

**PLUMBERS LOCAL 360 HEALTH & WELFARE FUND  
MEDICAL SCHEDULE OF BENEFITS**

For more specific details, please refer to your Summary Plan Description.

**DEDUCTIBLE, Per Calendar Year**

Individual \$300  
Maximum Per Family \$900

**OUT-OF-POCKET LIMIT, Per Calendar Year (In Addition to the Deductible)**

	<u>Tier 1/Tier 2</u>	<u>Non- Network</u>
Individual	\$700	no limit
Family	\$2,100	no limit

**BENEFITS**

Unless otherwise indicated, all charges are subject to the deductible.

<u>Services</u>	<u>Limitations</u>	<u>Benefit Percentage</u>		
		<u>Tier 1</u>	<u>Tier 2</u>	<u>Non-Network</u> All Eligible Charges will be limited to the Usual, Customary and Reasonable amount
<b>Hospital Services:</b>				
Inpatient		90%*	80%*	60%**
Outpatient		90%* after \$50 Co-pay	80%*	60%**
<b>Ambulatory Surgical and Dialysis Centers</b>		90%*	80%*	50%**
<b>Emergency Room</b>		100% after \$50 Co-pay (waived if admitted) No Deductible	100% after \$50 Co-pay (waived if admitted) No Deductible	100% after \$50 Co-pay (waived if admitted) No Deductible
<b>Urgent Care Services</b>		100% after \$35 co-pay	100% after \$35 co-pay	100% after \$35 co-pay
<b>Physician Services</b>				
Physician Office Visits		100% after \$15 Co-pay No Deductible	80%*	60%**
Other Physician Services		90%*	80%*	60%**
<b>Additional Surgical Opinion</b>		100% No Deductible	100% No Deductible	100% No Deductible

<b>Services</b>	<b>Limitations</b>	<b>Benefit Percentage</b>		
		<b>Tier 1</b>	<b>Tier 2</b>	<b>Non-Network</b> All Eligible Charges will be limited to the Usual, Customary and Reasonable amount
<b>Wellness Care</b>		100% No Deductible	100% No Deductible	Not Covered
<b>Private Duty Nursing</b>		100% after \$15 Co-pay No Deductible	80%*	60%**
<b>Physical Therapy</b>		100% after \$15 Co-pay No Deductible	80%*	60%**
<b>Occupational Therapy</b>		100% after \$15 Co-pay No Deductible	80%*	60%**
<b>Speech Therapy</b>		100% after \$15 Co-pay No Deductible	80%*	60%**
<b>Chiropractic Care</b>	Limited to 15 visits per Calendar Year	100% after \$15 Co-pay No Deductible	80%*	60%**
<b>Skilled Nursing Facility</b>	Semi-Private Room Limited to 100 days per illness per Calendar Year	90%*	80%*	60%**
<b>Home Health Care</b>	Limited to 100 visits per illness per Calendar Year	90%*	80%*	60%**
<b>Hospice Services</b>	Semi-Private Room	90%*	80%*	60%**
<b>All Other Covered Expenses</b>		90%*	80%*	60%**
<b>Mental Health &amp; Substance Abuse Treatment:</b>				
Inpatient Mental Health and Substance Abuse		90%*	80%*	60%**
Outpatient Mental Health and Substance Abuse		90%* after \$50 Co-pay	80%*	60%**

\*Until the Tier 1/Tier 2 Out-of-Pocket Limit amount is reached, then covered expenses will be paid at 100% for the remainder of that Calendar Year.

\*\*There is no limit on out-of-pocket expenses for Non-Network providers. Covered expenses are never paid at 100% for Non-Network providers, with the exception of Emergency Room and Urgent Care Services.

## PRESCRIPTION DRUG BENEFITS

Pharmacy Network	Supply Limitation	Benefit Percentage
MedTrak	Up to 34 days	75%*
MedTrak	Over 34 days	Not Covered
MedTrak Performance 90	Up to 90 days	75%*
Walgreens Mail Pharmacy	Up to 90 days	75%*
Non-Network	Up to 34 days	52.5%*
Non-Network	Over 34 days	Not Covered

\*If you get a brand name drug when a generic is available, the plan will only pay for the cost of the generic drug (see Section VIII.A.6 for details).

It is important that you purchase drugs from the appropriate Network of participating pharmacies. **If you purchase more than a 31-day supply of a prescription, you must use a retail pharmacy that is a member of MedTrak's Performance 90 network or obtain your prescription through the Walgreens mail pharmacy.** You may purchase up to a 34-day supply of prescription drugs from any pharmacy, however Non-Network pharmacies will charge you 100% of the undiscounted cost of the drug, which will generally be higher than the cost charged by a Network participating pharmacy. The Fund will reimburse you for only 52.5% of the cost of that drug. Therefore, if you go to a non-participating pharmacy not only will you be responsible for a larger percentage of the cost, but the base cost will in most cases be higher.

### Prescription Drug Out-of-Pocket Limits

Network Pharmacies	\$900
Non-Network Pharmacies	unlimited

The Out-of-Pocket Limit for Prescription Drugs is separate from, and in addition to, the Out-of-Pocket Limit for medical benefits.