October 15, 2026

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress passed the "Women's Health and Cancer Rights Act of 1998." Under this law, health plans must provide the following coverage after a mastectomy, as determined in consultation with the attending physician and the patient, for:

- All Stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the healthy breast to produce a symmetrical (balanced) appearance; and
- Prostheses (artificial replacement); and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be subject to the same deductibles and co-payments applicable to other medical and surgical benefits provided under this Plan.

Below is the HIPAA Notice of Privacy Practices Availability Notice:

The Idaho Pipe Trades Trust maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. You have the right to request a copy of the Plan's Notice of Privacy Practices from the Trust Administrative Office by submitting a written request to: PMB #116, 5331 S Macadam Avenue Suite 258, Portland, OR 97239. You may also obtain a copy of this notice on the Plan's website: http://www.IPTT.org.

If you have any questions, please contact the Trust Administrative office at 208-288-1610 or 800-808-1687 for more information.

Important Notice from Idaho Pipe Trades Trust 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 Idaho Pipe Trades Trust 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 a 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. **Idaho Pipe Trades Trust has determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

If you are Medicare-eligible and are enrolled in the Humana MAPD PPO Plan, you are already enrolled in Medicare prescription drug coverage. This notice does not apply to you.

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 to December 7th.

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

What Happens To Your Current Coverage If you Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Idaho Pipe Trades Trust coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you are covered by the Trust as an active employee or a Covered Dependent of an active employee, and you decide to enroll in a Medicare prescription drug plan, your coverage under the Trust will not be affected. The Trust will continue to be your primary coverage for prescription drugs.

If you are covered by the Trust as a retiree, or spouse of a retiree, and decide to enroll in a Medicare prescription drug plan, you will receive prescription drug benefits from the Medicare plan only. The Trust will not pay secondary benefits for prescription drugs, and the amount you must pay to the Trust for other health coverage will not change. Your current coverage pays for other health expenses, in addition to prescription drugs. If you choose to enroll in a Medicare prescription drug plan, you will still be eligible to receive all of your other current health benefits by continuing to pay the required monthly amount to the Trust.

If you decide not to enroll in a Medicare prescription drug plan

If you make the decision not to enroll in a Medicare prescription drug plan, your prescription drug benefits will continue through the Trust plan.

You should compare your current coverage through the Trust, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Idaho Pipe Trades prescription drug benefit

The Trust plan covers prescription drugs through the Express Scripts drug card program. This program features a network of participating pharmacies for your convenience. When you use a pharmacy within the Express Scripts network, you simply take your prescription and your Express Scripts drug card to the pharmacy and make the appropriate co-payment to receive up to a 30 day supply. Co-payments are as follows:

Type of Drug	Co-payment
Generic	$20.00
Preferred Brand	$40.00
Non-Preferred Brand	$70.00
Specialty Drugs	10% co-pay up to $120.00

If you choose to purchase a brand name drug when a generic equivalent is available, the plan will only pay the amount it would have paid for the generic drug. In addition to the copay listed above, you will have to pay the additional cost of the brand drug.

For maintenance drugs – those drugs you use on an ongoing basis and that are listed on the Express Scripts maintenance drug list – you are able to fill a 90-day prescription for two times the regular Retail co-payments for all tiers through the mail order program. If you choose to not use mail order for your maintenance drugs, you need to opt out of the mail order program and you can fill only a 30-day supply.

If you fill your prescription at a pharmacy outside the network, the same co-payments apply but you must pay the full cost when you make the purchase. Then, submit a claim form and the receipt to Express Scripts for reimbursement. These claims will be reimbursed at the negotiated pharmacy rate, less the appropriate co-payment. However, prescriptions filled at Wal-Mart are

not eligible for reimbursement.

If you do decide to join a Medicare drug plan and drop your Idaho Pipe Trades Trust prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Idaho Pipe Trades Trust and don't join a Medicare drug plan within 63 continuous days after your 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 creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have the 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 join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get a notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Idaho Pipe Trades 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 coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (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,

therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 13, 2026
Name of Entity/Sender:	Idaho Pipe Trades Health and Welfare Trust
Contact-Position/Office:	Trust Administrative Office
Address:	PMB #116 5331 S Macadam Avenue Ste 258 Portland, OR 97239
Phone Number:	208-228-1610 or 800-808-1687

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **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)**.

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 –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 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
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

IDAHO PIPE TRADES TRUST

Administrative Office

Idaho Pipe Trades

Health & Welfare Trust

LU 296 & LU 648

Plumbers & Pipefitters

Pension Trust

LU 296 LU 648 LU 41

HIPAA NOTICE OF PRIVACY PRACTICES

The Idaho Pipe Trades Trust ("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"). [1] 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

[1] 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.

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.

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 have provided prior 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 prior 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**.**

IV. COMPLAINTS

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

Any complaints or questions to the Plan about use of your health information should be made in writing to the Plan Manager at the address shown in the "Contact" Section of this Notice.

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:

Kim Gould
c/o BeneSys Inc
Address: PMB #116 5331 S. Macadam Ave., Suite 258
Portland, OR 97239
Phone: (800) 808-1687 or (208) 288-1610
Fax: (208) 288-1670
Email: Kim.gould@benesys.com

VI. EFFECTIVE DATE

This Notice is effective beginning February 16, 2026.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-808-1687 (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-808-1687 (TTY: 711) o hable con su proveedor.

中文 (Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-808-1687（文本电话： 711）或咨询您的服务提供商。

Tiếng Việt (Vietnamese) LƯU Ý: Nếu bạn nói một ngôn ngữ khác, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Gọi 800-808-1687 (TTY: 711) hoặc nói chuyện với nhà cung cấp của bạn.

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format.
Tumawag sa 800-808-1687 (TTY: 711) o makipag-usap sa iyong provider.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-808-1687 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք այլ լեզվով, ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Զանգահարեք 800-808-1687 (TTY՝ 711) կամ խոսեք ձեր մատակարարի հետ

فارسی (Persian) توجه :اگر به زبان دیگری صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است .خدمات کمکی و کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند .با T 800-808-1687 (TTY: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-808-1687 (TTY: 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) 注意: 別の言語を話す場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助手段やサービスも無料でご利用いただけます。800-808-1687 (TTY: 711) に電話するか、プロバイダーにお問い合わせください。

العربية (Arabic)
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800-808-1687 (711) أو تحدث إلى مقدم الخدمة.

ਗੁਰਮੁਖੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 800-808-1687 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖
ប្រសិនបើអ្នកនិយាយភាសាផ្សេង
សេវាជំនួយភាសាឥតគិតថ្លៃអាចរកបានសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏អាចរកបានដោយឥតគិតថ្លៃដងដែរ។
ទូរស័ព្ទទៅ 800-808-1687 (TTY: 711)
ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lwm hom lus, muaj kev pabcuam lus pub dawb rau koj. Cov kev pabcuam tsim nyog thiab cov kev pabcuam los muab cov ntaub ntawv hauv cov qauv siv tau kuj muaj pub dawb. Hu rau 800-808-1687 (TTY: 711) lossis tham nrog koj tus kws kho mob.

हिंदी (Hindi) ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 800-808-1687 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ภาษาไทย (Thai) หมายเหตุ: หากคุณพูดภาษาอื่น คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร 800-808-1687 (TTY: 711) หรือพูดคุยกับผู้ให้บริการของคุณ

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.

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**.

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 form below the box**.

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 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 form below the box**.

-OVER-

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ **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:

Idaho Pipe Trades Trust (IPTT) H&W Plan
PMB# 116, 5331 S Macadam Avenue Suite 258
Portland, OR 97239
Phone 208-288-1610 • Toll Free 800-808-1687 • Fax 208-288-1670
www.iptt.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, 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**: _____

SPOUSE SECTION

I, the **spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____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) for the reasons and with the explanations listed above, 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**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **dependent child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____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) for the reasons and with the explanations listed above, except 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 Benefit Office.