

# **Plumbers and Pipefitters Local Union #94 Fringe Benefit Funds**

**PAUL J. LAIR, Chairman**  
2541 Broad Avenue, NW  
Canton, Ohio 44708

33 Fitch Boulevard  
Austintown, Ohio 44515  
Phone: 330-270-0453  
Toll Free: 800-435-2388  
Fax: 330-270-0912

**JOSEPH M. FRIEDMAN, Secretary**  
Kauffman Plumbing & Heating  
600 - 3<sup>rd</sup> Street SE  
Canton, OH 44702

## **SUMMARY OF MATERIAL MODIFICATIONS FOR THE SUMMARY PLAN DESCRIPTION OF THE PLUMBERS AND PIPEFITTERS LOCAL UNION #94 HEALTH AND WELFARE FUND**

As previously advised effective May 1, 2011 the Plan has been amended to comply with provisions of the Affordable Care Act of 2010. The Plan has also been amended to comply with the Mental Health Parity and Addiction Act of 2008. Effective May 1<sup>st</sup>, 2011 mental health and substance abuse services will no longer be subject to lifetime or calendar year visit limitations. Enclosed is a Schedule of Benefits recap reflecting changes for both of these new laws. This schedule replaces pages 5 through 7 of your Summary Plan Description.

\* \* \*

Please keep this information with your Summary Plan Description.

**BOARD OF TRUSTEES  
PLUMBERS AND PIPEFITTERS LOCAL UNION #94  
HEALTH AND WELFARE FUND**

April 28, 2011



**ARTICLE I – SCHEDULE OF BENEFITS  
(FOR NON-MEDICARE ELIGIBLE PARTICIPANTS)**

<b>Benefits</b>	<b>Network</b>	<b>Non-Network</b>
Benefit Period	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
Dependent Age Limit	26 Removal upon end of month	
Pre-Existing Condition Waiting Period	Not subject to Pre-ex	
Blood Pint Deductible	Pints <sup>2</sup>	
Overall Annual Benefit Period Maximum	\$1,000,000	
Benefit Period Deductible – Single/Family <sup>1</sup>	\$250 / \$500	\$250 / \$500
Coinsurance	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$2,000 / \$4,000
<b>Physician/Office Services</b>		
Office Visit (Illness/Injury) <sup>2</sup>	\$15 copay, then 100%	\$15 copay, then 80%
Urgent Care Office Visit <sup>2</sup>	\$15 copay, then 100%	\$15 copay, then 80%
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine shots are covered services)	90% after deductible	80% after deductible
<b>Preventative Services</b>		
Routine Physical Exam (Ages 13 and over, two exams per benefit period) <sup>2</sup>	\$15 copay, then 100%	\$15 copay, then 100%
Well Child Care Services including Exam and Immunizations (Through age 12)	\$15 copay, then 100%	\$15 copay, then 80%
Well Child Care Laboratory Tests (Through age 12)	100%	80%
Routine Mammogram (One per benefit period)	90% no deductible	80% no deductible
Routine Pap Test (One per benefit period)	90% no deductible	80% no deductible
Hepatitis B vaccine	90% after deductible	80% after deductible
Influenza vaccine (flu shot)	90% after deductible	80% after deductible
PSA Tests	90% no deductible	80% no deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages 13 and over, one each per benefit period)	90% no deductible	80% no deductible
Routine Colonoscopy/Sigmoidoscopy (members/dependents 50 years and older)	90% no deductible	80% no deductible
<b>Outpatient Services</b>		
Surgical Services	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible
Physical/Occupation Therapy - Facility and Professional (40 visits per benefit period)	90% after deductible	80% after deductible
Chiropractic Therapy – Professional Only (12 visits per benefit period)	90% after deductible	80% after deductible
Speech Therapy – Facility and Professional (20 visits per benefit period)	90% after deductible	80% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible

<b>Benefits</b>	<b>Network</b>	<b>Non-Network</b>
Emergency use of an Emergency Room	90% no deductible	
Non-Emergency use of an Emergency Room	90% after deductible	80% after deductible
<b>Inpatient Facility</b>		
Semi-Private Room and Board	90% after deductible	80% after deductible
Maternity	90% after deductible	80% after deductible
Skilled Nursing Facility (90 days per benefit period)	90% after deductible	80% after deductible
<b>Additional Services</b>		
Allergy Testing and Treatments	90% after deductible	80% after deductible
Ambulance	90% after deductible	80% after deductible
Automatic Digital Blood Pressure Monitor	90% after deductible	80% after deductible
Durable Medical Equipment	90% after deductible	80% after deductible
Home Healthcare	90% after deductible	80% after deductible
Hospice	90% after deductible	80% after deductible
Organ Transplants	90% after deductible	80% after deductible
Private Duty Nursing (90 days per benefit period)	90% after deductible	80% after deductible
<b>Mental Health and Substance Abuse</b>		
Inpatient Mental Health and Substance Abuse Services	Benefits paid based on corresponding medical benefits.	
Outpatient Mental Health and Substance Abuse Services		

Note: Services requiring a copayment are not subject to the single/family deductible.

Deductible and coinsurance expenses incurred for services by a non-network provider will also apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a network provider will also apply to the non-network deductible and coinsurance out-of-pocket limits.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

<sup>1</sup>Maximum family deductible. Member deductible is the same as single deductible.

<sup>2</sup>The office visit copay applies to the cost of the office visit only and immunizations.