WELS Benefit Plans
Wisconsin Evangelical Lutheran Synod

WELS VEBA
GROUP HEALTH CARE PLAN

2025 Limited Open Enrollment Benefits Guide

Open enrollment period: **November 1 through December 2, 2024**

A NEW YEAR OF HEALTH BENEFITS **WITH WELS VEBA**

Welcome to the WELS VEBA Group Health Care Plan (WELS VEBA)

For more than 40 years, our church body has joined together through WELS VEBA to provide health care benefits to the families of called and lay workers at WELS and ELS sponsoring organizations. On behalf of the WELS VEBA Commission, I am pleased to offer you and your eligible family members a limited open enrollment opportunity for the 2025 plan year.

During this limited open enrollment, you can enroll for new coverage, add or remove any eligible family members, or change your deductible option under the WELS VEBA Medical Benefits. You may also apply for Dental Benefits, Group Term Life Insurance, and/or Voluntary Long-Term Disability Insurance.

This benefits guide provides a summary of the benefits available to you under WELS VEBA and explains what you need to do to make your elections. We encourage you to read the guide and consider your options carefully. Please remember that enrollment is only open for a limited time, so be sure to make your elections by this year's deadline: **December 2, 2024.**

If you do not wish to make any changes to your current benefit elections, no action is required and your 2024 elections will automatically carry over to 2025.

As we do every year, we have reviewed the WELS VEBA benefits to ensure that they remain valuable for our members and their families. We recognize that each member has unique needs for benefits coverage and we continuously strive to ensure we can offer you the best coverage at a competitive price.

We look forward to remaining your trusted health care benefits provider and partner in ministry.

In Christ's service,

Mr. Joshua Peterman
Director of Benefit Plans,
For the WELS VEBA Commission

Joshua Peterman

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BENEFITS IN SUMMARY

A reminder of the benefits available

WELS VEBA is proud to offer a comprehensive benefits package to the families of called and lay workers at WELS and ELS sponsoring organizations, including the following benefits for the 2025 plan year:

- **Medical Benefits**
- **Prescription drugs**
- **Routine Vision Benefits**
- **Dental Benefits**
- **Group Term Life Insurance**
- **Long-Term Disability Insurance**
- **Health resources**

Consistent benefits

WELS VEBA provides benefits that are consistent nationwide and are supported by more than 80% of WELS calling bodies. In addition, WELS VEBA's broad national provider network ensures that health coverage remains accessible wherever a worker may be called to serve or travel.

Consistent value

Through WELS VEBA, the cost of health care for workers' families is shared across all participating calling bodies throughout the synod. Grouping together all covered workers under one plan allows WELS VEBA premium costs to be as low as reasonably possible and stable over time.

Consistent with God's Word

WELS VEBA is purposefully designed for workers serving at WELS and ELS ministries. As a plan sponsored by a religious organization, WELS VEBA is uniquely consistent with both God's Word and the law.

2025 LIMITED OPEN ENROLLMENT

Don't miss your chance to benefit!

The WELS VEBA llimited open enrollment period for the 2025 plan year is open from **November 1, 2024, through December 2, 2024.** This limited open enrollment period is for the 2025 plan year, meaning that any changes you make will become effective on **January 1, 2025**.

Open enrollment periods are held solely at the discretion of the WELS VEBA Commission and are not held every year. Please take the time to consider all of the options available and make any elections before the enrollment period closes.

If you do not wish to make any changes to your current benefit elections, no action is required and your 2024 elections will automatically carry over to 2025. Please note that your sponsoring organization cannot make benefit elections on your behalf.

ELIGIBILITY

To be eligible for the WELS VEBA, a worker must:

- Be an active worker in an eligible sponsoring organization; and
- Be hired or called, and compensated, to work at least 20 hours per week and for five or more months per year.

OPEN ENROLLMENT OR LIMITED OPEN ENROLLMENT – WHAT'S THE DIFFERENCE?

An **open enrollment** is available to eligible workers at all WELS and ELS sponsoring organizations, including sponsoring organizations that do not participate in WELS VEBA when the open enrollment begins. During an open enrollment, eligible workers can enroll themselves and eligible family members for new WELS VEBA Medical Benefits. Eligible workers who are enrolled in WELS VEBA Medical Benefits can change deductible options and/or add or remove eligible family members.

A **limited open enrollment** is available to eligible workers at WELS and ELS sponsoring organizations with at least one active worker enrolled in WELS VEBA Medical Benefits when the limited open enrollment begins. During a limited open enrollment, eligible workers at participating sponsoring organizations can enroll themselves and eligible family members for new WELS VEBA Medical Benefits, and eligible workers who are enrolled in WELS VEBA Medical Benefits can change deductible options and/or add or remove eligible family members.

QUALIFYING LIFE EVENTS

If you do not enroll yourself or a dependent during this limited open enrollment, or you terminate WELS VEBA coverage in the future, you may be able to enroll if you experience one of the following **qualifying life events**:

- Gaining a dependent as a result of marriage, birth, adoption or placement for adoption.
- Loss of eligibility for coverage under another health plan for either you or your dependent(s) due to no fault of your own.
- Accepting a new call/position to a different WELS or ELS calling body or employer.
- Change in eligibility status for Medicaid and/or Children's Health Insurance Program (CHIP).

If you experience one of the qualifying life events above, you must log onto **wels.bswift.com** or call the WELS Benefits Service Center at **1-800-487-8322 (option 1)** within the first **60 days** of the event to report the event and change your benefit elections.

If you miss this opportunity to make a change, you must wait for the next open enrollment period or a subsequent qualifying life event to make benefit elections.

“Enrollment is only open for a limited time, so be sure to make your elections by December 2, 2024.”

↘ WHAT HAS CHANGED AND WHAT CAN I CHANGE?

Outlined below are the changes that can be made to your WELS VEBA benefit elections during the 2025 limited open enrollment period, as well as highlighted important benefit plan changes that will be effective on January 1, 2025.

Medical Benefits

Allowable changes during open enrollment:

- If you are not currently enrolled in WELS VEBA Medical Benefits, you may elect Medical Benefits for yourself and any eligible family members.
- If you are currently enrolled in Medical Benefits, you may change deductible options, add or drop dependents, or waive Medical Benefits.

Important:

- Geographic rate regions for Medical Benefits will change for all areas beginning in 2025 so that rates will better reflect current health care costs in local markets across the country. Inflation also continues to increase the costs of health care services and prescription drugs.
- The 2025 rates for Medical Benefits are available on welsbpo.net. Please carefully consider the 2025 rate changes and discuss with your sponsoring organization how the changes may affect your elections for 2025 Medical Benefits.
- The Plan Option 3 deductible amounts will increase to $3,300/individual and $6,600/family per IRS regulations to remain qualified for use with a Health Savings Account.
- Anthem will discontinue AllClear identity protection and recovery services as of January 1, 2025.

Dental Benefits

Allowable changes during open enrollment:

- If you are not currently enrolled in WELS VEBA Dental Benefits, you may elect Dental Benefits for yourself and any eligible family members.
- If you are currently enrolled in Dental Benefits, you may add or drop dependents, or waive Dental Benefits.

Important:

- Rates for Dental Benefits will not change. The 2024 rates for Dental Benefits will remain in effect for 2025.

Group Term Life and Long Term Disability

Applying for Group Term Life or Long-Term Disability Insurance

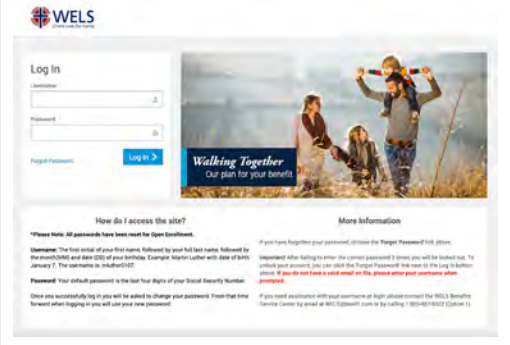
- You may apply for WELS VEBA Group Term Life or Voluntary Long-Term Disability Insurance at any time during the year. Applications for new or increased coverage are subject to evidence of insurability and approval by Sun Life.

Important:

- Long Term Disability Insurance coverage will remain unchanged in 2025 and premium rates for Voluntary Long-Term Disability Insurance will decrease by 10%.
- Coverage and premium rates for Group Term Life Insurance will remain unchanged in 2025.
- Online will preparation through ComPsych will be available at no cost to you if you are enrolled in Long-Term Disability or Employee Group Term Life Insurance in 2025.
- Support services through ComPsych will be available at no cost to you if you file a claim for Long-Term Disability or Group Term Life benefits in 2025.

↘ VIEW CURRENT BENEFITS

Visit the WELS Benefits Service Center website at **wels.bswift.com** to view your current WELS benefits and request changes during the 2025 limited open enrollment period.



↘ HOW DO I ENROLL?

The deadline to make election changes is **December 2, 2024**. Election changes must be made through the WELS Benefits Service Center online at **wels.bswift.com** (see page 18 of this guide for details) or by calling **1-800-487-8322 (option 1)**.

↘ IMPORTANT CONSIDERATIONS

If you do not wish to make any changes to your current benefit elections, no action is required and your 2024 elections will automatically carry over to 2025.

The confirmation statement included with this guide provides the total monthly premiums for the 2025 plan year for each benefit plan in which you are currently enrolled.

It's important to note that you may select any medical plan option you wish, regardless of the dollar amount that your calling body or employer will contribute toward your monthly premiums.

The selected plan option should best meet the health care and financial needs of your family, while considering the financial resources of your calling body or employer. We would, however, encourage you to check with your calling body or employer for the dollar amount of any contributions which may be required from you based on your benefit elections.

PROTECTING YOUR HEALTH

Medical Benefits | Anthem BlueCross BlueShield

In case of an illness or injury, as a member enrolled in WELS VEBA Medical Benefits, you and/or your family would receive coverage through one of **four** offered medical plan options. More detail on the services that are covered in each of these plan options are outlined in the table on the next page.

↘ HOW IT WORKS:

1. You and/or your sponsoring organization pay a monthly premium.

2. You pay for health care until you meet your *deductible*.

3. Your plan then kicks in and you pay only a portion of the cost *(coinsurance)*.

4. If you have high medical costs, you won't pay more than your *out-of-pocket maximum* for covered services obtained at In-Network providers.

To help you understand how the deductibles and percentages work, let's take Tom as an example…

Tom has selected the WELS VEBA Plan Option 2.

He has individual coverage and obtains all of his health care services at In-Network providers*. All of Tom's health care services are covered under WELS VEBA.

Tom's *deductible* for the year is:	Tom's *coinsurance* for the year is:	Tom's *out-of-pocket maximum* for the year is:
$1,000	**15%**	**$3,000**

During the year, Tom needs in-patient care at an In-Network hospital at a cost of: $20,000

First **$1,000**	Next **$2,000**	Balance of **$17,000**
Tom is responsible for paying the first $1,000 to satisfy the *deductible*.	With 15% *coinsurance*, Tom is also responsible for the next $2,000 which has been capped because he's reached his $3,000 *out-of-pocket maximum*.	The remaining $17,000 is covered by WELS VEBA.

* Using In-Network providers not only reduces your portion of the cost for your health care services, but it also reduces the cost for those services payable by WELS VEBA. As a result, using In-Network providers is a way that you can help to keep WELS VEBA costs low and ultimately reduce the premiums payable by your sponsoring organization for WELS VEBA coverage. You can find In-Network providers by visiting **welsbpo.net/health/find-a-provider**.

↘ WHAT IS COVERED UNDER EACH PLAN?

The table below outlines the coverage provided in each of the four medical plan options:

Benefit Highlights	Plan Option 1		Plan Option 2		Plan Option 3[2] (HSA Compliant)		Plan Option 4	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible								
Individual	$500	$500	$1,000	$1,000	$3,300	$3,300	$3,500	$3,500
Family	$1,000	$1,000	$2,000	$2,000	$6,600	$6,600	$7,000	$7,000
Annual Medical Out-of-Pocket Maximum								
Individual	$1,500	$1,500	$3,000	$3,000	$5,100	$5,100	$6,000	$6,000
Family	$3,000	$3,000	$6,000	$6,000	$10,200	$10,200	$12,000	$12,000
Coinsurance (Member Cost Share for Covered Medical Expenses after Deductible)	10%	30%	15%	30%	20%	30%	20%	50%
Doctor's Office								
Office Visits & Routine Care	Ded./10%	Ded./30%	Ded./15%	Ded./30%	Ded./20%	Ded./30%	Ded./20%	Ded./50%
Preventive Services[1]	0%	Ded./30%	0%	Ded./30%	0%	Ded./30%	0%	Ded./50%
Hospital Services								
In-patient Services	Ded./10%	Ded./30%	Ded./15%	Ded./30%	Ded./20%	Ded./30%	Ded./20%	Ded./50%
Outpatient Services	Ded./10%	Ded./30%	Ded./15%	Ded./30%	Ded./20%	Ded./30%	Ded./20%	Ded./50%
Emergency Room	Ded./10%	Ded./10%	Ded./15%	Ded./15%	Ded./20%	Ded./20%	Ded./20%	Ded./20%
Urgent Care	Ded./10%	Ded./30%	Ded./15%	Ded./30%	Ded./20%	Ded./30%	Ded./20%	Ded./50%
Prescription Drugs								
Retail (30-day supply)								
Generic	$10		$10		Subject to Deductible; No Charge after Deductible is met		$10	
Preferred Brand	$30		$30				$30	
Non-Preferred Brand	$60		$60				$60	
Mail Order (90-day supply)								
Generic	$25		$25		Subject to Deductible; No Charge after Deductible is met		$25	
Preferred Brand	$75		$75				$75	
Non-Preferred Brand	$150		$150				$150	
Prescription Drug Out-of-Pocket Maximum								
Individual	$1,000		$1,000		N/A; Combined with Medical		$500	
Family	$2,000		$2,000				$1,000	

[1] Preventive care services required by the Affordable Care Act of 2010 on all plans are covered at 100% and are not subject to the deductible if obtained at an In-Network provider. Preventive care services obtained at an Out-of-Network provider will be subject to the Out-of-Network deductible and coinsurance.

[2] WELS VEBA is not able to provide the banking services for a Health Savings Account (HSA). Members may set up an HSA for use in conjunction with Plan Option 3 with their own financial institution. Please be aware that certain benefits, such as prescription drugs, are covered differently under Plan Option 3. Please contact the WELS Benefits Service Center for additional information on this plan option.

SUPPORTING A HEALTHY CHOICE

Helping yourself, helping each other

Your health is, of course, more than just a once a year enrollment decision. But it's also important to remember that looking after your health is not just good for your **own** well-being. While it may seem obvious that leading a healthier lifestyle is likely to result in an improved quality of life, it can often be overlooked that healthy behaviors can also impact the whole plan – helping to **decrease** the costs of health care for families, sponsoring organizations, and our synod as a whole.

Through WELS VEBA, the health care costs of covered workers and their family members are **shared** across the synod. This is **our plan supported by our ministries**, so it is important for members to be good stewards of the available benefits and to take good care of their health. This will help to keep plan costs low over time, preserving valuable assets for ministry and ensuring workers are able to serve and perform their ministries more effectively.

WELS VEBA offers a variety of resources and information to help you maintain and improve your well-being. There are also a number of ways for you to utilize health care cost-effectively in your everyday life. Take a look at some of the resources available on page 12 and consider the following tips when it comes to your own health and well-being:

Use In-Network providers

Why?

Using In-Network providers reduces your portion of the cost for your health care services, and also reduces the cost for those services payable by WELS VEBA.

How?

- You can find In-Network providers by visiting **welsbpo.net/health/find-a-provider** or **anthem.com** or by calling Anthem at **1-877-512-7875**.
- You should also look for providers with high quality outcomes at low cost where possible – use Anthem's cost comparison tool for many common health care procedures by logging in to your account at **anthem.com**.

Access the appropriate level of care for your need

Why?

Using appropriate levels of care will help to reduce unnecessary expense on treatment when a more cost-effective solution may have been available.

How?

- Call the Anthem 24/7 NurseLine at **1-800-700-9184** to speak with a nurse about your condition and determine the best course of action.
- Use Anthem LiveHealth Online at **livehealthonline.com** to obtain a doctor visit for only $55.
- Limit visits to the emergency room to only those situations when you are having a real emergency or if you think you could put your health at serious risk by delaying care. Instead, consider using an urgent care center, retail health clinic, or a walk-in clinic.

Obtain preventive care services

Why?

Regular screenings are important to identify potentially dangerous conditions before they turn into chronic or life-threatening illnesses.

How?

- Check with your doctor to see which preventive care services are recommended for you and contact Anthem to determine the available benefits.
- WELS VEBA covers many preventive care services at no cost to you if obtained at an In-Network provider.
- Manage chronic conditions appropriately – if you have developed a chronic condition, be sure to obtain regular checkups/screenings and take any prescriptions as directed by your doctor.

Maintain a healthy lifestyle and behaviors

Why?

Among other things, eating healthy, getting more exercise, maintaining regular sleep patterns and reducing stress are common guidelines for maintaining good health.

How?

- Check with your doctor to determine if any significant lifestyle changes are recommended.
- Well-being resources are available by logging in to your Anthem account at **anthem.com**.

Manage your pharmacy benefits

Why?

There are a number of efficiencies to be found when it comes to prescription drugs, so why pay more than you need to?

How?

- Using generic drugs (as prescribed by your doctor) for medications that are equivalent to brand name alternatives helps to lower your copay amount and the cost paid by WELS VEBA.
- Using the mail service pharmacy for drugs that you regularly need to manage a health condition helps to lower your copay amount and the cost paid by WELS VEBA, and also provides the convenience of having the drugs delivered directly to your home.
- Manage your pharmacy benefits with Express Scripts online at **express-scripts.com** or call **1-800-818-6634**.

↘ AVAILABLE RESOURCES

If you become ill, we want to provide you with the support to get back to full health as quickly as possible. There are a number of plans and initiatives through WELS VEBA that you can take advantage of throughout the year that are designed to help you and your families get back to your work and the lifestyle you want to lead.

ANTHEM'S LIVEHEALTH ONLINE

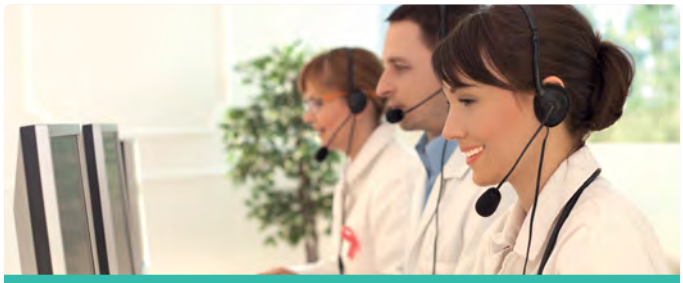
With Anthem's LiveHealth Online, you can see a doctor without ever leaving your home or office. In conjunction with Anthem BlueCross BlueShield, WELS VEBA members and their families have access to an online service 24 hours a day, 7 days a week, 365 days a year, all accessible from the comfort of your own computer or mobile device. Doctors can answer questions, make a diagnosis and may even prescribe basic medications (as legally permitted in certain states).

Simply enroll at **livehealthonline.com** or on the free mobile app.

PRESCRIPTION DRUG BENEFITS

WELS VEBA prescription drug benefits are provided through Express Scripts. Please see page 9 for a coverage summary.

Login to your account at **express-scripts.com** to manage your refills, schedule home deliveries, find information on prescribed drugs, and research lower-cost alternative medications. Or call Express Scripts at **1-800-818-6634** for assistance.



ANTHEM'S 24/7 NURSELINE

WELS VEBA members and their families have access to Anthem's 24/7 NurseLine – a free telephone service where you can talk with a registered nurse about your health concern. If you'd prefer not to talk about your health concern over the phone, a pre-recorded AudioHealth Library is also available.

WELS VEBA members can call the 24/7 NurseLine at **1-800-700-9184**.

24-HOUR TRAVEL ASSISTANCE SERVICES

A 24-hour travel assistance service is automatically included for members of the WELS VEBA health plan. Facilitated by Assist America, WELS VEBA members and their families have access to a comprehensive range of services designed to respond to most medical care situations and other emergencies you may encounter when you travel more than 100 miles away from home or in a foreign country.

For more information contact Assist America at **1-800-872-1414** (U.S. toll-free) or **1-609-986-1234** (outside U.S.).

FOCUSING **CLEARLY**

Routine Vision Benefits | VSP Vision care for life

Routine Vision Benefits through VSP are automatically included with enrollment in WELS VEBA Medical Benefits at no additional cost.

To access Routine Vision Benefits from an In-Network VSP provider, simply mention that you are a VSP member to your vision provider before your visit. There is no need for an ID card and they handle the paperwork for you.

The following table provides a summary of the Routine Vision Benefits:

Treatment	In-Network (any VSP provider)	Out-of-Network (any qualified non-network provider of your choice)
Frequency		
Exam	Every calendar year	Every calendar year
Lenses	Every calendar year	Every calendar year
Frames	Every other calendar year	Every other calendar year
Exam	Covered in full	$45 reimbursement allowance
Frames	$150 benefit allowance	$70 reimbursement allowance
Single Vision Lenses	Covered in full	$30 reimbursement allowance
Lined Bifocal Lenses	Covered in full	$50 reimbursement allowance
Lined Trifocal Lenses	Covered in full	$65 reimbursement allowance
Elective Contact Lenses in lieu of glasses	$150 benefit allowance	$105 reimbursement allowance
Exam for Contact Lens Fitting	Not to exceed $60 copay	Not covered
Routine Retinal Screening	$20 copay	Not covered

You can use any vision provider you wish; however, as you can see from the table above, vision benefits are greater when you utilize a vision provider within the VSP network.

To find VSP In-Network providers in your area, go to **vsp.com** and click on "Find a VSP Doctor" or call VSP customer service at **1-800-877-7195**.

Shop for glasses and contacts online at eyeconic.com. Login as a VSP member to receive In-Network benefits.

Please note that the VSP network includes retail chain affiliates such as VisionWorks.

- Benefits for services and hardware obtained at an In-Network VSP Doctor or Retail Chain Affiliate are administered automatically at point-of-sale; there are no claim forms to complete.
- To receive benefits for services and hardware obtained at an Out-of-Network VSP Doctor or Retail Chain, members must pay the full costs up front and submit a claim to VSP for reimbursement.

KEEPING YOU **SMILING**

Dental Benefits | DELTA DENTAL

Good oral care enhances overall physical health, appearance, and even mental well-being. Problems with the teeth and gums are common, but are usually easily-treated health problems and our voluntary dental plan can help keep your teeth healthy and your smile bright.

Dental Benefits are available on a voluntary basis at an additional premium cost and are not automatically included with enrollment in WELS VEBA Medical Benefits.

The following table provides a summary of the Dental Benefits:

Treatment	Plan benefits for covered services
Annual Deductible	Individual $50 / Family $150
Individual Annual Benefit Maximum	$1,000
Preventive Dental Services • Exam and cleaning (two per year) • Fluoride (two per year for dependent children to age 19) • X-rays (two per year for bitewings; 36-month intervals for full mouth) • Sealants (for dependent children to age 19)	100%
Basic Services: Fillings, Endodontics, Periodontics, Extractions	80%
Major Services: Crowns, Inlays, Onlays, Bridges, Dentures, Implants	50%
Orthodontic Services (for dependents through the end of the month they attain age 19) Individual lifetime maximum	50% $1,500

Please note: Under the **"Checkup Plus"** benefit, charges for covered diagnostic and preventive services will not be applied to members' annual maximum benefit amounts.

You can visit any dentist you wish, but your benefits and discounts will be greatest if you seek care from a Delta Dental PPO dentist. Delta Dental Premier dentists also offer reduced fees for services, but discounts are not as great as those offered by PPO dentists.

Out-of-Network dentists do not have discounts or maximum fee agreements with Delta Dental, so your costs for services will generally be higher than the costs for services obtained at PPO and Premier dentists.

For more information, or to find out if your dentist participates in the Delta Dental network, please visit **deltadentalwi.com** or call Delta Dental customer service at **1-800-236-3712**.

Monthly premiums for Dental Benefits will not change for 2025. The 2025 rates are as follows:

Coverage tier	Monthly premium
Employee Only	$37.28
Employee + Spouse	$76.25
Employee + Children	$92.31
Family	$151.40

A LITTLE PEACE OF MIND

Group Term Life Insurance | Sun Life Financial

Although it's something none of us want to think about, Group Term Life Insurance can provide valuable protection for workers and their families when financial help is needed the most. Group Term Life Insurance is available for eligible workers and their families with coverage amounts up to $400,000 per worker and $200,000 for a spouse.

Group Term Life Insurance is available on a voluntary basis at an additional premium cost and is not automatically included with enrollment in WELS VEBA Medical Benefits.

Please logon to **wels.bswift.com** to review premium rates and consider coverage options, which are outlined in the table below:

Coverage	Benefit
Worker	Coverage available: $10,000 $25,000 $50,000 $75,000 $100,000 $150,000 $200,000 $250,000 $300,000 $350,000 $400,000
Spouse	Coverage available: $5,000 $12,500 $25,000 $37,500 $50,000 $75,000 $100,000 $125,000 $150,000 $175,000 $200,000 *Spouse amount is limited to 50% of the worker amount.*
Dependent child	Coverage available: $5,000

HELPING TO **MAKE LIFE EASIER**

Long-Term Disability Insurance | Sun Life Financial

Long-Term Disability Insurance provides protection to eligible workers who, due to sickness or injury, are unable to perform the duties for which they have been called or hired.

Basic Long-Term Disability Insurance is automatically included with enrollment in WELS VEBA Medical Benefits at no additional cost for members who are active workers at WELS/ELS sponsoring organizations and enrolled in WELS VEBA Medical Benefits as the primary insured. Vicars, students, surviving spouses, retirees and dependents, including a worker who is covered as a WELS VEBA dependent, do not have basic Long-Term Disability Insurance under WELS VEBA Medical Benefits.

Workers who are eligible for but not enrolled in WELS VEBA Medical Benefits as the primary insured may apply for Long-Term Disability Insurance on a voluntary basis. Workers can apply for voluntary Long-Term Disability Insurance on any day of the year at **wels.bswift.com**. Applications are subject to evidence of insurability and approval by Sun Life. Please visit **welsbpo.net** for information and premium rates.

Benefits of coverage

- Benefits begin on the 91st day of a disability.
- Your benefit is 66.67% of your pre-disability monthly earnings. This amount may be reduced by other sources of income or disability earnings.
- Benefits may be payable up to your Social Security Normal Retirement Age (or older if a disability begins after you attain age 60).

GET **CONNECTED!**

Useful apps to help you look after your health

Did you know that many of our service providers offer an app to help you access their services straight from your mobile device? From managing claims, tracking prescriptions and accessing member savings, these apps are more than just "information-only" apps that you might expect. Check them out below and use the QR codes to download.

ANTHEM BLUECROSS BLUESHIELD

With Anthem's Sydney app you can access your health care wherever you are. With features such as estimating costs, finding a doctor and securely sending and receiving messages about your plan, this app gives you the ability to truly interact with your health care on the go.

IOS ANDROID

ANTHEM LIVEHEALTH ONLINE

Talk to a doctor today, tonight, anytime – 365 days a year. Including immediate doctor visits through live video, your choice of U.S. board-certified doctors and private, secure and convenient online visits.

IOS ANDROID

EXPRESS SCRIPTS

From up-to-the-minute order status, to a handy "medicine cabinet" to keep track of prescriptions, the Express Scripts app is an on-the-go pharmacy!

IOS ANDROID

VSP

The VSP app provides exclusive special offers from leading industry brands, totaling more than $2,500 in savings. Including extra money to spend on featured frame brands, savings on LASIK at NVision and TLC eye centers, and much more.

IOS ANDROID

DELTA DENTAL

Delta Dental's online member portal gives you access to a dentist search, claims and coverage, ID cards and more. There is even secure chat and messaging.

Go to **deltadentalwi.com** and click on "Register". After a few simple steps, you will be able to sign in any time you need access to your dental benefits information.

ASSIST AMERICA

With the Assist America app you can benefit from one-touch calls to their 24/7 Emergency Operations Center, up-to-the-minute travel alerts, pre-trip information, and much more.

IOS ANDROID

HOW TO **MAKE YOUR CHOICE**

A step-by-step guide

All eligible workers have access to an online system we call the **WELS Benefits Service Center**. As well as a useful resource for further information and to access electronic copies of documents such as this benefits guide, it is also where we encourage you to make your elections during the enrollment period.

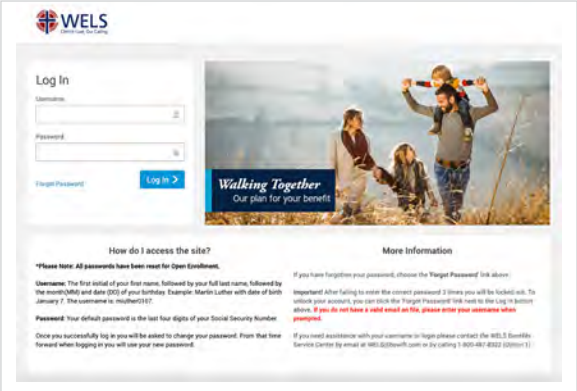
REMEMBER!
Take the time to consider all of the options available and make any changes before the enrollment period closes on **December 2, 2024**.

If you decide that you do not wish to make a change to your benefit coverage, no further action is required.

Ready to make your elections?

The following is a step-by-step guide to accessing the WELS Benefits Service Center website and takes you through the action required for this fall's open enrollment window.

➘ WHEN YOU'RE READY TO ENROLL: LOGIN TO THE WEBSITE

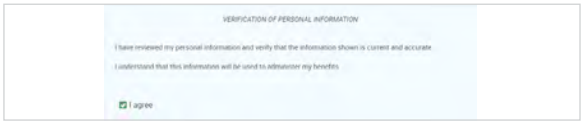


- Go to the WELS Benefits Service Center website: **wels.bswift.com**
- You will be required to enter a username and password to gain access to your personalized site.
- Your username is the *first initial* of your first name, followed by your *full last name*, followed by the *month (MM)* and *date (DD)* of your birth (e.g. Martin Luther, with a date of birth of January 7th is **mluther0107**).
- Your password to login is the last four digits of your Social Security Number, even if you have previously changed it.
- If you are having trouble logging in, follow the on-screen instructions or call the WELS Benefits Service Center at **1-800-487-8322 (option 1)**.
- When you are ready to make changes to your benefit elections, click on **Start Your Enrollment** from the homepage.

The enrollment process is broken down into the following 3 steps:

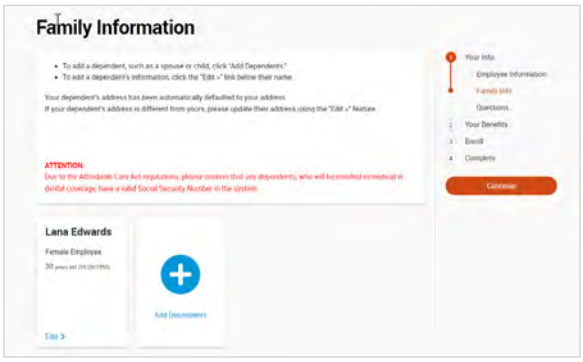
1 Verify Your Information → **2** Select Your Benefits → **3** Confirm

➘ STEP 1A: VERIFY YOUR PERSONAL INFORMATION



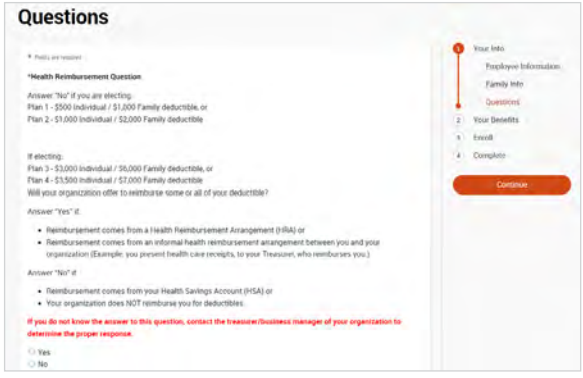
- Please verify the accuracy of your personal information. Any updates can be made directly on this page.
- Check **I agree** at the bottom of the page. Next click **Continue**.

➘ STEP 1B: VERIFY YOUR FAMILY INFORMATION



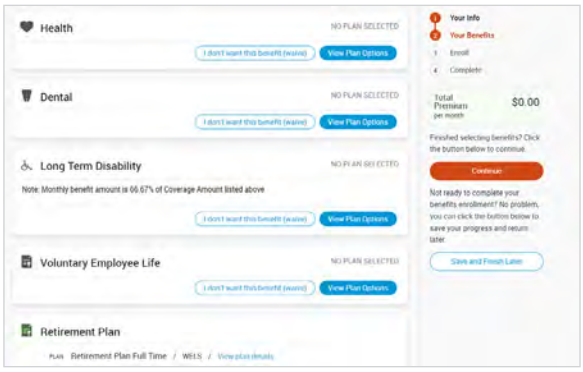
- Ensure all eligible dependents and their information is reflected.
- If a dependent's Social Security Number or date of birth is missing, click on their name to add the information.
- To add a dependent, click on the **Add Dependents** link.
- Verify all information is complete and accurate, then click on **I agree** and click **Continue**.
- **Please note:** on this screen **you are not** adding your family member to coverage, you are simply listing them as your valid dependent.

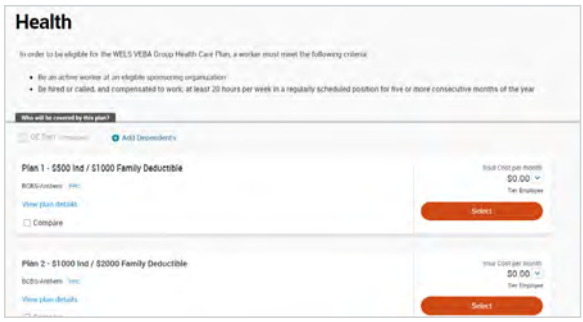
➘ STEP 1C: QUESTIONS

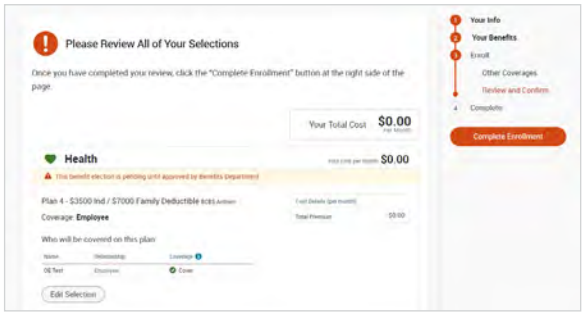


- Please be sure to answer any questions in the **Question** section in order to continue through enrollment.

➘ **STEP 2:** SELECT YOUR BENEFITS

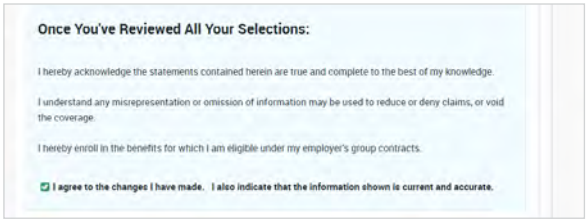


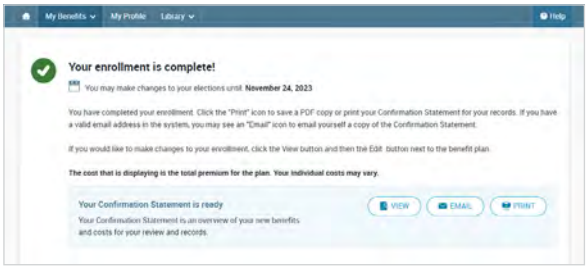




- The **Enrollment Page** is where you can view all of the benefit plans offered to you. All WELS benefit plans that you are eligible for will be listed.
- The website is designed to limit your modifications to only the allowable changes during this open enrollment period.
- The **Enrollment Page** will walk you through your available benefit plans, which will appear on the left side of the page.
- The total cost will show on the top right.
- From here, select the dependents that you want to cover.
- The plan will default to single coverage, you must click on the box next to each dependent you want to cover.
- If you notice a dependent is missing, add them using the **Add Dependents** link.
- As you select dependents, your coverage tier and premium automatically updates.
- If you want to see what each plan offers, select the **View Plan Details** link.
- You can select the **Compare Plans** button to see a side-by-side comparison.
- Select the plan you are interested in by clicking on the button next to the plan name.
- Then click **Save and Continue** to proceed.
- The next step asks if you or any of your covered dependents will be enrolled in a medical plan besides the WELS medical plan in 2025.
- If **Yes**, please complete the information, about the other medical plan. If not, select **No**.
- Then select **Continue**.
- Next you will see a summary of your elections. Please review your elections, and verify the dependents chosen to be covered.
- You can make changes by clicking on **Edit Selection**.

➘ **STEP 3:** CONFIRM





- Click the box at the bottom of the page stating: "I agree to the changes I have made, and I am finished with my enrollment. I also indicate that all the information shown is current and accurate."
- Then click on the **Save My Enrollment!** button.
- It is recommended that you send yourself an e-mail confirmation of your elections. To do so, click on the envelope icon. If you don't have an e-mail address in the system, you may print out the confirmation page before you leave the site by clicking on the printer icon.

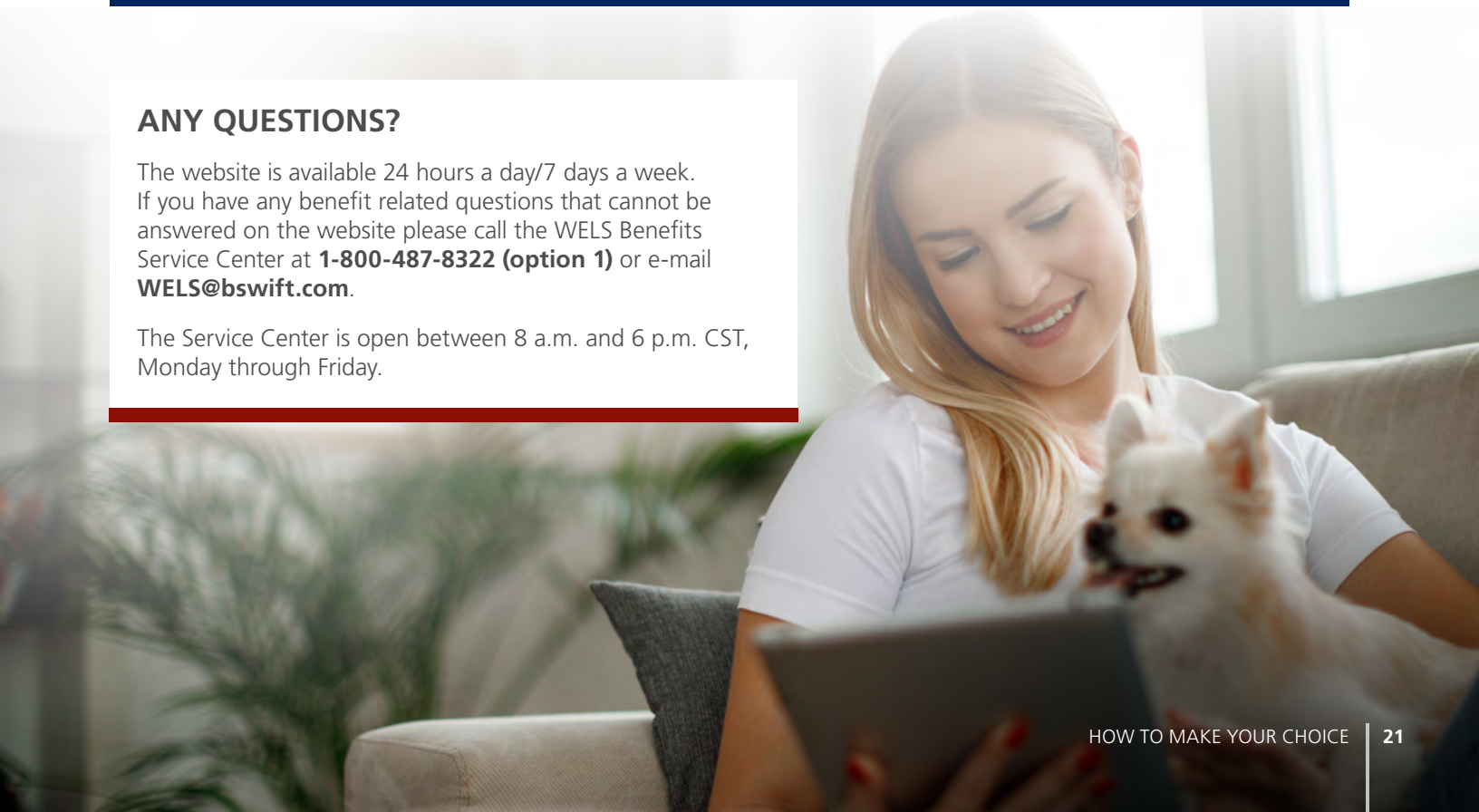
Helpful tips!

- Do NOT use the "back" button in your internet browser, as this will automatically log you out of the site.
- Once in the website, you will have year-round access to update your personal information such as address, phone, and e-mail. You will also be able to access detailed information about your benefits, as well as download a copy of your current benefit statement.
- Although the online benefits enrollment site is a secure site, and your information is encrypted during transit, it is important that you log off when you have completed your session. Click the **Log Off** icon in the upper right corner of the enrollment site to log off.
- For security purposes, you will be automatically logged out if you leave the system idle for more than 30 minutes.

ANY QUESTIONS?

The website is available 24 hours a day/7 days a week. If you have any benefit related questions that cannot be answered on the website please call the WELS Benefits Service Center at **1-800-487-8322 (option 1)** or e-mail **WELS@bswift.com**.

The Service Center is open between 8 a.m. and 6 p.m. CST, Monday through Friday.



IMPORTANT NOTICES

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: September 13, 2024

The WELS VEBA Group Health Care Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's legal duties and privacy practices with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan has a legal duty to notify any individual affected by a breach of unsecured PHI, if that should ever occur.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

SECTION 1
Notice of PHI Uses and Disclosures

Required PHI uses and disclosures.

Upon your request, the Plan is required to give you access to your PHI to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. Business associates are individuals and entities which perform various functions on the Plan's behalf, such as utilization review, subrogation or pharmacy benefit management.

The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan Sponsor: (1) PHI for purposes related to Plan administration (payment of health care operations); (2) summary health information for purposes of health or stop-loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Plan Sponsor has amended the Plan to protect your PHI as required by federal law. The Plan may not disclose an individual's genetic information for underwriting purposes.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization.

The Plan will obtain your authorization before releasing your PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. In most cases, the Plan must obtain your authorization for the use or disclosure of your PHI for marketing and, if financial remuneration is involved, the authorization must say so. The Plan must also obtain your authorization for any sale of your PHI resulting in remuneration to the Plan.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

1. The information is directly relevant to the family member or friend's involvement with your care or payment for that care; and
2. You have either agreed to the disclosure or have been given the opportunity to object and have not objected.

Additional rules and exceptions apply with family members. You may request additional information from the Plan.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Plan Sponsor.
3. Summary health information can be provided to the Plan Sponsor for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against

providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory *assurances* must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
9. When required by law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner or the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

SECTION 2
Rights of Individuals

Right to request restrictions on uses and disclosures of PHI.

You may request that the Plan restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request. You or your personal representative will be required to submit a written request to exercise this right.

Right to request confidential communications.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Right to inspect and copy PHI.

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to amend PHI.

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to receive an accounting of PHI disclosures.

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Plan Sponsor as authorized by the Plan or the HIPAA privacy regulations); (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to receive a paper copy of this Notice upon request.

You have the right to obtain a paper copy of this Notice.

A note about personal representatives.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. A power of attorney for health care purposes, notarized by a notary public;
2. A court order of appointment of the person as the conservator or guardian of the individual; or
3. An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

SECTION 3
The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 13, 2024, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice, or by such time that is required under any applicable regulation or other guidance.

Minimum necessary standard.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment;
2. Uses or disclosures made to the individual;
3. Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. Uses or disclosures that are required by law; and
5. Uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Plan Sponsor for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

SECTION 4
Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Officer.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

SECTION 5
Requests and Contacting the Plan for More Information

All requests that you may make under this Notice and any questions should be directed to the Plan's Privacy Officer at:

WELS Benefit Plans Office
N16W23377 Stone Ridge Drive
Waukesha, WI 53188
414-256-3299

CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

To: All Eligible WELS VEBA Group Health Care Plan Participants and Dependents

Re: Women's Health and Cancer Rights Act of 1998

Under this federal law, group health plans that provide medical and surgical benefits to a person who is receiving benefits from the Plan in connection with a mastectomy, must provide benefits for certain reconstructive surgery.

Although the WELS VEBA Group Health Care Plan (the "Plan") has previously considered this a benefit of the Plan, the law assures that coverage is available for all people who receive Plan benefits in connection with a mastectomy and then elect breast reconstruction.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Benefits for the above services will be provided subject to the same deductibles, coinsurance and limitations applicable to other covered services under the Plan.

If you have any questions regarding this benefit, please contact the Benefit Plans Office at **1-800-487-8322** or by e-mail to **bpo@wels.net**.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and y**ou must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+:
https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service:
1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid

Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-8

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137
(expires 1/31/2026)

Walking together

Our plan, for your benefit

GET **IN TOUCH**

Useful information and contact details

If you have questions, the WELS Benefits Service Center will serve as the primary contact for questions regarding the 2024 limited open enrollment period. However, as always, the WELS Benefit Plans Office will remain a resource for general benefit information. Key contact numbers for each benefit have also been included in the table below.

Plan or activity	Who to call	Phone no.	Web address
Plan information and enrollment	WELS Benefits Service Center	1-800-487-8322 (Option 1)	wels.bswift.com wels@bswift.com
General benefit information	WELS Benefit Plans Office	1-414-256-3299	welsbpo.net bpo@wels.net
Medical benefits	Anthem	1-877-512-7875	anthem.com
Pre-Certification	Anthem	1-866-776-4793	anthem.com
24/7 NurseLine	Anthem NurseLine	1-800-700-9184	n/a
Prescription drugs	Express Scripts	1-800-818-6634	express-scripts.com
Dental	Delta Dental	1-800-236-3712	DeltaDentalWI.com
Vision	Vision Service Plan (VSP)	1-800-877-7195	vsp.com
Travel assistance	Assist America	1-800-872-1414 (U.S.) 1-609-986-1234 (Outside U.S.)	assistamerica.com medservices@assistamerica.com
Identity theft protection	Assist America	1-877-409-9597	assistamerica.com/sunlife
Will reparation and claimant support	ComPsych	1-888-475-3827	estateguidance.com

ABOUT THIS GUIDE

This guide describes the benefit plans available to you as an employee of WELS or ELS. The details of these plans are contained in the official Plan Documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your Summary Plan Description (SPD) as described by the Employee Retirement Income Security Act. If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan documents, the formal wording in the Plan Documents will govern. Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of WELS.

WELS Benefit Plans
Wisconsin Evangelical Lutheran Synod