UTILITY WORKERS' UNION OF AMERICA
LOCAL 223
HEALTH AND WELFARE FUND

FREQUENTLY ASKED QUESTIONS

How are my benefits Funded?

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

What are the Fund's eligibility requirements?

To be initially eligible for benefits, you must have had a minimum of 140 hours multiplied by the current contribution rate contributed to the Fund on your behalf by your employer for at least two (2) consecutive months. Only employer contributions can be counted in meeting the initial eligibility provisions.

Eligibility begins on the first day of the month following a one (1) month accounting period after the initial eligibility requirements have been met. For example, if you work for a contributing employer who remits at least 140 hours of contributions for each of the months of April and May at the current contribution rate for work performed by you, you become eligible for benefits on July 1 and remain eligible for the entire month of July. Coverage for benefits is restricted to claims incurred on and after the date eligibility begins.

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

First call your employer. There may be a very good reason that 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 "Health and Welfare Enrollment Form" and submit copies of marriage or birth certificates to the Fund Office.

What do I do when I get divorced?

You must send a copy of your complete divorce decree to the Fund Office 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.

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 effective June 1, 2011. Therefore, if you are eligible for benefits and you have a child that was previously covered in the Plan, and their coverage was terminated, you should complete a "Request for Extension of Dependent Coverage" and return it to the Fund Office. 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.

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. The rates are 102% of the actual cost of providing benefits.

Do I have to pay for my health and welfare coverage?

Yes, most employers require that the employee pay a portion of the cost of coverage.

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 & Welfare Benefits?

The Fund has contracted with the BCBSM PPO to provide participants and the Fund with discounts on medical services. If a BCBSM participating provider is utilized the participant has reduced out of pocket expenses for hospitalization and other services.

The Fund has also contracted with Delta Dental to provide dental benefits. The Fund pays for in-network preventive services at 100% and restorative services from 60% to 80% depending on which network is utilized. The maximum annual benefit is $1,200.

The Fund contracts with VSP for your vision benefits. The Fund provides for a $20 co-payment for the examination and a $20 co-payment for the lenses and frames each 12 months if you utilize the services of a VSP participating provider.

The has also contracted with Guardian which provides Life Insurance Benefits of $15,000 for the participant as well as Accidental Death and Dismemberment Benefits of $15,000 in the event of the accidental death of the participant

Long Term Disability Benefit payments begin after the participant has been unable to work for 90 days. The Benefit provides for 60% of the participants monthly salary and the maximum monthly benefit is $2,000

For further details regarding the medical, dental and vision benefits available, please refer to the Summary Plan Description (SPD).