

Central Laborers' Welfare Fund

OPEN ENROLLMENT 2012



The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit it must be at least \$1.25 million.

Your health coverage, offered by Central Laborers' Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Your coverage has an annual limit of:

\$250,000 on all covered benefits and

\$150,000 on organ transplant benefits (no lifetime limit)

\$10,000 on substance abuse treatment (no lifetime limit)

\$25,000 on prosthetic devices (no lifetime limit)

\$750 for Well Child exams and immunizations

\$750 for adult Physical Exams

\$2,500 for Durable Medical Equipment

\$600 for Spinal Manipulation

This means that your health coverage might not pay for all the health care expenses you incur. For example, a stay in a hospital costs around \$1,853 per day. At this cost, your insurance would only pay for approximately 135 days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits of at least \$1.25 million this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2013.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to:

www.HealthCare.gov.

If you have any questions or concerns about this notice, contact Cynthia J Smith-Brannan, the Welfare Fund Director, at 1-800-252-6571. In addition, you can contact the Office of Consumer Health Insurance at 1-877-527-9431 (toll free) or go to the website at <http://www.insurance.illinois.gov/Main/consumer.asp>

HealthLink Open Access Plan for Active and Retired Participants

Medical Benefits	Network (HMO Provider)	PPO	Out-of-Network
	Care is coordinated through your primary care Physician	Care is received from a HealthLink PPO Physician or Hospital	Care is received from any qualified health care provider
Deductible Individual Family	None None	\$100 \$300	\$1500 \$4500
Out-of-Pocket Maximum Individual Family	\$7,500 \$22,500	\$7,500 \$22,500	No Limit No Limit
Maximum Calendar Year Benefit	\$250,000		
Hospital Benefits Inpatient Outpatient	Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	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's Office Visits	\$20 Co-payment	\$20 Co-payment (No Deductible)	Plan pays 50%; You pay 50%
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	\$750/Annual Maximum \$400 at 100%; Then \$350 at 80%	\$750/Annual Maximum \$400 at 100%; Then \$350 at 80%	
Well Child Benefits	\$750/Annual Maximum \$200 at 100%; Then \$550 at 80%	No Coverage except at a Public Health Department	
Emergency Room	\$125 Co-payment on Physician Services (waived if admitted) If not Medically Necessary, you pay 100%	\$125 Co-payment on Physician Services (waived if admitted) If not Medically Necessary, you pay 100%	Plan pays 50%; You pay 50%
Rehabilitation Services Inpatient Outpatient – Up to 60 visits per/yr	Not covered Plan pays 80%; You pay 20%	Not covered Plan pays 80%; You pay 20%	Not covered Plan pays 50%; You pay 50%
Mental Health Treatment * Inpatient - Up to 30 days per year Outpatient – Up to 30 visits per year	Plan pays 80% Visits 1-3: Plan pays 100% Visits 4-30: \$40 Co-payment	Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% Plan pays 40%; You pay 60%
Substance Abuse Treatment * \$10,000 Maximum/Year	Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Additional Surgical Option	Plan pays up to \$100 per consultation for 2 nd & 3 rd surgical opinions	Plan pays up to \$100 per consultation for 2 nd & 3 rd surgical opinions	Plan pays 50%; You pay 50%
Durable Medical Equipment \$2,500 MAXIMUM/YEAR 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 Calendar Year Maximum - \$600 Up to 60 treatments per year for related therapy	\$20 co-payment on Physician visit or manipulation services. All other services Plan pays 80%; You Pay 20% Plan pays 80%; You pay 20%	Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% Plan pays 50%; You pay 50%
Home Health Care Up to 40 visits per calendar year	Plan Pays 100%	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Podiatry Services Orthotics Calendar Year Maximum - \$500	\$20 Co-pay on physician services 80% on all other services	\$20 Co-pay on physician services 80% on all other services	Plan pays 50%; You pay 50%
TMJ Treatment Calendar Year Maximum - \$500	\$20 Co-pay on physician services 80% on all other services	\$20 Co-pay on physician services 80% on all other services	Plan pays 50%; You pay 50%
Transplant Benefits	Refer to your Summary Plan Description		

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	\$100 \$300	\$1,500 \$4,500
Out-of-Pocket Maximum Individual Family	\$7,500 \$22,500	No Limit No Limit
Maximum Calendar Year Benefit	\$250,000	
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's Office Visits	\$20 co-payment (No Deductible)	Plan pays 50%; You pay 50%
X-rays and Labs	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Preventive Care Services Physical Exam Benefit	\$750/Annual Maximum \$400 at 100%; Then \$350 at 80%	\$750/Annual Maximum \$400 at 100%; Then \$350 at 80%
Well Child Benefits	\$750/Annual Maximum \$200 at 100%; Then \$550 at 80%	No coverage except at a Public Health Department
Emergency Room	\$125 Co-payment on Physician Services (waived if admitted) If not Medically Necessary, you pay 100%	Plan pays 50%; You pay 50%
Rehabilitation Services Inpatient Outpatient - Up to 60 visits per year	Not covered Plan pays 80%; You pay 20%	Not covered Plan pays 50%; You pay 50%
Mental Health Treatment * Inpatient - Up to 30 days per year Outpatient - Up to 30 visits per year	Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50% Plan pays 40%; You pay 60%
Substance Abuse Services * \$10,000 Annual Maximum	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Additional Surgical Option	Up to \$100 per 2 nd & 3 rd consultation	Plan pays 50%; You pay 50%
Durable Medical Equipment \$2,500 MAXIMUM/YEAR Prosthetic Devices \$25,000 MAXIMUM/YEAR	Plan pays 80%; You pay 20%	Plan pays 50%; You pay 50%
Spinal Manipulation Calendar Year Maximum - \$600 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	\$20 Co-pay on physician services 80% on all other services	Plan pays 50%; You pay 50%
TMJ Treatment Calendar Year Maximum - \$500	\$20 Co-pay on physician services 80% on all other services	Plan pays 50%; You pay 50%
Transplant Benefits	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	
Deductible Individual Family	\$100 \$300	N/A
Out-of-Pocket Maximum Individual Family	\$7,500 \$22,500	N/A
Maximum Calendar Year Benefit	\$250,000	
Hospital Benefits Inpatient Outpatient	Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	No Benefits
Physician's Office Visits	\$20 co-payment (No Deductible)	No Benefits
X-rays and Labs	Plan pays 80%; You pay 20%	No Benefits
Preventive Care Services Physical Exam Benefit	\$750/Annual Maximum \$400 at 100%; Then \$350 at 80%	\$750/Annual Maximum \$400 at 100%; Then \$350 at 80%
Well Child Benefits	\$750/Annual Maximum \$200 at 100%; Then \$550 at 80%	No Benefits
Emergency Room	\$125 Co-payment on Physician Services (waived if admitted) If not Medically Necessary, you pay 100%	No Benefits
Rehabilitation Services Inpatient Outpatient - Up to 60 visits per year	Not covered Plan pays 80%; You pay 20%	No Benefits
Mental Health Treatment * Inpatient - Up to 30 days per year Outpatient - Up to 30 visits per year	Plan pays 80%; You pay 20% Plan pays 80%; You pay 20%	No Benefits
Substance Abuse Services * \$10,000 Annual Maximum	Plan pays 80%; You pay 20%	No Benefits
Additional Surgical Option	Up to \$100 per 2 nd & 3 rd consultation	No Benefits
Durable Medical Equipment \$2,500 MAXIMUM/YEAR Prosthetic Devices \$25,000 MAXIMUM/YEAR	Plan pays 80%; You pay 20%	No Benefits
Spinal Manipulation Calendar Year Maximum - \$600 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	\$20 Co-pay on physician services 80% on all other services	No Benefits
TMJ Treatment Calendar Year Maximum - \$500	\$20 Co-pay on physician services 80% on all other services	No Benefits
Transplant Benefits	Refer to your Summary Plan Description	

Prescription, Vision, Hearing & Dental Benefits for Active and Retired Participants	
Prescription Drug Benefits	Network
Retail Pharmacy (Express-Scripts) Generic Drugs Brand Name: No generic/formulary available Generic/formulary available 90 day supply may be purchased at retail for the same co-payments as mail order	For a 30-day supply, you pay: \$10 co-payment \$40 co-payment \$100 co-payment <i>plus</i> 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: \$20 co-payment \$80 co-payment \$200 co-payment <i>plus</i> 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	
Covered Services	\$300 per person per Plan Year
Hearing Care Benefits	
Hearing Exam	Up to \$75 per person once every 24 consecutive month period
Hearing Aid	Up to \$400 per person once every 60 consecutive month period
Dental Benefits	
Covered Services	Plan pays 80%; You pay 20%
Calendar Year Maximum Benefit	\$1,500 per person, including orthodontic service charges
Orthodontic Services— No Coverage for Invisalign® or similar forms of orthodontic treatment	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	1 st day after accidental Injury 8 th 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