Wisconsin Electrical Employee's Health and Welfare Plan

HEALTH AND WELFARE BENEFITS

608-276-9111 OR FUNDOFFICE@WEEBF.ORG

ELIGIBILITY UNDER THE HEALTH AND WELFARE FUND

Active Hourly Employees INITIAL Eligibility

1. You will become eligible on the FIRST Day of the calendar month following receipt by the Fund Office of Employer or Reciprocity contributions for 300 work hours within a 12-consecutive month period.

Example: You begin working April 1st. Your Employer makes contributions to the Plan for 150 Hours for April work month (received by Fund Office no later than May 20th) and another 150 hours for work month of May (received by Fund Office no later than June 20th), which combined total 300 hours and will make the Member's initial eligibility effective July 1st.

Continued Eligibility

Contributions received from Employers are applied to the second month of Health and Welfare Plan Eligibility/Coverage following the month the contributions are received by the Fund Office.

Example: January Hours received in February apply towards April eligibility
February Hours received in March apply towards May eligibility
March Hours received in April apply towards June eligibility

ACTIVE HOURLY EMPLOYEE ELIGIBILITY CONTINUED

After becoming eligible, you will continue to be eligible as long as your dollar bank contains enough money to pay for 1 month's coverage, unless you are terminated for a reason which causes you to lose your dollar bank.

Dollar Bank: Whenever you are credited with MORE contributions than those needed to provide 1 month's coverage, the excess money is accumulated in your dollar bank. If contributions received during a given month are for LESS than the prevailing rate needed for 1 month's coverage, excess credit in your dollar bank will be used to maintain your H&W coverage.

HOW TO CALCULATE YOUR CONTRIBUTIONS

Your Health and Welfare contribution rate is based on your Collective Bargained Agreement as an Inside Wireman, Residential Wireman, VDV, Construction Electrician, Construction Wireman.

Example: $12.00 IW H&W Contribution Rate
($ 1.05) Deduction to the Plan Reserve
($ 2.25) Transfer to the Flex Account (if applicable)
$ 8.70 Actual Contribution Rate for H&W

$8.70 x 150 hours = $1305.00 contributed towards Health and Welfare premium rate of $1244.00, $1305.00 contributions minus $1244.00 premium rate = $61.00 excess remains in the dollar bank which is carried forward. There is NO LIMIT or CAP on your dollar bank.

ACTIVE EMPLOYER STAFF EMPLOYEES

An Active Employer Staff Employee must either enroll to participate in the Plan or waive coverage. A written waiver must be completed within 30 days of becoming eligible.

If Staff Employee previously waived coverage with the Plan, they may elect coverage at a later date by providing written request within 30 days of other coverage termination, copy of other insurance termination notice and submitting an enrollment form.

An Active Employer Staff Employee shall become initially eligible on the first day of the calendar month following the date of hire and receipt of two months required Employer contributions by the 15th day of the month prior to the month for which coverage is intended. Active Employer Staff Employees cannot continue coverage by Self-Paying, only eligible for Cobra Continuation if employment ceases.

Active Employer Staff Employee shall cease on the earliest of the following:

1. The last day of the month following the month in which employment terminates;
2. the date the Plan is discontinued;
3. The end of the last period for which any required contribution has been made;
4. Death;
5. Date Employee enters the Armed Forces on full-time basis
6. If Employee participates in, assists or conceals any scheme, artifice, plan or conduct by an Employer which is intended to defraud the Plan.

AN ELIGIBILITY PACKET WILL BE SENT TO YOU ONCE YOU OBTAIN INITIAL ELIGIBILITY:

1. Complete the enrollment card in the initial packet (or online) and send to the Fund Office. The enrollment card should be completed in your name as it appears on your W2 as well as your Spouses name and full Dependent names, no nicknames. A Username and Password letter will be included in your Initial Eligibility packet for online login. ID Cards are sent out by Anthem BC/BS as soon as possible, however, the Fund will deny all claims until your completed enrollment card and all applicable documentation is received in-house. You have a 90-day Window from the date of initial eligibility in which to add Spouses and Eligible Dependents.

2. Newly Acquired Dependents will be included automatically as an eligible Dependent from the date of acquisition. NO claims will be paid until a completed enrollment card including proof of Dependent status is on file with the Fund Office. If the required documentation is NOT provided within 90 days from the date of acquisition of the Dependent, all pended claims will be denied. Coverage of the Dependent will become effective the 1st of the month following the date the Fund Office receives the required documentation.

3. It is your responsibility to update the Fund Office of any changes such as Marriage, Divorce, Newborn, Adoption, Step-Children, Spousal and/or Dependent Insurance Coverage, Active Military Duty or Death.

4. You are NOT required to add your Spouse onto your Plan, however, it is the same premium regardless if you have one or ten dependents on your policy. If you wish to add the Spouse later, than she will be eligible the month following receipt of an updated enrollment card with a copy of your marriage certificate, benefits will not pay retroactive. If you add your spouse, he/she may also opt out of your coverage later if written proof of enrollment in a High Deductible Health Plan offered by the Spouse's employer (or the parent's employer in the case of a Dependent child) in conjunction with a Health Savings Account covered under a High Deductible HSA. <u>This is ONLY if the Member is an Active Participant in the Plan (NOT Retired).</u>

TERMINATION OF ELIGIBILITY

An Active Hourly Employee's coverage under the Dollar Bank will terminate on the earliest of the following dates:

1. Last day of the calendar month in which the credits in the Dollar Bank Account fall below the required premium and no contributions received for 36 months;
2. The date he/she enters the Armed Forces of the US on Full-Time Active Duty;
3. Death
4. The date the Plan is discontinued;
5. Active Hourly Employee starts to work for an Employer who is NOT a contributing Employer and NOT subject to a written Agreement requiring contributions into the Plan. (Dollar Bank, Flex and Supplemental Accounts will be forfeited);
6. Any Active Hourly Employee who participates in, assists, or conceals any scheme, artifice, plan or conduct by a contributing Employer which is intended to defraud the Plan by paying contributions less than those which are due under the CBA;
7. The date of a Withdrawal;

Notification of loss of eligibility for any reason will be made by the Fund Office to the Active Hourly Employee so that he/she may elect to continue coverage under the Self-Payment or Cobra Continuation, whichever may be applicable.

REINSTATEMENT OF ELIGIBILITY

An Active Hourly Employee whose eligibility has terminated under the Dollar Bank shall again become eligible on the first day of the calendar month following the month in which the Fund Office receives contributions either from a participating Employer or through reciprocity for at least 150 work hours in a 12 consecutive month period.

A Participant will receive a Self-pay notice when there is not enough money in their dollar bank to continue coverage. If the Participant elects to make the benefit payment, there will be no break in eligibility or benefit coverage. if payment is not made, then your coverage will be lost for that month.

Employer contributions do NOT back date for reinstatement of eligibility even if the hours were missed and submitted in late. Reciprocal hours may take 2 months before received by the Fund Office and also do not back date.

HEALTH AND WELFARE BENEFIT COVERAGE – PARTICIPANTS ONLY

The Death Benefit and Accidental Death and Dismemberment Benefit are provided for the Participant only (not spouse or dependents). Benefits are as follows:

	Under 65	**65 – 69**	**70 and over**
Loss of Life	$10,000	$6,500	$5,000
Loss of both hands, both feet, both eyes or any two such members	$10,000	$6,500	$5,000
Loss of one hand, one foot or one eye	$5,000	$3,250	$2,500

LOSS OF TIME OR SHORT-TERM DISABILITY (STD) – PARTICIPANTS ONLY

If you suffer a disability from a NON-WORK related injury or illness, you can receive $500 per week for 26 weeks. You must be under the care of a licensed Physician (M.D., D.C., D.P.M., or D.O.) and unable to work because of such injury or illness. STD Benefits start on the following dates:

1. First day of an In-Patient over-night Hospital confinement;
2. First day of an accident or injury (disability form must be filed within 6 months of the accident of injury);
3. Eighth (8) day in the event of an illness.

Successive Disability periods will be considered separate disabilities only if the Employee is available to return to employment after the initial disability for at least two weeks of full-time employment or the two disabilities are due to entirely different and unrelated causes and are separated by at least one day for which the Employee is available to resume active work on a full-time basis. Cannot collect disability if on unemployment or for any time that you collected pay for attending school. Long-Term Disability available after STD is maxed.

Disability credits: three hours of coverage per day will be credited to the Employees dollar bank account up to a max of 90 days.

MEDICAL BENEFIT DEDUCTIBLES AND COINSURANCE

Medical Benefits	PPO	NON-PPO
Deductible		
individual	$500	combined with PPO
family	$1,500	combined with PPO
Maximum Out-Of-Pocket		
individual	$1,350	N/A
family	$4,050	N/A
Coinsurance		
Plan	90%	70%
Participant	10%	30%

Prior Authorization thru Conifer (number on the back of the ID Card) MUST be established for ALL planned surgical and non-surgical admissions, Inpatient confinements and services, Outpatient surgical requests, implantable devices and all related charges and for all Outpatient services performed in a Hospital, Licensed treatment facility or Ambulatory Surgical Center. Not required for Emergency Admissions or Maternity admissions unless complications.

MEDICAL BENEFITS PAID AT 90% IN-NETWORK UP TO MAXIMUM OF $13,500 IN ELIGIBLE CHARGES 100% THEREAFTER OR A FLAT 70% FOR OUT OF NETWORK :

Outpatient Hospital Benefits
Inpatient Hospital (must be pre-certified)
Surgery (precertification required)
Anesthesia
Emergency Room
Urgent Care
Diagnostic X-Ray and Laboratory
Imaging (CT/PET scans, MRI)
Doctors Inpatient, Outpatient and Office Visits
Prenatal Care, Postnatal Care and Delivery Services
Home Health Care (limited to 4 hours a day)
Inpatient M/N and Substance Abuse Counseling (pre-cert required)
Outpatient M/N and Substance Abuse Counseling
Ambulance (Ground and Air)
Chiropractic Benefits (limitations apply)
Transplants (Must be performed at a Provider Transplant Network Facility)
Orthotics to $10,000 aggregate, thereafter 50% paid
Orthotic for excluded diagnosis up to $500 max paid per five year period
Durable Medical Equipment (prior approval required – contact Fund Office)
Dietary and/or Nutritional counseling = 6 visits per person per year

ROUTINE PHYSICAL EXAMS = PAID AT 100% NO DEDUCTIBLE OR COPAY

Plan pays for preventive care services recommended by the United States Preventative Service Task Force with a Grade A or B, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as required by the Affordable Care Act.

Some of the preventative services are as follows (must be billed as Routine):

Routine Well Baby Check-ups and immunizations and care visits
Colonoscopy or Cologuard kit (effective January 1, 2023, age 45 and over)
Routine Mammography
Cervical Cancer screening
Routine Lab work

OUT OF NETWORK ROUTINE BENEFITS: benefits paid at 100% up to $450 maximum per person, per calendar year: after $450, Plan pays 10%.

Health Gauge Wellness Screening

Held Annually by the Local Union Offices and performs the following services FREE if you are an ELIGIBLE Participant, ELIGIBLE Dependents 18+ and ELIGIBLE Retiree.

Cardiogauge: Checks Carotid Artery for buildup of fatty blockages which can cause strokes.
Peripheral Artery Disease: Checks for blockages in the legs which can indicate high risk of coronary artery disease and peripheral arterial disease.
Abdominal Aortic Aneurysm: Visualizes the existence of an aneurysm in the abdominal aorta that can rupture and be fatal.
Biogauge: Height/Weight, Body Circumference, BMI, Blood Pressure, Lipd panel, Chemistry Panel, Hemoglobin, PSI and TSH.

PRESCRIPTION DRUG COVERAGE

Generic	$10 Participant Co-Pay per fill of 30 days or $15 Co-Pay for 61-90 day fill
Brand Name	$50 Participant Co-Pay per fill of 30 days or $75 Co-Pay for 61-90 fill
Diabetic Supplies and Insulin	Plan pays 80%, not subject to co-pay or calendar year maximum
Specialty Drugs Program	After Plan $10,000, then Plan pays 50% per calendar year of PPO prescription drug costs up to the maximum out of pocket. Subject to new Closed Specialty Drug Program.

Maximum 2025 Out-Of-Pocket Expense (per calendar year)		Rx and Medical OOP
Individual	$7,350	$9,200
Family	$12,850	$18,400

Prescription Coverage Continued…

Smoking Cessation Program: Limit Two 90-day supplies of stop smoking medications per calendar year if Physician prescribed – must following tiers in smoking cessation program. Zero Co-pay.

EFFECTIVE JANUARY 1, 2023 – New Drug Programs implemented:

HIA Enhancement – the medications filled at the Sav-Rx specialty pharmacy, will be increased to 90-day supply. Rx's include but not limited to migraine injections, anti-diabetic injections, HIV specialty drugs or medications which require sensitive handling.

Step Therapy – This applies to new treatment starts in certain drug classes like cholesterol and blood pressure which have many generic treatment options available. If a new start is prescribed a brand name medication on step therapy, the pharmacy messaging will indicate that the generics are required, and it will instruct the pharmacy to contact Sav-Rx if brand is required.

Closed Specialty Drug Program - Must be Prior Approved by Sav-Rx. Select Specialty medications will be EXCLUDED from the specialty drug program and Sav-Rx will help the Participant to file under the Patient Assistance Program for 100% coverage. The Participant MUST file for the Patient Assistance Program and if denied then Participant will need to try a Biosimilar medication that just became available on the market March 1, 2023. (for medications like Humeria, Amjiveta etc..)

PREVENTIVE DENTAL BENEFITS

Preventive Dental – Paid at 100% per person per calendar year, no deductible, limited to the following:

1. Two Routine Oral Exams per calendar year;
2. Two Routine Cleanings per calendar year;
3. Bitewing X-Ray once every 6 consecutive months;
4. Full-Mouth X-Ray once every 36 consecutive months;
5. Panoramic X-Ray once every 60 consecutive months;
6. Fluoride Treatment one per year for Dependents under age 16:
7. Sealants of Back Molars only for Dependents under age 16;
8. Certain space maintainers for premature lost teeth for children under age 19.

COMPREHENSIVE DENTAL BENEFITS

1. No Deductible and includes the Preventive Dental Services at 100%.
2. Major Services paid at 80% up to a maximum of $1700 per person per calendar year.
3. Includes Periodontal services, Oral Surgery, Extractions, Restorative, Fillings, Endodontic Treatment, Root Canal, Crowns, Inlays, Onlays, x-rays, Dentures, Bridgework, Relining or Rebasing of Dentures and Implants.

ORTHODONTIC

1. No Deductible;
2. First $1400 paid at 50%, next $1800 paid at 100% (maximum of $2500 paid out per person per lifetime)

Note: Orthodontic is paid out monthly due to your eligibility runs monthly.

ORAL SURGERY – PAID UNDER MEDICAL

ONLY the following procedures will be considered under the medical portion of the policy for benefit payment:

1. Repair or alleviation of damage to sound natural teeth caused by Injury sustained while an eligible individual under this Plan;
2. Removal of partially or completely unerupted impacted teeth;
3. Removal of tumors and csts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require pathological examination.
4. Removal of apex of tooth root, "apicoectomy" (does NOT include root canal)
5. Removal of exotoses, "growth of the jaw and hard palate";
6. Treatment of fractures of facial bones;
7. External incision and drainage of cellulitis;
8. Incision of accessory sinuses, salivary glands, or ducts;
9. Surgical treatment for the correction of temporomandibular joint dysfunction (TMJ);
10. Gingivectomy, excision of loose gum tissue to eliminate infection;
11. Aveolectomy, the leveling of structures supporting teeth for the purposes of fitting dentures;
12. Frenectomy, the cutting of the tissue in the middle of the tongue (frenulum); and
13. Osseous Surgery.

Vision Benefit

<u>Adults and Dependent Children:</u> No Deductible or co-pay, $400 maximum paid per person per calendar year for the following:

Eye exam, refraction fee, lenses, frames, contact lenses, tinting, coating, bi-focal, tri-focal etc…and Radial Keratotomy/Lasik Surgery.

Must be by a Doctors prescription.

FLEXIBLE SPENDING ACCOUNT (HRA, FLEX, FSA)

You CANNOT file for Flex Reimbursement until AFTER Medicare and ALL Other Insurance Plans have processed their liability. Proof of other insurance payment is required when filing. This also includes medical assistance programs.

You may use your FSA to pay for Out-of-Pocket expenses for Medical, Dental, Vision and prescription co-pays and for some over the counter items. If questions, contact the Fund Office.

You CANNOT cash out or transfer your FSA. Your FSA amount will roll over every year until depleted, if you maintain activity (i.e. file claims for reimbursement).

If there is no activity (no contributions to or benefits paid from) for five consecutive calendar years, or for accounts holding $400 or less an entire calendar year, your Flex account will be forfeited to the Fund.

If you sign up for a Subsidized Plan under the Affordable Care Act you CANNOT have a Health Reimbursement Account (HRA/Flex/FSA) per Federal Law as your Flex account is considered another Insurance Plan. You must send in written notice to the Fund Office to Freeze your flex account, however, above forfeiture rules apply.

You now can file your flex reimbursement requests directly from the WEEBF website at www.weebf.com and log in with your username and password. Flex reimbursement checks are mailed out every Friday, if administratively feasible.

SUPPLEMENTAL UNEMPLOYMENT BENEFIT ACCOUNT (Local 388 & 430 Only)

If you have the Supplemental Unemployment Benefit Account (Sub) established by your CBA, 8% of your employer pension contribution will be diverted into the Sub account until $4500 is reached, once reached the contribution will revert back into your pension account.

The Sub benefit pays $250 a week for those Participants who qualify for unemployment benefits and who have involuntarily terminated employment. All benefits paid from the Sub Account shall be subject to appropriate federal and state tax withholding. If you have a balance over $5500 in your Sub Acct an $300 Holiday check will be issued annually around Oct/Nov.

You must submit evidence that the Wisconsin Unemployment Dept. or other similar State Unemployment compensation program has determined that the Employee was unemployed for the affected week, which may include a receipt or payment stub, or other written confirmation that the Employee was unemployed. The Supplemental request form is located on the www.weebf.com website or you may contact the Fund Office directly.

The Plan will forfeit the assets in the Sub Account of any inactive Participant. You are considered inactive if no contribution is made to the Plan on your behalf for 24 consecutive months. In lieu of forfeiting, the Sub Account will be transferred to the flex account or Dollar Bank if either is maintained. Upon retirement, the SUB will be transferred into your Flex account.

EARLY RETIREMENT ELIBILITY UNDER THE HEALTH AND WELFARE FUND

Must be eligible under the Fund as an Active Employee, Active Employer Staff Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee for 24 consecutive months of continuous eligibility or eligible 9 out of 12 months for five calendar years.

Must be at least 55 years of age

Cease from Working in the Industry (withdraw name from job referral lists)

Complete a Retiree Notification Form (only if you wish the lower premium with reduced benefits)

NORMAL RETIREMENT ELIGIBILITY UNDER THE HEALTH AND WELFARE FUND

Must be eligible under the Fund as an Active Employee, Active Employer Staff Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee for 24 consecutive months of continuous eligibility or eligible 9 out of 12 months for five calendar years.

Must be at least 65 years of age and elect Medicare Part A and Part B coverage

Cease from Working in the Industry (withdraw name from job referral lists)

Complete a Retiree Notification Form (only if you wish the lower premium with reduced benefits)

MEDICARE OPTIONS AS A RETIREE

Medicare Part A: Hospitalization = no cost to you.

Medicare Part B: Doctors, Lab, X-Ray, Outpatient Services, etc…= automatic enrollment unless you waive.

As a Medicare Eligible Retiree your benefits are no longer covered under the Wisconsin Electrical Employees Benefit Fund (Anthem BC/BS Card) as you are moved over to the UnitedHealthcare Group Medicare Advantage PPO Plan which requires you to have Medicare Part A and Part B - ONLY IF YOU COMPLETE THE RETIREE NOTIFICATION FORM.

If the Member is eligible for Medicare and Retired but did NOT elect Medicare Part B then you could lose your coverage.

Medicare Part C: Advantage Plan = no need if continuing coverage with the Fund as UnitedHealthcare Group Advantage Plan is a supplemental Plan that handles the filing to Medicare and then processes under the UHC Advantage Plan as secondary carrier.

Medicare Part D: Drug program = no need if continuing coverage with the Fund as covered through UHC and Sav-Rx.

RETIREE BENEFIT – RETIREE NOTIFICATION FORM RECEIVED

Upon receipt of the Retiree Notification Form, a Members existing Dollar Bank Account and Supplemental Unemployment Account will automatically be transferred to the Flexible Benefit Account. You will be reclassed as Retired under the applicable premium based on dependents and Medicare eligibility. You will have medical and prescription drug coverage along with the life benefit for the Member only. You will also have a ONE-TIME option to elect the Dental and Vision Benefits at this time.

The Retiree Notification Form allows a Member to "Waive" or "Terminate" coverage under the Fund.

Waive Coverage: You can waive coverage under the Fund IF covered under another Employer sponsored Group Health Plan. Tricare and VA do NOT qualify, however, Medicare, both standard and individual, does qualify as does a Spousal Group Health Plan through Employment. Proof of Coverage is required. You have a One Time Opportunity to reinstate coverage in the Fund following termination of coverage under the other employer-sponsored group health plan by submitting an enrollment card to the Plan Office within 60 days following termination of said coverage with proof that you (and dependents if applicable) were continuously covered along with a Certificate of Termination.

Termination of Coverage: You can elect to terminate your coverage under the Fund. You will still have access to your Flex Account balance for reimbursement of out-of-pocket expenses, as long as you maintain activity. In order to get back into the Fund coverage you will need to return to work for a Contributing Contract and be reinstated the month following receipt of 150 hours.

MEDICARE ELIGIBLE RETIREES

Upon Retirement (completing the Retiree Notification Form) IF eligible for Medicare, the Plan requires you (or your dependent) to have both Medicare Part A and Part B in order for the Plan to move you to the UnitedHealthCare Retiree Group Advantage Plan which the Plan pays for as a Group.

If you Retiree and are eligible for Medicare Part A and Part B but do NOT enroll, then the Plan cannot reclass you to retiree status at the lessor premium rate and benefits. The Fund will allow you to continue to pay the full premium rate until you are signed up for both Medicare Part A & B for a limited time only.

UnitedHealthCare Plan has no deductible, copay or coinsurance. Benefits can be viewed on our website www.weebf.com select Health & Welfare Plan, then select UHC Group Medicare Advantage Plan.

You can ONLY have 1 Supplemental Plan as a Retiree. If you sign up for another Supplemental Plan this will automatically terminate you from the UHC Group Advantage Plan and your dependents under the Fund's coverage. Remember, the Policyholder must maintain eligibility under the Fund in order for any eligible dependents to also remain covered under the Plan insurance.

RETIREE INFORMATION CONTINUED…

Early Retirees and Medicare Eligible Retirees my remove a Dependent (not spouse) from their Plan provided the Member elects to continue medical coverage by making Self-Payments for Retirees, regardless if the Dependent has other Group Health Plan Coverage. A Dependent Opt-Out Form will be required.

No Retiree premium due notices are sent, therefore, Retiree premium payments can be auto deducted from your Flexible Benefit Account, if no flexible account available then self-payments are due by the 15th of the month prior to the month of coverage. (i.e.. June's premium payment is due by May 15th no later than May 20th). You may also sign up for an Authorization Agreement for ACH Debits from a checking or savings account OR you can now login online and make payment under the self-pay option (cannot pre-pay in advance).

**Please note that if you retire but wish to keep Full Benefit Coverage then you will remain classed as an **Active Participant and the full premium will be deducted from your Dollar Bank Account. Upon **depletion of your Dollar Bank Account or if you have No Dollar Bank Account, then you will need to **elect to continue coverage as an Active Self-Pay when the Fund mails you a Self-Pay notice. You **may continue to make full active premium payments for 18 months of coverage, an additional 18 **months of coverage ONLY if you (and Dependents) waive Cobra Rights, so please read and complete **the forms carefully as it makes a difference on how long you may continue coverage under the Fund **as an Active Self-Pay Participant. At anytime you may return to work and be reinstated as an Active **Hourly Employee by working 150 hours.

ADDITIONAL RETIREE INFORMTATION:

SPOUSE: If the Member is actively working, and the Spouse is retired and becomes eligible for Medicare Part B, the spouse does NOT need to sign up and pay for Medicare Part B at that time as the FUND would be the primary insurance carrier on her over Medicare. The Fund benefits qualify as "creditable coverage" however, the Spouse MUST be signed up for Medicare Part B when the MEMBER Retires and is re-classed under the Plan as a Retiree. Please contact Medicare directly for confirmation on waiving coverage and penalties.

Please note that when traveling outside the United States as a Retiree and covered under the UnitedHealthCare Group Retiree Advantage Plan they do offer coverage. More information will be provided to you in the Welcome Packet provided by UnitedHealthCare when you become eligible.

REMEMBER: If you, the Plan Participant, elect NOT to continue coverage under the Fund as your supplemental insurance through UHC Group Retiree Advantage Plan, you and your eligible dependents, will be terminated from the Plan coverage and the only way to obtain the Fund insurance again is by going back to work for 150 hours (the month following receipt of 150 hours you will be reinstated as an Active).

RETIREE CLASSIFICATIONS AND PREMIUM RATES EFFECTIVE JANUARY 1, 2026

$334.00	Retired, Medicare Member, single
$994.00	Retired, Medicare Member, Non-Medicare Spouse, Children
$635.00	Retired, Medicare Member, Medicare Spouse
$787.00	Retired, Medicare Member, Medicare Spouse, Children
$486.00	Retired, Medicare Member, Children
$937.00	Retired, Medicare Member, Medicare Spouse, Medicare Children
$568.00	Retired, Non-Medicare Member, Single
$1076.00	Retired, Non-Medicare Member, Non-Medicare Spouse
$869.00	Retired, Non-Medicare Member, Medicare Spouse
$1021.00	Retired, Non-Medicare Member, Medicare Spouse, Children
$1228.00	Retired, Non-Medicare Member, Non-Medicare Spouse, Children
$720.00	Retired, Non-Medicare Member, Children

Note: If you are a Local Union 14 Member, the above Rates are prior to the retire subsidy amount given by LU14 at the time of retirement. (deduct the LU14 Subsidy amount from the Retiree premiums above for what your Retiree rate would be).

RETIREE OPTIONAL BENEFITS

Please Note: One-Time election upon Retirement, there is no open enrollment offered at this time.

Dental Benefits Option and Rates for 2026:

	Comprehensive Dental	Preventive Dental	Vision
Single	$63.00	$28.00	$14.00
Married	$125.00	$57.00	$27.00
Family	$150.00	$68.00	$32.00

WHAT HAPPENS IF I DIE?

Your Eligible Spouse and/or Dependent Children under your policy may continue coverage as your Widow and may use any remaining Flex balances and/or dollar bank balances in your account to continue coverage with the Fund.

If the Surviving Spouse remarries prior to the exhaustion of the dollar bank she will be terminated and offered Cobra coverage for 36 months. If she elects Cobra, she can use the dollar bank to pay the premiums, if no Cobra election, the dollar bank is forfeited. After 36 months under Cobra the coverage will terminate, and any dollar bank balance left will be forfeited.

Your Spouse and/or Dependent children eligible on your "Active" policy at the time of your death may still use your Flex Account balance, until depleted, even if they are not continuing coverage under the Fund as your Widow.

Your Widow may elect only the benefits that they were covered for on the day of the Eligible Employees death or just medical only. Once a benefit is elected it cannot be changed later.

If you Retire, and your spouse/dependents waive or opt-off your policy, then upon your death any monies in your flex account will be forfeited to the Plan after all your out-of-pocket claims have been processed.

WIDOW CLASSIFICATIONS AND PREMIUM RATES EFFECTIVE JULY 1, 2025 - (2026 Rates change with Active Rates):

UNDER AGE 65

$1069.00 Medical only
$1113.00 Medical and Preventive Dental
$1142.00 Medical, Preventive Dental and Vision
$1167.00 Medical and Comprehensive Dental
$1197.00 Medical, Comprehensive Dental and Vision
$1098.00 Medical and Vision

OVER AGE 65 – Effective January 1, 2026

$331.00 Medicare Widow, Single
$632.00 Medicare Widow, Medicare Child(ren)
$483.00 Medicare Widow, Non-Medicare Child(ren) Only - 2 Eligible for Medicare

Widows do NOT have death, AD&D or Disability Benefits and can only elect the coverage in which the Participant had upon his/her death or medical only.

COORDINATION OF BENEFITS

If a Spouse or Dependent has Group Insurance Coverage for which benefits are payable, then Coordination of Benefits (COB) rules must be followed.

Participant and Spouse: The benefits of a Plan which covers the Individual on whose expenses are based other than a dependent (policyholder) shall be determined before the benefits of a Plan which covers the person as a dependent.

Dependent Children: If Parents not divorced or separated the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year. (birthday rule) If same birthday which ever Plan covered the parent longer will be primary. Birthday rule goes by Month first, then day, if the same birth month. The year is not taken into consideration.

Dependent Children and Step-Children: If divorced or separated a copy of the Divorce Decree with Marital Agreement must be submitted to the Fund Office for determination as based on the Court Decree language who would be primary insurance carrier.

Provider Portal on Website

On the WEEBF Website, www.weebf.com, there is a "Provider Portal" link that you and/or your Doctors Office, Hospital, Dentist etc.. can use for confirmation of eligibility and benefit coverage by answering the questions that pop-up once you click on the link.

It will ask you for the Patient's First Name, Participant ID Number, Patient's Date of Birth and the Date of Service, then click Get Eligibility/Benefit Summary.

A page will pop up showing Eligibility and what your Coverage is. If you scroll down the page, you will see separate boxes for Medical (In and Out of Network), Dental and Vision deductibles, Out-Of-Pocket amounts, Annual Maximums etc. used, along with current Out-Of-Pocket year to date totals.

Under each box is a Schedule of Benefits that if you click on will open a brief synopsis of what is covered (not full Plan Document).

PLEASE BE ADVISED:

Please notify your Employer, Local Union Office and the Fund Office in advance of any Active Military Service. Failure to provide advance timely notice may jeopardize your USERRA rights and benefits.

If you received a Social Security Disability Award you must notify the Fund Office and send in a copy of your Award as this may change your eligibility and benefit coverage.

If you are traveling for work outside Wisconsin, YOU are responsible for registering on the ERTS system which directs where you want your Pension and Health & Welfare contributions to go. Please remember that those hours are normally reported two months later instead of one month later. If any discrepancy of hours, please contact the Employer directly, not the Fund Office.

You can view all your family medical, dental and vision claim history online at www.weebf.com and login with your username and password, therefore, you do NOT need to receive your explanation of benefits (EOB) in the mail. You can opt-out of mailed EOB's and instead receive an Email notice when the Fund Office has processed a claim on you or your family. Opting to use the Electronic EOB option saves the Fund Office time and money on printing, paper, envelopes and postage which in turn saves YOU, the Participant, money. This option can be found on the website listed above under account settings.

If you forget your online password, you can reset it by clicking on "forgot may password" but only if you have input an email address under account settings on the website listed above.

INSURANCE CARDS

Your Anthem Blue Cross Blue Shield Insurance Card does not change for you or your dependents, when you Retiree and elect to draw full Active benefits from your dollar bank (regardless if you are over or under age 65). If you are under age 65 you will continue to use your existing Anthem BC/BS ID Cards.

Once you Retiree, over age 65, and paying the reduced premium for the Medical and Prescription coverage then you and your eligible dependents should receive new Anthem Blue Cross Blue Shield Insurance Cards indicating Medical and Prescription Drug Coverage only (not medical and dental). A separate Dental Card will be provided If you elected the optional dental benefit. The Vision benefit has no separate ID card, but benefits are paid out directly from the Fund Office.

If you are Medicare Eligible and Retired at age 65 or over, you will automatically be enrolled with the UnitedHealthCare Group Advantage Retiree Plan (UHC) and receive new insurance cards from UHC. You will also receive a new Sav-Rx prescription card and separate dental card if you do not have one already. UHC will send you a welcome packet that includes an enrollment form which you MUST sign and return within 90 days in order to continue coverage.

If you are Medicare Eligible and Retired over age 65, your eligible dependents under your policy, that are under age 65, will remain covered under the current Anthem BC/BS card for Medical and Prescription Drug Coverage only.

THINGS TO REMEMBER:

The Fund Office is the Receiving Agency only, if you do not agree with the hours reported, do NOT contact the Fund Office as we only record what was sent in by your Employer. You will need to contact your Employer directly if any discrepancy of hours.

ID Cards will be in the Participants Name only, will not show dependents due to frequent changes.

You may direct any questions directly to the Fund Office email at fundoffice@weebf.org or 1-608-276-9111. Option #1 is for the Claims Dept, Option #2 is for the Receiving Dept and Option #3 is for the Retirement/Pension Dept.

Helpful Phone Numbers:

- **1-410-919-4431 = Conifer Case Nurse (Andrea)**
- **1-866-315-6314 = Conifer Fax Number**
- **1-888-492-1860 = SwordHealth (Virtual Physical Therapy)**
- **1-866-233-4239 = Sav-Rx Pharmacy Benefit Manager**
- **1-888-548-3432 = LiveHealth Online (Video Visit with DR)**
- **1-888-893-6585 = Employee Assistance Program (Legal, Financial, Counseling, Worklife etc..)**
- **1-833-550-1678 = LaborFirst (UHC Group Advantage Plan Customer Service)**

QUESTIONS??