IBEW Local 125 – PGE
Health and Welfare Trust

Enrollment Guide 2027

Medical, Dental, Vision and Hearing Aid Coverages

January 1, 2027 – December 31, 2027

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This guide is a summary of your Trust-sponsored benefits and not a substitute for the official plan documents. If there's any discrepancy between the information in this guide and the official plan documents, the official plan documents will govern. The IBEW 125 – PGE Health and Welfare Trust retains the right to amend all plans at any time.

A Message From the Board of Trustees

The Board of Trustees is pleased to provide you with health care options to help you and your family protect your health and financial security. Your benefits are a valuable part of your overall compensation. We encourage you to learn more about the benefits available to you and how they work, so you can get the most out of them.

Open enrollment is November 2 through November 16, 2026

Open enrollment is your once-a-year opportunity to make sure your benefits continue to be the right fit for you and your family in 2027. You can change coverage—or add or drop dependents—November 2 to November 16.

Review this Enrollment Guide thoroughly and determine the benefits coverage that will best fit your needs in 2027. Consider the type of expenses you anticipate in the coming year. Choose whom to enroll and provide the required dependent information.

Active participants

Complete your open enrollment electronically in PGE's Workday system by **5 p.m. Pacific Time on November 16, 2026**. For assistance enrolling in the Workday system, call PGE at **503-464-7250**.

Non-active participants

Non-active participants include early retirees, divorced spouses, COBRA participants, surviving spouses, and long-term disability recipients.

Complete the Open Enrollment Election form and return it to the Trust Fund Office by **5 p.m. Pacific Time on November 16, 2026, by email or fax. Mailed enrollment forms must be postmarked by November 16.**

Things you should do

- Review all the information in this Enrollment Guide.
- Read about and understand your medical plan options.
- Use the HealthEquity tool to compare your estimated costs under the medical plans. Visit **www.comparemyhsa.com/ibew125pgetrust**.
- Complete enrollment, along with all required documentation, by **5 p.m. Pacific Time on November 16, 2026**. See page 3 for more information on how to enroll.

If you need assistance, feel free to contact the Trust Fund Office at **503-224-5906** or **877-545-9471** (toll-free) Monday–Friday, 8 a.m.–5 p.m.

Keep this enrollment guide for future reference. If you need any assistance, feel free to contact the Trust Fund Office at **503-224-5906** or **877-545-9471 (toll-free)**.

Need help? Call:

For Trust Plans and benefits, contact the Trust Fund Office at **503-224-5906** or **877-545-9471** (toll-free) for assistance with open enrollment and benefits questions.

For PGE Plans and benefits, active participants in need of Workday navigation assistance or who have questions about PGE's voluntary benefits and spending accounts, should contact PGE HR Connect at **503-464-7250**, or email **benefits@pgn.com**.

Active Participants – Be sure to read PGE's benefits guide for information on voluntary benefits, including life insurance, Flexible Spending Accounts, legal plan, and more.

What's New in 2027?

Hinge Health Now Available at No Cost

Eligible employees and dependents 18+ enrolled in a Regence Bluecross Blueshield of Oregon medical plan can get access to a personalized care plan and coaching to help accomplish health goals related to musculoskeletal (back, muscle, and joint) health.

To see how Hinge Health can help you, visit http://hinge.health/enroll-today, or call **(855) 902-2777.**

Amazon Pharmacy Mail Delivery Option
Amazon Pharmacy – New Home Delivery Option

Members who take maintenance medications, or experience access barriers to retail pharmacies, can have their prescriptions delivered to their home. Starting in 2027, this service will be provided by Amazon Pharmacy's MedsYourWay program. Here's what you need to know:

Members with existing prescriptions: Most existing prescriptions will be automatically transferred to Amazon Pharmacy from Express Scripts. However, members still need to register with Amazon Pharmacy (see below) and provide payment information.

Members with new prescriptions: Members need to register at Amazon Pharmacy Regence MedsYourWay Registration (visit amazon.com/regenceORMYW) or call **1-855-793-5327** for assistance setting up your profile. Once registered, ask your provider to send your prescription to Amazon Pharmacy.

Amazon Pharmacy delivers through the U.S. Post Office or Amazon delivery. However, medications must be shipped to a **physical address** (including most residences and apartment buildings), but **P.O. Boxes are not eligible delivery locations.** Members can track and manage prescriptions online or through the Amazon Pharmacy app.

Amazon Prime is not required to participate or receive prescriptions through Amazon Pharmacy. However, Prime members are eligible for free expedited shipping, while non-Prime members continue to have access to free standard delivery.

HSA Contribution Limits Increasing

In 2027 you can contribute up to $4,500 for individual coverage and $9,000 for family coverage. If you're age 55 or older, you may contribute an additional $1,000. Plus, PGE will contribute $986.40 for individual coverage and $1,972.44 for family coverage to help you save even more. This is for active participants only.

Who's Eligible?

You're eligible for coverage if you satisfy the eligibility requirements for one of the following categories:

- Active employee
- Early retiree (under age 65)
- Divorced spouse (age 55 or older)
- COBRA participant
- Surviving spouse
- Long-term disability recipient (under age 65 and not Medicare eligible)
- Dependent, including:
  - Spouse or domestic partner
  - Child up to age 26
  - Adult disabled child of any age, provided the child is unmarried and dependent upon you for financial support; incapable of self-support because of a physical, mental, or developmental disability; and the disability is ongoing and initially occurred before the child's 26th birthday
  - Surviving child or children

Please contact the Trust Fund Office at **503-224-5906** or **877-545-9471** if you have any questions about the eligibility requirements.

Verification of new dependent eligibility

If you will be enrolling your eligible dependents for the first time, you must provide all required documentation. A list of required documents is included with your enrollment materials; see the document titled "Eligibility Documentation Policy/Proof of Dependent Eligibility." Dependents are not enrolled unless you provide sufficient documentation verifying their status.

Newborns are automatically eligible for 60 days following birth. To ensure continued eligibility, you must provide all required documentation to enroll the newborn within the 60-day period.

How To Enroll

Active participants enroll using Workday

Enroll between November 2 and November 16 in PGE's Workday system. Access is available on any PGE-issued computer. For assistance with Workday enrollment, call PGE at **503-464-7250**.

You need to take enrollment action if you:

- Want to change medical plans
- Want to add or remove a dependent from coverage
- Have an HSA or will elect one for 2027. You must enter your HSA contribution amount. You need to make an election, even if it's $0, to receive PGE's HSA contribution and to start your 2027 contributions.

After open enrollment ends, you cannot make any changes to your 2027 Trust-sponsored medical, dental, and vision benefits, unless you experience a qualifying life event. These events include marriage, divorce, birth, adoption, or a change in employment status (you or your spouse) that affects your benefits eligibility.

If you don't submit your enrollment in Workday by 5 p.m. Pacific Time on November 16, you and your currently enrolled dependents who are eligible will be reenrolled automatically for the same Trust coverage you have for 2026. If you had an HSA in 2026, your contributions will end, and PGE will not automatically make a 2027 contribution. You must take action to receive a PGE contribution to your HSA account.

Steps to enroll for active participants

Log on to Workday from a PGE-issued computer (**myPGE** > **My Tools** > **Workday**) or the Workday app.

1. Click on the **Open Enrollment Change** task in your inbox. (If you are a new employee, you will see **Change Benefits for Life Event**.)
2. You will begin on a page showing all the available benefits and your current elections.
   - » Select **Manage** or **Enroll** for the first benefit. When finished with your selections, click **Confirm and Continue** to move to the next screen.
   - » Next, select dependents to be covered, using the check mark next to their name. To add dependents not yet on your list, use the **Add New Dependent** button.
   - » For life insurance, LTD, AD&D: Select the **Coverage** box for available options and cost.
   - » For Flexible Spending Accounts or HSAs: Type in the dollar amount you are electing per pay period or annually.
   - » Click **Save** when finished.
3. Scroll down the entire page, repeating the above steps for each benefit.
4. When all benefits elections are complete, click **Review and Sign** at the bottom. A summary of your choices, covered dependents, and any waived benefits will display. If you see something you need to edit, select **Cancel** to go back to the main screen.
   - » Review for accuracy, and read the electronic signature information.
   - » Select the **I Accept** box, authorizing PGE to make the required payroll deductions for the coverage you selected.
   - » Choose **Submit** to complete.
5. A printable confirmation statement is instantly available. Click the **View 2027 Benefits Statement** button. Print or save for your records.
6. If you've added new dependents, please refer to the Trust's list of dependent verification requirements, contact the Trust with questions on dependent verification.

Important! Selecting **Save for Later** will not submit your choices. You must return to Workday to **submit your enrollment.**

YOU MUST SUBMIT BEFORE THE OPEN ENROLLMENT PERIOD CLOSES, OR YOUR CHANGES ARE NOT FINALIZED.

Once open enrollment closes, all submissions will be final.

Non-active participants: How to enroll

Non-active participants are early retirees, divorced spouses, COBRA participants, surviving spouses, and long-term disability recipients.

To enroll, complete the enclosed Enrollment Form, and return it along with all required documentation to the Trust Fund Office no later than 5 p.m. Pacific Time on November 16, 2027. You need to take enrollment action if you:

- Want to change plans
- Want to add or remove a dependent or other family member from coverage

After open enrollment ends, you cannot make any changes to your 2027 Trust-sponsored medical, dental, and vision benefits, unless you experience a qualifying life event. These events include marriage, divorce, birth, adoption, or a change in employment status (you or your spouse) that affects benefits eligibility for you and your dependents.

If you don't return a completed enrollment form by November 16, you and your currently enrolled dependents who are eligible will be reenrolled automatically for the same Trust coverage you have for 2026.

Compare the medical plans

Here's a comparison of the HSA Qualified Plan and the PPO Plan.

Medical coverage is an important part of your IBEW Local 125 – PGE Health and Welfare Trust benefits. The Trust offers you two health plan options to choose from (both plans include the same dental and vision coverage):

- Preferred Provider Organization (PPO) Plan offers a lower deductible with a higher monthly cost share.
- HSA Qualified Plan offers a higher deductible with a lower monthly cost share. Under this option, you may elect to have a tax-free Health Savings Account (HSA). In addition, eligible participants may receive a PGE contribution to their HSAs.
  - **Full-time, active employees and those in an active status on a qualified leave of absence are eligible for PGE's HSA contribution. The following participants are not eligible for PGE's contribution, but they can elect to have an HSA opened and make their own contributions: early retirees, disabled dependent children age 26 and older (provided the child is unmarried and dependent upon you for financial support; incapable of self-support because of a physical, mental, or developmental disability; and the disability is ongoing and initially occurred before the child's 26th birthday), surviving and divorced spouses and their dependents, and dependents of retirees.**

What does it cost?

Your premium (your cost share) is noted on the accompanying rate sheet. The rate sheet provides important information you can use to estimate your out-of-pocket costs and cost share for the health care options you choose for 2027.

LTD participants (under age 65, not Medicare eligible)

Both medical plans require employee contributions (or cost share). Under the PPO Plan, you pay a cost share for medical, dental, and vision. Under the HSA Qualified Plan, you pay a cost share for dental and vision but no cost share for medical. The cost share under either plan does not change depending on the coverage level you choose (i.e., Employee Only, Employee and Spouse or Domestic Partner, Employee and Children, or Employee and Family).

For early retiree participants

Both medical plans require retiree contributions (or cost share). The Trust Fund Office will send you a monthly invoice for the full benefit cost. You separately receive an RRA (retiree reimbursement arrangement) company contribution to your Optum reimbursement account, which can be used to offset your cost share. The company contribution is based on the year you retired and your age. Submit proof of your premium payments to Optum for reimbursement of the company contribution amount. **You must be continuously enrolled in a Trust medical plan to receive a company contribution.** Your cost share for the PPO Plan or HSA Qualified Plan depends on the coverage level for which you are enrolled (i.e., Retiree Only, Retiree and Spouse or Domestic Partner, Retiree and Children, or Retiree and Family). For assistance submitting reimbursements, contact Optum at **877-298-2322**.

Understanding your medical plan options

Which plan is best for you depends on your health care needs, your budget, and whether you expect to use out-of-network providers. The HSA Qualified Plan is similar to the PPO Plan in several ways. The HSA Qualified Plan covers the same services, provides the same quality of care, and uses the same Regence Blue Cross Blue Shield (BCBS) network that is available under the PPO Plan.

Use HealthEquity's online tool to compare your plan options*

Participants have access to a HealthEquity online cost estimator to help compare potential 2027 medical plan costs under the HSA Qualified Plan and PPO Plan. Try the tool at **www.comparemyhsa.com/ibew125pgetrust**.

Retirees – Important note for Post-65 medical coverage!

You must take action to have coverage upon turning age 65. Post-65 medical coverage is offered through UnitedHealthcare Medicare Solutions. You will need to take action 30–90 days before your Medicare Parts A and B effective date to ensure that you are covered. Your current Regence Blue Cross Blue Shield medical benefit coverage, provided through the Trust, will end on your Medicare eligibility date. Contact the Trust Fund Office for additional information on how to enroll in Post-65 medical, as well as dental and vision coverage.

** The IBEW 125 – PGE Trust is providing this link to HealthEquity's online cost estimator to give participants a tool to help compare plans. The cost estimator does not take the place of a careful consideration of all aspects of plan design and costs. As the name implies, the cost estimator provides an estimate of potential cost savings. Cost estimator results are not guaranteed. Your savings may vary, depending on factors like your family's medical costs during the plan year and your individual income tax situation. The cost estimator tool allows you to pick an applicable tax rate. You may want to use your average tax rate, since both federal and Oregon tax rates are tiered (the tax rate changes as income increases). The cost estimator tool uses the word "premium." Active participants pay a pretax cost share pursuant to terms of the collective bargaining agreement rather than premiums (contributions).*

Compare the medical plans

Here's a comparison of the HSA Qualified Plan and the PPO Plan.

Plan Features	HSA Qualified Plan	PPO Plan	PPO Plan (early retirees)
Annual deductible	$1,750 per individual $3,500 per family	$200 per individual $400 per family	$250 per individual $500 per family
Out-of-pocket maximum (includes deductible)	$1,750 per individual $3,500 per family	$1,200 per individual $2,400 per family	$2,000 per individual $4,000 per family
Prescription drugs	**RETAIL and MAIL ORDER In-Network and Out-of-Network:** You pay the full cost for retail and mail-order prescriptions until you've met the deductible ($1,750 per individual or $3,500 per family). Then, the HSA Qualified Plan pays 100% of the cost. Deductible does not apply to certain preventive prescription drugs. Examples of these Optimum Value Medications include maintenance medications to help control diabetes, cardiovascular, cholesterol, respiratory, osteoporosis, and other conditions. Prescription drugs count toward the medical plan out-of-pocket maximum.	**RETAIL In-Network and Out-of-Network:** You pay: $5 generic $20 preferred brand-name $40 non-preferred brand-name **MAIL ORDER In-Network and Out-of-Network:** You pay: $10 generic $40 preferred brand-name $80 non-preferred brand-name **Prescription drugs have a separate out-of-pocket maximum from the medical plan.** This is the total amount of money you pay for prescription drugs ($1,000 per individual) each plan year before the plan pays 100% of most covered prescription drug costs.	**RETAIL and MAIL ORDER In-Network and Out-of-Network:** You pay: 20% generic 20% preferred brand-name 20% non-preferred brand-name **Prescription drugs have a separate out-of-pocket maximum from the medical plan.** This is the total amount of money you pay for prescription drugs ($700 per individual) each plan year before the plan pays 100% of most covered prescription drug costs.
		Some prescriptions, such as ACA Preventive drugs, are covered differently, which means you could pay less. Contact Regence BCBS directly for the latest list of covered medications.	
PGE contribution to your Health Savings Account (HSA)	**$986.40** individual coverage, and **$1,972.44** family coverage (based on eligibility)	NA	NA
Preventive care	Plan pays: 100% in-network		
Provider choice	Use any provider, but pay less when you use a Regence in-network provider.		
Tax advantages	Tax advantages: With the HSA, contributions, interest and investment earnings, and withdrawals used for eligible health care expenses are tax-free.	NA	NA
Use your Health Reimbursement Account (HRA) to pay for health care expenses once you retire	Yes, once you retire, your HSA and HRA work together to pay for your medical expenses in retirement.	Yes, once you retire.	Yes, in retirement your HRA is established, and you can submit for reimbursement of medical expenses until your balance is exhausted.

How does the HSA Qualified Plan work?

The plan is made up of two parts:

Medical Plan

Medical coverage
with a broad network of providers, comprehensive coverage through Regence BCBS, and an annual deductible

+

Health Savings Account (HSA)

An account
that lets you save and pay for eligible health care expenses tax-free

The two parts work together: The medical plan provides comprehensive medical and prescription coverage, and the HSA helps you save and pay for health care expenses, such as doctor's bills, hospital charges, prescriptions, dental and vision expenses, and more.

Medical coverage with the HSA Qualified Plan works a lot like other medical insurance plans.

Out-of-pocket maximum* is the top level.

If you reach your out-of-pocket maximum amount, you pay nothing for covered medical expenses for the rest of the calendar year.**

Annual deductible is the second level.

You pay the full cost for in-network care for covered services and prescriptions.

Preventive care is the first level.

Preventive care is 100% covered. You pay nothing.

** For family coverage, the deductible and out-of-pocket maximums include expenses across all covered individuals.*
*** If using out-of-network providers, balance billing may apply.*

When you receive care, you're responsible for paying 100% of your medical and certain prescription expenses until you reach the annual deductible. You can see any provider you like, but you'll pay less when you see providers in the Regence BCBS network. With this plan, once you meet the annual deductible, you've also reached the out-of-pocket maximum. This means that once you reach the out-of-pocket maximum, the HSA Qualified Plan will pay 100% of your covered medical and prescription expenses for the remainder of the year.

The HSA Qualified Plan out-of-pocket maximum: Your medical plan safety net

The out-of-pocket maximum, $1,750 individual or $3,500 family, is the MOST you spend on medical and prescription expenses during a year. Even if you have a serious health event or chronic condition, you won't pay more than this amount during the year.

Health Savings Account (HSA)

Available only to those who enroll in the HSA Qualified Plan

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used for qualified medical expenses today and can help you save for future expenses.

The HSA works a lot like a normal bank account, so it's easy to put money in and take it out. You can use the money in your HSA to pay for health care expenses for yourself and your family, as long as they are your qualified tax dependents (generally includes those claimed on your tax return).

Contributing tax-free to your HSA

Annual maximum: $4,500 individual or $9,000 family*

If you are age 55 or older, you can contribute an additional $1,000 to your HSA each year.
** 2027 IRS limits include your contributions and PGE's contributions combined.*

Did you know?

PGE contributes to your HSA!

$986.40 for individual coverage or $1,972.44 for family coverage. This applies to active employees and those in an active-status qualified leave of absence.

Pay for qualified medical, dental, and vision expenses

- Certain out-of-pocket expenses
- Certain medical and prescription drug expenses
- Eyeglasses and contacts
- Dental copays

For an expanded list of qualified medical expenses, visit **www.HealthEquity.com/qme**, or see IRS Publication 502, available at **www.irs.gov**.

Triple tax benefits

- Contributions are made pretax.
- Withdrawals are tax-free when used for qualified expenses.
- Account accumulates interest tax-free, and your balance grows tax-deferred.

Make informed decisions

Not sure how much to contribute or how much you'll save?
Visit **www.HealthEquity.com** to help you understand the benefits of an HSA and investment options available once your account reaches a $2,000 balance.

You must elect your HSA contribution amount each year. You will need to choose an HSA contribution, even if it is $0, to receive PGE's contribution. Elect your HSA in PGE's Workday site. This applies to active employees and those in an active-status qualified leave of absence.

Rules and regulations to be eligible for an HSA

In order to establish and contribute to the HSA, you:

- Must be enrolled in the HSA-qualified plan
- Can only have a Limited Purpose Flexible Spending Account (FSA) for dental and vision expenses, not a Health FSA or Health Reimbursement Account (HRA)
- Cannot be covered by another health plan, unless it is also an HSA-qualified plan and/or permissible coverage, such as vision or dental
- Cannot be enrolled in Medicare Part A or Part B, TRICARE, or TRICARE For Life
- Cannot have received Department of Veterans Affairs (VA) benefits within the past three months, except for preventive care. However, this exclusion does not apply if you are a veteran with a VA disability rating
- Cannot be claimed as a dependent on someone else's tax return

For more information, see IRS Publication 969, available at **www.irs.gov**.

Hearing Aids, Cochlear Implants, and Assistive Listening Devices

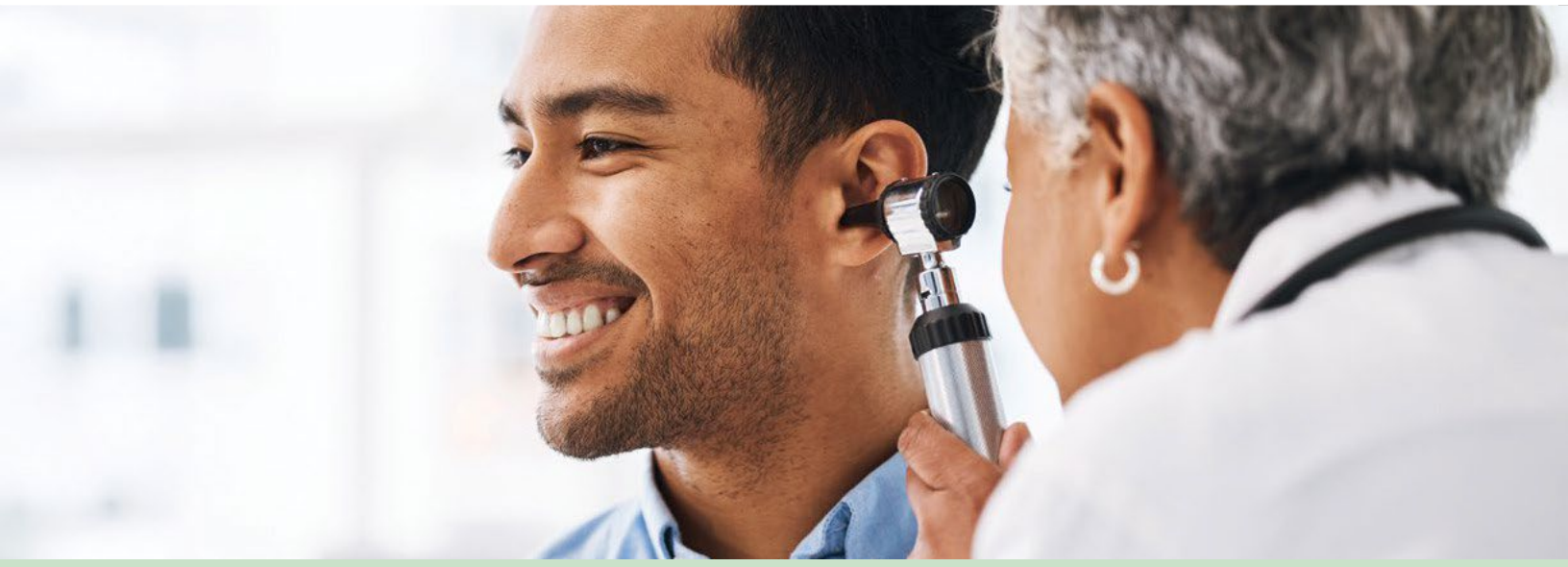
Coverage

- One hearing aid per ear every 48 months, or sooner if modifications to an existing device are insufficient to meet the member's needs. The benefit limit is $4,000 per device.
- Cochlear implants and the associated surgical services
- Ear molds and replacement ear molds
- One box of replacement batteries per year for each hearing aid
- Necessary diagnostic and treatment services, including hearing tests appropriate for a member's age or developmental need; hearing aid checks; aided testing
- Bone conduction sound processor and the associated surgical services, if necessary for appropriate amplification of the hearing loss, every 36 months
- Assistive listening devices if necessary for appropriate amplification of the hearing loss every 36 months
- Other components required for a hearing device to function properly and effectively
- Repair or replacement parts for a hearing aid or other assistive listening device, if the repair or parts are not covered by a warranty and are necessary for the device to be functional for the member. Hearing aids must be prescribed, fitted, and dispensed by a licensed audiologist with approval from a licensed physician. Over-the-counter hearing aids are not covered.

Participants keep their current benefit as stated below:

- **Active PPO:** Hearing Aids / Assistive Technology: not subject to deductible for category 1/2/3 providers;* participant pays 10% coinsurance category 1, 30% coinsurance category 2, 30% coinsurance category 3. One hearing aid per ear, every 48 months, applies to all members.
- **Early Retiree PPO:** Hearing Aids / Assistive Technology: not subject to deductible category 1/2/3 providers;* participant pays 20% coinsurance category 1, 40% coinsurance category 2, 40% coinsurance category 3. One hearing aid per ear, every 48 months, applies to all members.
- **Active HDHP HSA, Early Retiree HDHP HSA:** Hearing Aids / Assistive Technology: subject to deductible for all providers; participant pays 100% coinsurance until deductible is met, then pays 0% coinsurance. One hearing aid per ear, every 48 months, applies to all members.

* "Category 1/2/3 providers" refers to Preferred Network / Participating Network / Nonparticipating Network providers.



Care-on-Demand Resources

Your medical plan includes several resources for accessing care from the comfort and safety of home.

MDLIVE

Virtual visits through MDLIVE are available 24/7 and can take place anywhere you have access to the internet, on your computer, tablet, or mobile device. Doctors can diagnose your symptoms and prescribe medication over the phone or video. Virtual visits can be a cost-effective alternative to expensive emergency room or urgent care visits. With MDLIVE, you can also visit with a counselor or psychiatrist 24/7 from your home, office, or on the go.

DispatchHealth

Get quality care in the comfort of your own home. Request a visit, and a medical team will arrive, ready to treat your illness or injury in the privacy and comfort of your home. To request a visit, have your member ID ready, and download the app, visit **www.dispatchhealth.com**, or call **720-647-5329**. (Available in select locations in Idaho, Oregon, and Washington; use your zip code to verify access at **www.dispatchhealth.com/locations**.)

Find a provider, specialist, or place (urgent care or ER):

1. Use the **Regence find-a-doctor search tool**.
2. Sign in to your Regence account, or select **Choose a Network**.
3. Your network is found on the front of your Regence ID card, or type *Preferred Network* in the search box.
4. Search for a type of provider by name, specialty, or location.
5. Or call Regence customer service at **866-240-9580** for assistance.

Access quality health care from the comfort and safety of home. MDLIVE is included in your medical plan, so you pay only for a medical visit, and prescriptions can be quickly sent to your local pharmacy. Call **888-725-3097,** or visit **www.MDLIVE.com/regence-or**.

Register for care-on-demand resources, so you're ready when you need care.

Dental Benefits

Your Trust-sponsored plans include dental coverage for yourself and/or your eligible dependents. You can use any provider, but you'll pay less if you use a participating provider.

Delta Dental of Oregon (Delta Dental) Dental Plan*	
Calendar-year deductible	$25 per individual
Calendar-year maximum	$2,500 per individual
Preventive or diagnostic services • Routine exam or bitewing X-rays (twice per calendar year) • Cleanings (twice per calendar year) • Sealants • Fluoride • Space maintainers	Plan pays 80% after deductible
Basic services • Restorative fillings • Oral surgery • Endodontic • Periodontics	Plan pays 80% after deductible
Major services • Implants • Crowns • Cast restorations • Denture and bridge work	Plan pays 80% after deductible
Orthodontia	Plan pays 50%; lifetime maximum of $1,000 per individual

** Payment to a nonparticipating dentist or dental care provider is paid at the applicable coinsurance and limited to the nonparticipating dentist fee schedule. The allowable fee in states other than Oregon will be that state's Delta affiliate's nonparticipating dentist allowance.*

Vision Benefits

Your Trust-sponsored plans include vision coverage for yourself and/or your eligible dependents. You can use any provider, but you'll pay less if you use a participating provider.

VSP

	In-Network	Out-of-Network (reimbursement amounts)
Exam Adults and children: every calendar year	$10 copay Retinal screening: $10 copay (in lieu of dilation)	$10 copay, then up to $50
Prescription glasses	$25 copay	$25 copay
Lenses Adults and children: every calendar year	Single-vision, lined bifocal, lined trifocal: covered in full	• Single-vision: up to $50 • Lined bifocal: up to $75 • Lined trifocal: up to $100
Lens enhancements	• Standard progressives (covered in full in-network): $0 copay • Premium progressives: $80–$90 copay • Custom progressives: $120–$160 copay	Progressives: up to $75
Frames Adults and children: every other calendar year	$200 allowance for a wide selection of frames; $250 allowance for featured frame brands; $110 equivalent at Costco; 20% discount on amount over allowance at VSP doctors	Up to $70
Contact lenses (instead of glasses) every calendar year	$130 allowance for contacts (copay does not apply) Contact lens exam up to $60 copay	Up to $105 for contacts and contact lens exam

Ways To Save

Shop smart and save money

You can reduce your out-of-pocket costs during the year by following a few simple guidelines:

Get preventive care.

Help identify health problems before they become serious and costly. This includes services like annual checkups, immunizations, Pap tests, mammograms, colonoscopies, blood pressure screenings, and more. Plus, in-network preventive care is covered at 100%.

Use care-on-demand resources.

In non-life-threatening cases, choosing a care-on-demand option instead of the emergency room can save you time and money when you're not feeling well and want to stay home. For more information, see page 8.

Use in-network providers and facilities.

You will save money by using in-network providers and facilities.

Save on dental and vision expenses too!

You will also save money on dental and vision care if you use in-network providers. They will often cost less than non-contracted, out-of-network doctors and facilities. Make sure that you check whether your doctor and facility are in-network before you go.

Go to the emergency room for true emergencies.

The ER is the place to go if you need immediate treatment for a critical, life-threatening injury or illness (this can be the most expensive place to receive medical care). Retail clinics, urgent care facilities, and telehealth can save you money for nonurgent health concerns over costly emergency room visits.

Benefits Contact Information

Member Services, Eligibility, and IBEW 125 – PGE Health and Welfare Trust Administration	**Trust Fund Office—BeneSys Administrators** **Mailing address:** BeneSys, Inc. PMB 116, 5331 S. Macadam Avenue, Suite 258 Portland, OR 97239-3871 **Physical address:** BeneSys, Inc. 5331 S. Macadam Avenue, Suite 220 Portland, OR 97239-3839 **Phone:** 503-224-5906 **Toll-Free:** 877-545-9471 **eFax:** 781-398-9219 **ibew125pge@benesys.com** **www.ourbenefitoffice.com/IBEW125PGE/**
Workday Enrollment Assistance and PGE Voluntary Benefits – PGE HR Connect Team	**Phone:** 503-464-7250 7 a.m.–5 p.m., M–F **benefits@pgn.com**
Medical Group number 71318001	**Regence** 866-240-9580 **www.regence.com** **FlexAccess** 888-302-3618
Health Savings Account Administration	**HealthEquity** 866-960-8055 **www.healthequity.com** **www.comparemyhsa.com/ibew125pgetrust**
Telehealth or Virtual Visits	**MDLIVE** 800-400-6354 **www.MDLIVE.com/regence-or**
Dental Group number 10000153 (Active or Retirees)	**Delta Dental of Oregon** 888-217-2365 **www.deltadentalor.com**
Vision Group number 30022560	**VSP** 800-877-7195 **www.vsp.com**
Teladoc Group number IBEW125PGE	**Livongo by Teladoc Health** 800-945-4355 **www.Go.Livongo.com/IBEW125PGE/Register**

5331 S. Macadam Avenue, Suite 220 • Portland, OR 97239
PMB 116, 5331 S. Macadam Avenue, Suite 258 • Portland, OR 97239 • Phone 503-224-5906
Toll-Free 877-545-9471 • www.IBEW125PGEbenefits.org

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1-866-240-9580. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-866-240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,750 individual (single coverage) / $3,500 family* per calendar year. *An individual on family coverage will not have their in-network deductible exceed $3,500.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply." "No charge" means $0 copayment or 0% coinsurance, regardless of deductible applicability.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,750 individual (single coverage) / $3,500 family* per calendar year. *An individual on family coverage will not have their out-of-pocket limit exceed $3,500.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1-866-240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	None
	Specialist visit	No charge	No charge	
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply for childhood immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2027/OR/6tierLGStd	Tier 1 (Typically, generic drugs with highest overall value)	No charge / retail prescription; No charge / home delivery prescription	No charge / retail prescription; No charge / home delivery prescription	Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for insulin. 90-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery. Coverage includes compound medications at no charge. No charge, deductible does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 2 (Typically, generic drugs with moderate overall value)	No charge / retail prescription; No charge / home delivery prescription	No charge / retail prescription; No charge / home delivery prescription	
	Tier 3 (Typically, brand drugs with moderate overall value)	No charge / retail prescription; No charge / home delivery prescription	No charge / retail prescription; No charge / home delivery prescription	
	Tier 4 (Typically, brand drugs with lower overall value)	No charge / retail prescription; No charge / home delivery prescription	No charge / retail prescription; No charge / home delivery prescription	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 5 (Typically, specialty drugs with moderate overall value)	No charge / specialty drug	No charge / specialty drug	
	Tier 6 (Typically, specialty drugs with lower overall value)	No charge / specialty drug	No charge / specialty drug	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	None
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	
	Urgent care	No charge	No charge	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	None
	Physician/surgeon fees	No charge	No charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	None
	Inpatient services	No charge	No charge	
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	180 visits / year
	Rehabilitation services	No charge	No charge	30 inpatient days / year 30 outpatient visits / year Includes physical therapy, occupational therapy, massage therapy when provided as therapeutic intervention and speech therapy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge	No charge	30 neurodevelopmental visits / year Includes physical therapy, occupational therapy, massage therapy when provided as therapeutic intervention and speech therapy.
	Skilled nursing care	No charge	No charge	100 inpatient days / year
	Durable medical equipment	No charge	No charge	None
	Hospice services	No charge	No charge	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Infertility treatment	• Routine eye care
• Cosmetic surgery, except congenital anomalies	• Long-term care	• Routine foot care, except for diabetic patients
• Dental care	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Chiropractic care, 12 spinal manipulation visits / year	• Non-emergency care when traveling outside the U.S.
• Acupuncture, 12 visits / year	• Hearing aids	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1-866-240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-866-240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,750
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,810**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,950**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
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 Civil Rights Coordinator.

If you believe that Regence 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 grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041, (TTY: 711)

You can also 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.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

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。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1-866-240-9580. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-866-240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual / $400 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, prescription drug coverage and those services listed below as "deductible does not apply." "No charge" means $0 copayment or 0% coinsurance, regardless of deductible applicability.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred provider & participating provider: $1,200 individual / $2,400 family per calendar year. Non-participating provider: $3,200 individual / $6,400 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug out-of-pocket limit, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1-866-240-9580 for a list of network providers.	You pay the least if you use a provider in the preferred network. You pay more if you use a provider in the participating network. You will pay the most if you use a non-participating provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-participating provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Preferred Provider (You pay the least)	What You Will Pay: Participating Provider (You pay more)	What You Will Pay: Non-participating Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	30% coinsurance	No charge, deductible does not apply for childhood immunizations from non-participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2027/OR/3tierStd	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to participating provider and non-participating provider columns.	$5 copay, deductible does not apply / retail prescription; $10 copay, deductible does not apply / home delivery prescription; $10 copay, deductible does not apply / self-administrable cancer chemotherapy prescription	$5 copay, deductible does not apply / retail prescription; $10 copay, deductible does not apply / home delivery prescription; $10 copay, deductible does not apply / self-administrable cancer chemotherapy prescription	Prescription drugs not on the Drug List are not covered, unless an exception is approved. Out-of-pocket limit: $1,000 individual / year. 90-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery. Coverage includes compound medications at 50% coinsurance, deductible does not apply. Cost shares for insulin will not exceed $35 / 30-day supply or $105 / 90-day supply. No charge, deductible does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
	Tier 2 (Typically, brand drugs with moderate overall value)	Not applicable, refer to participating provider and non-participating provider columns.	$20 copay, deductible does not apply / retail prescription; $40 copay, deductible does not apply / home delivery prescription; $50 copay, deductible does not apply / self-administrable cancer chemotherapy prescription	$20 copay, deductible does not apply / retail prescription; $40 copay, deductible does not apply / home delivery prescription; $50 copay, deductible does not apply / self-administrable cancer chemotherapy prescription	drug available, you pay the difference in cost in addition to the copayment and/or coinsurance. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Tier 3 (Typically, brand drugs with lower overall value)	Not applicable, refer to participating provider and non-participating provider columns.	$40 copay, deductible does not apply / retail prescription; $80 copay, deductible does not apply / home delivery prescription; $100 copay, deductible does not apply / self-administrable cancer chemotherapy	$40 copay, deductible does not apply / retail prescription; $80 copay, deductible does not apply / home delivery prescription; $100 copay, deductible does not apply / self-administrable cancer chemotherapy	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
			prescription	prescription	
	Specialty drugs	Not applicable, refer to participating provider and non-participating provider columns.	Refer to tier 1, 2 and 3 drugs above.	Refer to tier 1, 2 and 3 drugs above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copay / visit	10% coinsurance after $100 copay / visit	10% coinsurance after $100 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	30% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance, deductible does not apply	10% coinsurance, deductible does not apply	30% coinsurance	None
	Inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	30% coinsurance	Deductible does not apply for newborn nursery care. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
					For example, an ultrasound billed separately is covered under the **If you have a test** above.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	30% coinsurance	180 visits / year
	Rehabilitation services	10% coinsurance	30% coinsurance	30% coinsurance	30 inpatient days / year 30 outpatient visits / year Includes physical therapy, occupational therapy, massage therapy when provided as therapeutic intervention and speech therapy.
	Habilitation services	10% coinsurance	30% coinsurance	30% coinsurance	30 neurodevelopmental visits / year Includes physical therapy, occupational therapy, massage therapy when provided as therapeutic intervention and speech therapy.
	Skilled nursing care	10% coinsurance	30% coinsurance	30% coinsurance	100 inpatient days / year
	Durable medical equipment	10% coinsurance	30% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	30% coinsurance	30% coinsurance	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture, 12 visits / year
- Chiropractic care, 12 spinal manipulation visits / year
- Hearing aids
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1-866-240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-866-240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of preferred provider pre-natal care and a hospital delivery)

The plan's overall deductible	**$200**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

Managing Joe's Type 2 Diabetes
(a year of routine preferred provider care of a well-controlled condition)

The plan's overall deductible	**$200**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$900**

Mia's Simple Fracture
(preferred provider emergency room visit and follow up care)

The plan's overall deductible	**$200**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
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 Civil Rights Coordinator.

If you believe that Regence 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 grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041, (TTY: 711)

You can also 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.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

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。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

IBEW 125 PGE Health & Welfare Trust
Active PPO Plan

Effective January 1, 2027 through December 31, 2027

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Cost Share Details		Preferred Provider	Participating Provider	Nonparticipating Provider
Annual Medical Deductible	The total deductible You pay per calendar year	$200 Individual $400 Family	Shared with Preferred Network	Shared with Preferred Network
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year	$1,200 Individual $2,400 Family	Shared with Preferred Network	$3,200 Individual $6,400 Family

Be aware that Your actual costs for Covered Services provided by a Nonparticipating Network Provider may exceed the Out-of-Pocket Maximum amount. In addition, Nonparticipating Providers can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits (*unless stated otherwise, a deductible applies*)		What You Pay		
		Preferred Provider	Participating Provider	Nonparticipating Provider
Primary Care Visits (for Illness or Injury)		10%	30%	30%
Specialist Visits		10%	30%	30%
Urgent Care Visits		10%	30%	30%
Other Professional Services		10%	30%	30%
Preventive Care / Immunizations		Covered in full	Covered in full	30%
Radiology and Laboratory - Outpatient		10%	30%	30%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	10%	30%	30%
Acupuncture	Chiropractic spinal manipulations and acupuncture services from any licensed provider (12 combined visits per calendar year)	10%	10%	10%
Ambulance Services		10%	10%	10%
Ambulatory Surgical Center		10%	30%	30%
Emergency Room (Including Professional Charges)		$100 copay per visit, then deductible and 10% coinsurance	$100 copay per visit, then deductible and 10% coinsurance	$100 copay per visit, then deductible and 10% coinsurance
Hearing Aids & Evaluations	$4,000 every 4/years	10% deductible waived	30% deductible waived	30% deductible waived
Home Health Care	180 visits per calendar year	10%	30%	30%
Hospice Care	14 days of respite care per lifetime	10%	30%	30%
Behavioral Health - Inpatient		10%	10%	30%
Behavioral Health - Outpatient		10%, deductible waived	10%, deductible waived	30%, deductible waived
Hospital Care		10%	30%	30%
Maternity Care		10%	30%	30%
Neurodevelopmental Therapy	30 visits per calendar year	10%	30%	30%
Nutritional Counseling		10%	30%	30%
Rehabilitation Services - Inpatient	30 days per calendar year	10%	30%	30%
Rehabilitation Services - Outpatient	30 visits per calendar year	10%	30%	30%
Skilled Nursing Facility	100 days per calendar year	10%	30%	30%
Spinal Manipulations - Osteopathic		10%	30%	30%

Prescription Medication Benefits		What You Pay
1 copay per 30-day supply* ***Insulin Cost Share Cap:* *Retail or home delivery: $35 cap on Claimant cost share per 30-day supply; $105 cap on Claimant cost share up to 90-day supply* *You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and / or coinsurance* *More information about prescription drug coverage, including tier specific information, is available at https://regence.com/go/2026/OR/3tierStd*		
Annual Deductible	The total deductible you pay per calendar year	Not Applicable
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance, and copays per calendar year	$1,000
Tier 1	90-day supply for retail or mail order	$5 retail prescription / $10 mail order prescription / $10 for each self-administrable Cancer Chemotherapy medication, deductible waived
Tier 2	90-day supply for retail or mail order	$20 retail prescription / $40 mail order prescription / $50 for each self-administrable Cancer Chemotherapy medication, deductible waived
Tier 3	90-day supply for retail or mail order	$40 retail prescription / $80 mail order prescription / $100 for each self-administrable Cancer Chemotherapy medication, deductible waived
Specialty Select	30-day supply for retail (the first fill for specialty drugs may be provided at a retail pharmacy, additional fills must be provided at a specialty pharmacy.)	Refer to tiers 1, 2 and 3 above for specialty drugs

Value-Added Services	
Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service.	
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions; the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.

Provider Networks

Your enrolled network is Preferred PPO. There are several Provider networks in Your state. Please note that these networks are not interchangeable and support different Providers. To find Providers in Your network, please sign into Your account and use Our Provider search tool: regence.com

Out-of-Area Services

Outside of the service area, Claimants have Preferred Provider benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Outside Preferred Providers, You may be balance billed. Call 1-800-810-BLUE (2583) to learn how to get access.

Frequently Asked Questions	
How is my privacy protected?	Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at regence.com.
Is there a cost for "Covered in full"?	No, if Your benefit is covered in full there is no copay or deductible.
What if I need access to specialty care? Do I need a referral?	You can receive care from any Preferred Providers without a referral. For some services, prior authorization may be required.

This benefit summary provides a brief description of Your plan benefits, limitations and / or exclusions under Your plan and is not a guarantee of payment. Once enrolled, You can view Your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND / OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY.** Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and Claimants under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and Claimants.

Customer Service: 1-866-240-9580 - TTY: 711 | 200 SW Market Street 11th Floor, Portland, OR 97201 | regence.com

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:
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 Civil Rights Coordinator.

If you believe that Regence 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 grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also 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.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

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。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) **'ਤੇ ਕਾਲ ਕਰੋ।**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

IBEW 125 – PGE Health & Welfare Trust

Active/Early Retiree

High-Deductible Health Plan HSA

Effective January 1, 2027 through December 31, 2027

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Cost Share Details		In-Network	Out-of-Network
Annual Medical Deductible	The total deductible You pay per calendar year	$1,750 Individual $3,500 Family	Shared with In-Network
Annual Out-of-Pocket Maximum	The combined total for Your deductible(s), coinsurance and copays per calendar year	$1,750 Individual $3,500 Family	Shared with In-Network

The In-Network Out-of-Pocket Maximum for any Claimant on Family Coverage is not to exceed $3,500, including the In-Network Deductible. If a Claimant reaches this maximum amount prior to satisfying the In-Network Family Out-of-Pocket Maximum, including the In-Network Deductible, benefits will be paid at 100% of the Allowed Amount for that Claimant.

Be aware that Your actual costs for Covered Services provided by an Out-of-Network Provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network Providers can bill You for the difference between the amount charged and Our Allowed Amount and that amount does not count toward any Out-of-Pocket Maximum.

Medical Benefits (*unless stated otherwise, a deductible applies*)		What You Pay	
		In-Network	Out-of-Network
Primary Care Visits (for Illness or Injury)		0%	0%
Specialist Visits		0%	0%
Urgent Care Visits		0%	0%
Other Professional Services		0%	0%
Preventive Care / Immunizations		0%, Deductible waived	0%
Radiology and Laboratory - Outpatient		0%	0%
Complex Imaging - Outpatient	CT / PET / SPECT scans, MRIs, MRAs, etc.	0%	0%
Acupuncture & Chiropractic Spinal Manipulations	12 combined visits per calendar year	0%	0%
Ambulance Services		0%	0%
Ambulatory Surgical Center		0%	0%
Behavioral Health - Inpatient		0%	0%
Behavioral Health - Outpatient		0%	0%
Emergency Room	Facility and professional services	0%	0%
Hearing Aids & Evaluations	$4,000 every 4/years	0%	0%
Home Health	180 visits per calendar year	0%	0%
Hospice	14 days of respite care per lifetime	0%	0%
Hospital Care		0%	0%
Maternity Care		0%	0%
Neurodevelopmental Therapy	30 visits per calendar year	0%	0%
Nutritional Counseling		0%	0%
Palliative Care	30 visits per calendar year		
Rehabilitation Services - Inpatient	30 days per calendar year	0%	0%
Rehabilitation Services - Outpatient	30 visits per calendar year	0%	0%
Skilled Nursing Facility	100 days per calendar year	0%	0%
Spinal Manipulations - Osteopathic		0%	0%

Prescription Medication Benefits (*unless stated otherwise, a deductible applies*)		What You Pay
Annual Deductible	The total deductible you pay per calendar year	Shared with Medical
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	Shared with Medical
Tier 1	90-day supply for retail or home delivery	0% retail prescription / 0% home delivery prescription
Tier 2	90-day supply for retail or home delivery	0% retail prescription / 0% home delivery prescription
Tier 3	90-day supply for retail or home delivery	0% retail prescription / 0% home delivery prescription
Specialty Select	30-day supply for retail or home delivery	0% retail prescription / 0% home delivery prescription

Value-Added Services	
Your Regence coverage includes access to the value-added services detailed here. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS.** For additional information regarding any of these value-added services, visit Our website or contact Customer Service.	
Kidney Health Management	If You are identified to participate, the Kidney Health Management program addresses the medical management needs of chronic kidney disease (CKD) stages 3, 4, 5 and unknown as well as end stage renal disease (ESRD).
Mobile APP	Quick access to: ID card, chat with Customer Service, View Claims, Estimate Treatment Cost, Pharmacy pricing.
Pregnancy Program	Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions; the Pregnancy Program can help.
Regence Advantages	Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services.

Provider Networks

Your enrolled network is Preferred PPO. There are several Provider networks in Your state. Please note that these networks are not interchangeable and support different Providers. To find Providers in Your network, please sign into Your account and use Our Provider search tool: regence.com

Out-of-Area Services

Outside of the service area, Claimants have In-Network benefits at Blue Cross and / or Blue Shield (Blue Plan) facilities across the country through the BlueCard® Program and worldwide through the Blue Cross Blue Shield Global® Core Program. Any other services will not be covered when processed through any Inter-Plan arrangements. Out-of-Network, You may be balance billed. Call 1-800-810-BLUE (2583) to learn how to get access.

Frequently Asked Questions	
How is my privacy protected?	Regence is committed to the confidentiality and security of Your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of Your personal information. You can view Our full privacy practices online at regence.com.
Is there a cost for "Covered in full"?	No, if Your benefit is covered in full there is no copay or deductible.
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Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
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Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

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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.

Language assistance

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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 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

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。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) **'ਤੇ ਕਾਲ ਕਰੋ।**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (**መስማት ለተሳናቸው:-** 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

2027 Delta Dental Premier Plan Benefit Summary

Delta Dental of Oregon & Alaska

IBEW 125 - PGE Health & Welfare Trust

Group ID: 10000153

Premier Option	
Calendar year costs	
Calendar year maximum, per member	$2,500
Calendar year deductible, per member	$25
Class 1	
Periodic Examinations / X-rays	80%
Prophylaxis (cleanings) / Periodontal Maintenance	80%
Sealants	80%
Space Maintainers	80%
Topical Application of Fluoride	80%
Class 2	
Restorative Fillings	80%
Oral Surgery (extractions & certain minor surgical procedures)	80%
Endodontics (treatment of teeth with diseased or damaged nerves)	80%
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	80%
Class 3	
Implants	80%
Crowns and other cast restorations	80%
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	80%

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

When you visit your dental provider, tell him or her you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:
Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:
Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered once twice per year. Supplementary bitewing x-rays are covered twice per year. Complete series x-rays or a panoramic film are covered once in any 3-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered twice per year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per year for members until age 19. For members age 19 and older, topical application of fluoride is covered twice per year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- Restorative Amalgam and composite fillings for the treatment of decay.
  A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a seven (7) year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a seven (7) year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past seven (7) years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Night Guard** (occlusal guard) covered at 100%, deductible waived, once in a five year period, up to $150 maximum. Over-the-counter night guards are excluded.
- **Athletic mouth guard** covered at 50%, once in any 12-month period for members age 15 and under and once in any 24-month period age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

Delta Dental orthodontia rider

Delta Dental of Oregon & Alaska

IBEW 125 - PGE Health & Welfare Trust

Group ID: 10000153

Adult & Child Ortho 1000	
Lifetime maximum	$1,000
	What members pay
Members age 19+	50%
Members under age 19	50%

How to use this dental plan

When you visit your dental provider, tell him or her you are a Delta Dental member.

Pre-determination

Your dental office can submit a pre-treatment plan to Delta Dental of Oregon on your behalf. We will return it to them indicating the dollar allowance which will be covered by your plan before you go forward with treatment.

vsp vision care

Make Eye Health a Priority with VSP!

With VSP® Vision Care and IBEW 125 PGE Health & Welfare Trust, your eye health matters. Take a look at your vision care coverage.

VSP members save an annual average of

$501*

Get an Additional $50 to spend on Featured Frame Brands.

Just look for the **VSP heart logo** on the lens to maximize your benefits.†

bebe Calvin Klein COLE HAAN

DRAGON FLEXON LONGCHAMP PARIS

and more at **vsp.com/framebrands**

Up to 40% savings on lens enhancements‡

Learn more at **vsp.com/offers**.

Create an account today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your eye doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members can get special savings on popular frame brands and contact lenses, and additional discounts on things like LASIK, and more.

The choice is yours!

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Simply connect your benefits when you log in to **eyeconic.com** and have a valid prescription ready when you check out.

Getting started is easy!

Make the most of your plan by creating an account on **vsp.com**. Log in to view your in-network coverage, find a VSP network doctor, download your Member ID card (and save it to your digital wallet), and discover extra savings.

*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association. †Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Availability of VSP Premier Edge™ may vary.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

©2026 Vision Service Plan. All rights reserved.
VSP, VSP (Heart) Logo, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 142819 VCCM

Classification: Restricted

Your VSP Benefits Summary

With a VSP plan through IBEW 125 PGE Health & Welfare Trust, you get affordable vision coverage for glasses, contacts, and more.

Provider Network:
VSP Signature
Effective Date:
01/01/2027

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 $0	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	**See frame and lenses**
FRAME[†]	• $250 Featured Frame Brands allowance • $250 Visionworks or Eyemart Express frame allowance on any frame • $200 frame allowance • 20% savings on the amount over your allowance • $110 Costco frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
RETINAL SCREENING	• Takes a picture of the back of your eyes and helps your VSP doctor find possible signs of eye disease.	$10	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam. • Get 20% off eyewear on **eyeconic.com** just for being a VSP member.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

Your plan provides the following out-of-network reimbursements:

Exam ..... up to $50	Lined Bifocal Lenses ..... up to $75	Progressive Lenses ..... up to $75
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $100	Contacts ..... up to $105
Single Vision Lenses ..... up to $50		

Maximize your benefits at an in-network location. Log in to **vsp.com** to choose an in-network doctor near you, including our large network of private practice and retail locations.

IBEW 125 – PGE HEALTH AND WELFARE TRUST
ELIGIBILITY DOCUMENTATION POLICY
PROOF OF DEPENDENT ELIGIBILITY DOCUMENTS

ELIGIBILITY REQUIREMENTS: SPOUSE	
Definition: Your legal spouse under state law.	
Not eligible as a spouse: • A dependent on active duty in the uniformed services or armed forces of any country. • A former spouse or the former spouse's dependents after a divorce, even if the divorce decree or settlement agreement requires you to provide coverage under the Active Participant Plan (the former spouse and/or dependents may be entitled to continue coverage under COBRA).	
Acceptable Supporting Documentation: Submit Two Documents. One from Proof A and one from Proof B.	
PROOF A: (to show event occurred) • Valid legal or religious marriage certificate, which must include: o Name of the employee and spouse o Date of marriage o Certifier's signature/official seal *(Employees married within the last 12 months do not need to provide Proof B.)* • Common Law Spouse – see requirements listed on page 4, below • Legal household/family registry document. The document must show spousal relationship. *(A registry document is only acceptable if you were married outside the U.S. and do not have a marriage certificate.)*	**PROOF B:** (to show current relationship status) • Your Federal 1040 or state income tax return, which must: o Be from the most recent two tax years o Contain name of member and spouse o Indicate married filing jointly or married filing separately *(Only the page listing filing status and exemptions is required-see sample on following pages. E-Files are not accepted.)* • Utility bill, which must: o Be dated within the last 12 months o Contain name of member and spouse as joint owners o Contain name of utility company • Document from a bank account or financial institution, which must: o Be dated within the last 12 months o Contain name of member and spouse as joint owners of the account o Contain name of financial institution • Insurance document (i.e., homeowner, renter or auto), which must: o Be dated within the last 12 months o Show member and spouse as joint account owners (Individuals listed as "drivers" on automobile insurance documents do not prove joint account ownership) o Contain name of insurance company • Mortgage document or current lease, which must: o Be dated within the last 12 months o Contain name of member and spouse as joint owners or joint renters o Contain name of mortgage company, landlord or rental company • Valid vehicle registration, which must: o Be dated within the last 12 months o Contain name of employee and spouse as joint owners o Contain name of state or county in which issued

IBEW 125 – PGE HEALTH AND WELFARE TRUST
ELIGIBILITY DOCUMENTATION POLICY
PROOF OF DEPENDENT ELIGIBILITY DOCUMENTS

ELIGIBILITY REQUIREMENTS: DOMESTIC PARTNER	
Definition: An eligible domestic partner must satisfy all of the requirements listed on the Plan's Affidavit of Domestic Partnership. The affidavit is available from the Trust Office.	
Ineligible as a domestic partner: • Any dependent on active duty in the uniformed services or armed forces of any country. • A former domestic partner and/or the former domestic partner's dependents after termination of the domestic partnership, even if a court order or settlement agreement requires you to provide coverage under the Active Participant Plan (the former domestic partner and/or dependents may be entitled to continue coverage under COBRA)	
Acceptable Supporting Documentation: Submit Two Documents. One from Proof C and one from Proof D.	

PROOF C:
• Valid IBEW 125 - PGE H&W Trust Domestic Partner Affidavit, which must include
  ○ Names of the employee and domestic partner
  ○ Date of Notarization
  ○ Signature of Notary
  ○ Notary stamp
	PROOF D:
	• Utility bill, which must:
	  ○ Be dated within the last 12 months
	  ○ Contain name of member and domestic partner as joint owners
	  ○ Contain name of utility company
	• Document from a bank account or financial institution, which must:
	  ○ Be dated within the last 12 months
	  ○ Contain name of member and domestic partner as joint owners of the account
	  ○ Contain name of financial institution
	• Insurance document such as homeowner, renter or automobile, which must:
	  ○ Be dated within the last 12 months
	  ○ Show member and domestic partner as joint account owners (Individuals listed as "drivers" on automobile insurance documents do not prove joint account ownership)
	  ○ Contain name of insurance company
	• Mortgage document or current lease, which must:
	  ○ Be dated within the last 12 months
	  ○ Contain name of employee and domestic partner as joint owners or joint renters
	  ○ Contain name of mortgage company, landlord or rental company
	• Valid vehicle registration, which must:
	  ○ Be dated within the last 12 months
	  ○ Contain name of member and domestic partner as joint owners
	  ○ Contain name of state or county in which issued
	• Your Federal 1040 or state income tax return, which must:
	  ○ Be from the most recent two tax years
	  ○ Name member as person filing
	  ○ Name of domestic partner listed as dependent with relationship of "Other"
	(Only the page listing filing status and exemptions is required – see sample on following pages. E-Files are not accepted)

IBEW 125 – PGE HEALTH AND WELFARE TRUST
ELIGIBILITY DOCUMENTATION POLICY
PROOF OF DEPENDENT ELIGIBILITY DOCUMENTS

ELIGIBILITY REQUIREMENTS: CHILDREN UNDER AGE 26

Definition: Your children and step children (step children are the children of your spouse or domestic partner) are eligible until the end of the month that they reach age 26 which includes:

- a ***biological child***;
- an ***adopted*** child or a child placed with for ***adoption;***
- *a* ***foster*** child;
- a child or grandchild for whom you have ***legal guardianship*** or ***court-ordered custody.*** The child must be related to you, your spouse or your domestic partner by blood or marriage; or
- Child for whom coverage is required under a ***Qualified Medical Child Support Order*** applicable to the Member.

Not eligible as a child:

- Any dependent on active duty in the uniformed services or armed forces of any country.

Acceptable Supporting Documentation: Submit One Document from Proof E:

PROOF E:

- Your Federal 1040 or state income tax return, which must:
  - Be from the most recent two tax years
  - List your dependent with the relationship as daughter, son or child

  (Only the page listing filing status and exemptions is required-see sample. E-Files are not accepted)
- Child's legal birth certificate, which must:
  - Contain the first and last name of member and spouse or domestic partner
  - Contain the name of the child
  - Indicate date of birth
- Legal household/family registry, must show relationship

  (This is only acceptable if the child was born outside the U.S. and you have no legal birth certificate.)
- Final divorce decree, parental custody agreement or Qualified Medical Child Support Order (QMCSO), which must:
  - Contain the name of the member, and spouse or domestic partner, indicating parentage of the child
  - Contain the name of the child
  - Official signature or stamp indicating document has been filed
- Legal adoption, guardianship or legal custody papers, which must:
  - Contain the name of the member, spouse or domestic partner
  - Contain the name of the child
  - Official signature or stamp indicating document has been filed

Additional Documentation for Step Children

A member providing documentation for a child of the Member's legal spouse or domestic partner must provide proofs listed above for Spouse (Proof A and B) or Domestic Partner (Proof C and D), even if member does not currently cover spouse or domestic partner.

IBEW 125 – PGE HEALTH AND WELFARE TRUST
ELIGIBILITY DOCUMENTATION POLICY
PROOF OF DEPENDENT ELIGIBILITY DOCUMENTS

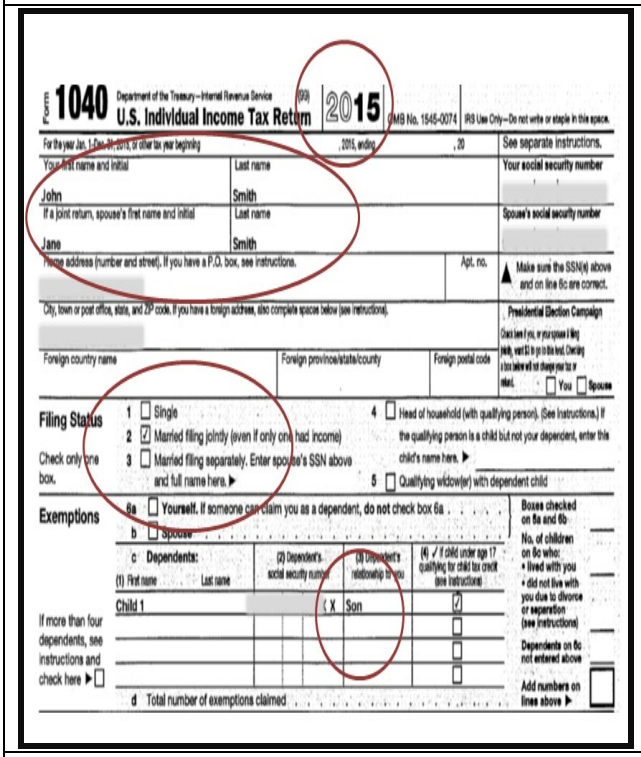
ELIGIBILITY REQUIREMENTS: CHILDREN AGE 26 AND OVER		
Definition: A child who is disabled and who is age 26 and older may be covered provided ALL of the following requirements are met: • The child is unmarried and dependent upon the Participant for support; • The child is incapable of self-support because of a continuing physical, mental, or developmental disability; and • The onset of the disability occurred before the child's 26th birthday.		
Acceptable Supporting Documentation: Submit Three Documents. One from Proof F, one from Proof G and one from Proof H.		
PROOF F: • Any one of the documents listed for Child under age 26.	**PROOF G:** • Physician statement certifying that the dependent child cannot support himself/herself because of a physical or mental disability. *(The physician statement must be made on the physician's letterhead or form and must be dated within the last 12 months.)*	**PROOF H:** • Trust Adult Child Enrollment Form, available from the Trust Office. *(The enrollment form must be completed and signed by the Member.)*
Additional Documentation for Step Children		
A member providing documentation for a child of the Member's legal spouse or domestic partner must provide proofs listed above for Spouse (Proof A and B) or Domestic Partner (Proof C and D), even if member does not currently cover spouse or domestic partner.		

ELIGIBILITY REQUIREMENTS: SPOUSE UNDER COMMON LAW MARRIAGE	
Acceptable Supporting Documentation: Submit Two Documents. One from Proof A and one from Proof B.	
Definition: A common law spouse may be treated as a spouse only if the state in which you reside recognizes common-law marriages and you satisfy the state requirements at the time of enrollment.	
PROOF A: (to show event occurred) • Presently valid state-issued certificate, declaration or registration of common law or informal marriage (in applicable states) which must include: o Name of the employee and spouse o Date of informal marriage o Certifier's signature/official seal	**PROOF B:** (to show current relationship status) • Any of the documents listed above for a Spouse (Proof B)

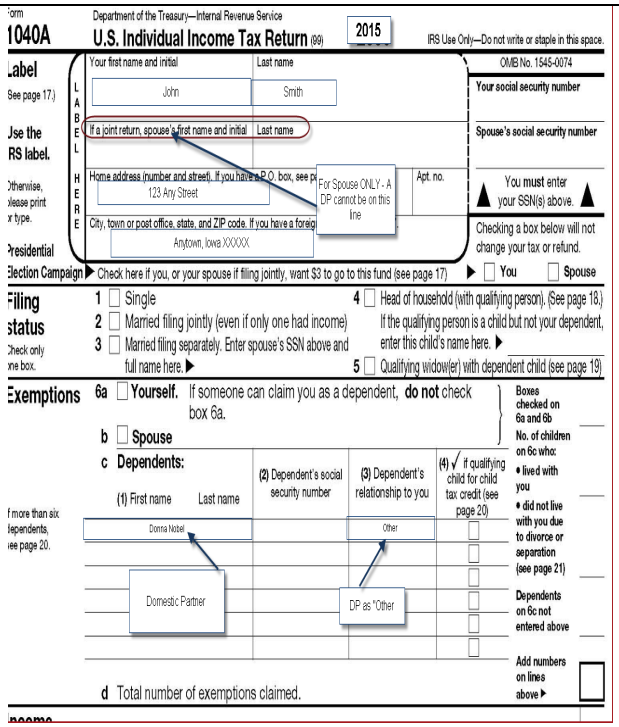
IBEW 125 – PGE HEALTH AND WELFARE TRUST
ELIGIBILITY DOCUMENTATION POLICY
PROOF OF DEPENDENT ELIGIBILITY DOCUMENTS

SAMPLE FEDERAL 1040 FORMs used as proof

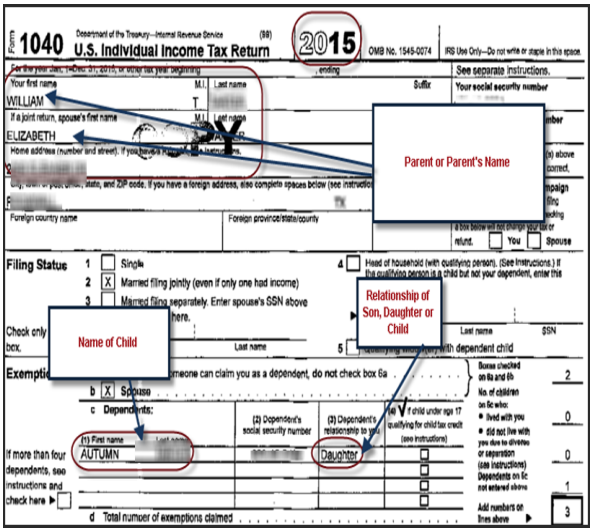
Proof for **Spouse**: Please mark out SSN's and financial information



Proof for **Domestic Partner**: Please mark out SSN's and financial information



Proof for **Child under age 26**: Please mark out SSN's and financial information



Active Plan: Medical, Dental, Vision		Employee cost per pay period	Company cost per pay period	PGE pays per pay period
Regence HSA Qualified Plan *	Employee Only	$6.42	$925.91	$932.33
	Employee and Spouse/Domestic Partner	6.42	925.91	932.33
	Employee and Child(ren)	6.42	925.91	932.33
	Employee and Family	6.42	925.91	932.33
Regence PPO Plan	Employee Only	$93.23	$839.10	$932.33
	Employee and Spouse/Domestic Partner	93.23	839.10	932.33
	Employee and Child(ren)	93.23	839.10	932.33
	Employee and Family	93.23	839.10	932.33

* HSA Qualified Plan premium cost share is $0; you are paying for the dental and vision cost share.
Domestic Partner Imputed Income: Per IRS rules, PGE will impute the fair market value of premiums for a domestic partner and/or domestic partner child/ren's coverage. Imputed income amounts are applied per-pay-period. Consult a tax advisor for advice surrounding imputed income. Monthly imputed income amounts are:

- HSA Plan: $763.22 domestic partner; $1,772.22 domestic partner plus their child(ren).
- PPO Plan: $842.00 domestic partner; $1,851.00 domestic partner plus their child(ren).

2027 Health Savings Account (HSA) Contribution Limits

You must be enrolled in the HSA Qualified Plan and meet other eligibility rules to participate in an HSA. Refer to your 2027 Open Enrollment Guide for participation and eligibility information.

IMPORTANT: If you elected the HSA Qualified Plan last year and elected to make Annual HSA Contributions, for 2027 you must re-elect an Annual HSA Contribution even if it is the same amount as last year. Your prior year's election will not automatically rollover into 2027.

PGE's HSA Contribution: During open enrollment, you'll be asked to elect a contribution amount. **You have to enter something, even if it's $0, to receive PGE's contribution**.

- **Individual coverage**: The 2027 IRS annual maximum is $4,500*.
  - The PGE contribution is **$986.40** for employee only coverage.
  - The most you can contribute before-tax is **$3,513.60**.
- **Family coverage**: The 2027 IRS annual maximum is $9,000*.
  - The PGE contribution is **$1,972.44** for employee and spouse, employee, and child(ren) or family coverage.
  - The most you can contribute before-tax is **$7,027.56**.
- **HSA Catchup Contribution:** If you are age 55 or older during the year and the account holder, you can contribute an additional $1,000 per year.

Your HSA election will be deducted from every paycheck during the year (26 pay periods). You can increase or decrease your annual election for the next available pay period, without a qualifying event. You can change your election in PGE's Workday system. Call PGE at 503-464-7250 for assistance.

**2027 IRS limits include your contributions and PGE's contributions combined.*

IBEW 125 - PGE
HEALTH & WELFARE TRUST

October 2026

RE: READ CAREFULLY!! IMPORTANT INFORMATION ENCLOSED

Enclosed with this letter, you will find the following important items regarding the IBEW 125 – PGE Health & Welfare Trust:

1) **Protected Health Information Release Form – ACTION REQUESTED**
2) HIPAA Notice of Privacy Practices Availability Notice
3) Annual Women's Health Notice
4) The Medicare Part D Annual Notice
5) Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Protected Health Information Release Form
Your privacy is important to us. **If you have never done so, you must return this form if you wish to allow us to speak with another person, such as a spouse about your claims, enrollment, and eligibility.** One form is needed for each adult in the family. If you already sent in a form, you do NOT need to send a new one.

Did you know that the Trust Office offers Eligibility access online?
Register online today! Quickly and securely register using our easy website registration process! Have your personal information at your fingertips 24 hours a day, 7 days a week! Click on "Create an Account" to get started. You will need to know your name, date of birth, SSN or Alternate ID, and zip code as they are recorded in the Trust Office. Go to www.IBEW125PGEbenefits.org. Problems? Click on Contact Us.

HIPAA Notice of Privacy Practices Availability Notice
"The IBEW 125 – PGE Health & Welfare Trust maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) is used or maintained by the Trust. You have the right to request a copy of the Trust's Notice of Privacy Practices from the Trust Office by submitting a written request to:

BeneSys, Inc. Attn: Privacy Officer
IBEW 125 – PGE Health & Welfare Trust
700 Tower Drive, Suite 300. Troy, MI 48098
Telephone: (248) 813-9800

You may also obtain a copy of this notice on the Plan's website: www.IBEW125PGEbenefits.org."

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**

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

3. **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**

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

3. **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**

-OVER-

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____**authorize The IBEW 125 - PGE Health and Welfare Trust (the "Trust"), 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:

IBEW 125 - PGE Health & Welfare Trust
PMB#116, 5331 S Macadam Avenue, Suite 258
Portland, OR 97239
Phone 503-224-5906 • Toll Free 877-545-9471

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.

NOTICE OF AVAILABILITY

IBEW 125 – PGE HEALTH AND WELFARE TRUST NOTICE OF PRIVACY PRACTICES

Date of Notice: October 2026

Plan Sponsor: IBEW 125 – PGE HEALTH AND WELFARE TRUST ("Trust")

The Trust is committed to protecting the privacy and security of your Protected Health Information ("PHI"). The Trust is required by the Health Insurance Portability and Accountability Act ("HIPAA") to maintain the privacy of your health information and to provide you with a comprehensive description of our legal duties and privacy practices.

Availability of the Notice of Privacy Practices

This is a periodic reminder that the Trust's full HIPAA Notice of Privacy Practices ("NPP") is available to you upon request. You received a copy when you first became eligible. The NPP details:

- How the Trust may use and disclose your medical information for treatment, payment, and health care operations.
- Your rights to inspect, copy, and request amendments to any health records maintained by the Trust.
- Your right to request restrictions on certain disclosures or receive confidential communications.
- The Trust's requirement to notify you following a breach of your unsecured health information.
- Procedures for filing a formal privacy complaint with the Trust or the U.S. Department of Health and Human Services (HHS) without fear of retaliation.

How to Obtain a Copy of the Notice

You can access or request a copy of the current NPP at any time through any of the following methods:

1. Online: View and download a digital copy directly from our participant portal at www.IBEW125PGEbenefits.org.
2. By Phone: Request a paper copy by contacting the Trust Office at the phone numbers provided in the Trust Office contact information at the bottom of this page.
3. In Person: Request a paper copy at the Trust Office (see contact information below).
4. By Mail: Request a paper copy by contacting the Trust's Privacy Officer at:

BeneSys, Inc.
Attn: Privacy Officer
IBEW 125 – PGE Health & Welfare Trust
700 Tower Drive, Suite 300. Troy, MI 48098
Telephone: (248) 813-9800

ANNUAL NOTIFICATIONS OCTOBER 2027 PLAN YEAR

WOMEN'S HEALTH AND CANCER-RIGHTS ACT OF 1998 NOTICE (WHCRA)

Your plan covers mastectomies, and reconstructive surgery and other mastectomy related services. This benefit applies to all plan participants, including a member's dependents.

In addition, your plan provides reconstructive surgery. Reconstructive surgery is determined in consultation with the patient and the patient's attending physician.

The benefit includes:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and physical complications in all stages of the mastectomy, including lymph edemas.

These benefits are subject to annual plan deductibles and co-insurance provisions.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Your plan generally does not restrict the length of a hospital stay in connection with childbirth, as explained below. These federal rules apply to the mother and/or the newborn child.

- The mother's hospital stay in connection with childbirth generally cannot be less than 48 hours (vaginal delivery) or 96 hours (cesarean).
- The mother's and/or newborn's attending provider, after consulting with the mother, may discharge the mother and/or her newborn earlier than 48 hours (vaginal delivery) or 96 hours (cesarean).
- Your plan may not require your provider to obtain prior authorization for prescribing a length of stay not in excess of 48 hours (vaginal delivery) or 96 hours (cesarean).

These benefits are subject to annual plan deductibles and co-insurance provisions.

IBEW 125 - PGE
HEALTH & WELFARE TRUST

October 2026

Important Notice from IBEW 125 – PGE Health and Welfare Trust ("Trust") About Your Prescription Drug Coverage and Medicare (No action is required on your part)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the 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. **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).**

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. The Medicare Part D prescription drug program is ***NOT a benefit paid through plans sponsored by the Trust.***
2. The Trust has determined that the prescription drug coverage offered by Trust sponsored plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays 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.

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?

When you first become eligible for Medicare[1], you will have the option to independently enroll in a Medicare Part D prescription drug plan.

- You may keep your prescription drug coverage under a Trust sponsored plan and decline Medicare Part D. No action is required on your part.
- If you are considering enrollment in a Medicare Part D prescription drug plan, please contact the Trust Office to determine if whether obtaining Medicare Part D coverage may affect your Plan benefits.

[1] Your Medicare Initial Enrollment Period will be the month in which you become age 65, plus the preceding three months and the succeeding three months.

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

If you ever drop or lose your current coverage under a Trust sponsored plan, 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. In the unlikely event that Trust coverage becomes non-creditable, having this notice will allow you to immediately enroll in a Part D plan without having to pay a late enrollment penalty. 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 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 join.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Review your "Medicare & You" handbook mailed by Medicare. You may be contacted directly by Medicare drug plans.
- 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).

This notice is to inform you that your current prescription drug benefit program through a plan sponsored by Trust is "creditable coverage". If you lose this notice and need another copy, please call the Trust Office at (503) 224-5906, or request a copy in writing from BeneSys, Inc., PMB #116, 5331 S Macadam Avenue, Suite 258, Portland, OR 97239-3871.

CERTIFICATE OF CREDITABLE PERSCRIPTION DRUG COVERAGE

The Trust hereby certifies that the prescription drug coverage provided under Trust sponsored plans to Medicare-eligibles is expected to pay out, on average for all such participants, at least as much as the standard Part D coverage would pay in calendar year. It is designated as providing "creditable coverage", meaning that any participant who later enrolls in a Part D plan will not be charged a late enrollment penalty for the time you are enrolled in this Plan.

Date:	October 2026
Plan Sponsor:	IBEW 125 - PGE Health & Welfare Trust
Administrator:	BeneSys, Inc.
Address:	PMB 116, 5331 S Macadam Avenue, Suite 258
	Portland, OR 97239-3871
Telephone:	(503) 224-5906

Rev. 2026

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)