PLUMBERS & FITTERS LOCAL UNION #295 HEALTH & WELFARE FUND

c/o NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
8657 Baypine Road – Bldg. 5, Ste 200 - Jacksonville, FL 32256-8364
(904) 538-0100 – Toll-Free (888) 396-5899 – Fax (904) 538-0088
Email: nebajax@secure.neba-fl.com

IMPORTANT – PLEASE READ

Dear Participant,

Enclosed with this letter is the 2021 Annual Participant Verification Form as well as the 2021 Wellness Initiative Form. Please continue reading as further action in required on your part.

2021 Annual Participant Verification Form

This form is required to be completed annually. **Please complete the form, sign, date and return to the Fund Office as soon as possible. This form is for the 2021 Plan Year (for claims incurred in 2021 - beginning January 1, 2021). Claims incurred beginning January 1, 2021 will not be paid until we receive this form completed in its entirety. Be sure to complete all sections, sign and date prior to returning it to the Fund Office. Be sure to include copies of any applicable marriage certificates, divorce decrees, birth certificates or social security cards when enrolling yourself and/or dependents for the first time. Incomplete forms will be returned to the participant and may delay the processing of claims.**

Again, be sure that all sections are complete and you sign and date the form before mailing it to the Fund Office. **Note, if a spouse and/or dependent adult-child (age 18 to 26) is listed for coverage, their signature is also required on the back side of the form.** If you need more space to list your dependent children, please contact the Fund Office and they will send additional forms.

As part of the annual audit of the Health & Welfare Fund, the Fund Auditor will conduct random Eligibility Audits to help ensure that the Fund is providing coverage to those participants and dependents that are truly eligible.

REMEMBER, EX-SPOUSES ARE NOT ELIGIBLE FOR COVERAGE UNDER THE FUND EVEN IF YOUR DIVORCE DECREE REQUIRES THAT YOU PROVIDE SUCH COVERAGE. CONTACT THE FUND OFFICE FOR MORE INFORMATION.

2021 Wellness Initiative Form

As you are aware, beginning January 1, 2021, the co-insurance level for medical benefits for all participants will be 80/20. This means that the Plan will pay up to 80% of eligible medical expenses with the patient/participant being responsible for 20%. However, effective January 1, 2021, the Annual Medical Deductible is increasing 10x if you and your spouse, if applicable, do not participate in the Wellness Initiative.

Annual Medical Deductible

	Current	January 1, 2021
Single:	$250	$2,500
Family:	$500	$5,000

As of the date of this mailing, a good number of members and their spouses have completed the 2021 Wellness Initiative and will have the advantage of the low deductible in 2021. Thank you for your compliance!

For those who have not completed the 2021 Wellness Initiative, there is still time. Enclosed is the necessary form for your treating physician to complete. Note, if you have a spouse covered by the Plan, they must also participate in the Wellness Initiative in order to take advantage of the lower deductible for the entire family!

DO NOT DELAY! This certification will be good through December 31, 2021!

If you have any questions/concerns regarding the Annual Participant Verification Form or the 2021 Wellness Initiative Form, please contact the Fund Office by calling 1-888-396-5899.

Sincerely,

Board of Trustees

Notice Continues of Reverse Side

Important Benefits, Just for you!

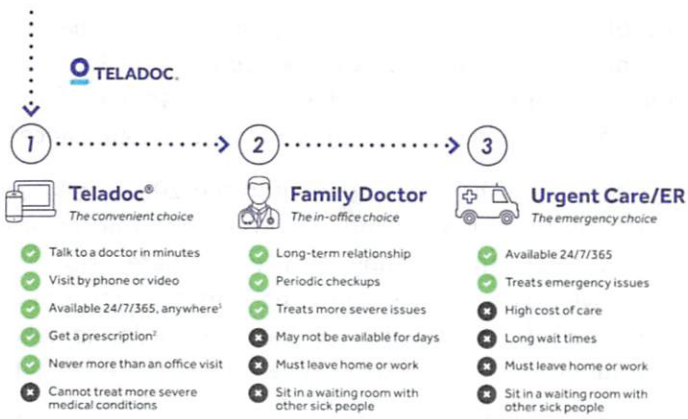
Teladoc is a national network of U.S. board-certified physicians and pediatricians that the Board of Trustees have contracted with to assist you in resolving your routine medical issues, on-demand 24/7, via phone or online video consultation from wherever you happen to be.

Step 1, setup your account online (www.teladoc.com), by phone (800-teladoc)

Step 2, speak with physician.

Step 3, if needed; go to pharmacy to pick up the prescription(s).

Teladoc is totally free…no copay, nothing!



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yourhearing network

The Board of Trustees have partnered with "Your Hearing Network" to bring you and your dependents a hearing care program. Your Hearing Network offers the best technology combined with the highest quality of service. Call "Your Hearing Network" at 1-888-770-0023 for more information.

Cigna's Lifestyle Management Program

Whether your goal is to lose weight, quit tobacco or lower your stress levels, you have the power to make it happen. Cigna/CareAllies Lifestyle Management Program can help and at no cost to you! Each program is easy to use and available where and when you need it. You can use each program online or over the phone, or both. Call 1-866-417-7848 or visit myCareAllies.com for more information.

Remember, it's free!

Minute, Convenience & Urgent Care Clinics are 100% free to use!!!

All services received at Minute, Convenience and Urgent Care Clinics are covered at 100% and not subject to any deductible or co-pay. These clinics can be found in your community and are conveniently located within stores such as CVS, Walgreens, Publix, Wal-Mart, Target and as stand-alone businesses such as CareSpot, Centra Care, Twin Lakes, MediQuick, Palm Coast Urgent Care, Urgent Care New Smyrna and Ormond Beach and Brevard County Health First Walk in Clinic.

Remember, medical emergencies should always be directed to the closest Emergency Room. When it's not an emergency, use a Minute, Convenience or Urgent Care Clinic. This will save you and the Fund money!

Remember, it's free!

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rightway

The Board of Trustees has partnered with a firm called "Rightway Healthcare". Rightway provides you with concierge support for your healthcare needs. Using this service will help you save time, money and reach better outcomes. Call Rightway at 1-305-851-7310 for more information on how they can help you.

Remember, it's free!

PLUMBERS & FITTERS LOCAL UNION #295 HEALTH & WELFARE FUND

Annual Participant Verification Form

2021

IMPORTANT NOTICE This form must be filed with the Fund Office on an annual basis. If the Fund Office receives claim(s) for you and/or your dependents and this form is not on file for the Calendar Year in which the claim(s) were incurred, your claim(s) will be denied pending receipt of this form by the Fund Office. If you submit this form within 12 months from the date of service, your claim(s) will be reprocessed. If you do not submit the form within 12 months from the date of service, your claim(s) will remain denied and the provider will be able to bill you for services rendered.

Employee Full Name:		**Social Security #:**	
		Date of Birth:	
Employee Mailing Address:		**Home Phone #:**	
		Cell Phone #:	

Do you have other coverage (this includes Medicare or Medicaid): (Circle One) YES NO

If yes, to the above – please provide the name of the carrier, phone number, effective date and your policy number or identification number in the space below:

HEALTH PLAN - THIS SECTION MUST BE COMPLETED TO ENROLL YOUR SPOUSE AND/OR CHILD(REN) IN THE HEALTH PLAN.

Full Name of Spouse* *Include a copy of your marriage certificate if you are a new employee or if you recently married/remarried. Also, you must include a copy of your spouse's birth certificate and social security card when enrolling the first time.	**Date of Birth**	**Social Security Number**	**Does your spouse have other Medical coverage?**	**If your spouse has other Medical coverage (this includes Medicare or Medicaid), please provide the requested information below.**	
			YES NO Please circle your response	Insurance Carrier Name:	Coverage Effective Date:
				Insurance Carrier Phone #:	Policy Identification #:

Full Name of Child(ren)** **Include a copy of the divorce, support or paternity decree for any child NOT born of your current marriage or who does NOT live with you. Also, you must include a copy of each dependent child's birth certificate and social security card when enrolling the first time.	**Date of Birth**	**Social Security Number**	**Does your child(ren) have other Medical coverage?**	**If your child/children have other Medical coverage (this includes Medicare or Medicaid), please provide the requested information below.**		
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

BENEFICIARY DESIGNATION – YOUR BENEFICIARY WILL RECEIVE ANY DEATH BENEFITS PAYABLE BY THE FUND IN THE EVENT OF YOUR DEATH

Beneficiary's Full Name:	Relationship to You:	Social Security Number:
Address, if Different than Yours:		

CONTINUE ON REVERSE SIDE

DENTAL PLAN - THIS SECTION MUST BE COMPLETED IF YOU ENROLLED YOUR SPOUSE AND/OR CHILD(REN) IN THE HEALTH PLAN (ABOVE).

Full Name of Spouse *Include a copy of your marriage certificate if you are a new employee or if you recently married/remarried.	**Does your spouse have other Dental coverage?**	**If your spouse has other Dental coverage, please provide the requested information below.**	
	YES NO Please circle your response	Insurance Carrier Name:	Coverage Effective Date:
		Insurance Carrier Phone #:	Policy Identification #:

Full Name of Child(ren) **Include a copy of the divorce, support or paternity decree for any child NOT born of your current marriage or who does NOT live with you.	**Does your child(ren) have other Dental coverage?**	**If your child(ren) have other Dental coverage, please provide the requested information below.**		
	YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
		Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
	YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
		Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
	YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
		Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

EMPLOYEE ACKNOWLEDGEMENT & SIGNATURE

I certify that the information provided on this Annual Participant Verification Form is true and correct to the best of my knowledge and that the dependents I have enrolled meet the Plan's definition of a Dependent as defined in the Plan Document and Summary Plan Description (SPD).

I understand that it is my responsibility to notify the Fund Office within 60 days of a divorce or legal separation from my spouse.

Employee Signature: _____ Date: _____

EMPLOYEE & SPOUSE (IF APPLICABLE)

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment directly to the provider(s) of the surgical, medical, dental, vision and/or prescription benefits, if any, otherwise payable to me for services.	PARTICIPANT/EMPLOYEE SIGNATURE: DATE	SPOUSE SIGNATURE, IF APPLICABLE: DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider(s) to release any information acquired in the course of my examination or treatment in order to determine benefit coverage and/or to process claims for payment.	PARTICIPANT/EMPLOYEE SIGNATURE: DATE	SPOUSE SIGNATURE, IF APPLICABLE: DATE

DEPENDENT ADULT-CHILD(REN) - DEPENDENT ADULT-CHILD(REN) MUST COMPLETE IF THEY WILL BE AGE 18 TO 26 ANYTIME DURING THE APPLICABLE YEAR

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment directly to the provider(s) of the surgical, medical, dental, vision and/or prescription benefits, if any, otherwise payable to me for services.	1. DEPENDENT ADULT-CHILD NAME (PRINT): DATE	1. DEPENDENT ADULT-CHILD SIGNATURE & DATE: DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider(s) to release any information acquired in the course of my examination or treatment in order to determine benefit coverage and/or to process claims for payment.	2. DEPENDENT ADULT-CHILD NAME (PRINT): DATE	2. DEPENDENT ADULT-CHILD SIGNATURE & DATE: DATE

FUND OFFICE:
NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC. • 8657 BAYPINE ROAD, BLDG. 5 – STE. 200 • JACKSONVILLE, FL 32256
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