# Central Laborers' Welfare Fund Schedule of Benefits 2027

CENTRAL LABORERS' WELFARE FUND
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# BlueCross/BlueShield Blue Choice Options Plan for Active and Retired Participants

| Medical Benefits | Network (BCO Provider) | PPO | Out-of-Network |
|---|---|---|---|
| Deductible<br>Individual<br>Family | <br>None<br>None | <br>$160<br>$480 | <br>$2,400<br>$7.200 |
| Out-of-Pocket Maximum<br>Individual<br>Family | <br>$9,500<br>$28,500 | <br>$9,500<br>$28,500 | <br>No Limit<br>No Limit |
| Maximum Calendar Year Benefit | None | | |
| Hospital Benefits<br>Inpatient<br>Outpatient | <br>Plan pays 80%; You pay 20%<br>Plan pays 80%; You pay 20% | <br>Plan pays 80%; You pay 20%<br>Plan pays 80%; You pay 20% | <br>Plan pays 50%; You pay 50%<br>Plan pays 50%; You pay 50% |
| Physician's Office Visit/Telehealth Visit | $30 co-payment (No Deductible) | $30 co-payment (No Deductible) | Plan pays 50%; You pay 50% |
| Physician Supervised Weight Loss Visit<br>(Criteria must be met.)<br>Diet Assessment/Behavioral Counseling | $30 co-payment (No Deductible)<br><br>Plan pays 80%; You pay 20% | $30 co-payment (No Deductible)<br><br>Plan pays 80%; You pay 20% | Plan pays 50%; You Pay 50% - applicable to all services |
| Nutritional Counseling<br>(Criteria must be met.)<br>Testing and other services | $30 co-payment (No Deductible) for Counseling Service<br>Plan pays 80%; You pay 20% | $30 co-payment (No Deductible) for Counseling Service<br>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<br>Physical Exam Benefit | <br>$400 at 100%; Then 80% thereafter | <br>$400 at 100%; Then 80% thereafter | <br>$400 at 100%; Then 80% thereafter |
| Well Child Benefit | $200 at 100%; Then 80% thereafter | $200 at 100%; Then 80% thereafter | No Coverage except at a Public Health Department |
| Emergency Room<br>(If not Medically Necessary, you pay 100%) | $200 co-payment on Physician Services (waived if admitted inpatient, not observation) | $200 co-payment on Physician Services (waived if admitted inpatient, not observation) | $200 co-payment on Physician Services (waived if admitted inpatient, not observation) |
| Rehabilitation Services<br>Inpatient<br>Outpatient – Up to 60 visits per year | <br>Not covered<br>Plan pays 80%; You pay 20% | <br>Not covered<br>Plan pays 80%; You pay 20% | <br>Not covered<br>Plan pays 50%; You pay 50% |
| Mental Health Treatment<br>Inpatient<br><br>Outpatient | <br>Plan pays 80%; You pay 20%<br><br>MD Visits 1-3: 100%;<br>then $30 co-payment thereafter;<br>Plan pays 80%; You pay 20% on all other services | <br>Plan pays 80%; You pay 20%<br><br>$30 co-payment thereafter;<br>Plan pays 80%; You pay 20% on all other services | <br>Plan pays 50%; You pay 50%<br><br>Plan pays 50%; You pay 50% |
| Substance Abuse Services<br>Inpatient<br><br>Outpatient | <br>Plan pays 80%; You pay 20%<br><br>MD Visits 1-3: 100%;<br>then $30 co-payment thereafter;<br>Plan pays 80%; You pay 20% on all other services | <br>Plan pays 80%; You pay 20%<br><br>$30 co-payment on Physician Exams<br>Plan pays 80%; You pay 20% on all other services | <br>Plan pays 50%; You pay 50%<br><br>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/calendar yr<br>(Unless otherwise required by applicable law) | Plan pays 80%; You pay 20% | Plan pays 80%; You pay 20% | Plan pays 50%; You pay 50% |
| Spinal Manipulation<br>Calendar Year Maximum - $1,000<br><br><br><br>Up to 60 treatments per year for related therapy | <br>$30 co-payment on Physician Visit or manipulation services;<br>All other services<br>Plan pays 80%; You pay 20%<br><br>Plan pays 80%; You pay 20% | <br>Plan pays 80%; You pay 20%<br><br><br><br>Plan pays 80%; You pay 20% | <br>Plan pays 50%; You pay 50%<br><br><br><br>Plan pays 50%; You pay 50% |
| Home Health Care<br>Up to 40 visits per calendar year | Plan pays 100% | Plan pays 80%; You pay 20% | Plan pays 50%; You pay 50% |
| Podiatry Services<br>Orthotics Calendar Year Maximum - $500 | $30 co-payment on Physician Exams<br>80% on all other services | $30 co-payment on Physician Exams<br>80% on all other services | Plan pays 50%; You pay 50% |
| TMJ Treatment<br>Calendar Year Maximum - $500 | $30 co-payment on Physician Exams<br>80% on all other services | $30 co-payment on Physician Exams<br>80% on all other services | Plan pays 50%; You pay 50% |

FOR MORE DETAILS REFER TO YOUR SUMMARY PLAN DESCRIPTION

| Prescription, Vision, Hearing & Dental Benefits for All Active and Retired Participants | |
|---|---|
| **Prescription Drug Benefits** | **Network Pharmacy** |
| Retail Pharmacy – 30-day supply<br>Generic Drugs<br>Brand Name:<br>No generic/formulary available<br>Generic/formulary available | <br>$15 co-payment<br><br>$65 co-payment<br>$160 co-payment *plus* the difference in cost between the generic/formulary and brand name drug |
| CVS (Mail Order or Retail Pharmacy) – 90-day supply<br>Generic Drugs<br>Brand Name:<br>No generic/formulary available<br>Generic/formulary available | <br>$30 co-payment<br><br>$130 co-payment<br>$325 co-payment *plus* the difference in cost between the generic/formulary and brand name drug |
| Network Specialty Pharmacy – 30-day supply | 20% coinsurance up to a maximum of $100/prescription |
| Prescription drug co-payments are not applied to the annual individual medical out-of-pocket maximum | |
| **Vision Care Benefits – for individuals 0-18 years of age** | |
| One vision exam per year and one pair of standard glasses (lenses and frame) will be covered at 100%.<br>Any additional vision exam services and all other vision aids will be subject to the $600 child vision maximum. | |
| **Vision Care Benefits – for individuals 19 years of age and above** | |
| Covered Services | $600 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** | |
| Routine cleaning, exams, bitewing x-rays, and fluoride – every 6-months<br>Panorex/Complete mouth x-rays - once every 3-years<br>Sealants - once every 3-years(through age 17) | 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 of age and above** | |
| 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<br>(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 |