%; You pay 50%
Outpatient	MD Visits 1-3: 100%; then \$25			on physician	Plan pays 50%; You pay 50%
	co-payment thereafter	exams		Vou nov 000/	
	Plan pays 80%; You pay 20% on all other services		ays 80%; er services	You pay 20% on	
Substance Abuse Services	Plan pays 80%; You pay 20%			You pay 20%	Plan pays 50%; You pay 50%
Inpatient	MD Visits 1-3: 100%; then \$25			on physician	Plan pays 50%; You pay 50%
Outpatient	co-payment thereafter	exams			
	Plan pays 80%; You pay 20%			You pay 20% on	
	on all other services		er services		
Additional Surgical Option	Plan pays up to \$100 per		ays up to S		Plan pays 50%; You pay 50%
	consultation for 2 nd & 3 rd			and & 3rd surgical	
Durable Medical Equipment	surgical opinions Plan pays 80%; You pay 20%	opinior Plan p		You pay 20%	Plan pays 50%; You pay 50%
שיימטיל וווכעולמו בעטוףווולוונ	i iaii pays 00 /0, i 00 pay 20%		ayo 00%,	10u pay 20%	n an pays 50 %, 100 pay 50 %
Prosthetic Devices \$25,000 MAXIMUM/YEAR	Plan pays 80%; You pay 20%	Plan pa	ays 80%; `	You pay 20%	Plan pays 50%; You pay 50%
Spinal Manipulation	\$25 co-payment on Physician				
Calendar Year Maximum - \$1,000	visit or manipulation services				
	All other services Plan pays	Plan pa	ays 80%; `	You pay 20%	Plan pays 50%; You pay 50%
	80%; You pay 20%		0001	0001	
Up to 60 treatments per year for related therapy Home Health Care	Plan pays 80%; You pay 20%			You pay 20%	Plan pays 50%; You pay 50%
Up to 40 visits per calendar year	Plan pays 100%	rian pa	ay5 00%;	You pay 20%	Plan pays 50%; You pay 50%
	\$25 co pourport on physician	\$25.00	navmont	on physician	Plan pays 50%; You pay 50%
Podiatry Services Orthotics Calendar Year Maximum - \$500	\$25 co-payment on physician exams	\$25 co exams		on physician	Fian pays 50%; You pay 50%
	80% on all other services		n all other	services	
TMJ Treatment	\$25 co-payment on physician	\$25 co-payment on physician		on physician	Plan pays 50%; You pay 50%
Calendar Year Maximum - \$500	exams	exams			
			n all other	services	
FOR MORE DETAILS	Refer to your Summary Plan De				

	or All Active and Retired Participants Regardless of the Network Chosen
Prescription Drug Benefits	Network
Retail Pharmacy CVS/Caremark Generic Drugs	For a 30-day supply, you pay: \$15 co-payment
Brand Name:	φ το co-payment
No generic/formulary available	\$50 co-payment
Generic/formulary available	\$125 co-payment <i>plus</i> the difference in cost between the generic/formulary and brand name
90-day supply may be purchased for the same	drug
co-payments as mail order if the purchase is	
made at a CVS pharmacy.	
Mail Order Service	For up to a 90-day supply, you pay:
Generic Drugs	\$25 co-payment
Brand Name:	¢100
No generic/formulary available Generic/formulary available	\$100 co-payment \$250 co-payment <i>plus</i> the difference in cost between the generic/formulary and brand name
Generic/formulary available	drug
Patient expenses do not apply to out-of-pocket	
maximums.	
Vision Care Benefits – for individuals 0 - 18 year Vision Exam	
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 o	
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 a Dental Exam	ge 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,
Dental Benefits – for individuals 19 years old and	including orthodontic service charges. See the Orthodontic Benefit information below.)
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
	ED BELOW ARE OFFERED TO ACTIVE PARTICIPANTS ONLY
	AN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)
Loss of Time Benefit (Active Participants Only) PARTICIPANTS)	(NOT AVAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA
	\$250
Weekly Benefit Amount	
Maximum Benefit Period	13 weeks
Payment Starts	1 st day after accidental Injury; 8 th day of disability due to Illness
-	VAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)
Death Benefit (Active Participants Only) (NOT A	\$10,000
Benefit Amount	
	VAILABLE TO PLAN SPOUSES, DEPENDENTS, RETIREES OR COBRA PARTICIPANTS)
	\$10,000
Death or Dismemberment	
Partial Dismemberment	\$5,000
N	

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 <u>www.caremark.com</u>