

**CONNECTICUT LABORERS' HEALTH FUND**  
**SCHEDULE OF BENEFITS**

MAY 1, 2024

**PLEASE VISIT OUR WEBSITE AT: [WWW.CTLABORERSFUNDS.COM](http://WWW.CTLABORERSFUNDS.COM)**

**ACTIVE PARTICIPANTS:**

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	<b>PLAN PAYS</b>
<b>Life Insurance</b>	
Active Participant (Member Only) .....	\$20,000
Active Participant Maintaining Coverage Through FULL COBRA .....	\$20,000
<b>Accidental Death Benefits</b>	
Principal Sum (Active Member and FULL COBRA Only). .....	\$40,000
Workplace Accidental Death Benefit (Active Member and FULL COBRA Only). .....	\$50,000
<b>Dismemberment Benefits</b>	
Partial Payment up to Principal Sum (Member and FULL COBRA Only). .....	\$40,000
<b>Weekly Disability Income Benefits (Non-Work-Related) *</b>	
Maximum Weekly Payment. ....	\$400
Maximum Period of Benefit .....	26 weeks
<i>*Benefits start on the first day of disability due to Injury and on the eighth day of the disability due to Illness. This seven-day waiting period is waived where the recovery period resulting from a member's illness or major surgery is shown by a medical professional to be two (2) weeks or more</i>	
<i>Benefits are not payable if you are collecting unemployment, retired and collecting a pension.</i>	

**MEDICAL BENEFITS: IN-NETWORK (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

<b>Lifetime Maximum/Calendar Year Maximum</b> .....	None
<b>Deductible</b> .....	None
<b>Calendar Year Out-of-Pocket Maximum</b> .....	\$2,000 per person
.....	\$4,000 per family

This is a combined medical and prescription drug in-network out-of-pocket maximum. All in-network copayments for services recognized by the Plan as a covered charge will accumulate toward the calendar year out-of-pocket maximum, except copayments for dental, vision and hearing services. Once you're in-network copayments reach this threshold, the balance of your in-network expenses for the remainder of the calendar year will be paid in full without being subject to a copayment. All covered charges are paid in full when provided by a participating hospital, physician or provider, subject to the following copayments:

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 2

**TO ACCESS AETNA:**

Go to [aetna.com](http://aetna.com) for In-Network Medical Providers and choose the **Aetna Choice POS II Plan**. In-network Aetna Dental providers can be found on the same website – for In-Network Dental Providers choose the Dental PPO Plan.

**IN-NETWORK BENEFITS**

**In-network hospitals and providers are through the Aetna PPO Network**

All Covered Charges are paid in full when provided by a participating Hospital, Physician or provider, subject to the following co-payments:

	<b>YOU PAY</b>
<b>Primary Care Physician Office Visit</b> .....	\$25 copayment
<b>Specialist Office Visit</b> ..... (Dermatology \$25 copayment)	\$40 copayment
<b>Hospital Admission (per admission)</b> .....	\$250 copayment
<b>Inpatient Surgery</b> .....	\$0 copayment
<b>Anesthesia</b> .....	\$0 copayment
<b>Outpatient Surgery</b> .....	\$0 copayment
<b>Major Imaging (CAT Scan, PET Scan etc.)</b> .....	\$25 copayment
<b>X-Ray and Other Imaging</b> .....	\$25 copayment
<b>Emergency Room and Free-Standing Medical Centers</b> .....	\$235 copayment
When services are for a diagnosis considered an emergency (copayment waived if admitted to the hospital).	
<b>Non-Emergency Room and Free-Standing Medical Centers</b> .....	\$235 copayment
<b><u>Teladoc:</u></b>	
<b>General Medicine</b> .....	\$25 copayment
(Behavioral Health \$0 copayment)	
<b>Urgent Care Centers</b> .....	\$40 copayment
<b>Walk-In Clinic Other Than a Primary Care Physician</b> .....	\$25 copayment
<b>CVS Minute Clinic</b> .....	\$0 Copayment

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 3

	<b>YOU PAY</b>
<b>Routine Physical Examination (once per calendar year)</b> .....	\$0 copayment
<b>Adult Immunizations</b> .....	\$0 copayment
Includes immunizations required to travel abroad	
<b>Gynecologist Visit (Preventive)</b> .....	\$0 copayment
<b>Mammograms (Preventative)</b> .....	\$0 copayment
<b>Well Baby Care</b> .....	\$0 copayment
First 12 months—seven visits	
Age 13 months to 24 months—three visits	
Age 25 months to 36 months—three visits	
Age 3 years and older—annually	
<b>Colonoscopy (From age 45)</b> .....	\$0 copayment
<b>Diagnostic Laboratory</b> .....	\$25 copayment
<b>Physical, Speech and Occupational Therapy (Restorative)</b> .....	\$40 copayment
Maximum combined treatment sessions per calendar year .....	
<b>(Includes OP Hospital)</b> .....	
<b>Chiropractic Services</b> .....	\$40 copayment
Maximum visits per calendar year .....	
<b>Chemotherapy</b> .....	\$0 copayment
<b>Allergist Visits (home/office/Out-Patient Hospital)</b> .....	\$40 copayment
Copayments do not apply to follow up injections without an Office Visit	
<b>Naturopathic Visits</b> .....	\$25 copayment
Excludes vitamins and supplements	
<b>Nutritional Counseling</b> .....	\$0 copayment
Maximum visits per calendar year .....	
<b>Acupuncture</b> .....	\$25 copayment
30 visits per calendar year. Additional visits may be authorized by Aetna's managed care review	
<b>Educational Outpatient Disease Management Program</b> .....	\$0 copayment
<b>Cardiac Rehabilitation Program</b> .....	\$40 copayment

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 4

	<b>YOU PAY</b>
<b>Skilled Nursing Facility</b> .....	\$250 copayment per admission
Maximum days per calendar year .....	120
<b>Home Health</b> .....	\$0 copayment
Maximum visits per calendar year .....	120
<b>Hospice</b> .....	\$250 copayment per admission
(Paid in Full under Aetna's Compassionate Care Program)	
<b>Maternity, Obstetrical, Midwifery:</b>	
1st Office Visit will be subject to \$40 copay with all follow up office visits paid in-full. In-Network charges for ultrasound and laboratory services etc. will be subject to standard copayments	
<b>Organ/Tissue Transplants</b> .....	\$250 copayment
(Coverage is subject to pre-certification)	
<b>Infertility Services</b> .....	Standard copayments for hospital or outpatient treatment
(Coverage subject to Aetna's managed care review)	
<b>Ambulance (Includes Air Ambulance)</b> .....	\$0 copayment
Air Ambulance Benefit Maximum .....	None
For medical emergencies to nearest hospital that can provide appropriate care.	
<b>Durable Medical Equipment</b> .....	\$0 copayment
Subject to review for medical necessity and reasonable and customary charges, along with restrictions on purchase, rental and useful life of equipment	
<b>Prosthetics</b> .....	\$0 copayment
<b>Orthotics</b> .....	20% of Covered Charges
Benefit Limitations .....	Limited to a prescribed insert or shoe once every 36 months
<b>Massage Therapy</b> .....	\$50 maximum reimbursement/12 visits per calendar
<b>Gene Therapy (In-Network)</b> .....	\$40 copayment
(Out-of-Network not covered)	
<b>Bariatric (In-Patient Hospital)</b> .....	\$250 copayment
(Coverage subject to Aetna's managed care review)	

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 5

**Employee Assistance Program (EAP)**

Call **Tri-State EAP Services, Inc.** at (845) 228-8303 to pre-certify In-Patient or Out-Patient Care. **Tri-State EAP** is confidential and available to help members and their eligible dependents with personal or family problems, anger management, stress, anxiety, etc. Call them at (845) 228-8303.

**YOU PAY**

**In-Patient Mental Health/Behavioral Health/Substance Use Treatment** ..... \$250 copayment per admission

**Out-Patient Mental Health/Behavioral Health/Substance Use Treatment** ..... \$0 copayment per visit

**YOU PAY**

**Habilitative, Physical, Occupational and Speech therapy For Autism Spectrum Disorder (pervasive developmental disorder) and developmental delay is covered without age, visit or dollar limit**.....\$40 copayment per visit

**Applied Behavior Analysis (ABA Services) are covered, without age, visit or dollar limits:** .....\$0 copayment

**Behavioral Health — "outpatient all other" In Network is covered,** .....\$0 copayment

**Behavioral Health — "outpatient all other" Out of Network is covered, after deductible:** .....20% coinsurance

**Methadone/Dolophine Treatment for inpatient/outpatient Substance Use.**  
Subject to review for medical necessity and preauthorization.....Copayment is subject to place of service

**MEDICAL BENEFITS: OUT-OF-NETWORK (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

Out-of-network charges are subject to reasonable and customary limitations.

**YOU PAY**

**Individual Deductible** ..... \$200 per calendar year  
**Family Deductible** ..... \$400 per calendar year

**Coinsurance** .....After the deductible the you are responsible for 20% coinsurance of Allowable Charges

**Calendar Year Out-of-Pocket Maximum** ..... **Individual: \$4,000/Family: \$8,000**

*Medical In-Patient services require precertification. Failure to pre-certify such services or to satisfy the requirements of the Utilization Review Program will result in a 20% reduction in benefits, subject to a maximum penalty of \$500 per occurrence. Call Aetna at 800-245-1206 to pre-certify*

**CVS CAREMARK PRESCRIPTION DRUG BENEFITS (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

Log onto CVS website at: <https://www.caremark.com/wps/portal> or download Caremark App:



If you use a CVS Pharmacy, you can fill up to a 90-day supply.

	<b>YOU PAY</b>
<b>Retail Pharmacy</b> (Up to a 30-day supply)	
Tier I, (Typically Generic Drugs) Copayment.....	\$10 per prescription
Tier II, Preferred Brand Name Drug Copayment .....	\$25 per prescription
Tier III, Non-Preferred Brand Name Drug Copayment.....	\$50 per prescription
<b>Mail Order Program</b> (Up to a 90-day supply)	
Tier I, (Typically Generic Drugs) Copayment.....	\$20 per prescription
Tier II, Preferred Brand Name Drug Copayment .....	\$50 per prescription
Tier III, Non-Preferred Brand Name Drug Copayment.....	\$100 per prescription

Generic birth control prescriptions and brand name birth control prescriptions without a generic equivalent have a \$0 copayment.

No payment will be made by the Fund for any prescription drugs obtained from a non-network pharmacy.

**DENTAL BENEFITS (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

Out-of-network charges are subject to reasonable and customary limitations.

**Calendar Year Maximum** .....\$2,000 per person  
 Calendar Year Maximum does **not** apply to children under 19 years of age

	<b>YOU PAY</b>
<b>Preventive Care Services</b> .....	\$0
<b>Basic Services</b> .....	20% coinsurance
<b>Major Services</b> .....	30% coinsurance
<b>Orthodontia Benefit (eligible dependent under age 19 only)</b> .....	20% coinsurance
(\$5,000 lifetime maximum applies to Orthodontic expenses)	
<b>Temporomandibular Joint Dysfunction (TMJ)</b> .....	20% coinsurance
(Coverage is subject to Aetna's managed care review)	

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 7

**HEARING CARE BENEFIT (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

**OPTION 1 (You may choose EITHER Option 1 or 2) PLAN PAYS**

**Hearing Evaluation**..... 100%

One exam every three years, or more frequently if recommended by a University of Connecticut audiologist. Includes evaluation, medical examination and molds.

**Hearing Aids**.....100% of the first \$2,000 per appliance and 80% of the Excess Charges  
Benefits payable if provided by the University of Connecticut Speech and Hearing Clinic.

**OPTION 2 (You may choose EITHER Option 1 or 2) PLAN PAYS**

**Hearing Evaluation**..... 100%

One exam every three years, or more frequently if recommended by an Aetna Audiologist. Includes evaluation, medical examination and molds.

**Hearing Aids**

If a participant uses an **Aetna Audiologist** the Health Fund (Aetna) will pay the first \$2,000 per Hearing Aid (which includes the examination, etc.) at 100%. Once every three (3) consecutive years unless recommended by the Audiologist.

**IMPORTANT: All Charges in excess of the \$2,000 per Hearing Aid have to be paid by the participant directly to the Audiologist.**

**You MUST** submit itemized receipts from the Audiologist (hearing aid description, cost and amount paid by the participant) to the Health Fund and the participant will be reimbursed on a self-funded basis at 80% coinsurance with a Maximum Out of Pocket of \$250 per Hearing Aid.

**VISION EXPENSE BENEFIT (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

Log onto Eye Med by accessing their website at: <https://member.eyemedvisioncare.com/member/en>

Eligible Participant, Spouses and Dependent children up to age 26..... once per Plan Year

**In-Network Benefit** ..... **PLAN PAYS**

**If you utilize an Eye Med optometrist, the eye examination and refraction is paid in full. Most frames, lens types and coating options are paid in full if obtained from an Eye Med Vision provider.**

**Eye Examination** ..... 100%

**Optomap Retinal Examination** ..... 100%

**Eyeglass Frames** ..... up to a \$200 Allowance

**Freedom Pass Frames at Lenscrafters or Target Optical**..... 100%  
(excludes certain designer frames)

**Eyeglass Lenses** ..... 100%

Copayments apply for anti-reflective coatings and other features such as photosensitive lenses, and Polycarbonate lenses, etc.

**Contact Lenses** ..... up to a \$200 Allowance

**Laser (LASIK) Vision Correction Surgery** ..... 15% off retail or 5% off promotional price

**\*\*\*No payment is made for the replacement of lost or stolen eyeglasses\*\*\***

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 8

**VISION EXPENSE BENEFIT (ACTIVE PARTICIPANTS AND ELIGIBLE DEPENDENTS UP TO AGE 26)**

**Vision Benefits Out-of-Network Benefit**

<b>Eye Examination</b> .....	\$40
<b>Retinal Imaging</b> .....	\$20
<b>Frames</b> .....	\$140
<b>Single Lenses</b> .....	\$30
<b>Bifocal Lenses</b> .....	\$50
<b>Trifocal and Lenticular</b> .....	\$70
<b>Progressive Lenses</b> .....	\$50
<b>Contact Lenses</b> .....	\$140

**Retiree Benefits**

To be Eligible for Retiree Benefits whether you are Eligible for Medicare or Not Eligible for Medicare if you are an Active Participant (including related entities, such as the staff of the Connecticut Laborers' Legal Services Fund, the staff of the Connecticut Laborers' Fund Office, the staff of affiliated Local Unions, Connecticut Laborers' District Council, Organizing Fund, Training Fund, etc.:

1. You must have maintained Active Eligibility (including COBRA) in the Health Fund immediately prior to your retirement; and,
2. You must be eligible for and receiving a monthly pension benefit from the Connecticut Laborers' Pension Fund or the Pension Plan for the Staff of Connecticut Laborers'; and
3. You must have worked 10,000 hours in Covered Employment for which contributions were received by the Health Fund during the fifteen (15) consecutive calendar years, prior to your retirement; and,
4. You must agree to make the required monthly payment.

**Non-Bargained Employees**

To be Eligible for Retiree Benefits whether you are Eligible for Medicare or Not Eligible for Medicare if you are an Employee of a Contributing Employer that participates in the Health Fund via a Participation Agreement:

1. You must have maintained Active Eligibility (including COBRA) in the Health Fund immediately prior to your retirement; and,
2. You must have maintained coverage for at least 10 consecutive years; and,
3. You must agree to make the required monthly payment.



**RETIREE BENEFITS PROGRAM (FOR RETIREES AND COVERED DEPENDENTS UNDER AGE 65 OR OTHERWISE NOT ELIGIBLE FOR MEDICARE)**

<b>Life Insurance</b>	\$10,000 (only if eligible and electing to participate in Retiree Medical Insurance Program)
	\$5,000 Self-Funded benefit for participants who retire in the Connecticut Laborers' Pension Fund with Thirty (30) or more Pension Credits.
<b>Hospital and Medical Coverage</b>	Same benefits as an active member
<b>Hospice Benefit</b>	Same benefits as an active member
<b>Prescription Drug Benefit</b>	Same benefits as an active member
<b>Dental Benefit</b>	Same benefits as an active member
<b>Vision Benefit</b>	Same benefits as an active member
<b>Hearing Benefit</b>	Same benefits as an active member
<b>Weekly Disability Benefits</b>	None

**RETIREE AETNA MEDICARE ADVANTAGE PLAN (FOR RETIREES AND COVERED DEPENDENTS ELIGIBLE FOR MEDICARE PARTS A AND B)**

<b>Life Insurance</b>	\$5,000 (only if eligible and electing to participate in Retiree Medical Insurance Program)
	\$5,000 Self-Funded benefit for participants who retire in the Connecticut Laborers' Pension Fund with Thirty (30) or more Pension Credits.
<b>Hospital, Medical and Prescription Drug Coverage</b>	Aetna Medicare Advantage PPO with Extended Service Area (ESA) Plan. Must be enrolled in both Medicare Part A and Part B.

**DENTAL BENEFITS (MEDICARE RETIREES & COVERED MEDICARE DEPENDENTS)**

**Dental – Premier ESA**  
**Coverage includes cleanings, checkups, X-rays and comprehensive services.**  
**Annual Benefit Maximum - \$1,000 each year**

Preventive Dental Services .....	\$0 dental deductible 0% coinsurance for each dental service
Comprehensive Services .....	\$0 dental deductible 50% coinsurance for each dental service

CONNECTICUT LABORERS' HEALTH FUND

Schedule of Benefits

May 2024

Page 10

**RETIREE AETNA MEDICARE ADVANTAGE PLAN (FOR RETIREES AND COVERED DEPENDENTS ELIGIBLE FOR MEDICARE PARTS A AND B)**

**Vision Benefit** Same benefits as an active member

**Hospice Benefit** This benefit is for a terminally ill Eligible Retiree or Dependent when a Physician has determined that the Eligible Retiree or Dependent has six (6) months or less to live; and,  
1. If the Eligible Retiree or Dependent is unable to perform, without substantial assistance from another person, at least two (2) Activities of Daily Living, as determined by the Health Fund's Case Manager; and,  
2. The Health Fund's Case Manager determines that the Family cannot care for the Eligible Retiree or Dependent with only periodic nurse and/or home health aide visits.  
The Connecticut Laborers Health Fund self-funded Plan will reimburse up to \$275.00 per day for either Room & Board at a Hospice Facility or to reimburse the services of a Certified Live-In Caregiver who is not a family member, for up to a maximum period of six (6) months.

**Hearing Benefit - OPTION 1** (You may choose EITHER Option 1 or 2)

**PLAN PAYS**

**Hearing Evaluation**..... 100%  
One exam every three years, or more frequently if recommended by a University of Connecticut audiologist. Includes evaluation, medical examination and molds.

**Hearing Aids**.....100% of the first \$2,000 per appliance and 80% of the Excess Charges Benefits payable if provided by the University of Connecticut Speech and Hearing Clinic. Once every three (3) consecutive years unless recommended by the Audiologist.

**Hearing Benefit - OPTION 2** (You may choose EITHER Option 1 or 2)

**Hearing Evaluation**..... 100%  
One exam every three years, or more frequently if recommended by an Aetna Audiologist. Includes evaluation, medical examination and molds.

**Hearing Aids**..... you **MUST** use an **Aetna Audiologist:**  
**All Charges per Hearing Aid must be paid by the Medicare Retiree directly to the Audiologist.**

The Health Fund will reimburse the Medicare Retiree the first \$2,000 per Hearing Aid at 100% (which includes the examination, etc.) and the Medicare Retiree will be reimbursed for any charges in excess of \$2,000 per Hearing Aid at 80% up to a Maximum Out of Pocket of \$250 per Hearing Aid. You must submit itemized receipts from the Audiologist (hearing aid description, cost and amount paid by the participant) to the Health Fund and the Medicare Retiree will be reimbursed on a self-funded basis at 80% coinsurance with a Maximum Out of Pocket of \$250 per Hearing Aid.