PLUMBERS AND PIPEFITTERS LOCAL #333 FRINGE BENEFIT FUNDS

FREQUENTLY ASKED QUESTIONS

How are my benefits funded?

The primary source of financing for the benefits provided under the Health Plan and for the expenses of Fund operations is employer contributions.

What are the Fund's eligibility requirements?

Active Participants become eligible for benefits on the first day of the month following the month in which the Fund receives either (a) at least two-hundred fifty (250) hours of Employer Contributions in any consecutive two (2)-month period or (b) at least five-hundred (500) hours of Employer Contributions in any consecutive five (5)-month period.

Continuing eligibility requires 130 hours of employer contributions per month. Continuing Eligibility is based on a three (3)-month bookkeeping system, in which hours worked in the current month provide coverage as the first day of the third month thereafter. For example, 130 hours worked in September make the participant eligible in December.

Is there a way to expedite eligibility?

Yes, under certain circumstances. Employees of newly organized Employers may elect to expedite eligibility by starting with a negative 250-hour balance in the Hour Bank. The negative balance will be made up through hours you work in excess of the requirements for Continuing Eligibility. If you want to use this option, you must notify the Plan Administrator within ten **(10) days** of starting Covered Employment so that the Plan Administrator can activate your coverage. This option is not available to you if are a current or past Employee or Participant.

What do I do if my employer does not remit my fringes?

First, call your employer. There may be a very good reason why the fringes have not been remitted. If your employer cannot explain the reason to your satisfaction, you should contact the Local Union.

How can I add my dependents to the Plan?

Complete a "Healthcare (BCBSM) Enrollment Form and Yearly Coordination of Benefits and Dependent Status Statement" and submit copies of marriage or birth certificates. Click HERE to download form.

What do I do when I get divorced?

You must send a copy complete copy of your divorce decree otherwise coverage will be maintained for your ex-spouse. If the Fund pays for benefits that should not be paid because your spouse no longer meets the definition of a dependent, you will be held responsible.

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When does coverage stop for my dependent children?

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend Adult child coverage up to age 26. Coverage may continue until the last day of the month in which that adult child turns 26 years old or earlier if you do not maintain your eligibility under the Plan. This requires annual verification.

Can I continue coverage when I retire?

Yes, provided you meet the retiree requirements for maintaining coverage. Refer to page 15 of the Summary Plan Description. Click HERE to open.

What do I do if I am injured or ill and cannot work?

The Fund provides disability benefits which may continue your coverage for health care benefits. You should complete a disability form. Click HERE to download form.

What is COBRA?

COBRA is the Consolidate Omnibus Budget Reconciliation Act of 1986. COBRA requires that the Fund provide coverage for participants and their dependents that may not otherwise be offered. COBRA is available for dependents who no longer meet the definition of a dependent as defined by the Plan. Please contact the Fund Office for the current COBRA rates.

What is Coordination of Benefits?

Coordination of Benefits or COB coordinates benefits with other health benefits you may have such as coverage through your spouses' employer.

What are the Health Plan Benefits?

The Plan has contracted with BCBSM (Blue Cross Blue Shield of Michigan) to provide participants and the Fund with discounts on medical services. If a BCBSM participating provider is utilized the participant has a $500 deductible per person and $1,000 deductible per family. Benefits are then paid at 80%. The maximum out-of-pocket expense is $1,500 per person and $3,000 per family. Preventive services are generally paid at 100%. For further details regarding the medical benefits available, please refer to the Summary Plan Description (SPD).

To find a participating doctor, click HERE to visit that topic on the
Blue Cross Blue Shield of Michigan website.

Click the links below to review Benefits at a Glance for:
Active Employees and Early Retirees
Medicare Advantage – Low Option
Medicare Advantage – High Option