Central Laborers' Welfare Fund
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619
http://www.central-laborers.com

WELCOME TO YOUR 2023 OPEN ENROLLMENT

Your Enrollment Period

During this designated time, you should either complete your enrollment online by following the links provided at www.central-laborers.com or complete and return the enclosed multi-page Open Enrollment Application.

YOUR ONLINE ENROLLMENT WILL ONLY BE AVAILABLE THROUGH THE DEADLINE DATE LISTED BELOW. IF YOU MISSED THE DEADLINE, BUT STILL WISH TO SUBMIT YOUR ENROLLMENT ONLINE, PLEASE CONTACT THE FUND OFFICE AT 1-800-252-6571, OPTION 5 FOR ASSISTANCE. OTHERWISE, PLEASE COMPLETE AND SUBMIT THE PAPER FORM.

The 2023 Plan Year

Enclosed please find your Open Enrollment information for the 2023 Plan Year for the Central Laborers' Welfare Fund (hereinafter "Fund" or "Plan"). Also included in this packet are several forms and notifications that the Fund Office is required to distribute in order to comply with the terms of the Patient Protection and Affordable Care Act (PPACA) and other legislative mandates. It is very important that you read each of the notices and review the benefit grids carefully as there may be changes that will affect you and your dependents on or after January 1, 2023.

Should you find you need assistance understanding any of the enclosed information or you need help in determining how to complete any of the required forms, please do not hesitate to contact the Fund Office at 1-800-252-6571, option 5.

THE 2023 OPEN ENROLLMENT PROCESS

PLEASE REMEMBER, EVEN IF YOU DO NOT HAVE ANY CHANGES TO REPORT, DEPENDENTS TO ADD OR A CHANGE IN THE NETWORK UNDER WHICH YOU PARTICIPATE, THE FUND 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 2023.

Before you complete your 2023 Open Enrollment, please consider the following:

1. Examine the network descriptions on the benefit grid documents enclosed in this enrollment packet. Please review the available benefits, deductibles, co-payments and co-insurance rates associated with each network.

2. **If you plan to enroll online please reference the detailed instructions provided for you starting on page 12 of the enclosed brochure.**

3. Online enrollment allows you to electronically sign your 2023 form.

4. **If you plan to enroll via paper application, please use the Open Enrollment form attached to the enclosed brochure. Please note, all areas of the form that pertain to you or your dependents must be completed.**

5. If you choose to complete the paper form, please mail your completed Open Enrollment information to the Fund Office in the enclosed envelope.

6. **If you or any of your dependents have other insurance or Medicare, please provide that information, either online or on the paper application. Then, please provide copies of any other insurance card(s) or Medicare card(s).**

7. If you are becoming eligible for the first time or are changing networks in 2023, you will be issued new medical identification cards. In most instances, new cards will not be mailed to you for approximately ten (10) days to two (2) weeks following your enrollment. If you require medical care prior to when you receive your cards, you may use the identification number listed on your dental card. (For newly eligible members, a dental card has been enclosed.)

Adult Dependent, Dependent and Spouse Eligibility

Effective January 1, 2011, the PPACA extended coverage to adult dependents. Individuals will be allowed to enroll such adult dependents annually during open enrollment and in special situations described elsewhere in your enrollment materials and in your Summary Plan Description. Eligibility of such dependents will be effective the later of the first day the Participant's eligibility is effective, on or after January 1, 2023 or the first day of the month following receipt of all documents needed to confirm a dependent's eligibility for benefits.

Please remember that any dependent(s)' eligibility may be subject to verification and may require you to provide additional documents such as a birth certificate(s), divorce decree(s), marriage license, death certificate(s) or other forms necessary to confirm a dependent's relationship and eligibility for benefits. Please note that if the required documentation is not received timely, eligibility may not be provided to your dependent(s) or their eligibility could be delayed. In addition, some documents may require updating throughout the year.

Please be sure to contact the Fund Office with any new or updated information regarding other coverage you, your dependents or spouse may have. In addition, you are encouraged to watch your mail and review all mailings to ensure compliance with any requests from the Fund office.

- **Please remember, if your spouse is employed full-time and insurance is offered through his or her employer, your spouse must enroll in the most comparable plan before benefits can be coordinated by the Fund.**

Notice that Central Laborers' Welfare Fund is a Grandfathered Plan

The Central Laborers' Welfare Fund ("Fund") 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 Fund 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 Fund 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, Cynthia Smith-Brannan, 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 Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

CENTRAL LABORERS' WELFARE FUND OPEN ENROLLMENT 2023

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

TABLE OF CONTENTS

WELCOME TO OPEN ENROLLMENT 2023

HOW TO ENROLL

This enrollment booklet provides you with detailed information intended to guide you through the enrollment process. The next several pages outline the benefits for which you are eligible, including particulars related to the plan deductible, co-insurance levels and maximum allowances. This information can help you understand what is paid by Central Laborers' Welfare Fund and assist you as you plan for your potential annual out of pocket expense.

Although Central Laborers' Welfare Fund does not cover every possible medical, dental, vision and prescription drug cost you may incur, it does provide coverage for the most common services, which are more specifically defined in your Summary Plan Description. To better understand your benefits, how claims are paid or to get assistance with the enrollment process, please contact one of our knowledgeable customer service representatives by calling 1-800-252-6571. For medical benefit information choose option 6 and then 2 and for dental benefit information select option 6 and then 5. For enrollment assistance, choose option 5.

To get started we suggest you take the following steps:

1) Review the benefits starting on page 5.
2) Compare the available networks highlighted on page 10.
3) Confirm your doctors and hospitals participate in the network you are considering for 2023 by calling or going online with the network using the contact information on page 11.
4) Ensure the network you are considering for 2023 has providers where you will be living or traveling.
5) Review the enrollment processes beginning on page 12
6) Contact the Central Laborers' Welfare Fund for assistance with the enrollment process by calling 1-800-252-6571, Option 5

THE 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 specific coverages you have available, please reference the chart below. If you have questions regarding your eligibility type or concerns about an anticipated status change you will experience in 2023, please contact the Fund Office at 1-800-252-6571, option 5.

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

BlueCross/BlueShield PPO Plan for Active Participants Only (Not offered to Retired Participants)

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

BlueCross/BlueShield PPO Plan for Retired Participants

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

HealthLink Open Access Plan for Active and Retired Participants

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

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

THE NETWORK OPTIONS

Central Laborers' Welfare Fund offers you two network options. Although the benefits provided under each are nearly identical, the physicians, hospitals and geographic area the network covers will differ.

Highlights regarding each network are provided below. To determine which network is the best fit, you are encouraged to contact the network representatives using the contact information on the next page or call Central Laborers' Welfare Fund at 1-800-252-6571, option 5.

BlueCross/BlueShield

- The BlueCross/BlueShield network has nationwide access, meaning they have providers across the United States.
- Both in-network and out-of-network benefits are available to eligible Active plan participants and their eligible dependents.
- Only in-network benefits are available to eligible Retiree participants and their eligible dependents.
- The BlueCross/BlueShield network includes general practitioners, specialty physicians, hospitals and surgical facilities.

HealthLink

- The HealthLink network is primarily confined to Illinois, Missouri and a few of the surrounding states.
- Both in-network and out-of-network benefits are available to eligible Active and Retiree participants and their eligible dependents.
- The HealthLink network includes general practitioners, specialty physicians, hospitals and surgical facilities.
- The HealthLink providers may contract as an HMO or PPO provider. Depending on the physician, hospital or ancillary contract services you receive, you may be eligible for a waiver of your annual deductible.

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	1-800-624-2680	WEBSITE www.healthlink.com
CVS/CAREMARK	1-866-818-6911	WEBSITE www.caremark.com

ONLINE ENROLLMENT

1. If you already have an account, skip steps 2-10 and visit www.central-laborers.com, click on the "OPEN ENROLLMENT" in the middle of the page and login to your account.
2. If you do not have an account, visit the Central Laborers' website at www.central-laborers.com locate and click on the link, "OPEN ENROLLMENT", in the middle 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.
4. Please note, your member ID is the number that is on your benefit cards. That number begins with 803 and will be 9 digits long.
5. Also note, you must enter your name as it appears on your ID cards or on the mailing label from your open enrollment packet.
6. 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
7. Click on the link located in the email, login using your user name and one-time login password provided in the email and you will be prompted to change your password. Please create your new password. Please note that passwords are case sensitive, including the one in the email.
8. **Close all your browsers.**
9. Return to the Central Laborers' website at www.central-laborers.com
10. Click on the "OPEN ENROLLMENT" link, log into your newly set up account and complete the open enrollment online form.

ONLINE ENROLLMENT (CONTINUED)

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 at 1-800-252-6571 option 5 or view the member access portal guide (pdf) or online open enrollment guide (pdf) located on the Central Laborers' website.

PAPER ENROLLMENT

If you will be completing your enrollment via paper you will need to pull out all four (4) pages of the Open Enrollment Form 2023 that is located on the back pages of this booklet. Complete all 4 pages including the last page, which is where you will mark your 2023 network choice, you will identify your enrollment status and you will sign and date the form, after reading the important information provided. Then remove the form from the booklet, combine with the required documents and submit to the 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.

Again, please remember to select your network choice by checking the box at the top of the back page and sign and date 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 at 1-800-252-6571 option 5

PLEASE REVIEW THE FOLLOWING LIST OF REQUIRED DOCUMENTS, WHICH MAY BE NEEDED BY THE FUND IN ORDER TO CONFIRM A DEPENDENT'S ELIGIBILITY. IF ANY OF THE LISTED CIRCUMSTANCES PERTAIN TO YOUR PERSONAL SITUATION, PLEASE PROVIDE COPIES OF THE INFORMATION REQUESTED.

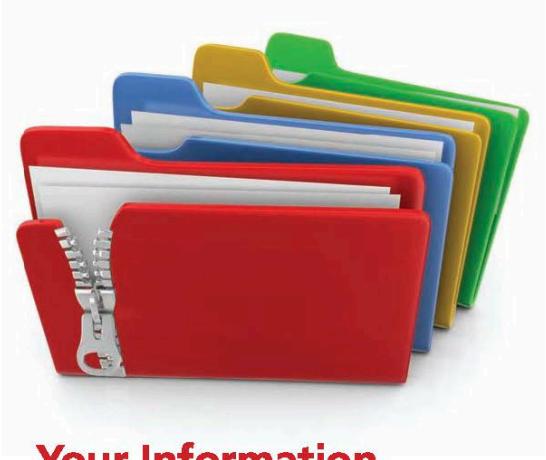
SITUATION	REQUIRED DOCUMENTS
BIOLOGICAL DEPENDENT (PARENTS MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S BIRTH CERTIFICATE
BIOLOGICAL DEPENDENT (PARENTS NEVER MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S BIRTH CERTIFICATE AND A VOLUNTARY ACKNOWLEDGMENT OF PATERNITY OR LEGAL DOCUMENT SHOWING PARTICIPANT'S 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, OPTION 5

PRIVACY NOTICE

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

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 your 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. Ask us 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. Ask us 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.

PRIVACY NOTICE (CONT)

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 paper 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.
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. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • 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.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, 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

PRIVACY NOTICE (CONT)

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 arrange additional 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:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

Our Uses and Disclosures

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 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.

PRIVACY NOTICE (CONT)

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.

1. *Administrative release forms or documents to confirm your/your authorized representative's identity, may be required.*
2. *To help protect your health information, change of address documents may require signature verification before any health information is forwarded to a new address.*
3. *Central Laborers' Welfare Fund provides you access to your health information through its Member Portal Access. Although the federal regulations require Central Laborers' Welfare Fund to protect and secure your health information, those regulations are not applicable if you download or choose to share your information through print, email, social media, etc.*

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 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.**

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 web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

CENTRAL LABORERS' WELFARE FUND

Central Laborers' Welfare Fund
PO Box 1267
Jacksonville, IL 62651-1267

www.central-laborers.com
Privacy Official's Phone – 1-800-252-6571
Privacy Official's email – claims@central-laborers.com

SPECIAL NOTICES

Central Laborers' Welfare Fund
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619
http://www.central-laborers.com

GRANDFATHERED PLAN NOTICE

The Central Laborers' Welfare Fund ("Fund") 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 Fund 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 Fund 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, Cynthia Smith-Brannan, 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 Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

SPECIAL NOTICES (CONT)

Central Laborers' Welfare Fund
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619
http://www.central-laborers.com

NEWBORN'S ACT DISCLOSURE

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 HMO level provider (HealthLink Open Access Plan only)– No deductible; Physician Office Exam - $25 co-payment; All other allowable services – 20% co-insurance.
- In-network services from a PPO level provider – Individual Deductible - $125.00/Calendar Year; Physician Office Exam - $25 co-payment; All other allowable services – 20% co-insurance.

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

SPECIAL NOTICES (CONT)

Central Laborers' Welfare Fund
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619
http://www.central-laborers.com

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 A Children's Health Insurance Plan (CHIP)

However, you must request enrollment within 31 days after your spouse or dependent(s) coverage ends or after the employer stops contributing toward the other coverage.

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, you request enrollment and provide the required documents within 31 days after the marriage, adoption, placement for adoption or appointment of legal guardianship.

If you have a new dependent or dependent(s) as a result of a birth, you may be able to enroll your new dependent(s), provided you are eligible at the time, if you request enrollment and provided the required documents within 90 days after the birth.

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

SPECIAL NOTICES (CONT)

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, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

SPECIAL NOTICES (CONT)

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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 5218

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, 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

SPECIAL NOTICES (CONT)

Central Laborers' Welfare Fund
P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • 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.

SPECIAL NOTICES (CONT)

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 (CONT)

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: Cynthia J Smith-Brannan, RN, LNCC
Welfare Fund Director
Address: PO Box 1267, Jacksonville, IL 62651-1267
Phone Number: 1-800-252-6571

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average eight hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

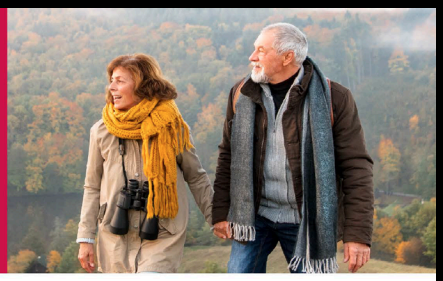
CLWF2017-2023

WHAT'S NEW

Effective January 1, 2023, Central Laborers' Welfare Fund has partnered with Amplifon Hearing Health Care to provide you and your family members with more affordable options in hearing aids. Although you are not required to go to a specific hearing aid specialists when considering or purchasing hearing aids, Amplifon has experienced providers and hearing aid discount programs that may help your hearing device dollars stretch further.

The information that follows summarizes the Amplifon program for you. For more information regarding services and to get started setting an appointment with an Amplifon professional call 1-855-890-0289 or visit their website at www.amplifonusa.com/lp/clwf.

Treat your hearing loss, easily and affordably



What causes hearing loss?

Hearing loss can be temporary and caused by simple things like ear wax or a cold. It can also be permanent, caused by damage to the tiny hair-like cells in the inner ear as a result of exposure to noise, aging, other health conditions, or certain medications.

When should I get my hearing checked?

Hearing loss can come on so gradually that you may not even notice it's happening. In general, you should have your hearing screened every three to five years, and tested annually if you are over the age of 50 or experiencing any of the following:

- **Consistent exposure** to loud noises.
- **Difficulty understanding** in noisy environments or in groups.
- **Hearing mumbling** or feeling as though people are not speaking clearly.
- **Ringing** in your ears.

How can I check my hearing?

Getting your hearing checked is now easier than ever with in-person and at-home options:

- **Virtual screening** allows you to confirm if hearing loss is detected from the comfort of home
- **Professional hearing evaluations** take place in a hearing care clinic setting. A hearing care professional will work with you to complete an in-depth evaluation of your hearing and propose solutions if hearing loss is indicated.

Learn more at www.amplifonusa.com/lp/clwf

amplifon Hearing Health Care.

Your Hearing Program

amplifon Hearing Health Care.

If you think you may have hearing loss, rest easy. Central Laborers' Welfare Fund has teamed up with Amplifon to offer you quality hearing health care.

	Level 1	Level 2	Level 3	Level 4	Level 5
	Hearing aid options from the top brands with an average savings of 66% off retail pricing.				
Amplifon Price (per ear)	$995/ear	$1,495/ear	$1,795/ear	$2,195/ear	$2,645/ear
Your Plan Benefit (For add'l savings)	$750 every 60 consecutive months				

New virtual services

Virtual screening – determine need from the comfort of home
Personalized coaching – enhance adjustment and use of hearing aids
On-demand virtual visits – convenient care for non-clinical support

Risk-free trial

Find your right fit by trying your hearing aids for 60 days

Complimentary aftercare

1-year follow-up care - ensures smooth transition to your new hearing aids
2-year battery support - battery supply or charging station to keep you powered
3-year warranty - coverage for loss, repairs, or damage

To learn more, call 855-890-0289 TTY: 771 | Hours: Mon-Fri 7am - 8pm CT or visit: www.amplifonusa.com/lp/clwf

You and your provider will determine the best device to meet your hearing loss, lifestyle, and technology needs.
Risk-free trial - 100% money-back guarantee if not completely satisfied, no return or restocking fees
Follow-up care - for one year following purchase. **Batteries** - two-year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. **Warranty** - exclusions and limitations may apply. Contact Amplifon 855-890-0289 for details.
Virtual screening does not take the place of a diagnostic exam by a licensed professional. Not all virtual services are available on all products.
Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Central Laborers' Welfare Fund and Amplifon are independent, unaffiliated companies. Hearing services are administered by Amplifon Hearing Health Care, Corp.

3309MEMR/Central Laborers' Welfare Fund

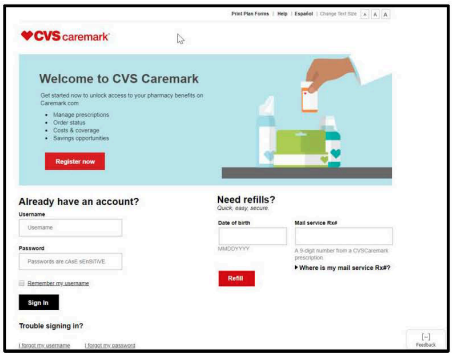
WHAT'S NEW

Beginning January 1, 2023, the Fund Office will no longer be processing secondary prescription reimbursement requests. January 1, 2023, individuals with primary prescription drug coverage can submit any secondary prescription reimbursement requests directly through the Carmark.com website or via the CVS Mobile App. The process is quite simple and, on the following pages, we provide you with a picture guide that is intended to assist you, step-by-step with the submission of a claim.

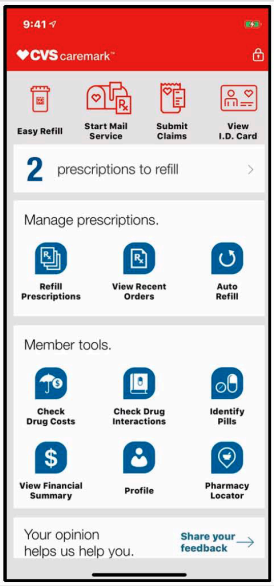
Should you encounter any difficulties or need assistance, please contact the Fund Office at 1-800-252-6571 or call CVS/Caremark at 1-866-818-6911 or 1-800-378-9442 (CVS/Caremark web support line).

Claim Submission Methods

CAREMARK.COM WEBSITE



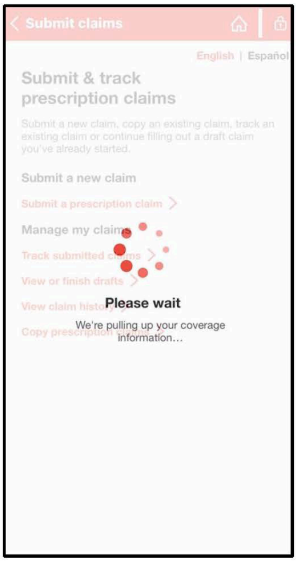
MOBILE APP

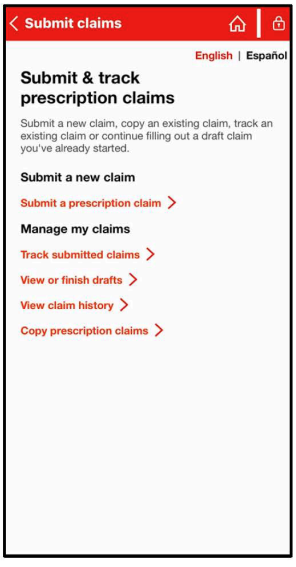


CVSHealth

Digital Claim Submission Menu

ELIGIBILITY VERIFICATION

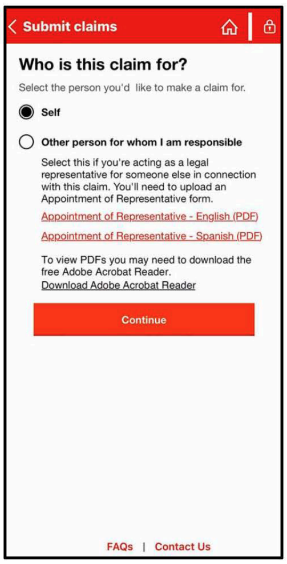


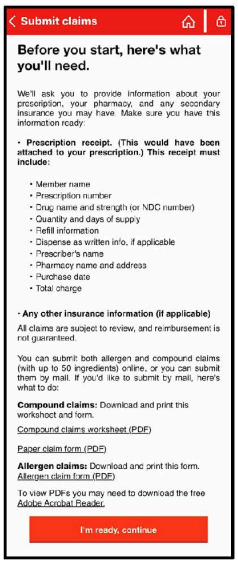


CVSHealth

Submitting a Digital Claim

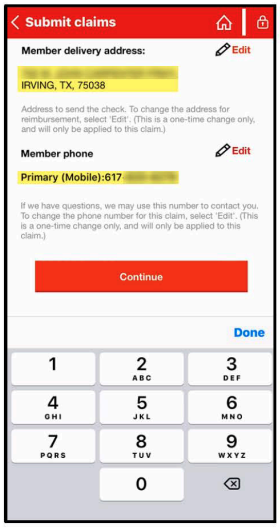
MEMBER SELECTION



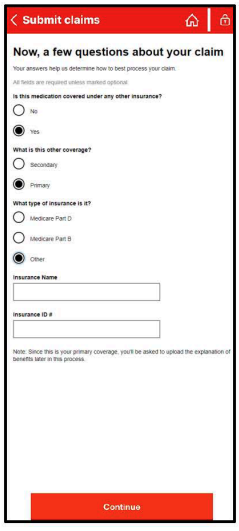


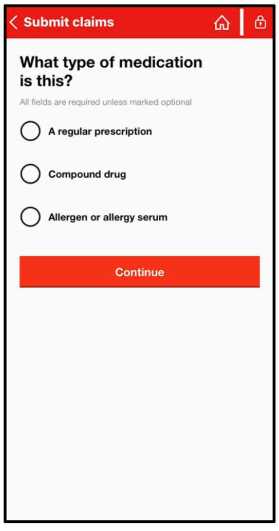
CVSHealth

MEMBER VERIFICATION



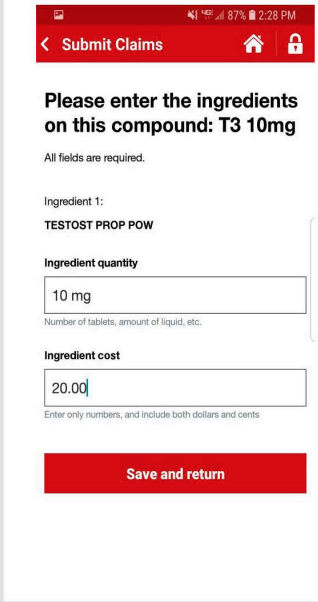
INITIAL QUESTIONS



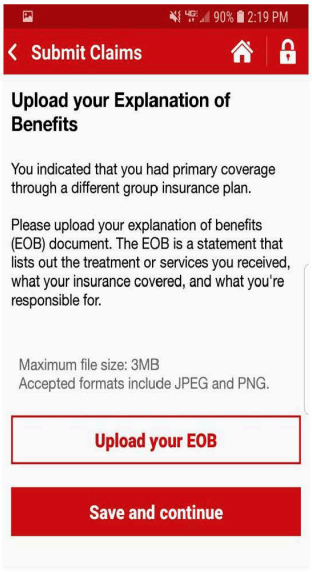


CVSHealth

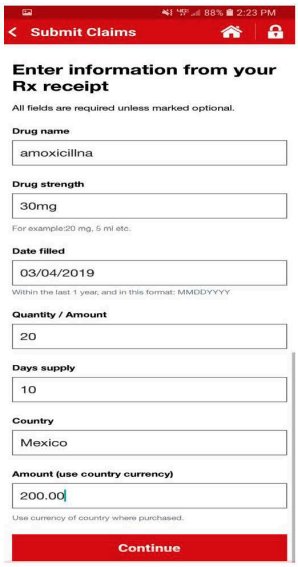
COMPOUND SCREEN



EOB SCREEN

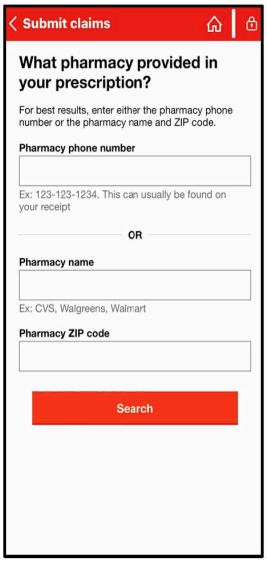


FOREIGN CLAIMS

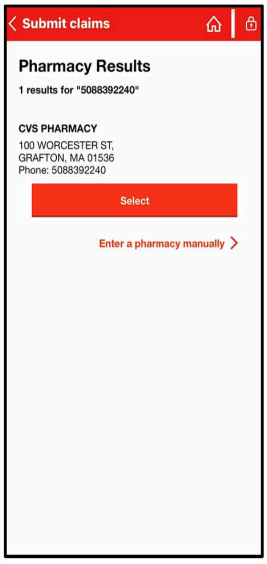


CVSHealth

PHARMACY SEARCH

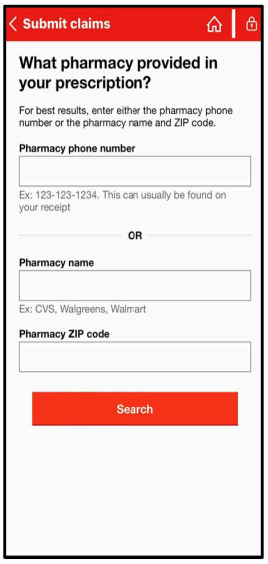


PHARMACY SELECTION



CVSHealth

PHARMACY SEARCH



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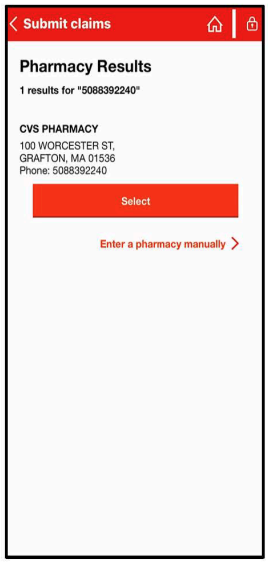
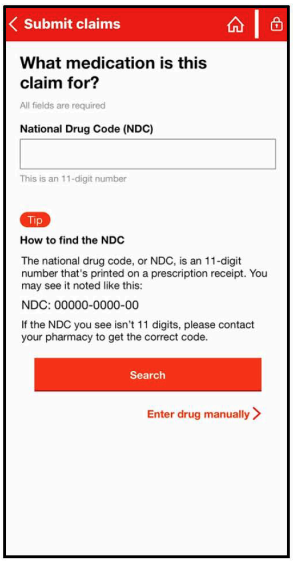


CVSHealth

NDC SEARCH

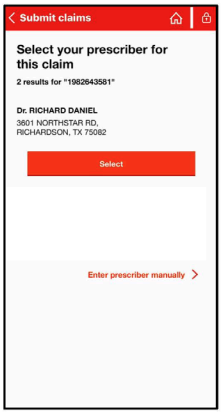


PRESCRIPTION CLAIM INFO

CVSHealth

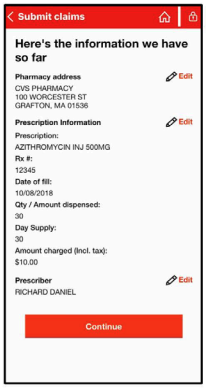
PRESCRIBER SEARCH

PRESCRIBER SELECTION

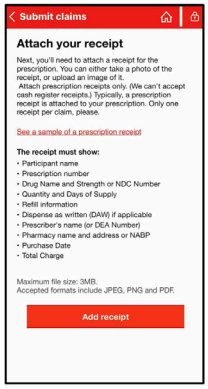


CVSHealth

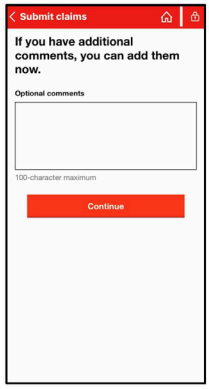
CLAIM REVIEW



RECEIPT UPLOAD



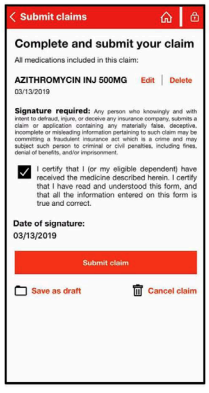
CLAIM COMMENTS

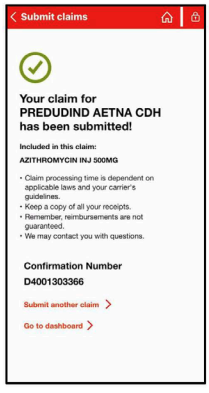


CVSHealth

CLAIM VERIFICATION

SUBMISSION AND CONFIRMATION





CVSHealth

IMPORTANT INFORMATION

TELADOC

Effective January 1, 2023, Central Laborers' Welfare Fund will no longer cover Telehealth services if receive through TelaDoc. Although individuals who are currently receiving services through TelaDoc can continue, the cost of those visits will not be covered under your Central Laborers' Welfare Fund plan of benefits.

Be assured, telehealth services will still be available to all eligible individuals. However, telehealth services would need to be sought from a network provider and will be subject to the $25.00 co-payment per visit or, if a visit takes place with an out of network provider, the service would be subject to the out of network deductible and co-insurance rate.

Please reference the benefit grids on page 6 of this booklet for more information about telehealth visits or contact the Fund Office at 1-800-252-6571.

IMPORTANT INFORMATION

SPOUSE INSURANCE REQUIREMENT

If your spouse is employed full-time and has medical coverage offered through his or her employer, he or she must enroll in the employer's comparable plan before any medical benefits can be paid under the Central Laborers' Welfare Fund's plan of benefits.

IF YOU MOVE

If you or any of your dependents change address 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 Funds' website – www.central-laborers.com – or by calling the Fund Office at 1-800-252-6571 and asking that a form be mailed to the new address.

Release of 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 forms can be downloaded from the Forms Gallery at www.central-laborers.com or obtain one by calling 1-800-252-6571, option 5

CENTRAL LABORERS' WELFARE FUND
OPEN ENROLLMENT FORM 2023

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 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 copy of the dependent's Birth Certificate if not on file.)		
Name:	Relationship: (i.e.-Natural Child; Step-Child; 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 copy of the dependent's Birth Certificate if not on file.)		
Name:	Relationship: (i.e.-Natural Child; Step-Child; 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 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 →

I ELECT TO ENROLL IN THE FOLLOWING NETWORK FOR THE 2023 PLAN YEAR

☐ **Blue Cross PPO** ☐ **HealthLink (Open Access Plan)**

MY ENROLLMENT STATUS

☐ **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. 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 delayed in processing, 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, 2023 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 who 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) is not 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 Central Laborers' Welfare Fund (Fund) 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 Fund 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 Fund 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 web site 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 and/or Dental Benefits under the Welfare Fund for myself or my Dependents even though such Benefits are provided at no additional cost to me. I also understand that, to cease either of these coverages, I will need to provide written notice to the Fund Office of my intention to cease coverage. Cessation of vision 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 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 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:**