Plumbers and Pipefitters Local Union No. 630 Welfare Fund

SCHEDULE OF BENEFITS A

EFFECTIVE JANUARY 1, 2019

COMPLETE COVERAGE BARGAINING UNIT EMPLOYEES/JOURNEYMEN EMPLOYEES AND THEIR DEPENDENTS
NON-BARGAINING UNIT EMPLOYEES AND THEIR DEPENDENTS
HELPER EMPLOYEES AND THEIR DEPENDENTS (As determined by the Board of Trustees)
RETIREES UNDER AGE 65 AND
RETIREES' DEPENDENTS UNDER AGE 65

Calendar Year Maximum:	**None**
Calendar Year Deductible:	**$200/person & $400/family (In-Network)** **$400/person & $1,200/family (Out-of-Network)**
Calendar Year In-Network Out-of-Pocket Maximum:	**$7,000/person** Deductibles, Copayments and Coinsurance apply towards the maximum. Retail/Mail order prescription drugs are excluded
Calendar Year Rx Out-of-Pocket Maximum:	**$1,500/person for Retirees and their Dependents only**
Lifetime Maximum	**Unlimited**
Fee Schedule:	**PPO Provider (In-Network) – Contracted PPO Network negotiated fee schedule**
	Non-PPO Provider (Out-of-Network)- 25th percentile of the ADP Context fee schedule
	Special fee schedule - 85th percentile of the ADP Context fee schedule

MAJOR MEDICAL BENEFITS

Pre-Certification Voluntary

Type of Service	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
	Plan Covered Percentage	**Plan Covered Percentage**
Hospital Services	**Calendar year deductible applies**	**Calendar year deductible applies**
Per Admission Deductible	None	$500
Necessary Days (semi-private room)	80%	50% (Maximum $185/day)
Hospital Ancillary Charges	80%	50%
Hospital Out-Patient Charges: Surgical, Physical Therapy, Diagnostic, X-Ray, and Laboratory	80%	50%
Ambulatory Surgical Facility	80%	50%
Emergency Room Facility Charges	80%, after $75 copayment (copayment waived if admitted) Subject to calendar year deductible	50% after $75 copayment (copayment waived if admitted) Subject to calendar year deductible
Physician Services	**Calendar year deductible applies**	**Calendar year deductible applies**

In-Patient Physician Charge	85% of fee schedule	50% of fee schedule
Emergency Room Physician Charge	85% of fee schedule	50% of fee schedule
Urgent Care Charges	$15 copayment/visit (deductible waived) 80% of fee schedule for other charges	50% of fee schedule
Out-Patient Physician Charge	85% of fee schedule	50% of fee schedule
Primary Physicians (Family Practice, Internal Medicine, Psychiatrist, OB/GYN, and Pediatrics)	$15 copayment for office visit only Calendar year deductible is waived	50% of fee schedule
Physician Services (Continued)	**Calendar year deductible applies**	**Calendar year deductible applies**
Physician Specialists	$35 copayment for office visit only Calendar year deductible is waived	50% of fee schedule
All other charges during office visit -This includes Diagnostic X-Ray, Laboratory Testing	80% of fee schedule after calendar year deductible	50% of fee schedule after calendar year deductible
Radiology and Pathology (Diagnostic imaging services, etc.)	70% of fee schedule after calendar year deductible	50% of fee schedule after calendar year deductible
Charges incurred with certain Out-of-Network Non-PPO providers will be paid at 70% of a special fee schedule (85th percentile of the ADP Context Fee Schedule) after the in-network calendar year deductible, if there are no PPO providers available in the hospital. These charges (listed below) MUST be incurred at an In-Network hospital or out-patient facility.		
Out-of-Network Radiologists	Plan will pay 70% of ADP Context Fee Schedule (when service is incurred at an In-Network hospital or out-patient facility) , after the In-Network calendar year deductible	
Out-of-Network Pathologists	Plan will pay 70% of ADP Context Fee Schedule (when service is incurred at an In-Network hospital or out-patient facility) , after the In-Network calendar year deductible	
Out-of-Network Anesthesiologists	Plan will pay 70% of ADP Context Fee Schedule (when service is incurred at an In-Network hospital or out-patient facility) , after the In-Network calendar year deductible	
Out-of-Network Emergency Room Physicians	Plan will pay 70% of ADP Context Fee Schedule (when service is incurred at an In-Network hospital or out-patient facility) , after the In-Network calendar year deductible	
Charges incurred relating to emergency illnesses and accidents, with certain Out-of-Network Non-PPO providers (listed below) will be paid at the in-network copayment and coinsurance applied to a special fee schedule (85th percentile of the ADP Context Fee Schedule) after the In-Network calendar year deductible, if any.		
Out-of-Network Emergency and Urgent Care Facilities	Plan will pay 80% of ADP Context Fee Schedule after the copayment (copayment waived if admitted) ($75 for Emergency Facility and $15 for Urgent Care Facilities) and after the In-Network calendar year deductible	
Out-of-Network Ancillary Charges (e.g. labs and x-rays)	Plan will pay 80% of ADP Context Fee Schedule after the In-Network calendar year deductible	
Out-of-Network Emergency Room Physician Charges	Plan will pay 85% of ADP Context Fee Schedule after the In-Network calendar year deductible	
Wellness Benefits	**Deductible and office visit copayment waived**	**No Out-of-Network Benefits**
Adults	Plan will pay 100% of fee schedule for Eligible Charges	N/A
Child (newborn) for well baby care in the hospital	Plan will pay 80% for hospital services and 85% of fee schedule for in-patient physician services after calendar year deductible	N/A

Child (newborn through 12 months of age)	Plan will pay 100% of fee schedule of Eligible Charges. Excludes new born care in the hospital which is shown above	N/A
Child (13 months of age up to age 18)	Plan will pay 100% of fee schedule of Eligible Charges	N/A
Ambulance Benefits	**Calendar Year deductible applies**	**In-Network Calendar Year deductible applies**
Ground Ambulance	80% of fee schedule up to a maximum of $1,200 per illness or injury	80% of a special fee schedule (85th percentile of the ADP Context fee schedule) up to a maximum of $1,200 per illness or injury,
Medically Necessary Air Ambulance	80% of fee schedule up to a maximum of $6,000 per illness or injury	80% of a special fee schedule (85th percentile of the ADP Context fee schedule) up to a maximum of $6,000 per illness or injury
Chiropractic Benefits	**Calendar Year Deductible Applies**	**Calendar Year Deductible Applies**
First Chiropractic Visit	70% of fee schedule, up to a $50 maximum (not including x-rays).	50% of fee schedule up to a $50 maximum (not including x-rays).
First Chiropractic Visit X-Rays	70% of fee schedule	50% of fee schedule
Subsequent Chiropractic Visits (maximum number of visits In-Network and Out-of-Network are combined)	70% of fee schedule, up to a $25 maximum for up to 15 visits per year.	50% of fee schedule, up to a $25 maximum for up to 15 visits per year.
Other Benefits (In-Network and Out-of-Network maximums are combined)	**Calendar Year Deductible Applies**	**Calendar Year Deductible Applies**
Hospice Benefits	70% of fee schedule	70% of fee schedule
Home Health Care	70% of fee schedule	70% of fee schedule
Physical, Occupational or Speech Therapy	80% of fee schedule	50% of fee schedule
Private Duty Nursing	70% of fee schedule up to $2,000 maximum per calendar year	70% of fee schedule up to $2,000 maximum per calendar year
Durable Medical Equipment	70% of fee schedule	70% of fee schedule
Drug & Alcohol Treatment	**Not covered**	**Not covered**
Out-of-Area Benefits when the Participant is traveling, resides in an non-network area or for emergency illness and accidents		**Paid at the In-Network copayment and coinsurance applied to a special fee schedule (85th percentile of the ADP Context Fee Schedule) after the In-Network calendar year deductible, if any.**

PRESCRIPTION DRUG BENEFITS

Deductible $25, per person, per calendar year

Out-of-pocket maximum is $1,500 per person per calendar year for **Retirees Under Age 65 and Retirees' Dependents Under Age 65 only.** Deductible and Copayments apply towards the maximum.

Clinical Management including prior authorization, quantity limits and post limit review requirements apply for certain drug categories.

Retail (up to a 30 day supply)	**Calendar Year Deductible Applies**
Generic Drug Copayment:	20% of cost, with $5 minimum
Brand Drug Copayment:	Preferred 30% of cost, with $20 minimum Non Preferred 30% of cost, with $30 minimum
Mail Order (up to 90 days supply)	**Calendar Year Deductible Applies**
Generic Drug Copayment:	$10
Brand Drug Copayment:	Preferred $40 Non Preferred $60

DENTAL BENEFITS

Deductible: $20 per person per calendar year (waived for Preventive and Diagnostic Care)

Maximum Annual Dental Benefit: $3,000 per person per calendar year (waived for pediatric dental check ups)

Lifetime Maximum Orthodontia Benefit: $1,250 per child

Type of Service	**PPO Provider (In-Network)**	**Non-PPO Provider (Out-of-Network)**
	Plan Covered Percentage	**Plan Covered Percentage**
Preventive and Diagnostic Care	80%, deductible waived	80%, deductible waived
Basic Care	80%, after deductible	80%, after deductible
Major Care	80%, after deductible	80%, after deductible
Orthodontia	50%, deductible waived	50%, deductible waived

VISION BENEFITS

See Superior Vision certificate for details.

DEATH BENEFITS & LOSS OF TIME **COMPLETE COVERAGE BARGAINING UNIT EMPLOYEES/JOURNEYMEN EMPLOYEES** **HELPER EMPLOYEES (As determined by the Board of Trustees)** (Not including Non-Bargaining Unit Employees, Retirees or Dependents)	
Death Benefit	$5,000
Accidental Death & Dismemberment (principal sum)	$2,000
Loss of Time	$100 weekly benefit, beginning on first day of a disability for a non-occupational accident; on the eighth consecutive day of a disability for a non-occupational illness Maximum benefit period: 13 weeks per disability

SCHEDULE OF BENEFITS B
Effective January 1, 2019

RETIREES OVER AGE 65 AND RETIREES' DEPENDENTS OVER AGE 65

Calendar Year Maximum: None

Lifetime Maximum: Unlimited

HOSPITAL SERVICES – PER BENEFIT PERIOD*

	MEDICARE PAYS IN 2019	PLAN PAYS
Service: Hospitalization*		
Semi-private room and board, general nursing and miscellaneous services and supplies:		
First 60 days	All but $1,364	$1,364 (Part A Deductible)
61st through 90th day	All but $341 a day	$341 a day
91st day and after:		
While using 60 lifetime reserve days	All but $682 a day	$682 a day
Once lifetime reserve days are used:		
Additional 365 days	$0	100% of Medicare Approved Expenses
Beyond the Additional 365 days	$0	$0
Service: Skilled Nursing Facility Care*		
First 20 days	All approved amounts	$0
21st through 100th day	All but $170.50 a day	$0
101st day and after	$0	$0
Service: Hospice Care		
Hospice care	All approved amounts	$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Medicare Payments for 2019 are shown in the chart. Note that Medicare Deductibles and Per Day Payments for the current year apply.

MEDICAL SERVICES – PER CALENDAR YEAR*

	MEDICARE PAYS	PLAN PAYS
Service: Medical Expenses		
In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, diagnostic tests and imaging, physical and speech therapy, Emergency room and urgent care facility services and emergency medical transportation, durable medical equipment rental:		
First $185 of Medicare Approved Amounts**	$0	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0
Service: Blood		
First 3 pints	$0	All cost
Next $185 of Medicare Approved Amounts**	$0	$0
Remainder of Medicare Approved Amounts	100%	$0

Service: Clinical Laboratory Services, X-rays and Other Diagnostic Tests		
Clinical Diagnostic Lab Services Medicare Approved Amounts	100%	$0
X-rays and Imaging and Diagnostic Tests	80%	20%
Service: Home Health Care Medicare Approved Services:		
Medically necessary skilled care services and medical supplies	100%	$0
Service: Wellness Benefits Medicare Approved Services:		
Routine physicals and screening tests based on Medicare's guidelines	100%	$0
**Once you have met your $185 Medicare Part B Deductible per calendar year ($185 in 2019) with services which are noted with double asterisk.		
Note: For some services, the Medicare coverage shown requires that the provider accepts assignment.		

Services covered by Medicare will be considered covered expenses under the Plan unless specifically excluded or limited by the Plan. Services with limits include but are not limited to the following:

Ambulance Benefits	➢ Plan Maximum: 80% of a special fee schedule (85th percentile of the ADP Context fee schedule) up to a maximum of $1,200 per illness or injury, except that medically necessary air ambulance is limited to a maximum of $6,000 per illness or injury.
Chiropractic Benefits	➢ Maximum visits per Calendar Year: 15
Drug & Alcohol Treatment	➢ Not covered
Private Duty Nursing	➢ $2,000 maximum per calendar year
Foreign Travel (when covered by Medicare)	➢ Medicare will pay 80% of the Medicare allowable, the Plan will pay the remaining 20%
Hospice Care	➢ Medicare covers Hospice care at 100%

Expenses that are not covered by Medicare which are covered by the Plan are shown below.

OTHER BENEFITS – NOT COVERED BY MEDICARE		
	MEDICARE PAYS	**PLAN PAYS**
Service: Foreign Travel Medically necessary emergency care services (which are not covered by Medicare) beginning during the first 60 days of each trip outside the USA :		
First $250 each calendar year	$0	$0
Remainder of charges	$0	80%

PRESCRIPTION DRUG BENEFITS – HUMANA MEDICARE EMPLOYER™ PDP PLAN

Deductible $25, per person, per calendar year

Out-of-pocket maximum is $1,500 per person per calendar year. Deductible and Copayments apply towards the maximum. If the actual drug cost is less than the minimum copay, you will only pay the actual drug cost.

Clinical Management including prior authorization, quantity limits and step therapy apply for certain drug categories.

Retail (up to a 30 day supply)	**Calendar Year Deductible Applies**
Generic Drug Copayment:	20% of cost, with $5 minimum
Brand Drug Copayment:	Preferred 25% of cost, with $20 minimum Non Preferred 25% of cost, with $30 minimum
Specialty Drug Copayment:	25% of cost, with $30 minimum
Retail (up to a 90 day supply)	**Calendar Year Deductible Applies**
Generic Drug Copayment:	20% of cost, with $15 minimum
Brand Drug Copayment:	Preferred 25% of cost, with $60 minimum Non Preferred 25% of cost, with $90 minimum
Mail Order (up to 90 days supply)	**Calendar Year Deductible Applies**
Generic Drug Copayment:	$10
Brand Drug Copayment:	Preferred $40 Non Preferred $60

DENTAL BENEFITS

Deductible $20 per person per calendar year (waived for Preventive and Diagnostic Care)

Maximum Annual Dental Benefit: $3,000 per person per calendar year Lifetime Maximum Orthodontia Benefit: $1,250 per child

Type of Service	**PPO Provider (In-Network)**	**Non-PPO Provider (Out-of-Network)**
	Plan Covered Percentage	**Plan Covered Percentage**
Preventive and Diagnostic Care	80%, deductible waived	80%, deductible waived
Basic Care	80%, after deductible	80%, after deductible
Major Care	80%, after deductible	80%, after deductible
Orthodontia	50%, deductible waived	50%, deductible waived

VISION BENEFITS

See Superior Vision certificate for details.