IBEW LOCAL 234 HEALTH AND WELFARE PLAN

October 2026

ANNUAL NOTICES REGARDING YOUR BENEFITS AND CERTAIN PLAN RULES

Dear Participants and Dependents,

This Notice includes Annual notices the Plan is required to provide you with under the Affordable Care Act and other Federal Laws. This Notice also includes other reminders and is for informational purposes only. No action is necessary.

Grandfathered Health Plan Reminder

The Board of Trustees believes that the IBEW Local 234 Health and Welfare Plan ("Plan") is a "Grandfathered health plan" under the Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as a Non-Grandfathered plan). Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on Plan benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office at (925) 208-9988. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform.* This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health and Cancer Rights Act

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for:

- mastectomy-related services including all stages of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction to restore the physical appearance of the breast),
- all stages of reconstruction and surgery to achieve symmetry between the breasts,
- prostheses, and treatment of physical complications resulting from all stages of the mastectomy, including lymphedema (swelling that sometimes happens after treatment for breast cancer).

This coverage may be subject to the Plan's deductibles, coinsurance, and/or co-payment provisions (consistent with those for other Plan benefits). You may contact the Plan Office at 408-588-3753 or toll free at 877-885-3753 if you have questions.

Newborns and Mothers Health Protection Act

Under Federal law, Group Health Plans and Insurers, may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours). The Plan and Insurers may not set level of benefits or out-of-pocket costs so that any portion of the 48-hour (96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan and Insurers cannot require that a physician or health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs you may be required to obtain precertification. Call the Plan Office at 408-588-3753 for more information.

HIPAA Privacy Notice Reminder

This Notice is to remind you that, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will only use or disclose your individual health information, known as protected health information, in accordance with the Plan's Notice of Privacy Practices. You may obtain a copy of the Plan's Notice of Privacy Practices at any time by calling the Plan Administrator to request that a copy be mailed to you. Within a reasonable period of time of your request, the Plan administrator's office will mail you a copy of the Notice. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice.

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 are 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 are not eligible for Medicaid or CHIP, you are not 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 live in California, California is no longer a state that provides premium assistance to help pay for Medicaid or CHIP coverage; however, the Medi-Cal Program will continue to provide health, dental, and vision benefits to California's low income uninsured children. Information is available at www.coveredca.net.

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 are not already enrolled. This is called a "special enrollment" opportunity, and **you 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)**.

You may be eligible for assistance paying your employer health plan premiums. The list by state located at the following website is current as of July 31, 2026: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf.

Contact your State for more information on eligibility –To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

Availability of Summary of Benefits & Coverage

Under the Affordable Care Act, Group health plans are responsible for providing a Summary of Benefits Coverage, also known as an SBC, to eligible new Participants and their dependents. The SBC provides a summary of what the Plan covers and what it costs. You have the right to request and receive within 7 business days an SBC for the Plan. If you desire a copy of the Plan's SBC and/or more details about your coverage and costs, please contact the Plan Office.

MEDICARE ADVANTAGE (PART C) FOR RETIREES WHO ARE ELIGIBLE FOR MEDICARE– You are Required to Enroll

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, those under age 65 with certain disabilities, and for those who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program or "Original Medicare", the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

Medicare Part C or "Medicare Advantage" is a type of health insurance plan that cover services under Part A and Part B and other benefits not available under Original Medicare. Under a Medicare Advantage plan, all medical coverage is provided through private insurance companies. **If you are retired and eligible for Medicare, the Plan has contracted with Anthem Blue Cross to offer a Medicare Advantage plan under a fully insured arrangement with no deductible and $0 copays for all Medicare covered services. To be eligible to enroll in the Anthem Blue Cross Medicare Advantage plan, you must be enrolled in Medicare Part A and Part B to receive coverage.**

Medicare's prescription drug plan (**Medicare Part D**) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Plan. If you earn a higher income (above $109,000 for individuals or above $218,000 for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years ago (thus, the fee in 2026 will be based on your adjusted gross income on your 2024 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination. For more information on Medicare, please call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov*. TTY users should call 877/486-2048. If you have any questions, please contact the Plan Office at (775) 826-7200.

Reminder NO SURPRISES ACT- YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS!

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. You shouldn't be charged more than your copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your Plan pays, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your Plan's deductible or annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services.
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your Plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for such services.

Certain services at an in-network hospital or ambulatory surgical center.
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the Department of Health and Human Services at 1-800-985-3059 to submit a complaint regarding potential violations of the No Surprises Act for enforcement issues related to federally regulated plans such as the self-funded Anthem Blue Cross PPO Plan.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law. You can find information about your rights under your state's law at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

For the State of California law information please visit www.HealthHelp.ca.gov.