



September 2026

**RE: READ CAREFULLY!! IMPORTANT INFORMATION ENCLOSED**

Dear Participant or Dependent,

Attached please find the Annual Notices the Plan is required to provide you with under the Patient Protection and Affordable Care Act ("ACA") and other Federal Laws. It also includes other reminders and is for informational purposes only. Please review the information contained below and share it with your covered dependents. The Annual Notices include the following:

- Availability of Summary of Benefits and Coverage ("SBC")
- Notice of Nondiscrimination
- Medicare Part D Notice Regarding Prescription Drug Coverage
- Women's Health & Cancer Rights Act
- Dependent Children Eligible for Coverage up to Age 26
- Newborns' and Mother's Health Protection Act
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Notice of Privacy Practices
- Authorization for Release of Protected Health Information
- Summary Annual Report

You should also retain this document with your copy of the Plan's Summary Plan Description (which is also the Plan Document). You should also review the Cigna evidence of coverage booklets for benefit information. If you have any question on the enclosed materials, please contact the Administrative Office:

BeneSys Administrators  
5295 S. Commerce Dr., Suite #220 (Bridge Building)  
Murray, UT 84107

Sincerely,

Board of Trustees

**If you (and or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 5-7 for more details.**

### **AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (“SBC”)**

The Trust Fund is responsible for providing a Summary of Benefits and Coverage (“SBC”) to eligible 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 seven (7) business days an SBC for the Plan’s PPO benefits offered. If you want a copy of the SBC and/or more detail about your coverage, please contact the Trust Fund Office at (801) 904-4897. The SBC is also available on the website.

### **NOTICE OF NONDISCRIMINATION**

Discrimination is Against the Law

**Ironworkers Intermountain Health & Welfare Fund** (“the Health Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). The Health Plan does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Health Plan at **(801) 904-4897**.

### **ATTENTION: FOR FREE LANGUAGE ASSISTANCE CALL 1-801-904-4897**

|                           |                                                                                                                            |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <b>Español</b><br>Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-801-904-4897. |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------|

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|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>繁體中文</b><br>Chinese                 | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-801-904-4897.                                                                                               |
| <b>Tiếng Việt</b><br>Vietnamese        | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-801-904-4897.                                  |
| <b>Tagalog</b><br>Filipino             | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-801-904-4897. |
| <b>한국어</b><br>Korean                   | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-801-904-4897 번으로 전화해 주십시오.                                                                  |
| <b>العربية</b><br>Arabic               | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-801-904-4897                                     |
| Arabic                                 | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-801-904-4897                                     |
| <b>Kreyòl Ayisyen</b><br>French Creole | ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-801-904-4897.                                    |
| <b>Русский</b><br>Russian              | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-801-904-4897.                             |
| <b>日本語</b><br>Japanese                 | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-801-904-4897 まで、お電話にてご連絡ください。                                                                            |
| <b>Հայերեն</b><br>Armenian             | ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1-801-904-4897.    |
| <b>فارسی</b><br>Persian (Farsi)        | توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فتماس بگیرد. 1-801-904-4897 یا فراهم می باشد.                     |
| <b>Français</b><br>French              | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-801-904-4897.            |
| <b>Deutsch</b><br>German               | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-801-904-4897.       |
| <b>ਪੰਜਾਬੀ</b><br>Punjabi               | ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-801-904-4897 'ਤੇ ਕਾਲ ਕਰੋ।                          |
| <b>ខ្មែរ</b><br>Cambodian              | ប្រយ័ត្ន: ៖ ើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយមនុស្សភាសា ពោយមិនគិត គឺអាចមានសេវា ើអ្នក ើង ១ 1-801-904-4897                                  |



If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

*This document has been uploaded and is available on the participant website at: [www.iiwbenefits.org](http://www.iiwbenefits.org)*

**Important Notice from the Board of Trustees of the  
Ironworkers Intermountain Health and Welfare Trust Fund  
About Your Prescription Drug Coverage and Medicare**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ironworkers Intermountain Health and Welfare Trust Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Board of Trustees of Ironworkers Intermountain Health and Welfare Trust Fund (the "Plan") has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Creditable Coverage If You Decide To Join A Medicare Plan?**

If you decide to join a Medicare drug plan, your current coverage through your Ironworkers Intermountain Health and Welfare Trust Fund option will be affected. Your current coverage covers other health expenses, in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, coverage under the Plan will end for you and your eligible dependents.

**If you do decide to join a Medicare drug plan and drop your Ironworkers Intermountain Health and Welfare Trust Fund coverage, be aware that you and your dependents will not be able to get this coverage back.**

**Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.**

If you wish to keep your current prescription drug coverage through Ironworkers Intermountain Health and Welfare Trust Fund, you do not need to do anything.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your coverage with Ironworkers Intermountain Health and Welfare Trust Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

### **For more information about this notice or your current prescription drug coverage...**

Contact our office for further information at (801) 904-4897. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ironworkers Intermountain Health and Welfare Trust changes. You also may request a copy of this notice at any time.

### **For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug plans:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov) or call them at 1-800-722-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).**

*This document has been uploaded and is available on the participant website at: [www.iiwbenefits.org](http://www.iiwbenefits.org)*

### **WOMEN'S HEALTH & CANCER RIGHTS ACT**

Your Health and Welfare Plan is required by federal law to provide you annually with the following notice, which applies to breast cancer patients who elect to have reconstructive surgery in connection with a mastectomy.

Under a federal law known as the Women's Health and Cancer Rights Act of 1998, if Cigna provides medical and surgical benefits for a mastectomy it must provide benefits for reconstructive surgery, in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed, including coverage for nipple and areola reconstruction, and repigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). **If you have any questions about whether the self-funded indemnity Plan covers mastectomies or reconstructive surgery, you may contact the Plan at (801) 904-4897, or you can contact Cigna directly at (855) 352-1604.**

### **DEPENDENT CHILDREN ELIGIBLE FOR COVERAGE UP TO AGE 26 (END OF MONTH WHEN TURN 26)**

As a reminder, your eligible child(ren) may be enrolled and maintained as a Dependent under the Ironworkers Intermountain Health & Welfare Plan ("Plan") through the end of the month in which he or she attains age 26, regardless of whether the child is eligible for coverage under his or her Employer Sponsored Group Health Plan (or his or her Spouse's plan).

### **NEWBORNS' AND MONTHER'S HEALTH PROTECTION ACT**

Under Federal law, Group health plans (such as this Plan), Insurers, and PPOs (such as Cigna) generally may not, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following natural birth delivery (vaginal delivery) or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). 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 provider obtain authorization from the Plan or the issuer for prescribing a length of stay not more than 48 hours (or 96 hours as set forth above). However, to use certain providers or facilities, or to reduce your

out-of-pocket costs you may be required to obtain precertification. Call the Trust Fund Office at (801) 904-4897 for more information.

### **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](http://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](http://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 **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](http://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, 2026. Contact your State for more information on eligibility –**

| <b>ALABAMA – Medicaid</b>                                                                 | <b>ALASKA – Medicaid</b>                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a><br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a><br>Phone: 1-866-251-4861<br>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a><br>Medicaid Eligibility:<br><a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a> |

| ARKANSAS – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CALIFORNIA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a><br/> Phone: 1-855-MyARHIPP (855-692-7447)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>Health Insurance Premium Payment (HIPP) Program<br/> Website:<br/> <a href="https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/">https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/</a><br/> Phone: 916-445-8322<br/> Fax: 916-440-5676<br/> Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a></p>                                  |
| COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FLORIDA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>Health First Colorado Website:<br/> <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a><br/> Health First Colorado Member Contact Center:<br/> 1-800-221-3943/State Relay 711<br/> CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a><br/> CHP+ Customer Service: 1-800-359-1991/State Relay 711<br/> Health Insurance Buy-In Program (HIBI):<br/> <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a><br/> HIBI Customer Service: 1-855-692-6442</p> | <p>Website:<br/> <a href="https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html">https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html</a><br/> Phone: 1-877-357-3268</p>                                                                                                                                                                                                   |
| GEORGIA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ILLINOIS - Medicaid                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a><br/> Phone: 678-564-1162, Press 1<br/> GA CHIPRA Website:<br/> <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a><br/> Phone: 678-564-1162, Press 2</p>      | <p>Illinois Medicaid Premium Assistance Information<br/> Medicaid application website: <a href="https://abe.illinois.gov">https://abe.illinois.gov</a><br/> HIPP Hotline Number: 217-524-8268<br/> HIPP Email: <a href="mailto:mhfs.boc.hipp@illinois.gov">mhfs.boc.hipp@illinois.gov</a></p>                                                                                                                                   |
| INDIANA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | IOWA – Medicaid and CHIP (Hawki)                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>Health Insurance Premium Payment Program<br/> All other Medicaid<br/> Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a><br/> <a href="http://www.in.gov/fssa/dftr/">http://www.in.gov/fssa/dftr/</a><br/> Family and Social Services Administration<br/> Phone: 1-800-403-0864<br/> Member Services Phone: 1-800-457-4584</p>                                                                                                                                                                                                               | <p>Medicaid Website:<br/> <a href="#">Iowa Medicaid   Health &amp; Human Services</a><br/> Medicaid Phone: 1-800-338-8366<br/> Hawki Website:<br/> <a href="#">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a><br/> Hawki Phone: 1-800-257-8563<br/> HIPP Website: <a href="#">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a><br/> HIPP Phone: 1-888-346-9562</p> |

| KANSAS – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | KENTUCKY – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a><br/> Phone: 1-800-792-4884<br/> HIPP Phone: 1-800-967-4660</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br/> <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a><br/> Phone: 1-855-459-6328<br/> Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a><br/> KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a><br/> Phone: 1-877-524-4718<br/> Kentucky Medicaid Website:<br/> <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p> |
| LOUISIANA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MAINE – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p>Louisiana Medicaid Website:<br/> <a href="https://www.ldh.la.gov/healthy-louisiana">https://www.ldh.la.gov/healthy-louisiana</a><br/> Medicaid Customer Service Line: 1-888-342-6207<br/> Louisiana Medicaid email: <a href="mailto:healthy@la.gov">healthy@la.gov</a><br/> Louisiana Health Insurance Premium Program (LaHIPP) Website:<br/> <a href="https://www.ldh.la.gov/lahipp">https://www.ldh.la.gov/lahipp</a><br/> LaHIPP phone: 1-877-697-6703<br/> LaHIPP email: <a href="mailto:La.HIPP@la.gov">La.HIPP@la.gov</a><br/> LaHIPP fax: 1-888-716-9787<br/> LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p> | <p>Enrollment Website:<br/> <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a><br/> Phone: 1-800-442-6003<br/> TTY: Maine relay 711<br/> Private Health Insurance Premium Webpage:<br/> <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a><br/> Phone: 1-800-977-6740<br/> TTY: Maine relay 711</p>                                                                                                             |
| MASSACHUSETTS – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | MINNESOTA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a><br/> Phone: 1-800-862-4840<br/> TTY: 711<br/> Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>Website:<br/> <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a><br/> Phone: 1-800-657-3672</p>                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MISSOURI – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | MONTANA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>Website:<br/> <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br/> Phone: 573-751-2005</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <p>Website:<br/> <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br/> Phone: 1-800-694-3084<br/> Email: <a href="mailto:HHSHIPPPProgram@mt.gov">HHSHIPPPProgram@mt.gov</a></p>                                                                                                                                                                                                                                                                                                                  |
| NEBRASKA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | NEVADA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p>Website: <a href="http://accessnebraska.ne.gov">http://accessnebraska.ne.gov</a><br/> Phone: 1-855-632-7633<br/> Lincoln: 402-473-7000<br/> Omaha: 402-595-1178</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a><br/> Medicaid Phone: 1-800-992-0900</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

| NEW HAMPSHIRE – Medicaid                                                                                                                                                                                                                                                                                                                                                                    | NEW JERSEY – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a><br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a> | Medicaid Website: <a href="https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/">https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/</a><br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br>CHIP Phone: 1-800-701-0710 (TTY: 711)                                                       |
| NEW YORK – Medicaid                                                                                                                                                                                                                                                                                                                                                                         | NORTH CAROLINA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br>Phone: 1-800-541-2831                                                                                                                                                                                                                                             | Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a><br>Phone: 919-855-4100                                                                                                                                                                                                                                                                                                                                                             |
| NORTH DAKOTA – Medicaid                                                                                                                                                                                                                                                                                                                                                                     | OKLAHOMA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a><br>Phone: 1-844-854-4825                                                                                                                                                                                                                                                                         | Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br>Phone: 1-888-365-3742                                                                                                                                                                                                                                                                                                                                                         |
| OREGON – Medicaid                                                                                                                                                                                                                                                                                                                                                                           | PENNSYLVANIA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br>Phone: 1-800-699-9075                                                                                                                                                                                                                                                 | Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a><br>Phone: 1-800-692-7462<br>CHIP Website: <a href="http://www.pa.gov/en/services/dhs/childrens-health-insurance-program-chip">Children's Health Insurance Program (CHIP) (pa.gov)</a><br>CHIP Phone: 1-800-986-KIDS (5437) |
| RHODE ISLAND – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                            | SOUTH CAROLINA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RItE Share Line)                                                                                                                                                                                                                                              | Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br>Phone: 1-888-549-0820                                                                                                                                                                                                                                                                                                                                                                       |
| SOUTH DAKOTA - Medicaid                                                                                                                                                                                                                                                                                                                                                                     | TEXAS – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br>Phone: 1-888-828-0059                                                                                                                                                                                                                                                                                                         | Website: <a href="http://www.texas.gov/health-insurance-premium-payment-program">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a><br>Phone: 1-800-440-0493                                                                                                                                                                                                                                                                     |

| UTAH – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | VERMONT– Medicaid                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Utah’s Premium Partnership for Health Insurance (UPP)<br>Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a><br>Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a><br>Phone: 1-888-222-2542<br>Adult Expansion Website:<br><a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a><br>Utah Medicaid Buyout Program Website:<br><a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a><br>CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a> | Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a><br>Phone: 1-800-250-8427                              |
| VIRGINIA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WASHINGTON – Medicaid                                                                                                                                                |
| Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a><br><a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a><br>Medicaid/CHIP Phone: 1-800-432-5924                                                                                                                                | Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a><br>Phone: 1-800-562-3022                                                                      |
| WEST VIRGINIA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | WISCONSIN – Medicaid and CHIP                                                                                                                                        |
| Website: <a href="https://bms.wv.gov/">https://bms.wv.gov/</a><br><a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)                                                                                                                                                                                                                                                                                                                                                                | Website:<br><a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a><br>Phone: 1-800-362-3002 |
| WYOMING – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                      |
| Website:<br><a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a><br>Phone: 1-800-251-1269                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                      |

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/agencies/ebsa](http://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](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

*This document has been uploaded and is available on the participant website at: [www.iiwbenefits.org](http://www.iiwbenefits.org)*

## HIPAA NOTICE OF PRIVACY PRACTICES

The Ironworkers Intermountain Health & Welfare Plan (“Plan”) may use your health information, which may constitute protected health information (“PHI”) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).<sup>1</sup> The Plan has established policies and procedures to guard against unnecessary disclosure of your health information.

**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.**

### **I. YOUR INDIVIDUAL RIGHTS**

When it comes to your health information, you have certain rights, as follows. **To exercise or ask about any of these rights, please contact the Plan Manager, listed in the “Contact” section at the end of this Notice.**

1. **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. The Plan is not required to agree to your request, and so the Plan may say “no” if it would affect your care.
2. **Right to Receive Confidential Communications.** You may ask us to contact you in a specific way. For example, you may ask that the Plan only communicate with you confidentially at a certain telephone number or by email or to send mail to a different address. The Plan must approve all reasonable requests for confidential communications.
3. **Right to Inspect and Copy Your Health Information.** You may inspect and copy your health information. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs, and postage—if applicable—associated with your request. The Plan may deny your request in limited situations.
4. **Right to Amend Your Health Information.** You may request that the Plan amend its records (e.g., if you think they are incomplete or inaccurate). The Plan may deny your request in certain instances—for example: (1) if you do not include a reason supporting the amendment; (2) if your health information records were not created by the Plan; (3) if the health information you are requesting to amend is not part of the Plan’s records; (4) if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy; or (5) if the Plan determines the records containing your health information are accurate and complete.
5. **Right to an Accounting.** The Plan may share your health information—for example, see the permissible uses and disclosures discussed below. You may request a list (i.e., an “accounting”) of the times the Plan shared your health information for six (6) years prior to the date you ask, including who we shared it with, and why. Your request for an accounting must specify the period for which you are requesting the information and cannot be for a period older than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge, but additional accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

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<sup>1</sup> This Notice is a summary, and as such, this notice does not include all of the restrictions, procedures, and exceptions established in HIPAA. For example, some of the uses and disclosures permitted in this notice may have additional conditions or requirements not detailed in this summary. Additional detail on the precise scope of the Plan’s obligations regarding your health information can be found in sections 164.102 through 164.535 of Title 45 to the Code of Federal Regulations.

6. **Right to a Paper Copy of this Notice.** You may request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

## **II. USE AND DISCLOSURE OF HEALTH INFORMATION**

**Except for the situations described above, the Plan may not use or disclose your health information unless you provide written authorization to do so. Once you provide written authorization, you have the right to revoke that authorization at any time by communicating the revocation in writing to the Plan.**

**The following is a summary of the circumstances and purposes for which your health information may be used and disclosed *without* your authorization.**

1. **To Make or Obtain Payment.** The Plan may use or disclose your health information to pay or collect payment from third parties, such as providers, related to the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.
2. **To Conduct Health Care Operations.** The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. For example, the Plan may use your health information to conduct case management, quality improvement, and utilization review; for provider credentialing activities; or to engage in customer service and grievance resolution activities.
3. **For Treatment.** The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the Plan may disclose that you are eligible for benefits to a health care provider contacting the Plan to verify your eligibility. This may also include using your health information to inform you about or recommend possible treatment options or alternatives, as well as health-related benefits or services that may be of interest to you.
4. **To Business Associates.** The Plan may share your health information with its Business Associate (as defined in HIPAA) as part of a contract or agreement for the Business Associate to perform services for the Plan, but only after the Business Associate has agreed in writing to implement appropriate safeguards regarding your PHI.
5. **For Public Health Risks.** The Plan may disclose your health information for public health activities, in certain situations, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence, if authorized or required by law, or if you have consented to such disclosure
  - Preventing or reducing a serious threat to anyone's health or safety by sharing this information with someone reasonably able to help prevent or lessen the threat

6. **For Underwriting and Related Purposes.** The Plan may use or disclose your health information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of health insurance, but your genetic information will not be used or disclosed for such purposes.
7. **In Connection with Judicial and Administrative Proceedings.** As permitted or required by state law, the Plan may disclose your health information in response to a court or administrative order, or in response to a subpoena, but only if certain conditions are satisfied—such as providing notice to you or obtaining certain assurances from the requesting party.
8. **For Law Enforcement, Worker’s Compensation, and Other Government Requests.** As permitted or required by state law, the Plan may use or share health information about you:
  - For workers’ compensation claims.
  - For law enforcement purposes or with a law enforcement official, in certain situations.
  - With health oversight agencies for activities authorized by law. (However, the Plan may not disclose your health information if you are subject to an investigation which does not arise out of or is not directly related to your receipt of health care or public benefits.)
  - For special government functions such as military, national security, and presidential protective services.
9. **When Legally Required.** The Plan may disclose your health information when required by federal or state law.
10. **To Coroners, Medical Examiners and Funeral Directors.** The Plan may share health information with a coroner, medical examiner, or funeral director when an individual dies.
11. **Organ and Tissue Donation.** The Plan may share health information about you with organ procurement organizations.
12. **Family, Friends, and others.** The Plan may disclose your health information to a family member, friend, or other person involved in your health care if you are present and do not object to the sharing of PHI, or in the event of an emergency. You may also appoint a personal representative to access your health information, such as through a medical power of attorney form. If this appointment is sufficient under state (or other applicable) law, your personal representative may generally act on your behalf regarding the health information described in this Notice, including accessing and authorizing the Plan’s use or disclosure of your health information.

#### **ADDITIONAL RESTRICTIONS FOR CERTAIN INFORMATION**

If any of your health information is subject to state or federal privacy laws that are more stringent than HIPAA, the Plan must also satisfy those additional laws in order to use or disclose such information—even for uses and disclosures described above. For example, Part 2 of Title 42 to the Code of Federal Regulations (42 C.F.R. Part 2) provides additional privacy restrictions for records generated by certain substance use disorder treatment programs. In order to use or disclose these substance use disorder treatment records, the requirements of 42 C.F.R. Part 2 must *also* be satisfied, even if it’s for a use or disclosure described as permitted in this Notice.

Additionally, if the Plan receives substance use disorder treatment records for you from a program subject to 42 C.F.R. Part 2 (or testimony relaying the content of such records), these records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or unless a court order requires their use or disclosure, as provided in 42 C.F.R. Part 2. Any court order authorizing use or

disclosure must be accompanied by a subpoena or other legal requirement requiring disclosure.

Without your authorization, the Plan cannot use or disclose notes prepared by a psychotherapist regarding your conversations with your mental health professional during a counseling session. This does not apply to summary information about your mental health treatment.

### **III. THE PLAN'S DUTIES**

The Plan is required by law to maintain the privacy and security of your PHI. The Plan is required to abide by the terms of the notice currently in effect. The Plan may change the terms of this Notice, and the changes will apply to all of your information with the Plan. Any new notice will be available upon request and on our web site, and a copy will be mailed to you in its next annual mailing.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **IV. COMPLAINTS**

You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

Any complaints to the Plan should be made in writing to the Plan Manager at the address shown in the "Contact" Section of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information.

**You will not be retaliated against in any way for filing a complaint.**

### **V. CONTACT**

Communications to the Plan Manager (including any of the requests or complaints described in this Notice) must be sent as follows:

Ironworkers Intermountain Health & Welfare Fund  
c/o BeneSys Administrators  
P.O. Box 30580  
Salt Lake City, UT 84130-0580

Phone: (801) 904-4897  
Toll Free: (888) 867-9510  
[www.iiwbenefits.org](http://www.iiwbenefits.org)

### **VI. EFFECTIVE DATE**

This Notice is effective beginning February 16, 2026.

*This document has been uploaded and is available on the participant website at:*  
[www.iiwbenefits.org](http://www.iiwbenefits.org)



## Authorization for Release of Protected Health Information

### MEMBER/RETIREE SECTION

I (print name) \_\_\_\_\_ authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Intermountain Ironworker's Trust Funds  
P.O. Box 30580  
Salt Lake City, UT 84130-0580

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

Signature of Member \_\_\_\_\_ Date Signed: \_\_\_\_\_

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member \_\_\_\_\_ Date Signed: \_\_\_\_\_

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### SPOUSE SECTION

I, the **spouse** (print name) \_\_\_\_\_, of the above named member, have also read, understand, and authorize the Plan, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Spouse \_\_\_\_\_ Date Signed: \_\_\_\_\_

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse \_\_\_\_\_ Date Signed: \_\_\_\_\_

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**DEPENDENT(S) OVER THE AGE OF 18 SECTION**

I, the **dependent child(ren)** over the age of 18 (print name) \_\_\_\_\_ have also read, understand, and authorize the Plan, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Signature of Dependent** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

-OR- ☐ I do not want my Health Information released to anyone but myself.

**Signature of Dependent** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

|                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office. |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### *Instructions for completing the*

#### **Authorization for Release of Protected Health Information**

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

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#### **Member Section/Retiree Section**

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) -or-  
**If you are not married or you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". Please sign and date below the box.**

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#### **Spouse Section**

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse)  
**If you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".**

3. **Please sign and date below the box.**

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#### **Dependent(s) over the age of 18 Section**

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother)  
**If you want to give someone other than your parents** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".**

**3. Please sign and date below the box.**

Only an electronic image copy of the Authorization Form will be kept on file at the Health Care Office. If you wish to retain a copy of the document for your records, please make one before mailing.

**IRONWORKERS INTERMOUNTAIN HEALTH & WELFARE TRUST**

5295 S. Commerce Dr.  
MURRAY, UT 84107

**Summary Annual Report for  
IRONWORKERS INTERMOUNTAIN HEALTH & WELFARE TRUST**

This is a summary of the annual report for IRONWORKERS INTERMOUNTAIN HEALTH & WELFARE TRUST, EIN 87-6123188, Plan Number 501, for the period November 1, 2024 to October 31, 2025. The annual report has been filed with the Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

**Insurance Information**

The plan has (a) contract(s) with UNITEDHEALTH CARE INSURANCE COMPANY, UNITEDHEALTH CARE INSURANCE COMPANY, and HCC LIFE INSURANCE COMPANY to pay the following types of claims incurred under the terms of the plan:

The total premiums paid for the plan year ending October 31, 2025 were \$1,280,225.

Because (it is a) (they are) so called "experience-rated" contract(s), the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending October 31, 2025, the premiums paid under such experience-rated contract(s) were \$1,280,225 and the total of all benefit claims paid under the(se) experiences-rated contract(s) during the plan year was \$0.

**Basic Financial Statement**

The value of plan assets, after subtracting liabilities of the plan, was \$34,912,709 as of October 31, 2025, compared to \$34,566,346 as of November 1, 2024. During the plan year the plan experienced a change in its net assets of \$346,363. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$26,221,998 which included employer contributions of \$21,489,323, employee contributions of \$529,230, other contributions of \$0, gain/loss of \$0 from the sale of assets, and earnings from investments of \$4,203,445.

Total plan expenses were \$26,592,812. These expenses included \$2,037,474 in administrative expenses and \$24,555,338 in benefits paid to participants and beneficiaries, and \$0 in other expenses.

### Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- An accountant's report
- Financial information and information on payments to service providers
- Assets held for investment
- Insurance information including sales commissions paid by insurance carriers
- Information regarding any common or collective trusts, pooled separate accounts, master trusts, or 103-12 investment entities in which the plan participates

To obtain a copy of the full annual report, or any part thereof, write or call the office of:

IRONWORKERS INTERMOUNTAIN HEALTH & WELFARE TRUST  
5295 S. Commerce Dr.  
MURRAY, UT 84107  
(801) 904-4897

The report is furnished without charge.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

IRONWORKERS INTERMOUNTAIN HEALTH & WELFARE TRUST  
5295 S. Commerce Dr.  
MURRAY, UT 84107

and at the U.S. Department of Labor in Washington, DC, or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room  
Room N-1513  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, N.W.  
Washington, DC 20210