Plumbers and Steamfitters Local Union No. 486 Benefit Fund
PO Box 10 • Troy, MI 48099
Toll Free (855) 505-0462 • Phone (443) 573-3639 • Fax (443) 455-1014
www.PlumbersSteamfitters486Benefits.org

September 2025

IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE
PLEASE READ CAREFULLY!

Re: Plumbers and Steamfitters Local #486 Medical Fund Open Enrollment–2026

Dear Participant:

This notice contains important information about the Plumbers and Steamfitters Local #486 Medical Fund (the Fund) and the upcoming Open Enrollment period for your 2026 benefits. Please read the entire letter and enclosed documents carefully, as they contain crucial information about the benefits and costs.

The Fund will host two open enrollment in-person meetings for you to attend. Below are the details:

Dates: Friday, October 3, 2025, from 5:00 P.M. until 8:00 P.M.
Friday, October 10, 2025, from 5:00 P.M. until 8:00 P.M.

Location: Plumbers and Steamfitters Training School
1201 66th Street
Rosedale, MD 21237

OPEN ENROLLMENT PERIOD

Open Enrollment will run through **November 30, 2025**. If you wish to make any changes to your coverage, your completed enrollment application must be postmarked by November 30, 2024. All changes will be effective **January 1, 2026**.

BENEFIT CHANGES

No benefit changes are anticipated in 2026. Your medical, including Prescription, Dental, Vision, accident and sickness benefits, will continue at the same benefit levels as you currently have. This stability ensures your peace of mind.

WHAT DO YOU NEED TO DO

You only need to complete a new Fund Enrollment Form if you wish to:

- Change your level of coverage (Individual or Family) or
- Complete the enrollment form if you wish to add or drop any dependents. You may enroll your child(ren) under the age of 26.

Changes to your level of coverage can only be made now during Open Enrollment or if you have a qualifying event and request the change within 31 days of the of the event. Qualifying events include marriage, birth of a child, divorce, death, or involuntary loss of other coverage. You will be required to provide documentation of the event.

If your spouse or dependent children may have other medical benefits, you will need to complete a **Coordination of Benefits Form**.

If you would like a spouse, parent, union representative, attorney, or other person to have the authority to speak on your behalf, you will need to complete an **Authorization for Release of Protected Health Information Form.**

BENEFICIARY: If you wish to update your beneficiary, you will need to complete a **Beneficiary Designation Form.**

All forms are available at the monthly enrollment meetings or, you can request one from the Fund Office.

If you have any questions or need assistance completing the enrollment form, please contact the Fund Office at (443) 573-3639 or toll-free at (855) 505-0462. Membership Service Representatives are available Monday through Friday from 8:30 AM until 5:00 PM.

Remember, you have until November 30, 2025, to complete and submit your new enrollment forms. This clear deadline ensures ample time to make any necessary changes. All enrollment will be effective January 1, 2026.

Sincerely,

The Board of Trustees

Open Enrollment Options for Jan 1, 2026

- Open enrollment will run until November 30, 2025
- Your decision applies to coverage from January 1, 2026, to December 31, 2026.

Options For Medical and Prescription Coverage

- Self-Funded Medical Coverage – Local 486 Medical Fund w/Express Scripts Rx
  - Net Lease if you reside in Maryland and DC Area (A39 is the prefix for claims)
  - Flex Link if you reside outside of the Maryland and DC Area

Special Note: If you have a child(ren) attending school outside of the Maryland, District of Columbia and Northern Virgina and you are enrolled in Netlease, you should contact the Fund Office to move you and your family to Flexlink. If you are enrolled in Netlease and you take a job assignment outside of the Maryland, District of Columbia and Norther Virigina, you should contact the Fund Office to move you and your family to Flexlink.

- Kaiser Permanente – Insured HMO (Medical and Prescription)
  - White Marsh Medical Center – 4920 Campbell Blvd, Nottingham MD 21236
  - Abingdon Medical Center – 3400 Box Hill Corporate Center Drive, Suite 100, Abingdon
  - Towson Medical Center – 1447 York Road, Lutherville MD 21093
  - Annapolis Medical Center – 888 Bestgate Road, Suite 111, Annapolis MD 21401
  - Harbor Medical Center – 815 E Pratt Street, Baltimore MD 21202
  - South Baltimore Medical Center - 1701 Twin Springs Road, Halethorpe MD 21227

Kaiser Permanente medical facilities

Maryland

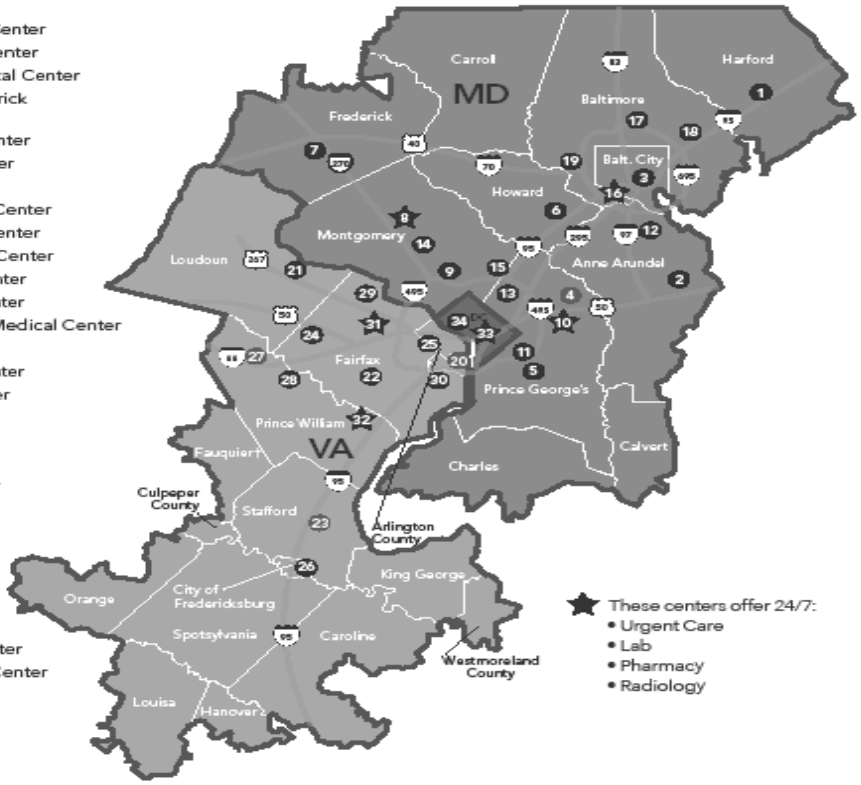
1 Abingdon Medical Center
2 Annapolis Medical Center
3 Kaiser Permanente Baltimore Harbor Medical Center
4 OPENING LATE 2020 Bowie Fairwood Medical Center
5 Camp Springs Medical Center
6 Columbia Gateway Medical Center
7 Kaiser Permanente Frederick Medical Center
8 Gaithersburg Medical Center
9 Kensington Medical Center
10 Largo Medical Center
11 Marlow Heights Medical Center
12 North Arundel Medical Center
13 Prince George's Medical Center
14 Shady Grove Medical Center
15 Silver Spring Medical Center
16 South Baltimore County Medical Center
17 Towson Medical Center
18 White Marsh Medical Center
19 Woodlawn Medical Center

Virginia

20 NOW OPEN Alexandria Medical Center
21 Ashburn Medical Center
22 Burke Medical Center
23 NOW OPEN Colonial Forge Medical Center
24 Fair Oaks Medical Center
25 Falls Church Medical Center
26 Fredericksburg Medical Center
27 NOW OPEN Haymarket Crossroads Medical Center
28 Manassas Medical Center
29 Reston Medical Center
30 Springfield Medical Center
31 Tysons Corner Medical Center
32 Woodbridge Medical Center

Washington, DC

33 Kaiser Permanente Capitol Hill Medical Center
34 Northwest DC Medical Office Building



Please check kp.org/facilities for the most up-to-date listing of the services located at Kaiser Permanente medical centers.

†Kaiser Permanente's service area in Fauquier County includes ZIP codes: 20119, 22720, 22728, 20181, 22406, and 22556; as of January 1, 2020, the service area will include: 20115, 20116, 20117, 20119, 20128, 20137, 20138, 20139, 20140, 20144, 20181, 20184, 20185, 20186, 20187, 20189, 20198, 22406, 22556, 22639, 22642, 22643, 22720, 22728, and 22739.

Benefit Comparison

	Helpers and First Year Apprentice only Self-Insured Plan	2nd year through Journeyman may select Kaiser Select HMO
Annual Deductible	$100/$200 single/family	None
Coinsurance	$80% Coverage, 20% coinsurance	Co-pay per visit, no coinsurance
Annual Out of Pocket	$600/$1,200 single/family	$1,000/$2,000 single/family
<u>Physician Services</u>		
Primary Care	Major Medical – 80% coverage after deductible	$5 copay
Specialist		$10 copay – referral required
Surgeon		$10 copay
Mental Health		$5 copay
Substance Abuse		$5 copay
<u>Preventive Care</u>		
Physical Exam	Covered at 100% if in Network, if out of network, covered under Major Medical	Covered at 100% at Kaiser Facility, no coverage elsewhere
Immunization		
Mammogram		
Colonoscopy		

Benefit Comparison

	Helpers and First Year Apprentice only Self-Insured Plan	2nd year through Journeyman may select Kaiser Select HMO
<u>Outpatient Services</u> Labwork/Radiology Physical Therapy Speech Therapy Occupational Therapy Chiropractic	Major Medical – 80% coverage after deductible Therapy limited to 50 visits per year combined – (Virtual Physical Therapy available with no limits)	Covered at 100% Therapy $10 copay limited to 30 visits per therapy
<u>Hospital Care</u> Inpatient	Major Medical – 80% coverage after deductible - requires authorization	Covered at 100% - requires authorization
Emergency Room	Major Medical – must meet emergency definition	$10 copay at urgent care centers, $100 copay at ER
<u>Maternity Benefits</u> Prenatal Visits Delivery	Major Medical – 80% coverage after deductible	Covered at 100%

Benefit Comparison

	Helpers and First Year Apprentice only Self-Insured Plan	2nd year through Journeyman may select Kaiser Select HMO
<u>Prescription Coverage</u>		
Generic	Not Covered	$0 copay at KP, $15 elsewhere
Brand, Formulary	Not Covered	$25 copay at KP, $35 elsewhere
Brand, Non-Formulary	Not Covered	$50 copay at KP, $60 elsewhere
Mail Order (90 day)	Not Covered	2 copayments
<u>Other Benefits</u>		
Infertility	Not Covered	Limited Coverage

Additional Benefits

2nd year through Journeyman

Weekly Disability – Non-Occupation Illness or Injury

- Begins on 1st day is accidental or hospitalization, Begins on 8th day if illness
- Benefit is $500 per week for up to 26 weeks while a member is disabled

Dental – Cigna Dental DPPO $2000 annual maximum; Unlimited for children under age 19

- **In Network – Member pays coinsurance. provider writes off difference between billed and allowed.**
  - Diagnostic/Preventive – 100%
  - Basic restorative (fillings, extractions, perio, oral surgery) – 80%
  - Endodontics – 80%
  - Major Restorative (crowns, bridges, dentures, implants) – 50%
- **Out of Network – member pays coinsurance plus difference between billed and allowed**
  - Diagnostic/Preventive – 80%
  - Basic restorative (fillings, extractions, perio, oral surgery) – 65%
  - Endodontics – 70%
  - Major Restorative (crowns, bridges, dentures, implants) – 40%

Vision – NVA

- Exam and 1 pair of lenses per calendar year or contact lens exam and contacts once every 12 months
- Frames are covered once every 24 months
- Exam - in-network $10 copay. Out of network: $38 covered out of network
- Lenes - In network $10 copay, out of network: $30 single vision, $40 Bifocal, $50 Trifocal, $75 lenticular

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".

3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".

3. **Please sign and date form below the box**.

Only an electronic image copy of the Authorization Form will be kept on file at the Health Care Office. If you wish to retain a copy of the document for your records, please make one before mailing.

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ **authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

PLUMBERS AND STEAMFITTERS LOCAL 486 MEDICAL FUND
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone Numbers: 443-573-3639 - 855-505-0462 - Fax: 410-687-7600

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____**Date Signed:** _____

-OR- □ I do not want my Health Information released to anyone but myself.

Signature of Member_____**Date Signed**: _____

SPOUSE SECTION

I, the **spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____ **Date Signed**: _____

-OR- □ I do not want my Health Information released to anyone but myself.

Signature of Spouse_____ **Date Signed**:_____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **dependent child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- □ I do not want my Health Information released to anyone but myself.

Signature of Dependent_____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete

PLUMBERS AND STEAMFITTERS LOCAL 486 MEDICAL FUND

7130 Columbia Gateway Drive, Suite A

Columbia, MD 21046

Telephone Numbers: 443-573-3639 - 855-505-0462 - Fax: 410-687-7600

Web: www.PlumbersSteamfitters486Benefits.org

BENEFICIARY DESIGNATIONS FORM

The purpose of this form is to designate beneficiaries for the following:

Plumbers and Steamfitters Local 486 Severance & Annuity/401(K) Plan

Plumbers and Steamfitters Local 486 Pension Plan

This form has three sections. The first section requests general information about you. The following two sections request that you designate a beneficiary for each benefit. If you designate more than one beneficiary for a particular benefit, and the total percentages is not 100%, the distribution will be divided equally among those designated. You must notify the Funds immediately if your marital status changes. **You are not required to elect the same beneficiaries for each benefit. This is a multiple page form. Please fill out all pages. You MUST sign the last page.**

Section I – General Information

Last Name	First Name	Middle Initial	
Social Security Number	Gender	Date of Birth	Union Card Number
Street Address		City, State, Zip	
Telephone Number (include area code)		Marital Status (Circle One) Single Married Divorced	
E-Mail Address			

Section II – Plumbers and Steamfitters Local 486 Pension Plan Beneficiary Designations

If you are married, your spouse is automatically your beneficiary for your pension benefit. You may elect another beneficiary with your spouse's written consent. You will not be able to elect the spousal pension if you name a beneficiary other than your spouse. If you are not married, you may name anyone you wish to be your beneficiary.

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

BENEFICIARY DESIGNATIONS FORM

Section III – Plumbers and Steamfitters Local 486 Severance & Annuity/401(K) Plan

I hereby designate the following people as my beneficiaries to receive benefits, if any, payable at my death from the Plumbers and Steamfitters Local 486 Severance & Annuity/401(K) Plan. I understand that under the terms of the Plan, my spouse may be entitled to benefits instead of the beneficiaries named below. I also understand that when I retire, my spouse must give written consent to my designation at that time or thereafter.

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

Name	SS#
Street Address	City, State, Zip
Relationship	Percentage

I hereby make the designation of beneficiary for each of the benefits specified above and revoke any previous designations. I understand that the beneficiaries named above may be revoked at any time by filing a new designation in writing on the Fund office's form. I understand that if all of the above designated beneficiaries predecease me, the distribution will be made in accordance with the terms of the Plan. **I agree to notify the Fund Office immediately of any change in my marital status.**

_____ _____

Signature of Participant Date

Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

☐ ***If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

B SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

☐ **Medical**/Rx Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical**/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

☐ **Medical**/Rx Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical**/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

☐ **Medical**/Rx Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical**/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical**/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle) *****

1.) Is child(ren) covered by Medicare or other Federal-State coverage? □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): □ Yes or □ No ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____

Employer: _____ Date of Birth: _____

Insurance Company name: _____ Insurance Company City & State: _____

Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____

Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

****If court decree is present please PROVIDE A COPY of the court documents ****

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____

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ENROLLMENT FORM

1st YEAR APPRENTICE/HELPER

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PHONE NUMBER: (____) _____ EMAIL: _____

GENDER: (Circle One) Male Female MARITAL STATUS: (Circle One): Single Married Divorced

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

MEDICAL PLAN (Provided By):

☐ Plumbers and Steamfitters Local 486 Medical Fund
*Network provided by CareFirst BlueCross BlueShield

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

ATTACH LEGAL DOCUMENTATION THAT APPLIES: birth certificate(s), marriage certificate, adoption papers, guardianship papers

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE _____ **DATE:** _____

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ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PHONE NUMBER: (____) _____ EMAIL: _____

GENDER: (Circle One) Male Female MARITAL STATUS: (Circle One): Single Married Divorced

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

MEDICAL PLAN (Provided By):	**DENTAL PLAN (Provided By):**	**VISION (Provided By):**	**RX (Provided By):**
☐ KAISER ☐ Plumbers and Steamfitters Local 486 Medical Fund ***Network provided by CareFirst BlueCross BlueShield**	CIGNA – Dental Shared Administration Taft Hartly – Dental PPO Plus	National Vision Administrations, L.L.C. (NVA)	EXPRESS SCRIPTS – Pharmacy Benefits Administrators

DEPENDENTS - (Including Spouse)

ATTACH LEGAL DOCUMENTATION THAT APPLIES: birth certificate(s), marriage certificate, adoption papers, guardianship papers

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____ _____

Signature Required for the Kaiser Permanente Plan **Date**

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE_____ **DATE:** _____

Flex Link Member

Attention – Plumbers and Steamfitters Local 486 Medical Plan Members

The Plan participates in a "Preferred Provider Organization" (PPO). A PPO is a group of select physicians, specialists, hospitals, and other treatment centers which have agreed to provide their services to Plan participants for a discount. A PPO can be used for routine or emergency medical problems. It is not mandatory that you use a participating provider in the PPO, but it very strongly encouraged, as noted below.

Here's why:

Using out-of-network providers can lead to balance billing. Balance billing is a practice used in the healthcare industry where a provider bills a patient for the difference between the Fund's plan allowed amount and the provider billed amount.

These unexpected expenses can catch you off guard and create Severe Financial Stress as noted in the examples below.

Example[1]	1	2	3
Out-of-Network Provider Bill	$5,000	$30,000	$50,000
Fund Allowed	$1,000	$10,000	$15,000
Member Deductible	$100	$100	$100
Member Cost Share at 20% of remaining allowed amount	$180	$500	$500
Total Member Cost Share before balance billing	$280	$600	$600
Potential Balance Bill Becomes YOUR RESPONSIBILITY	**$4,000**	**$20,000**	**$35,000**

To avoid these pitfalls, always check the link below to make sure your provider is in the network before seeking medical care:
https://provider.bcbs.com/app/public/#/one/city=&state=&postalCode=&country=&insurerCode=BCBSA_I&brandCode=BCBSANDHF&alphaPrefix=&bcbsaProductId

[1] Assumes member has not paid their deductible or had any out-of-pocket expenses.

Network Lease Member

Attention – Plumbers and Steamfitters Local 486 Medical Plan Members

The Plan participates in a "Preferred Provider Organization" (PPO). A PPO is a group of select physicians, specialists, hospitals, and other treatment centers which have agreed to provide their services to Plan participants for a discount. A PPO can be used for routine or emergency medical problems. It is not mandatory that you use a participating provider in the PPO, but it very strongly encouraged, as noted below.

Here's why:

Using out-of-network providers can lead to balance billing. Balance billing is a practice used in the healthcare industry where a provider bills a patient for the difference between the Fund's plan allowed amount and the provider billed amount.

These unexpected expenses can catch you off guard and create Severe Financial Stress as noted in the examples below.

Example[1]	1	2	3
Out-of-Network Provider Bill	$5,000	$30,000	$50,000
Fund Allowed	$1,000	$10,000	$15,000
Member Deductible	$100	$100	$100
Member Cost Share at 20% of remaining allowed amount	$180	$500	$500
Total Member Cost Share before balance billing	$280	$600	$600
Potential Balance Bill Becomes YOUR RESPONSIBILITY	**$4,000**	**$20,000**	**$35,000**

To avoid these pitfalls, always check the link below to make sure your provider is in the network before seeking medical care:
https://carefirst.sapphirecareselect.com/?ci=networklease-disableiFrame&network_id=70&geo_location=39.391936,-76.529468&locale=en

[1] Assumes member has not paid their deductible or had any out-of-pocket expenses.