Central Laborers' Welfare Fund Open Enrollment 2027

CENTRAL LABORERS' WELFARE FUND
PO BOX 1267
JACKSONVILLE, IL 62651-1267
1-800-252-6571
www.central-laborers.com

IF NEEDED, A PAPER ENROLLMENT FORM IS LOCATED AT THE END OF THIS BROCHURE.

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The 2027 Enrollment

This enrollment booklet is designed to help you understand your benefits and make the enrollment process as straightforward as possible. In the pages that follow, you will find general information about the benefits and programs available to you through the Central Laborers' Welfare Fund, along with important information about enrolling for the 2027 Plan Year. Detailed information regarding your Plan's deductible, coinsurance, benefit limits, and other specific coverage amounts is provided separately in the 2027 Schedule of Benefits. Please review the Schedule of Benefits along with this booklet to better understand your coverage and the expenses you may be responsible for throughout the year. As you review your benefit information, please pay special attention to the changes and updates for the 2027 Plan Year. While the Central Laborers' Welfare Fund provides coverage for many commonly used medical, dental, vision, and prescription drug services, not every health care expense is covered by the Plan. Complete information regarding your benefits, limitations, and exclusions can be found in your Summary Plan Description (SPD) and applicable Plan amendments. If you have questions about your benefits, claims, or the enrollment process, please contact the Fund Office Customer Service Department at 1-800-252-6571.

IMPORTANT: You must complete your 2027 enrollment, either by paper or online, before benefits can be paid for the 2027 Plan Year. Completing your enrollment by the required deadline helps ensure eligible dependents remain covered and prevents unnecessary delays in the processing of your claims.

GET STARTED BY FOLLOWING THESE STEPS:

1) Review your benefits
2) Check your coverage limits
3) Read the Plan's Notice of Privacy Practices and other special notices
4) Reference the pages containing important information
5) Complete your enrollment
6) Contact Customer Service for assistance by calling 1-800-252-6571

CONTACT	CONTACT PHONE NUMBER	CONTACT WEBSITE/EMAIL
CENTRAL LABORERS' WELFARE FUND	1-800-252-6571 FOR QUESTIONS REGARDING: ELIGIBILITY ENROLLMENT MEMBER PORTAL BENEFITS: MEDICAL DENTAL VISION	WEBSITE www.central-laborers.com EMAIL claims@central-laborers.com
BLUECROSS/ BLUESHIELD	1-800-810-2583	**WEBSITE** **www.bcbsil.com**
CVS/ CAREMARK	1-866-818-6911	**WEBSITE** **www.caremark.com**

Understanding Your Blue Choice Options PPO Network

The BlueCross/BlueShield Blue Choice Options PPO is the provider network for the Central Laborers' Welfare Fund. The network includes three tiers of providers. The network tier your doctor or provider participates in can make a significant difference in how much you pay out of pocket.

➢ **TIER 1 — Blue Choice Options PPO** consists of providers in the Blue Choice Options PPO network. Enjoy no deductible when you visit doctors or hospitals within Tier 1 of the Blue Choice Options PPO network.
➢ **TIER 2 — PPO** consists of providers who are not in the Tier 1 network but are in the broader PPO Tier 2 network. When you visit Tier 2 providers, a deductible will apply.
➢ **TIER 3 — OUT-OF-NETWORK** includes providers that are outside both Tier 1 and Tier 2 networks. You will pay significantly more compared to using in-network providers.

How the Tiered Network Works

Your level of benefits depends, in part, on the tier of the provider you choose. A primary care physician is not required, and you do not need a referral to see a specialist. The tiered network gives you flexibility while allowing you to save money by choosing Tier 1 providers whenever possible.

For specific information regarding deductibles, coinsurance, and other out-of-pocket costs for each tier, please refer to the 2027 Schedule of Benefits.

For questions about the BlueCross/BlueShield of Illinois Blue Choice Options PPO provider network or assistance locating a participating provider, contact BlueCross/BlueShield of Illinois at 1-800-810-2583 or visit their website at www.bcbsil.com.

For questions about how your Central Laborers' Welfare Fund benefits apply under the tiered network, please contact the Fund Office at 1-800-252-6571.

YOUR BENEFITS

➢ **Benefits available to you will differ depending on whether you are eligible as an actively working participant, a retired participant, or a participant covered under COBRA. To help you better understand, the chart on the right provides a breakdown of specific coverages.**

➢ **The level of the most common services is outlined in the Schedule of Benefits included in this packet. More detailed information regarding the benefits available to participants and their family can be found in the Central Laborers' Welfare Fund Summary Plan Description. To obtain a copy of the Summary Plan Description, visit www.central-laborers.com and download the latest version by going to Health/Welfare – Health and Welfare Coverage Information – Summary Plan Description or contact the Fund Office and request a copy be mailed.**

Actively Working Participants

Medical benefits
Prescription benefits
Dental benefits
Vision benefits
Hearing benefits
Loss of Time benefits
Death & Accidental Death and Dismemberment benefits

Retiree Participants

Medical benefits
Prescription benefits
Dental benefits
Vision benefits
Hearing benefits

COBRA Participants

Medical benefits
Prescription benefits
Dental benefits
Vision benefits
Hearing benefits

If you have questions regarding your eligibility or concerns about an anticipated change in eligibility you will experience in 2027, please contact the Fund Office at: 1-800-252-6571.

IMPORTANT INFORMATION

SPOUSE INSURANCE REQUIREMENT

If your spouse works full time and has medical coverage offered through his or her employer, he or she must enroll in that employer's comparable plan before any medical benefits can be paid under this Plan. Notwithstanding the foregoing, the Plan will deem comparable coverage to not exist in the event the monthly cost to your spouse of obtaining/maintaining medical coverage through his or her employer exceeds the Plan's current self-payment rate on a monthly basis. In such an event, your spouse will not be required to enroll in his or her employer's medical coverage, but you and your spouse must annually verify the cost to your spouse of obtaining/maintaining medical coverage through his or her employer on a form prescribed by the Fund Office in order to receive coverage under the Plan. This provision does not apply to the spouse of a Retiree who becomes independently eligible for Retiree benefits.

ANNUAL ENROLLMENT REQUIREMENT

Please remember, even if you do not have any changes to report or dependents to add, the Plan requires you to complete your enrollment online or return a signed Open Enrollment Form to the Fund office before any claims may be paid in 2027.

IMPORTANT INFORMATION

IF YOU MOVE

In the event of an address change for yourself or a dependent during the plan year, please update your address by completing a "Change of Address" form that can be downloaded from the Forms Gallery located on the Central Laborer's Pension, Welfare & Annuity Funds website at:

www.central-laborers.com

or

by calling the Fund Office at:

1-800-252-6571

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Central Laborers' Welfare Fund cannot release protected health information pertaining to a person who is age 18 years of age or older if that person or his or her legal representative has not authorized, in writing, the release of such information.

Authorization to Release PHI forms can be downloaded from the Forms Gallery at:

www.central-laborers.com

or

request one by calling 1-800-252-6571.

ABOUT THE SPECIAL NOTICES

As part of the Open Enrollment process for Central Laborers' Welfare Fund (the Plan), the Plan is required to provide you with special notices that outline important rights and responsibilities related to your health coverage. These notices ensure that you are fully informed about various legal protections and options available under federal and state laws. By including these notices, the Plan hopes to help you make informed decisions about your healthcare benefits.

Federal regulations, such as the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), and other relevant healthcare laws, require that the Plan provide specific information to Plan participants. On the following pages you will find the information that is designed to protect your rights and explain key provisions related to your coverage. These special notices also ensure that you are aware of special rights that may impact your enrollment or benefits.

In addition to the Notice of Privacy Practices, the next pages provide the following special notices:

1. Grandfathered Plan Notice: This notice informs participants that their health plan is classified as a "grandfathered" plan under the Affordable Care Act (ACA). These plans are exempt from some ACA requirements, such as covering preventive services without cost sharing. The notice explains that the Plan is still subject to other protections under the ACA, and it outlines the rights of participants.
2. Medicare Part D Creditable Coverage Notice: If applicable, this notice informs you whether your prescription drug coverage is considered "creditable" under Medicare rules, meaning it is expected to pay, on average, as much as standard Medicare prescription drug coverage.
3. Newborns' and Mothers' Health Protection Act (NMHPA): This notice outlines your rights regarding coverage for hospital stays in connection with childbirth.
4. Women's Health and Cancer Rights Act (WHCRA): This notice explains your rights to benefits related to having a mastectomy, including reconstructive surgery and prostheses.
5. Notice of Special Enrollment Rights: This informs you of your rights to enroll in the Plan outside of the Open Enrollment period if you experience certain life events such as marriage, birth, or loss of other health coverage.
6. Mental Health Parity and Addiction Equity Act (MHPAEA) Notice: This notice informs you that mental health and substance use disorder benefits must be treated the same as medical and surgical benefits.

It is important to review these notices carefully during Open Enrollment. They contain vital information about your healthcare coverage, your rights, and any actions you may need to take. For example, if you need to make changes to your coverage due to a life event, the Special Enrollment Rights notice will explain how to do so. Similarly, if you are nearing Medicare eligibility, the Medicare Part D notice will guide you on how to evaluate your prescription drug coverage options.

Please take the time to read these notices thoroughly and contact the Fund Office at 1-800-252-6571 if you have any questions or need further clarification.

SPECIAL NOTICES

GRANDFATHERED PLAN NOTICE

The Central Laborers' Welfare Fund (the Plan) believes that it 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 the 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. The Plan will notify you when certain other consumer protections are adopted.

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 Welfare Fund Director, Christy Brake, at 1-800-252-6571. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

SPECIAL NOTICES

OMB #0938-0990

Central Laborers' Welfare Fund
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/479-3600 • Fax 217/243-8619
http://www.central-laborers.com

Important Notice from Central Laborers' Welfare Fund About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Central Laborers' Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Central Laborers' Welfare Fund (Fund) has determined that the prescription drug coverage offered by the Fund is, on average for all Plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

OMB #0938-0990

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to join a Medicare drug plan and drop your current Fund coverage, be aware that you and your dependents will be able to get this coverage back as long as you are eligible for benefits under a Central Laborers' Welfare Fund and not a Central Laborers' Welfare Fund Retiree or COBRA recipient who has been determined to be ineligible under the COBRA eligibility rules.

If you are not a Central Laborers' Welfare Fund Retiree or COBRA recipient, but are eligible for Central Laborers' Welfare Fund benefits at the time you join a Medicare drug plan, Central Laborers' Welfare Fund will be the primary payer on all allowable prescription purchases unless your Medicare coverage is due to end stage renal disease, transplant or other condition in which Medicare considers itself the primary provider of your healthcare coverage.

When Will You Pay a Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Central Laborers' Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person or organization listed below for further information. For information from Central Laborers' Welfare Fund, you may call 1-800-252-6571. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Central Laborers' Welfare Fund changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

SPECIAL NOTICES

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Central Laborers' Welfare Fund

Contact--Position/Office: Christy Brake
Welfare Fund Director
Address: PO Box 1267, Jacksonville, IL 62651-1267
Phone Number: 1-800-252-6571

SPECIAL NOTICES

NEWBORNS' AND MOTHERS' PROTECTION ACT(NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- **All stages of reconstruction of the breast on which the mastectomy was performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **Prostheses; and**
- **Treatment of physical complications of the mastectomy, including lymphedema.**

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance may apply:

- **In-network services from a BCO level provider - No deductible; Physician Office Exam - $30 co-payment; All other allowable services - 20% coinsurance.**
- **In-network services from a PPO level provider - Individual Deductible - $160.00/Calendar Year; Physician Office Exam - $30 co-payment; All other allowable services - 20% coinsurance.**

If you would like more information on WHCRA benefits, call Central Laborers' Welfare Fund at 1-800-252-6571.

SPECIAL NOTICES

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, and that coverage ends due to one or more of the following events, you may be able to enroll your dependent in this plan:

- **Exhaustion of COBRA;**
- **Loss of eligibility for other coverage due to a legal separation or divorce (but only if it causes a loss of eligibility);**
- **Loss of dependent status;**
- **Death of the employee covered under an employee group health care plan;**
- **Termination of employment or reduction in hours;**
- **Employer contributions for a non-COBRA coverage ceases;**
- **Loss of coverage under Medicaid or Children's Health Insurance Plan (CHIP)**

However, you must request enrollment within 31 days after your spouse or dependent(s) coverage ends under another employer sponsored or individual insurance coverage or within 61 days of loss of coverage under Medicaid or CHIP.

In addition, if you have a new dependent or dependent(s) as a result of marriage, adoption, placement for adoption or due to new appointment of legal guardianship, you may be able to enroll your new dependent(s), provided you are eligible at the time, if you request enrollment and provide the required documents within the designated time frames after marriage, birth, adoption, placement for adoption, or appointment of legal guardianship. (Please reference the Summary Plan Description)

To request special enrollment or obtain more information, contact Central Laborers' Welfare Fund at 1-800-252-6571.

SPECIAL NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

SPECIAL NOTICES

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

SPECIAL NOTICES

Notice Regarding Mental Health and Substance Use Disorder Benefits

As a part of the Plan provided by Central Laborers' Welfare Fund (the Plan), you are entitled to mental health and substance use disorder benefits. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that the financial related matters, such as co-payments and deductibles, and treatment limitations for mental health and substance use disorder benefits must be no more restrictive than the most common financial requirements and treatment limitations applied to medical and surgical benefits covered by your plan. What this means is that the Plan cannot impose higher co-payments, coinsurance, or deductibles for mental health or substance use disorder services than it does for medical and surgical services nor can the number of visits or days of coverage for mental health or substance use disorder treatment be less that the limits applied to medical and surgical services. The Act also requires that the Plan ensure both in-network and out-of-network coverages are offered for mental health or substance use disorder treatment if both in-network and out-of-network coverages are offered under the medical and surgical benefits.

If you believe the Plan is not compliant with the MHPAEA, you have the right to file a complaint. You can request documents from the Plan Administrator that show how the limitations on mental health and substance use disorder benefits are applied in comparison to medical and surgical benefits. You may also contact the Department of Labor's Employee Benefits Security Administration (EBSA) for more information or to submit a complaint. For more detailed information about your mental health and substance use disorder benefits or how they are administered, please contact Christy Brake at 1-800-252-6571.

ABOUT YOUR PRIVACY

At Central Laborers' Welfare Fund (the Plan), we are committed to safeguarding the privacy of your health information. As part of this commitment, we comply with all applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). The following Notice of Privacy Practices outlines how the Plan will collect, use, and protect your personal health information, as well as your rights regarding that information.
Your health information is personal, and we recognize the importance of keeping it private. We collect your health information for purposes such as administering benefits, processing claims, and conducting healthcare operations, while ensuring that it is only shared in ways permitted by law. In certain situations, we require your explicit authorization to release specific details of your health information to third parties.
An authorization to release protected health information is a legal document that grants the Plan permission to share your protected health information (PHI) with designated individuals or entities. Completing this form is critical in situations where your healthcare information needs to be shared outside the routine operations of the health plan.

The key reasons to complete an authorization form include:

1. The authorization allows you to maintain control over who has access to your sensitive health information. You can specify exactly what information is shared and with whom.
2. Certain disclosures, such as sharing information with your employer(s) (in certain limited situations) or legal counsel, require written authorization. Without this, we cannot release your information except under rare legal circumstances.
3. When you choose to authorize specific parties to access your health records, it can help streamline processes related to your claims or appeals, ensuring that all relevant parties are informed and can act on your behalf.
4. Certain sensitive health information, such as mental health, substance use or HIV/AIDS-related information, often requires explicit authorization before it can be shared. Completing the authorization allows us to provide better support in managing these aspects of your care while complying with privacy regulations.
5. A signed authorization provides clear documentation of your wishes regarding your information. This can help prevent misunderstandings or delays in benefit administration by ensuring that the appropriate people have the necessary access.

Completing an authorization to release protected health information is a crucial step in protecting your rights while ensuring that your health information is shared appropriately to manage your health benefits. You may revoke this authorization at any time by submitting a written request.

We take your privacy seriously and are available to assist with any questions or concerns you may have regarding the use and disclosure of your health information. For your convenience, an authorization form has been included in your packet for completion. If additional copies are needed, an authorization can be downloaded from the Forms Gallery at www.central-laborers.com or request a copy by calling 1-800-252-6571.

Central Laborers' Welfare Fund
NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

In limited circumstances, federal privacy law permits us to share your information only as described below, and generally only after giving you an opportunity to agree or object, when practicable:

- Answer coverage questions from your family and friends
- Provide disaster relief

If you are not able to tell us your preferences, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Uses and Disclosures Requiring Your Written Authorization

In the following situations, we are required to obtain your written authorization before using or disclosing your information:

- Marketing purposes
- Selling your information
- Most uses and disclosures of psychotherapy notes

You may revoke an authorization at any time in writing, except to the extent we have already relied on it.

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Contact us for instructions on how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Contact us for instructions on how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly, free of charge.
- You also have the right to receive an electronic copy of this notice upon request. If you would prefer to receive it electronically or through another preferred method, let us know, and we will provide the notice in the requested format.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information to the extent permitted by law.
- We will verify that the person has the legal authority to act on your behalf before taking any action based on their requests, including reviewing required documentation such as a power of attorney or guardianship papers.
- Once we confirm their authority, your designated representative may request access to your health information, receive copies of your records, and make requests regarding your privacy rights on your behalf, subject to applicable law.
- If a parent or guardian has authority to act on behalf of a minor child, they may exercise the child’s rights under this notice, except where state or federal law provides additional privacy protections for certain types of health information.

File a complaint if you feel your rights are violated

- If you believe your privacy rights have been violated, you can file a complaint with us using the contact information provided below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting:

  www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint. Filing a complaint will not affect your coverage, the services you receive, or the benefits available to you under your health plan.

Your Choices

For certain health information you have the right to make choices about what we share.

If you have a clear preference for how we share your information in the situations described below, let us know, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most uses and disclosures of psychotherapy notes

You may revoke an authorization at any time in writing, except to the extent we have already relied on it.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can initiate timely authorizations for services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration. *Example: We provide fiduciaries with certain statistics to determine the contributions rates.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health-related research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena, in compliance with applicable legal requirements.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here, or as permitted or required by law, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Substance Use Disorder Records (42 C.F.R. Part 2)

If we receive or maintain records relating to substance use disorder treatment from a program subject to 42 C.F.R. Part 2, those records are subject to additional federal confidentiality protections beyond HIPAA. Such records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order, except as otherwise permitted by law, including applicable payment and health care operations disclosures. This means that outside of applicable payment and health care operations disclosures, we will not share substance use disorder and treatment records without your written permission or a court order (except as otherwise permitted by law).

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Privacy Official

The Central Laborers' Welfare Fund ("Fund") is a multiemployer, self-funded group health plan administered in accordance with the Employee Retirement Income Security Act ("ERISA"). The Fund is administered by its Board of Trustees, which serves as the plan administrator. The privacy official of the Fund is Christy Brake, telephone: 1-800-252-6571, email: cbrake@central-laborers.com, address: 201 N Main Street, P.O. Box 1267, Jacksonville, IL 62651-1267.

ONLINE ENROLLMENT

1. If you already have an account, skip steps 2-8 and visit www.central-laborers.com, click on the "Health/Welfare Portal" on the right of the page and log in to your account.
2. If you do not have an account, visit Central Laborers' website at www.central-laborers.com locate and click on the image, "Health/Welfare Portal", on the right side of the home page, which will take you to a login page.
3. On the login page, locate the "New Member/Dependent Registration" link and click on it. Then, complete the registration form.
    - Please note, your member ID is the number that is on your benefit cards. That number begins with 803 or 757 and will be 9 digits long.
    - Also note, you must enter your first name as it appears on your ID cards or on the mailing label from your Open Enrollment Packet.
4. Once you have completed the registration form and submitted your information, access your email and retrieve your one-time system generated password. The email you receive will be from HIPAAScheduler@BeaconSpyGlass.com
5. Click on the link located in the email, log in using your username and one-time login password provided in the email and you will be prompted to change your password. Please create your new password. (passwords are case sensitive, including the one in the email)
6. Close all your browsers.
7. Return to the Central Laborers' website at www.central-laborers.com
8. Click on the "Health/Welfare Portal" link, log in to your newly set up account and complete the Open Enrollment Online Form.

While completing your online enrollment, you will be prompted to upload various documents. Those can be scanned, or you may take a picture of the completed document(s), email them to yourself and then upload them from your computer to your online enrollment.

If you have any difficulty or need assistance, please contact the Fund Office by calling 1-800-252-6571.

PAPER ENROLLMENT

If you will be completing your enrollment via paper, you will need to locate the detachable 2027 Open Enrollment Form **(4 pages)** located inside the back cover of this booklet. **Complete all 4 pages** including the last page, which is where you will identify your enrollment status and you will sign and date the form, after reading the important information provided. Then remove **BOTH PAGES** of the form from the booklet, combine with any required documents and submit to Central Laborers' Welfare Fund using the self-addressed envelope provided.

Each section of the paper enrollment form will list required documents that will need to be completed or copied and submitted with your paper enrollment form.

Please remember to complete all 4 pages, and sign and date the back page confirming your understanding of the information provided on the form and in the enrollment documents.

If you have any difficulty or need assistance, please contact the Fund Office by calling 1-800-252-6571.

While completing your enrollment, you will be asked to provide various documents. Please reference the list of documents on the next page, which are required for various situation.

REQUIRED DOCUMENTS

SCENARIO	REQUIRED DOCUMENTS
BIOLOGICAL DEPENDENT (PARENTS MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S CERTIFIED BIRTH CERTIFICATE
BIOLOGICAL DEPENDENT (PARENTS NEVER MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S CERTIFIED BIRTH CERTIFICATE OR A FILED VOLUNTARY ACKNOWLEDGMENT OF PATERNITY OR LEGAL DOCUMENT SHOWING PARTICIPANT'S RESPONSIBILITY TO COVER
LEGALLY ADOPTED OR PENDING ADOPTION (ANY AGE)	COPY OF ADOPTION PAPERS OR SWORN STATEMENT WITH DATE OF PLACEMENT
STEP-CHILD (ANY AGE) OR BIOLOGICAL CHILD (PARENTS NOW DIVORCED)	COPY OF NATURAL PARENT'S DIVORCE DECREE. MUST BE A FILED COPY AND INCLUDE INFORMATION REGARDING HEALTHCARE BENEFIT RESPONSIBILITY.
DEPENDENT PLACED UNDER FOSTER CARE OR UNDER LEGAL GUARDIANSHIP (ANY AGE)	COPY OF DOCUMENT PLACING THE DEPENDENT IN THE PARTICIPANT'S HOME FOR FOSTER CARE OR LEGAL GUARDIANSHIP DOCUMENTS.
ADULT DEPENDENT (DISABLED)	A DEPENDENT CONFIRMATION FORM AND A STATEMENT, FROM A LICENSED PHYSICIAN OR A COURT DOCUMENT, CONFIRMING THE DEPENDENT'S DISABILITY
SPOUSE	COPY OF THE MARRIAGE CERTIFICATE AND YOUR SPOUSE'S OTHER INSURANCE CARDS (IF YOUR SPOUSE IS EMPLOYED FULL TIME AND INSURANCE IS OFFERED THROUGH THAT EMPLOYMENT, YOUR SPOUSE IS REQUIRED TO ENROLL IN THE EMPLOYER'S COMPARABLE PLAN).
REMOVING SPOUSE, DEPENDENT/STEP-CHILDREN DUE TO DIVORCE OR LEGAL SEPARATION	FILED COPY OF THE DIVORCE DECREE OR LEGAL SEPARATION PAPERS
TERMINATING SPOUSE OR DEPENDENT COVERAGE DUE TO DEATH	COPY OF THE DEATH CERTIFICATE

QUESTIONS?
PLEASE CALL 1-800-252-6571

CENTRAL LABORERS' WELFARE FUND
OPEN ENROLLMENT FORM 2027

Participant/Employee Information

Name:		
Local No.	SSN:	Home Phone:
Cell Phone:		E-mail:
Current address:		
City:	State:	ZIP Code:
Date of Birth:	Gender:	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Participant's Other Insurance Information (THIS MAY INCLUDE COVERAGE BY A PARENT OR SPOUSE)
(Coverage other than with Central Laborers' Welfare where you are the policyholder.)

(Please enclose a copy of the front and back of the cards.)

Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____

Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier/Medicare:	Group No.	ID No.

Spouse Information, if Married (Please enclose a copy of your Marriage License if not on file.)

Name:		
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender:
Current address, if different from Participant:		

Employed: ☐ Full Time ☐ Part Time ☐ No | Self Employed: ☐ Yes ☐ No | Work Phone:

Employer Name:	Employer address:	
City:	State:	ZIP Code:

Spouse's Other Insurance Information: (THIS MAY INCLUDE COVERAGE BY A PARENT)

(Please enclose a copy of the front and back of the cards.)

Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____

Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier/Medicare:	Group No.	ID No.

PLEASE REMEMBER:

1. **INCLUDE A COPY OF YOUR MARRIAGE LICENSE/CERTIFICATE SHOWING PROOF OF LEGAL MARRIAGE IF YOU ARE ADDING A SPOUSE FOR THE FIRST TIME.**
2. **INCLUDE A CERTIFIED COPY OF A BIRTH CERTIFICATE OR LEGAL DOCUMENT SHOWING PROOF OF A DEPENDENT'S RELATIONSHIP TO YOU IF YOU ARE ADDING A DEPENDENT FOR THE FIRST TIME.**
3. **INCLUDE A COPY OF THE CARDS FROM ANY OTHER INSURANCE COVERAGE ON YOU, YOUR SPOUSE OR DEPENDENT(S).**

CONTINUE TO THE NEXT PAGE ⇨

Adult Dependent – Age 19 until age 26 (Please enclose a certified copy of the dependent's Birth Certificate if not on file.)

Name:	Relationship: (i.e.-Natural Child; Stepchild; Foster Child)	
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender:
Current address, if different from Participant:		
Employed: ☐ Full Time ☐ Part Time ☐ No	Self-Employed: ☐ Yes ☐ No	Work Phone:
Employer Name:	Employer address:	
City:	State:	ZIP Code:

Adult Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards.)

Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier/Medicare:	Group No.	ID No.

Adult Dependent – age 19 until age 26 (Please enclose a certified copy of the dependent's Birth Certificate if not on file.)

Name:	Relationship: (i.e.-Natural Child; Stepchild; Foster Child)	
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender:
Current address, if different from Participant:		
Employed: ☐ Full Time ☐ Part Time ☐ No	Self-Employed: ☐ Yes ☐ No	Work Phone:
Employer Name:	Employer address:	
City:	State:	ZIP Code:

Adult Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards.)

Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier/Medicare:	Group No.	ID No.

Dependent age 0 until age 19 (Please enclose a certified copy of the dependent's Birth Certificate if not on file.)

Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		
Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		

CONTINUE TO THE NEXT PAGE ⇨

Dependent age 0 until age 19 (Continued)		
Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		
Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		
Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		

Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards.)		
Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
Policy Holder Name:		Effective Date:
Name of dependent(s) covered by the Policies:		
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.

Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards.)		
Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
Policy Holder Name:		Effective Date:
Name of dependent(s) covered by the Policies:		
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.

IF YOU HAVE MORE DEPENDENTS, PLEASE PROVIDE THE REQUESTED INFORMATION FOR EACH ON A SEPARATE PIECE OF PAPER.

DEATH BENEFIT BENEFICIARY INFORMATION

COMPLETE THE FOLLOWING SECTION IF YOU ARE A PARTICIPANT NOT COVERED BY COBRA OR A RETIREE PLAN. BE SURE YOU SIGN AND DATE THE BENEFICIARY ELECTION.

PRIMARY DEATH BENEFICIARY:		
Beneficiary Name:		Relationship:
Beneficiary Address:		
Beneficiary City:	Beneficiary State:	Beneficiary ZIP code:

ALTERNATE BENEFICIARY IF PRIMARY BENEFICIARY PRE-DECEASES ME:		
Beneficiary Name:		Relationship:
Beneficiary Address:		
Beneficiary City:	Beneficiary State:	Beneficiary ZIP code:
Signature of the Participant:		Date:

USE MY ALTERNATE BENEFICIARY IF I AM DIVORCED FROM THE PRIMARY BENEFICIARY. ☐ Yes ☐ No

CONTINUE TO THE NEXT PAGE ⇨

PLEASE SELECT YOUR 2027 ENROLLMENT STATUS FOR THE BLUECROSS/BLUESHIELD BLUE CHOICE OPTIONS PLAN

☐ Open Enrollment - Active ☐ Open Enrollment - Retiree ☐ Open Enrollment - COBRA

READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED

I agree that this application is subject to acceptance by the Central Laborers' Welfare Fund (the Plan). I understand, that if I, and any of my dependents, are eligible to participate in the Plan, that the healthcare services available to me and/or my dependent will be subject to the exclusions, limitations, deductibles, co-payments, coinsurance and other conditions of the Summary Plan Description ("SPD") and in any amendment(s) to the SPD. I further understand that the contribution(s) necessary for me, and my dependents, to be eligible (or to maintain eligibility) under the Plan may be subject to change.

I understand that my eligibility and that of my dependent(s) may be subject to verification and may require additional documentation from me including items such as marriage license, divorce decree(s), birth certificate(s), death certificate(s), official documents and/or other information before I or my dependent(s) are added and eligible on any plan offered by Central Laborers' Welfare Fund. I understand that, should I fail to submit needed verification documentation within the timeframes required, eligibility for benefits on expenses incurred by my dependent(s) or me may be denied payment until such information is provided or denied eligibility all together by Central Laborers' Welfare Fund.

I certify that all the information recorded in this application is true and correct to the best of my knowledge and belief. I understand that any misrepresentation, misstatement or omission ("incorrect information") made regarding this application, whether intentional or not, will be cause for rejection of this application. In the event that this application is approved before the incorrect information is discovered, such discovery may result in termination of my coverage under the Plan or that of my dependent(s) (if such incorrect information relates to my dependent(s)), and I may be required to reimburse the Plan. Termination of my coverage or that of my dependent(s) may be retroactive to the date of enrollment. I understand that if the terminated dependent(s) is/are a minor, then I or any other responsible parent or guardian will be required to reimburse the Plan for any and all sums expended on the dependent(s) minor's behalf for healthcare services, together with reasonable attorneys' fees and expenses incurred in collection of such sums.

I confirm that Central Laborers' Welfare Fund offered me the opportunity to enroll my dependent(s) who will be under the age of 26 years on or after January 1, 2027, or who is an unmarried dependent over age 26 and meets the definition of a disabled dependent and whose coverage was never initiated, ended or was denied. I understand that the opportunity to enroll such a dependent must be done within the 31 days of my Open Enrollment period if that dependent's eligibility is to begin the first day of the plan year for which I am enrolling or the effective date of my eligibility, whichever is later. I further understand that, should all the required documents needed to confirm the eligibility of my dependent(s) not be received within the 31 days of my Open Enrollment period, the eligibility effective date of my dependent(s) will be the first day of the month following receipt of my Open Enrollment Form and all required documentation.

I confirm that Central Laborers' Welfare Fund informed me that my Plan has eliminated all lifetime and annual limits on the dollar value of essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

I confirm that the Plan informed me that it believes it is a "grandfathered health plan" under the Patient Protections and Affordable Care Act (the Act) and, as permitted by the 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 the Plan may not include certain consumer protections of the Act that apply to other plans, for example, the requirements for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. I understand the Plan will notify me when certain other consumer protections are adopted.

I confirm that Central Laborers' Welfare Fund provided me specific contact information where I may obtain answers to questions regarding which protections apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status. The contact information included the Central Laborers' Welfare Fund at 1-800-252-6571, the Employee Benefits Security Administration, the 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.

I confirm that I understand I can elect to cease coverage for Vision, Hearing and/or Dental Benefits under the Welfare Fund for myself or my dependent(s) even though such Benefits are provided at no additional cost to me. I also understand that, to cease any of these coverages, I will need to provide written notice to the Fund Office of my intention to cease coverage(s). Cessation of Vision, Hearing or Dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

I also confirm that I understand that if I previously elected to cease coverage for Vision, Hearing and/or Dental Benefits under the Welfare Fund, I may reinstate coverage by providing written notice to the Fund Office. I further understand that reinstatement of Vision, Hearing or Dental coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you.

I understand that, in the event of a conflict between the wording in this application, the open enrollment materials and the Plan Document that governs the Plan, the Plan Document shall govern. I further understand that the Trustees reserve the right to amend, modify and terminate the Plan at any time.

Print Name of Participant:	
Signature of Participant:	**Date:**