YOUR 2026 RATE SHEET CAN BE FOUND IN THE OPEN ENROLLMENT PACKET.

WHAT'S INSIDE

MESSAGE FROM THE BOARD OF TRUSTEES

Welcome to Open Enrollment for the IBEW/Western Utilities Health & Welfare Trust Fund (the Fund). Open Enrollment is your once-a-year opportunity to review the health care and financial protection programs available to you and your eligible dependents through the Fund and to make your benefit elections for coverage that will be effective January 1, 2026. This year's Open Enrollment period runs from **October 20 through October 31, 2025**.

Medical Plan Enrollment Options

- If you have never enrolled in benefits before and do not actively enroll in one of our medical plan options for 2026 benefits, you will automatically be defaulted into the Consumer Driven Health Plan (CDHP). There is no opt-out option. **NOTE:** Employees hired through the Union's hiring hall, casual, temporary, or leased employees who work at least 130 hours are eligible under ACA rules and may opt out of coverage altogether.
- If you enroll in the CDHP, and you are eligible, you will have a Health Savings Account (HSA) that will help you save money and manage your out-of-pocket costs by allowing you to pay for qualified medical expenses with pretax dollars, including expenses for dental and vision care. You may also open up a Limited Health Care Flexible Spending Account (LHCFSA) that may be used only for dental and vision expenses.
- If you do not actively enroll for 2026 benefits and you are currently enrolled in the Comprehensive Health Plan, Premium Health Plan, or Kaiser Health Plan, you will automatically be defaulted back into that plan option, with any dental and vision benefits (if previously elected) and life insurance.
- When you enroll, you may elect different tiers for dental and/or vision coverage for yourself and your dependents than you elect for medical coverage.
- The Fund will offer two health-related FSA options—the LHCFSA, which you may use for dental and/or vision expenses if you enroll in the CDHP, or the Health Care Flexible Spending Account (HCFSA) that you can use to pay medical, vision, dental, prescription drug, and other eligible health care expenses if you enrolled in the Comprehensive Health Plan or Premium Health Plan.
- Under each of the medical plan options, except the CDHP, the Plan will cover 100% of the cost of certain generic maintenance medications when they are purchased through mail order. To find out if a particular medication applies, contact Sav-Rx at **866-233-4239**.

You'll find information about other Plan provisions for 2026 in this ***Enrollment Guide***.

If you'd like to view the *Summary of Benefits and Coverage* (SBC), please visit ibew-west.com. All current documents are available there for your reference.

The 2026 Benefits Program

The Fund continues to offer a benefits program that allows you to choose from many plan options to meet your needs and those of your family. This ***Enrollment Guide*** provides a summary of the following Fund-sponsored benefits:

- **Health care coverage—**medical, prescription drug, dental and vision benefits for you and your family;
- **Wellness services**—smoking cessation assistance, health advocacy services, and an Employee Assistance Program (EAP) that offers you and your family confidential help to deal with a range of life's issues or disease management;
- **Flexible Spending Accounts—**providing you with an opportunity to realize tax advantages on eligible health care and dependent care expenses; and a
- **Financial protection plan—**offering you cost-effective life and accidental death and dismemberment insurance.

For more detailed information about your benefits, refer to the Summary Plan Description found online at **ibew-west.com**.

Changes Coming in 2026

- **As of January 1, 2026, we will no longer be offering the Premium Plus Health Plan.** If you are currently enrolled in the Premium Plus Health Plan, please select a new Plan during Open Enrollment. If you do not actively select a new Plan during Open Enrollment, you will be defaulted to the Premium Health Plan.
- **Starting January 1, 2026, Wellmark will be the Fund's new medical network and claims administrator.** *If you're currently in treatment, you may qualify to continue seeing your provider for a limited time.* Contact the administrative office for more details. You'll find more information on page 7.
- **There is a new Kaiser plan option** called the Kaiser Everyday Care Plan. For more information, please refer to page 8.
- **Doctor On Demand will serve as the new telemedicine providers.** Details can be found on page 8.
- **ComPsych will be the new employee assistance program (EAP).** More information is available on page 17.
- The IRS **maximum Health Care FSA** contribution is $3,400 for 2026. The IRS **maximum HSA contribution** for 2026 is $4,400 for a single and $8,750 for a family.
- Employee **basic life and AD&D insurance** allows 2 times coverage and will see a change in the maximum allowable amount, from $300,000 to $400,000. **Note:** Premiums will increase due to the higher coverage volume reflected in the updated plan.

Verification of Dependent Eligibility

Participants with newly eligible dependents must provide sufficient documentation verifying their status before they can be enrolled in health insurance benefits. If such documentation is not received by PacifiCorp within ten (10) days from the day you enroll your dependents, your dependent coverage will be terminated.

Required Documentation. The following documentation must be provided for your eligible enrolled dependent(s). Dependent name and Social Security number MUST match the individual's Social Security card. Please do not send original documents.

Proof of Spouse

- Copy of marriage certificate (if married within last 31 days, marriage certificate only); ***or***
- Copy of previous tax year's joint federal tax return if filing jointly (first page only).

Proof of Naturally Born, Legally Adopted, or Legal Guardianship

- Birth certificate showing the child's parent and date of birth; ***and/or***
- Court documentation listing the employee as the legal guardian or custodian for any dependent, including dependents who are adopted or in foster placement.

Proof of Stepchild

- Birth certificate showing your spouse as the child's parent, and date of birth.

Proof of Disabled Dependent

- If you have a dependent who is disabled, or mentally or physically handicapped, notify PacifiCorp Employee Benefits, and request the Statement of Dependent Eligibility form.

You may submit your dependent(s) eligibility documents by:

Dependent Document is uploaded to Benefitfocus enrollment system within 10 days of adding a dependent.

If your eligible dependents were previously enrolled in the Company plan, you will not need to provide ocumentation.

Monthly Employee Contributions for 2026 Health Care Coverage

It's important that you understand how the Fund's Plan options work and how your elections will affect your out-of-pocket costs. Please review this ***Enrollment Guide*** thoroughly with your family.

All our Plan options, except the Consumer Driven Health Plan (CDHP), require employee contributions. Your monthly contributions for the cost of medical (including prescription drug), dental, and/or vision coverage will depend on the health plan options that you elect and the coverage level you choose (i.e., You only, You + spouse, You + 1 child, You + children, or You + family). The percentage of pay formula that helps determine employee contributions may change from year to year. Your contributions are deducted from your paychecks in equal amounts throughout the year, on a pretax basis. Accompanying this ***Enrollment Guide*** are inserts that identify the premiums in effect for 2026, so that you have an idea of what your out-of-pocket costs will be, depending upon the health care options that you choose.

This ***Enrollment Guide*** explains the Fund's benefits program in detail and provides direction on what you need to do to enroll for coverage. Look for "Tips" at various points throughout this ***Enrollment Guide*** that will help you during the enrollment process and assist you with the decisions that you need to make. If you need any assistance, feel free to contact the Administrative Office.

Sincerely,
The Trustees

The Trustees are always assessing our benefits and the providers with whom we partner. The Plan offerings provided by the Fund may be changed at any time at the discretion of the Trustees.

You Can Enroll Online!

The amount that you must contribute per pay period toward the cost of your medical, dental, and/or vision benefits depends on the health plan options that you choose. Refer to the inserts in your Enrollment Kit for details.

WHO'S ELIGIBLE TO ENROLL?

Employees

You can participate in the Fund's benefits plan if you are an active member of IBEW Local 125 and you are actively employed. This includes all regular full-time and part-time employees of Local 125 who are scheduled to work 20 hours or more per week. It also includes those currently on long-term disability or eligible in accordance with the ACA 30-hour rule.

Dependents

Your dependents are eligible for coverage on the date you (the active employee) become eligible. Eligible dependents include your:

- Legal spouse, except when legally separated;
- Children (except for children under a legal guardianship), up to the end of the month in which they turn age 26 for medical, dental, vision, and life insurance;
- Children under a legal guardianship and under age 26 for medical, dental, vision, and life insurance, provided the child is a qualified tax dependent; and
- Disabled adult children (age 26 and older) who are unable to support themselves due to a physical and/or mental disability, if they were disabled before turning age 26. You must provide proof of your child's disability in order for coverage to continue after the child turns age 26.

If you are enrolling dependents for coverage, you need to provide their Social Security numbers. Their Social Security numbers are needed in order for the Plan to comply with federal Medicare coordination of benefits regulations. If you add any new dependents, you will be required to submit supporting documentation of dependent status. Contact Employee PacifiCorp Benefits or the Administrative Office for details.

Dependent Eligibility

Ineligible dependents receiving benefits are a major cause for concern with any Fund, especially with a self-funded Plan like ours. To pay for unauthorized health benefits, the Fund has to use assets meant to be allocated to all legally eligible participants and their family members. Those assets can only be replaced if the Fund discovers the unauthorized practice and receives reimbursement in full from the participant who is abusing the system.

You will be required to refund the Plan for these expenses paid in error, and your coverage may be terminated, or PacifiCorp may take disciplinary action. Under IRS rules, you will continue to be charged for coverage until the end of the year, but the dependent will not be covered if you fail to notify PacifiCorp Employee Benefits by completing the Change Form and returning it to them within 31 days of becoming an eligible dependent.

If you have questions about who is or is not an eligible dependent, call the Administrative Office at **855-617-2478**.

THE OPEN ENROLLMENT PROCESS

What Is Open Enrollment?

Open Enrollment is your first opportunity to review the benefits available during the upcoming year so that you can enroll in one of the Fund's Plan options.

This year's Open Enrollment runs from **October 20 through October 31, 2025**. Any elections or changes you make to your current benefits during this year's Open Enrollment will be in effect January 1 through December 31, 2026.

Instructions for online enrollment are on page 6. Take your time, and review the benefits that will be available in 2026 so that you and your family will be confident in your choices for the upcoming plan year.

Your Responsibility During Open Enrollment

- **Review the plan options with your family**—Review this ***Enrollment Guide*** thoroughly, and determine the level of coverage that will best fit your needs in 2026. Consider the type of expenses you anticipate in 2026. Will they be mostly preventive and routine? Or, based upon your and your family's health, is it more likely you will need more medical care?
- **Choose whom to enroll**—You can cover You only, You + spouse, You + 1 child, You + children, or You + family.
- **Provide the required dependent information**—You'll need to provide the Social Security numbers of any new dependents you are enrolling for coverage and supporting documentation for any new dependents you are adding, if they were not previously enrolled under the Company plan.
- **Take enrollment action if you:**
  - ✓ Are a new employee who wants to enroll and make your own elections
  - ✓ Are currently enrolled, but want to change your benefits or change dependent coverage in 2026
  - ✓ Want to open or direct money to a Flexible Spending Account (FSA) or HSA to use for 2026 expenses
  - ✓ If you are currently enrolled in the Premium Plus Plan, please note that it will end at the end of 2025.
- **Make your elections**—Refer to "How to Make Your Elections" on page 6, and then **complete your online enrollment by October 31, 2025.**
- **Select the coverage tier**—When enrolling in a medical, dental, and/or vision plan, you may elect the same tier of coverage for all the plans, or you may elect different tiers. In other words, if you elect "You only" coverage on a medical plan, you may also elect "You + family" coverage on the dental and/or vision plan.

If you decide not to take action—If you are not currently enrolled in a plan option offered by the Fund, you will automatically be defaulted into the Consumer Driven Health Plan (CDHP) (HSA Medical Plan) at no cost to you.

You MUST act if you want to:

- Change your benefit elections.
- Open a Flexible Spending Account (FSA) to use for 2026 expenses.
- Open a Health Savings Account (HSA) to use alongside the CDHP option for 2026.
- Contribute to an HSA account for 2026.

We recommend you review this ***Enrollment Guide*** to become familiar with the Fund's offerings for 2026.

If you are enrolling for the first time, you **MUST** do so by October 31, 2025, in order for the benefits you elect to be effective January 1, 2026. If you miss the deadline, you will not be able to enroll or make changes until next year's Open Enrollment, unless you have a midyear change in status. Refer to page 24 to learn more about midyear change-in-status events.

IMPORTANT REMINDER

COVERAGE ELECTIONS

Electing **family medical coverage** does not automatically extend to **dental and vision plans**.

To ensure that your dependents are covered under each Plan, you must **make a separate election** for dental and vision coverage.

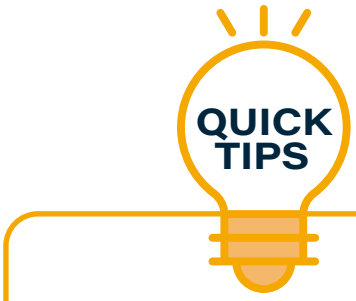
ACTION REQUIRED

During Open Enrollment, individually review and select the dependents you want covered for **medical, dental, and vision.**

HOW TO MAKE YOUR ELECTIONS FOR 2026

Easy Enrollment Through Benefitfocus

You will make all your 2026 Open Enrollment elections through the Benefitfocus portal or app by visiting **PacifiCorpActive.hrintouch.com**.



Try the app!

Download the Benefitplace app by Benefitfocus from Google Play or the Apple App Store. This will allow you to access your benefits from anywhere you have your smartphone after you have registered on the website.

Things to Do Before Enrollment Begins

Follow these steps to make sure you're ready to enroll. If enrolling a NEW dependent, have the dependent's verification documents ready, i.e., marriage certificate, tax form, child birth certificate, etc., so you can upload them during the enrollment process.

- **If you didn't register last Open Enrollment,** you will need to register before you can make any 2026 changes.
- **Register (using Google Chrome) directly on the Benefitfocus website at PacifiCorpActive.hrintouch.com.** Once you click **Create an account**, you will be asked to create a username and a password. Once you have established a username and password, follow the steps to complete your account setup.
- **If registered and you forgot your login**, click on the **Can't access your account** link under the login button

Things to Consider During the Enrollment Process

- Once you start enrolling, you will need to complete the whole process and **save your enrollment** at the end. **You must finish the process completely; otherwise, your elections will not be saved**, and you will need to re-enter everything.
- If you'd like to make changes to your initial elections, please make sure you do so **prior to the October 31, 2025, enrollment deadline**. If you are in the CDHP medical plan and you wish to contribute to your HSA for 2026, you must make this election in the system.
- **Add any new dependents before making your own elections.** Have their names, dates of birth, and Social Security numbers handy. If you are enrolling new dependents, you will need to upload into Benefitfocus your dependent verification documents. Make sure to have them ready to complete the process within 10 days of your enrollment, or their coverage will be denied.
- In the enrollment system, you will be asked to name your beneficiaries for your life insurance coverage. You will need their names, addresses, DOBs, and phone numbers.

Important!

Enroll at a time when you won't be interrupted. The system will time out after several minutes of inactivity, and your elections won't be saved.

When you have finished enrolling

Review the summary of your benefit elections (including dependents!), and print a copy for your records.

You will not receive a printed confirmation statement in the mail after enrollment. This can be found under the **Resource** tab at the top right of your Benefitfocus page. Make sure you confirm dependent coverage by Plan.

THE HEALTH PLANS

Your Medical Plan Options

Medical coverage is an important part of your IBEW/Western Utilities Health & Welfare Trust Fund benefits. The Fund offers you five health plan options from which to choose:

- The Consumer Driven Health Plan (CDHP)
- The Comprehensive Health Plan
- The Premium Health Plan
- The Kaiser Permanente Traditional Plan
- The Kaiser Permanente Everyday Care Plan

If you enroll in the CDHP, the Comprehensive Health Plan, or the Premium Health Plan, you will have access to the Wellmark provider network.

The Consumer Driven Health Plan

The CDHP is a high-deductible health plan that provides coverage for emergencies, inpatient and outpatient hospital services, major medical care, as well as chiropractic benefits, once you meet an annual deductible of $2,500 per person or $5,000 per family for in-network services and $5,000 per person or $10,000 per family for out-of-network services. While this plan option has a higher deductible than the other medical plan options, you are not required to pay a copay when you visit the doctor. Dental and vision coverage is offered to CDHP participants at full cost.

The CDHP includes a Health Savings Account (HSA) component, administered by HealthEquity. The HSA will help you save money and manage your out-of-pocket costs by allowing you to pay for qualified medical expenses with pretax dollars, including expenses for dental and vision care. You may also open up a Limited Health Care FSA (LHCFSA) that may be used only for dental and vision expenses. See page 20 for more information.

When you elect the CDHP medical plan you will need to complete the survey asking about your eligibility for the Trust HSA contribution and whether you may contribute. Funds out of your payroll check will get forwarded to BeneSys. BeneSys will validate that your HSA is open and then forward those funds to HealthEquity.

The Premium Health Plan

The Premium Health Plan provides coverage for emergencies, inpatient and outpatient hospital services, and major medical care, as well as chiropractic benefits. You are required to meet an annual deductible of $250 per person or $750 per family when you use network providers, and an annual deductible of $500 per person or $1,500 per family when you go out-of-network for care.

The Comprehensive Health Plan

The Comprehensive Health Plan also provides coverage for emergencies, inpatient and outpatient hospital services, and major medical care, as well as chiropractic benefits. However, you are required to meet an annual deductible of $300 per person or $900 per family when you use network providers, and an annual deductible of $600 per person or $1,800 per family when you go out-of-network for care. In addition, you will have to pay a higher copay when you receive care from a specialist or at an emergency room and when you purchase prescribed medications. The out-of-pocket limit for prescription drugs does not accumulate toward the $2,000 or $4,000 annual coinsurance maximum under the Comprehensive Plan. However, it does accumulate toward the TOTAL out-of-pocket limit on in-network cost sharing of $6,600 or $13,200.

Important:

You must meet certain eligibility requirements in order to qualify for the HSA. Refer to page 18 for more information about the HSA, including how to qualify.

If you do not actively enroll for 2026 benefits, you will be defaulted into the plan you were in for 2025.

As of January 1, 2026 we will no longer be offering the Premium Plus Health Plan.

If you are currently enrolled in the Premium Plus Health Plan please select a new plan during Open Enrollment. If you do not actively select a new plan during Open Enrollment you will be defaulted into the Premium Health Plan.

While each option offers access to a network consisting of doctors, hospitals, and ancillary care providers, there are important differences in the benefit coverage the Fund offers under each option.

THE HEALTH PLANS - CONTINUED

The Kaiser Permanente Traditional Plan

The Kaiser Permanente Traditional Plan is only available to Local 125 participants living in certain areas of Washington and Oregon. There is no annual deductible to meet, and, for most services, you will only have to pay a copay before the Plan begins to pay 100% of any eligible expenses. There is no out-of-network coverage, except for emergency and urgent care.

NEW: The Kaiser Permanente Everyday Care Plan

The Kaiser Permanente Everyday Care Plan is new. Most services are subject to copay, with no coinsurance minimizing the need for members to keep track of accumulations. The exception is for fertility services (office visits and lab tests) which are covered at 50% after the deductible. Very few services, such as inpatient hospital, outpatient surgery, and skilled nursing, are subject to the Plan deductible. Primary care, specialty care, urgent care, lab, and generic prescriptions are all offered at a $10 copay and not subject to the deductible.

The annual deductible is $4,000 individual or $8,000 family. The out-of-pocket maximum is $4,000 individual or $8,000 family.

Kaiser Permanente offers telehealth visits via phone, email, and video. They are free of charge and become a part of members' electronic medical records. Appointments may be scheduled by calling membership services at **800-813-2000**, or through **kp.org**. For more information, refer to the Kaiser Permanente flyer included in your enrollment kit.

TELEHEALTH

Doctor On Demand: Care When You Need It Most

Doctor On Demand provides 24/7 virtual access to board-certified physicians, licensed therapists, and psychiatrists for those enrolled in the Consumer Driven Health Plan (CDHP), the Comprehensive Health Plan or the Premium Health Plan. You can connect with a provider in minutes from your smartphone, tablet, or computer. Whether you're managing a cold, anxiety, or need a prescription refill, it's a fast, convenient, and confidential way to get care without leaving home.

Get Started

Visit **doctorondemand.com** or download the Doctor On Demand app. For support, call **800-997-6196**.

UNDERSTANDING THE FUND'S BENEFIT OPTIONS

How the Program Works

Wellmark's network is comprised of doctors, hospitals, ancillary service providers, and health care facilities that have agreed to provide quality services at discounted fees. **Network disruptions should be minimal with the switch to Wellmark.**

You can also find information about Wellmark's providers by logging in to Wellmark's secure member web site at **wellmark.com**.

When you or your eligible dependents receive medical treatment, most covered expenses will be paid according to a benefit formula, which will be used to assess the portion of the billed charges the Fund will pay and the amount, if any, that you and your eligible dependents will have to pay:

- **Copay**—This is a flat dollar amount that you and your eligible dependents will pay for prescription medications and certain services and supplies, such as doctor's office visits, before the Fund begins to pay benefits.
- **Deductible**—This is the amount you and your eligible dependents must pay each calendar year before the Fund begins to pay benefits. Services from in-network and out-of-network providers are combined to meet your annual deductible, and each of the plan options has both an individual per-person deductible and a family deductible. Once three people in a family reach their per-person deductible, no further deductibles are required of any family member for the rest of the calendar year.
- **Coinsurance**—This is how you, your eligible dependents, and the Fund will split the cost of certain covered medical expenses after the deductible is met. Coinsurance is generally expressed as a percentage of the charges that will be paid by you and/or the Fund.
- **Out-of-Pocket Limit**—The Fund limits how much you and your eligible dependents pay out of your pocket each year. All the plan options, except the CDHP, have two separate out-of-pocket limit provisions: one that identifies the maximum amount of coinsurance you and your eligible dependents are responsible to pay each calendar year, in addition to the deductible and copays, before the Fund pays more of your eligible claims; and another that identifies the maximum amount of deductibles, copays, and coinsurance you are responsible to pay each calendar year for in-network essential health benefits and prescription drug out-of-pocket amounts before the Fund pays the remainder of your eligible claims that year. Each out-of-pocket limit has an individual per-person and a family limit. If you are enrolled in the CDHP, when you reach the out-of-pocket limit, out-of-network services are paid at 100%. For all plan options, charges in excess of the allowable limits, and services or supplies not covered by the Plan, do not count toward the annual out-of-pocket limit.

Highlights of the Health Plans

The copays, deductibles, coinsurance, and out-of-pocket limits for each option are listed in the Schedule of Benefits on pages 12-14. You can also refer to the Fund's *Summary Plan Description* (SPD) available on the Fund's website at **ibew-west.com**.

Provider Search

Want to check whether your provider will remain in-network once the transition to Wellmark happens? Look no further!

Follow these steps to look up your provider without needing to log in to a member account:

1. Visit **wellmark.com**.
2. Choose **Find care** in the top navigation bar, and then select **Individual, family, and employer**.
3. Scroll down and select **Find a provider**.
4. In the pop-up on your screen, select **Continue to new site**.
5. Once taken to the new site, select **Choose a location and plan**.
6. After putting in your location, enter the following plan prefix: **BKG for Utah members or BKR for non-Utah members**.
7. You're all set. Happy searching!

Note: After the transition to Wellmark, you will be able to create a member account on the Wellmark site and app for easier access to a provider search and other resources.

Utilization Review

The Fund contracts with Wellmark to ensure that you and your eligible family members get the right care at the right time for the most cost-effective price. Wellmark performs precertification to determine whether certain services received are medically necessary; a concurrent or continued-stay review to make sure you get the most efficient care while you're in a hospital or other health care facility; and case management to help you follow the treatment plan your doctor has designed for you.

NOTE: Precertification indicating that a service or treatment is medically necessary does not indicate a guarantee of benefit payment.

Be sure your provider calls Wellmark at **800-640-7009** when the Plan requires you to precertify a service or treatment. This will help ensure that the medical care you receive is efficient and cost-effective.

PRESCRIPTION DRUG BENEFITS

The Fund's Prescription Drug Coverage

Prescription drug coverage can play an important role in your overall health and is included with any of the PPO plans offered by the Fund. Recognizing the importance of this coverage, the Fund has contracted with Sav-Rx to provide access to a national retail pharmacy network and a mail-order service that are easy, convenient, and can save you money on your medications.

The Sav-Rx Performance Formulary provides a reference list of safe, effective, high-quality, cost-effective medications. The Sav-Rx Performance Formulary is a list of commonly prescribed medications, which ranks drugs in terms of costs and therapeutic efficacy. It is recommended that you and your physician consider these medications for the best therapeutic outcome and lower out-of-pockets costs to you. Remember, with the Performance Formulary, a generic option within a therapeutic class will always be the most cost-effective.

The Retail Program

The Sav-Rx retail pharmacy network includes participating pharmacies throughout the United States, including national and regional chains and independent pharmacies. You can have your prescriptions for short-term medications—a 34-day supply—filled at any network retail pharmacy.

The program offers you discounted prices on your prescriptions when you go to a participating retail pharmacy and present your prescription drug ID card. Your level of coverage will depend on whether your prescription medication is a generic, preferred brand, or non-preferred brand, as shown in the Schedule of Benefits on pages 12 and 13. When you have your prescription filled at a participating pharmacy, you won't have to file a claim form to be reimbursed for prescription drug expenses. The Fund will automatically pay a percentage of the cost of the medication, after you have met the retail pharmacy annual deductible.

If you are enrolled in the CDHP and you do not have your prescription filled at a participating pharmacy, the Plan will not cover the cost of your prescription. You will be responsible for the full cost of your medication (perhaps by using the funds in your HSA). However, if you are enrolled in one of the other PPO plan options and you do not have your prescription filled at a participating pharmacy, you will have to pay the full cost of your prescription at the pharmacy and then submit a claim to Sav-Rx for reimbursement. You will be reimbursed 60% of the discounted cost of your medication, minus your copay.

Under each of the medical plan options, except the CDHP, the Plan will cover 100% of the cost of certain preventive and generic maintenance medications when they are purchased at network pharmacies or through mail order. To find out if a particular medication applies, contact Sav-Rx at **866-233-4239**.

If you are enrolled in the CDHP, the Plan will cover 100% of the cost of your preventive medication (generic and/or brand name) when it is purchased at either a Sav-Rx retail pharmacy or through the mail-order facility.

The Plan continues to cover 100% of the cost of vaccines for influenza (the flu) and shingles (check with your doctor to see if you are eligible age-wise!) when services are provided at a network pharmacy or by an in-network physician or provider.

The Mail-Order Program

You can have your prescriptions for maintenance medications—a 90-day supply—filled through mail order. The program is especially convenient for filling prescriptions for arthritis, high blood pressure, heart conditions, and diabetes, and for others that you take on a long-term basis. Your level of coverage will depend on whether your prescription medication is a generic, preferred brand, or non-preferred brand.

When you receive a new prescription, you should talk with your doctor about all the known side effects of the medication and ask if a generic is available and applicable for your care. Also, ask your doctor to first provide a prescription for a 34-day supply so that you can test-run the medication. If after two weeks of taking the medication you experience no ill side effects, you can switch to the mail-order program. See box below.

If you are close to finishing your 34-day supply and you and your doctor have determined that the medication is appropriate, ask your doctor for two prescriptions: a 90-day, refillable one and another 34-day prescription to hold you over until your 90-day supply arrives in the mail. Once you have your 90-day prescription from your doctor, you'll need to contact Sav-Rx at **866-233-4239**, or download a mail-order form online at **savrx.com**. Then follow the instructions. Your medication will arrive within a few days of Sav-Rx receiving your prescription.

All plan participants will enjoy the convenience of being able to purchase a 90-day supply of maintenance medications at most network retail pharmacies. You will pay 3 times the 34-day retail copay.

The Clinical Programs

The Fund offers clinical programs through Sav-Rx that help ensure you are taking your medications as directed by your doctor and that you are receiving the most cost-effective and medically appropriate treatment. Here are just a few of the programs:

- **Step Therapy Programs**—The Step Therapy Programs are designed to ensure that you take the most cost-effective medications to treat certain conditions. They promote the use of generic medications, because they are proven to be as safe and effective as brand-name medications for most patients but cost much less. In addition, under your prescription benefit, your copay is less when you purchase generics. The Step Therapy Programs group certain medications into steps. Generic medications, which are the most cost-effective, fall into the first-step category; preferred brand-name medications fall within the second-step category; and non-preferred brand-name medications, which are the least cost-effective, fall into the third-step category. The Step Therapy Programs steer members to take a first-step medication before taking a second-step medication, and to take a second-step medication before taking a third-step medication.
  - **The Expanded Step Therapy Program**—A pharmacist is required to get prior authorization before filling a new brand prescription for the following classifications:
    - Antidepressants (SSRI/SNRI)
    - Nasal sprays
    - Anti-inflammatory (COX-2 and NSAID)
    - Osteoporosis medications
    - ARB and combination antihypertensives
    - Sleep medications
    - Beta blockers
    - Statins for cholesterol
    - Glaucoma eye drops
    - Triptans for migraines
    - Lyrica
  - **The Proton Pump Inhibitor (PPI) Step Therapy Program**—PPIs slow the production of gastric acid by the stomach, which allows the inflamed and damaged lining in the esophagus and the stomach to heal. The Fund offers a PPI Step Therapy Program to ensure that these highly prescribed medications are being used in accordance with approved FDA guidelines. If you have any questions about the program, you can call Sav-Rx Prescription Services anytime at **866-233-4239**.
  - **The Non-Sedating Antihistamines (NSAHs) Step Therapy Program**—This program has safeguards to ensure you're getting the right medication at the best savings. Under the program, a pharmacist is required to get prior authorization before filling a prescription for certain medications that are used to treat allergy symptoms.
- **The Specialty Prescription Drug Program**—Specialty drugs are scientifically engineered medications used to treat complex diseases such as hemophilia, multiple sclerosis, rheumatoid arthritis, or hepatitis. These drugs often require special handling, are date-sensitive, and are usually available only in a 30-day supply. Through this program, you will receive educational materials about your drug therapy, and your medication will be sent to your home, caregiver, or doctor's office, as needed. For more information on this program, contact Sav-Rx at **866-233-4239**.
- **The Therapeutic Quantity Limitation Program**—This program is designed to promote appropriate medication use and enhance patient safety. Sav-Rx reviews the use of certain drugs, such as those used to treat migraines, arthritis, severe pain, asthma, and allergies.

Sav-Rx requires that you pay up front for any medications you receive through mail order. You can pay by check, money order, or with a credit card.

Purchasing a non-prescription over-the-counter (OTC) medication may cost you less than a doctor's visit and prescription drug copays.

Talk to your doctor about OTC medications and any others that he or she prescribes to ensure you take the right medicine and receive the best savings.

The Fund participates in the High Impact Advocacy Program, which manages the use of selected specialty medications to reduce or eliminate your out-of-pocket expense, as well as reducing the cost to the Fund. To continue receiving your medication at the most affordable cost, your prescription will be filled at the Sav-Rx Specialty Pharmacy. Sav-Rx will enroll you in a manufacturer-sponsored coupon program.

All specialty medications require prior approval, and most are limited to a 30-day supply. However, certain specialty agents, such as generic transplant and generic HIV medications, non-insulin diabetic injections and oral agents, chronic migraine agents, and injectable cholesterol-lowering agents, are eligible for 90-day supply fills.

If you are enrolled in the CDHP, the amount of the copay you will be required to pay for a specialty medication will depend on whether the medication is purchased at a retail pharmacy or through mail order.

SCHEDULE OF BENEFITS

Highlights of the plan options for 2026 are shown in the following chart. Take a moment to become familiar with how the Fund pays benefits and any copays and coinsurance you will incur under each plan option.

NOTE: All coinsurances are paid after deductible is met.

HEALTH PLAN	CONSUMER DRIVEN HEALTH PLAN		COMPREHENSIVE HEALTH PLAN	
Medical	**In-Network[1]**	**Out-of-Network**	**In-Network[1]**	**Out-of-Network**
Annual Deductible[2]	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$300 per person $900 per family	$600 per person $1,800 per family
Annual Out-of-Pocket Limits[3]	**Total Annual Out-of-Pocket Limit** $6,450 per person $12,900 per family	Emergency Services: accumulate to the in-network out-of-pocket limit. All other services: Unlimited	**Annual Out-of-Pocket Limit on Coinsurance Only** $2,000 per person $4,000 per family **Total Annual Out-of-Pocket Limit** $6,600 per person $13,200 per family	Unlimited
Lifetime Maximum	Unlimited for all plans			
Annual Maximum Benefit	Unlimited for all plans			
Doctor's Office Visits	Plan covers 80%	Plan covers 50%	$25 copay (primary care physician); $50 copay (specialist), then Plan covers 100%	Plan covers 50%
Urgent Care Facility Visits	Plan covers 80%	Plan covers 50%	$50 copay, then Plan covers 100%	Plan covers 50%
Emergency Room Visits	Accumulate to the in-network out-of-pocket limit; Plan covers 80%		$250 copay, then Plan covers 100%[4] (copay waived if admitted)	
In- or Outpatient Hospital Services (includes surgeon, laboratory, and X-ray)	Plan covers 80%	Plan covers 50%	Plan covers 90%	Plan covers 50%
Well-Adult (routine physical)	Plan covers 100%[4]	Plan covers 50%	Plan covers 100%[4]	Plan covers 50%
Well-Child Office Visits – birth through age 5 – ages 6 through 26 (1 visit per year)	Plan covers 100%[4] Plan covers 100%[4]	Plan covers 50%	Plan covers 100%[4] Plan covers 100%[4]	Plan covers 50% Plan covers 50%
Hearing Aids[5]	Plan covers 80%	Plan covers 50%	Plan covers 90%	Plan covers 50%
Chiropractic[5]	Plan covers 80%, $500 max per year	Plan covers 50%, $500 max per year	Plan covers 90%, $500 max per year	Plan covers 50%, $500 max per year
PRESCRIPTION DRUG BENEFITS				
Annual Deductible	Included in medical deductible	Not covered	$75 per person, $150 per family	
Annual Out-of-Pocket Limit[6]	Included in medical out-of-pocket limit		None	
Retail[7] *a 34-day supply* **NOTE:** Participants can purchase a 90-day supply of maintenance medications at all network retail pharmacies. You will pay 3 times the 34-day retail copay.	**Generic:** Plan covers 90% (min $5) **Preferred Brand:** Plan covers 80% (min $10)[8] **Non-Preferred Brand:** Plan covers 80% (min $10)[8]	Not covered	**Generic:** Plan covers 90% (min $10, max $25) **Preferred Brand:** Plan covers 80% (min $20, max $50)[8] **Non-Preferred Brand:** Plan covers 50% (min $50, no max)[8]	Plan covers 60% of discounted cost of drug
Mail Order[9] *up to a 90-day supply* ▪ Specialty Drug Program – up to a 30-day supply. Subject to prior authorization.	**Generic:** You pay $10 copay **Preferred Brand:** You pay $20 copay[8] **Non-Preferred Brand:** You pay $40 copay[8]	Not covered	**Generic:** You pay $10 copay **Preferred Brand:** You pay $50 copay[8] **Non-Preferred Brand:** You pay $100 copay[8]	Not covered

[1] If you reside outside the network service area, eligible charges may be paid at the in-network level of benefits, after any applicable deductibles have been met.

[2] All services listed are subject to the deductible, unless otherwise noted.

[3] When you use network providers, the Plan's coverage will increase to 100% of eligible expenses for the rest of the year, once your out-of-pocket expenses for the year reach the total annual in-network annual out-of-pocket limit amount shown.

SCHEDULE OF BENEFITS - CONTINUED

NOTE: All coinsurances are paid after deductible is met.

HEALTH PLAN	PREMIUM HEALTH PLAN	
Medical	**In-Network[1]**	**Out-of-Network**
Annual Deductible[2]	$250 per person $750 per family	$500 per person $1,500 per family
Annual Out-of-Pocket Limits[3]	**Annual Out-of-Pocket Limit on Coinsurance Only** $1,000 per person $2,000 per family **Total Annual Out-of-Pocket Limit** $6,600 per person $13,200 per family	Unlimited
Lifetime Maximum	Unlimited for all plans	
Annual Maximum Benefit	Unlimited for all plans	
Doctor's Office Visits	$20 copay, then Plan covers 100%	Plan covers 75%
Urgent Care Facility Visits	$50 copay, then Plan covers 100%	Plan covers 50%
Emergency Room Visits	$100 copay, then Plan covers 100%[4] (copay waived if admitted)	
In- or Outpatient Hospital Services (includes surgeon, laboratory, and X-ray)	Plan covers 90%	Plan covers 50%
Well-Adult (routine physical)	Plan covers 100%[4]	Plan covers 50%
Well-Child Office Visits – birth through age 5 – ages 6 through 26 (1 visit per year)	 Plan covers 100%[4] Plan covers 100%[4]	 Plan covers 50% Plan covers 50%
Hearing Aids[5]	Plan covers 90%	Plan covers 50%
Chiropractic[5]	Plan covers 90%, $500 max per year	Plan covers 50%, $500 max per year
PRESCRIPTION DRUG BENEFITS		
Annual Deductible	$75 per person, $150 per family	
Annual Out-of-Pocket Limit[6]	$1,000 per person, $2,000 per family	
Retail[7] *a 34-day supply* **NOTE:** Participants can purchase a 90-day supply of maintenance medications at all network retail pharmacies. You will pay 3 times the 34-day retail copay.	**Generic:** Plan covers 90% (min $5) **Preferred Brand:** Plan covers 80% (min $10)[8] **Non-Preferred Brand:** Plan covers 80% (min $10)[8]	Plan covers 60% of discounted cost of drug
Mail Order[9] *up to a 90-day supply* ▪ Specialty Drug Program – up to a 30-day supply. Subject to prior authorization.	**Generic:** You pay $10 copay **Preferred Brand:** You pay $20 copay[8] **Non-Preferred Brand:** You pay $40 copay[8]	Not covered

[4] Deductible does not apply.
[5] See the Plan Document for details.
[6] This is a separate maximum and in addition to the medical plan out-of-pocket limit, except for the CDHP.
[7] A minimum copay for generic and brand-name drugs applies to the retail prescription drug benefit. Your cost will be the greater of this minimum or the Plan's regular coinsurance rate after the deductible is satisfied.
[8] You also pay the difference in cost between the brand and generic drug, if you choose a brand-name drug when a generic drug is available, and the difference in cost, if you choose a non-preferred brand when preferred brand drug is available.
[9] There is no charge for generic drugs used for maintenance purposes when purchased through the mail-order service. For a list of drugs that are considered maintenance drugs, contact the prescription drug program.

SCHEDULE OF BENEFITS

Highlights of the Kaiser Permanente Traditional Plan and Everyday Care Plan for 2026 are shown in the following chart. Take a moment to become familiar with how the Fund pays benefits and any copays and coinsurance you will incur if you elect one of these HMO plan options.

KAISER PERMANENTE PLANS		
MEDICAL	**Traditional Plan**	**Everyday Care Plan**
Annual Deductible	None	$4,000 single / $8,000 family
Annual Out-of-Pocket Limit[1]	$750 per person, $1,500 per family	$4,000 single / $8,000 family
Office Visits		
Primary Care	$5 for first 3 visits; then $20 for additional visits in the same year	$5 for first 3 visits; then $10 for additional visits in the same year
Prenatal Care Exams	Plan covers 100%	Plan covers 100%
Preventive Care for Infants Under Age 2	Plan covers 100%	Plan covers 100%
Preventive Care for Age 2 to Adult	$20 copay, then Plan covers 100%	Plan covers 100%
Specialist	$20 copay, then Plan covers 100%	$10 copay
Urgent Care	$40 copay, then Plan covers 100%	$10 copay
Ambulance	$100 copay, then Plan covers 100%	$500 per transport
Labs	Plan covers 100%	$10 per department visit
X-Ray, imaging, and special diagnostic procedures	Plan covers 100%	$50 per department visit
CT, MRI, PET scans:	$100 per department visit	$500 per department visit
Emergency Room Medical Services	$250 copay (waived if admitted to hospital), then Plan covers 100% minus any supplemental charges	$500 (waived if admitted)
Primary Care	$5 for first 3 visits; then $20 for additional visits in the same year	$5 for first 3 visits; then $10 for additional visits in the same year
Naturopathic Medicine	$5 for first 3 visits; then $20 for additional visits in the same year	$5 for first 3 visits; then $10 for additional visits in the same year
Behavioral Health Services		
Mental Health	$5 for first 3 visits; then $20 for additional visits in the same year	$5 for first 3 visits; then $10 for additional visits in the same year
Substance Use Disorder	$5 for first 3 visits; then $20 for additional visits in the same year	$5 for first 3 visits; then $10 for additional visits in the same year
Hospital Services		
Inpatient	$100 copay per admission, then Plan covers 100%	$0 after deductible
Outpatient	$20 copay, then Plan covers 100%	$0 after deductible
Hearing Aids	One aid per ear every 3 years, $500 maximum per ear (for individuals 26 years old and up) One aid per ear every 3 years, (for individuals under 26 years old)	One aid per ear every 3 years (for individuals under 26 years old)
Durable Medical Equipment	Plan covers 80%	$0 after Deductible
PRESCRIPTION DRUG BENEFITS		
Retail: 30-day supply	$10 copay for generic $20 copay for preferred brand $20 copay for non-preferred brand $20 copay for specialty	$10 copay for generic $50 copay for preferred brand $125 copay for non-preferred brand $250 copay for specialty
Mail Order: 90-day supply	$20 copay for generic $40 copay for preferred brand $40 copay for non-preferred brand	$20 copay for generic $100 copay for preferred brand $250 copay for non-preferred brand

[1]The annual limit does not include expenses for hearing aids. Prescription drug expenses do contribute to the out-of-pocket maximum. Refer to Kaiser Permanente's documents for more information. If any information in this chart differs from Kaiser Permanente's documents, Kaiser Permanente's documents will govern.

DENTAL AND VISION BENEFITS

Dental Benefits

If you enroll in the Consumer Driven Health Plan (CDHP), Comprehensive Health Plan or the Premium Health Plan, you can elect dental coverage through the program offered by the Fund that is administered by Delta Dental.

Dental benefits help you pay for dental care—whether it's your biannual exam and cleaning or braces for your teenager. The Fund will pay up to $2,000 per person per year in eligible dental expenses and $2,000 per person per lifetime for orthodontia. Most dental benefits have an annual deductible of $50 per person or $150 per family. Refer to the following chart for details.

Delta Dental offers two provider networks—PPO and Premier. You can see any dental provider, but when you go to a Delta Dental PPO provider, you'll receive the highest level of benefits. If you reside more than 25 miles outside the Delta Dental PPO and Premier network area, you can see any provider, and eligible charges will be paid at the Premier network level of benefits, after any applicable deductibles have been met.

If you currently receive coverage for dental and vision care and you do not enroll, you will automatically receive the same coverage in 2026.

Dental coverage is offered to participants enrolled in the CDHP at 50% of full cost.

DENTAL BENEFITS			
Annual Deductible	$50 per person, $150 per family		
Dental Benefit Maximums	$2,000 per person per calendar year; $2,000 lifetime maximum for orthodontia		
Trust Fund Pays:	**Delta Dental PPO**	**Delta Dental Premier**	**Non-Delta Dental Provider**
Oral Exam (3 per calendar year)	100%	100%	70%
Diagnostic or Preventive (deductible does not apply)	100%	100%	70%
Basic Services	90%	80%	50%
Restorative Services	90%	80%	50%
Denture Repairs	90%	80%	50%
Crowns, Jacket, and Cast Restoration	60%	50%	30%
Prosthodontic Services	60%	50%	30%

Vision Benefits

If you elect medical coverage under the Consumer Driven Health Plan (CDHP), Comprehensive Health Plan, Premium Health Plan, or Kaiser Health Plan, you can elect VSP vision coverage, the vision carrier offered by the Fund. The vision benefits include exams and hardware. The hardware (eyeglasses or contact lenses, in lieu of glasses) is covered in full, up to plan limitations every calendar year. You'll receive the best coverage when you go to an in-network provider. To find an in-network VSP provider, register on **vsp.com**, and make an appointment directly with that provider.

VISION BENEFITS	
Eye Exam	$0 copay, Plan covers 100% every calendar year
Single-Vision Lenses	$0 copay, Plan covers 100% every calendar year
Lined Bifocal Lenses	$0 copay, Plan covers 100% every calendar year
Lined Trifocal Lenses	$0 copay, Plan covers 100% every calendar year
Lenticular Lenses	$0 copay, Plan covers 100% every calendar year
Contact Lenses	$60 fitting fee, then Plan covers up to $250 every calendar year
Frames	$0 copay, Plan covers 100% up to $250 every calendar year

IMPORTANT: The $250 allowance may be used for either frames or contact lenses, but **NOT BOTH**.

WELLNESS BENEFITS

Preventive Benefits That Could Save Your Life

It's good to know there are simple medical procedures that can detect certain cancers early enough to possibly prevent the spread of the disease—and that an immunization can prevent an illness from even occurring. *You can have such preventive procedures performed for FREE.* Your Plan covers preventive or wellness benefits like physical exams, immunizations, influenza and shingles vaccines, mammograms, Pap smears, prostate blood tests, and colonoscopies at 100% when a Wellmark network provider performs the service. No copay or deductible applies.

Smoking Cessation Benefit

Regardless of the plan option you elect, the Fund covers the cost of tobacco cessation products, like nicotine gums and patches, and offers other services or programs designed to help you stop smoking or using tobacco products. This drug benefit is not available through the mail-order program.

QUICK TIPS

The pharmacist must be provided with a written prescription from your doctor in order for the Fund to cover any OTC or prescribed tobacco cessation product.

QUICK TIPS

We recommend that you take advantage of the preventive benefits offered by your Plan. It could mean the difference between life and death.

For Women:

Mammograms are used to check for breast cancer, even before there are any signs or symptoms. According to the National Cancer Institute, random clinical trials and other studies show that screening mammography can help reduce the number of deaths from breast cancer among women ages 40 to 70, and especially for those over age 50.

For Men:

Prostate-specific antigen (PSA) blood tests are performed to check for prostate cancer. PSAs are also used to monitor prostate cancer during and after treatment.

THE EMPLOYEE ASSISTANCE PROGRAM

Our Employee Assistance Program (EAP) or EAP is called **GuidanceResources®** and is administered by ComPsych. **All employees and their household members have automatic access to confidential support, available 24/7, whenever and wherever they need it.** With ComPsych, you and your household members can speak with a GuidanceConsultant to help you with a range of life's issues.

What GuidanceResources Offers:

Confidential Counseling

- Anxiety, depression, stress
- Grief, loss, life adjustments
- Relationship or marital conflicts

Work and Lifestyle Support

- Child, elder, and pet care
- Moving and relocation
- Shelters, government assistance

Legal Guidance

- Divorce, adoption, family law
- Wills, trusts, estate planning
- Free consultation and discounted local representation

Financial Resources

- Financial planning, retirement, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy

Digital Tools and Support

- Immediate connection to counseling, work-life support, and more
- Personalized guided behavioral health and well-being programs
- Interactive articles, videos, on-demand trainings, digital self-care tools
- Accessible resources for anxiety, stress, mindfulness, sleep, and more

How to Access Services

GuidanceResources is available 24/7, online or by phone.
All assistance is confidential.

- Phone: **855-206-4843**
- Website: **guidanceresources.com**
  WebID: **IBEWEAP**

EAP / Behavioral Health / Substance Abuse – Schedule of Benefits[1]

	CONSUMER DRIVEN HEALTH PLAN		COMPREHENSIVE HEALTH PLAN		PREMIUM HEALTH PLAN	
EAP Services						
Plan covers 100% (up to 8 free counseling visits per person per issue or unlimited telephonic sessions)						
Behavioral Health and Substance Abuse Services						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient[1]	Plan covers 80%[2]	Plan covers 50%[2]	Plan covers 90%[2]	Plan covers 50%[2]	Plan covers 90%[2]	Plan covers 50%[2]
Outpatient	Plan covers 80%[2]	Plan covers 50%[2]	$25 copay per visit, then Plan covers 100%	Plan covers 50%[2]	$20 copay per visit, then Plan covers 100%	Plan covers 50%[2]

[1] You must get pre-authorization from Wellmark before the Plan will pay benefits.
[2] Subject to the deductible

THE HEALTH SAVINGS ACCOUNT

How the HSA Works

If you enroll in the CDHP, a Health Savings Account (HSA) is opened for you after you take the survey and confirm you are eligible. The HSA is a tax-free savings account that is funded by pretax payroll contributions from you and the Trust Fund. The Trust Fund will contribute $750 per person or $1,500 per family each year to your HSA up front, regardless of the coverage level you choose. In addition, since you own the HSA, you can decide to contribute as well, up to the permitted annual IRS limit in 2026 of $4,400 per individual and $8,750 per family. Payroll can automatically deduct funds from your paycheck in equal amounts on a pretax basis over a 12-month period and send them to the Trust. You can also make contributions directly to HealthEquity online at **myhealthequity.com**, or you can mail your contributions directly to HealthEquity, or you can make contributions manually online by linking your personal checking account to the HSA, then requesting funds be pulled from your checking account into the HSA. If a participant makes contributions outside of the payroll contributions they need to adjust the payroll contribution so that they do not exceed IRS maximums. This includes if you are in the company Plan versus the Trust Plan.

- Contributions are posted to your HSA within 4 to 5 days after they are received from your payroll check.
- If you are over age 55, you can also set aside an additional $1,000 as a catch-up contribution in addition to the annual IRS limit.
- Your HSA—including all the money you and the Fund contribute—is yours. If you don't spend it, and you won't lose it if you change jobs, retire, or leave the health plan as it is your HSA bank account.
- Your HSA contribution will NOT automatically continue into 2026 unless you reenroll during Open Enrollment.
- You may be able to use the money in your HSA—which you would have otherwise used to pay for higher health insurance premiums—to pay for qualified medical expenses like deductibles, prescription drug copays, coinsurance, certain uncovered health care expenses, and many over-the-counter medicines and supplies if you have a prescription from your doctor.
- You may be able to use the money in your HSA to invest in mutual funds that are available through HealthEquity. To invest in mutual funds, your HSA balance must meet a minimum threshold.
- You never pay taxes on withdrawals for qualified medical expenses.
- Your money earns interest, and you don't pay taxes on the interest earned.
- Your payroll contributions are tax-free and reduce your overall taxable income.
- Your HSA funds may be used by you, your spouse, and your dependent children, if applicable..

Available Customer Service Support and Online Tools

HealthEquity provides 24/7 support for members through its Member Services hotline, **866-346-5800**, and its website, **myhealthequity.com**. The website provides access to a wide range of decision-support resources, including a plan comparison tool that allows you to compare the CDHP option to the other options being provided by the Fund.

Also, if you elect the CDHP, when you log on to the website, you can:

- Make one-time or recurring post-tax individual contributions;
- Make claim payments to providers or reimburse yourself for out-of-pocket expenses;
- Access monthly statements and annual tax forms; and
- Manage investments online by adding and/or removing funds from your portfolio and executing trades.

You can also request a free HealthEquity® Visa® Health Account debit card via Member Services (phone, online, or email) for your use in managing your HSA account, and HealthEquity provides a series of training videos and printed educational materials for viewing and download from its website.

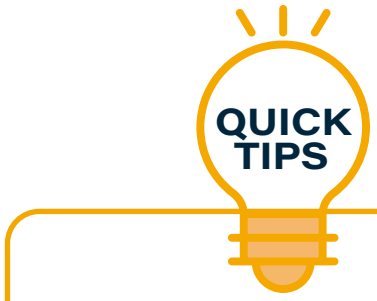
How to Qualify for the HSA

To qualify for the HSA, you:

- Must be enrolled in the CDHP.
- Can't be covered under other health insurance such as Medicare, or receive medical benefits from the Department of Veterans Affairs (VA) or the Indian Health Service (IHS). However, you can have HSA contributions, as long as you have not received care from IHS or the VA in the prior three months.
- Can't be covered through another group health plan under a non-high-deductible health plan (e.g., one offered by your spouse's employer).
- Can't be claimed as a dependent on someone else's taxes.

If an HSA is opened for you, you may still open a DCFSA and/or an LHCFSA. **NOTE:** Funds in your LHCFSA can only be used for reimbursement of eligible dental and vision expenses (refer to page 20 for more information on the LHCFSA).

NOTE: When you enroll in Benefitfocus, you will be asked to complete a survey relating to your eligibility to receive an IBEW Trust HSA contribution and your eligibility to contribute.



Important: In 2026, the Trust's and your HSA contributions combined cannot exceed the IRS maximum contribution amount of $4,400 if you enroll in Individual coverage or $8,750 if you enroll in Family coverage.

- How much will I pay out of my paycheck for each plan?
- What is the deductible for each plan type?
- What is the out-of-pocket limit for each plan?
- How much will I want to contribute to my HSA?
- How much will I spend on health care in 2026?
- What are my out-of-pocket costs for each plan type?
- Am I in a financial position to pay the annual deductible amount under the CDHP if my family or I have large medical expenses in 2026?
- Are my medical expenses generally limited to preventive care?
- Can I make additional voluntary contributions to an HSA so that funds can accumulate for future health care expenses?

The Trust Fund has selected HealthEquity to administer your HSA. If you have any questions about the HSA, you can contact HealthEquity 24/7 via its toll-free hotline, **866-346-5800**, or visit its website at **myhealthequity.com**.

Turning 65? Are you a veteran? Or Native American?

As soon as you become covered by other health insurance such as Medicare, or receive benefits from the Department of Veterans Affairs (VA) or the Indian Health Service (IHS), you generally cannot have contributions made to the HSA by the Trust Fund or yourself.

If you wish to make a change to your personal HSA contribution during the year, you need to log in to Benefitfocus and make your election change with their system four days before a payroll cycle. Otherwise, the change will be effective on the following pay cycle.

You will be responsible for ensuring that you do not exceed the HSA calendar-year IRS limits. The Trust is not aware of whether you made personal post-tax contributions or transferred from another plan, including other company plans outside of the Trust groups. These additional premiums are not accumulated within the limits, and you may find that your HSA is overfunded for 2026. If that happens, you will need to take action and withdraw the funds from HealthEquity before it becomes a taxable event and subject to a 10% tax penalty. If your W2 has been issued, a correction cannot be made. Make sure you are managing your HSA limits, and do not exceed those limits each year.

FLEXIBLE SPENDING ACCOUNTS

What Is a Flexible Spending Account (FSA)?

An FSA is an account you set up and contribute to through payroll deductions before taxes are calculated. You then use the funds in the account to get reimbursed for eligible health and dependent care expenses you initially paid for out of your own pocket; this lowers your taxable income and boosts your spending power. When you have an eligible expense, you file a claim, and you are reimbursed from your account with ***tax-free*** dollars.

Types of FSAs Available

The Fund offers three types of FSAs: a Health Care FSA (HCFSA), a Dependent Care FSA (DCFSA), and a Limited Health Care FSA (LHCFSA), which covers only dental and vision benefits.

A **Health Care FSA** is a special account you put money into that you use to pay for certain out-of-pocket health care costs. You don't pay taxes on this money. This means you'll save an amount equal to the taxes you would have paid on the money you set aside.

A **Dependent Care FSA** is an account used to pay for eligible dependent care services, such as preschool, summer day camp, before- or after-school programs, and child or adult day care. It's a smart, simple way to save money while taking care of your loved ones so that you can continue to work.

A **Limited Health Care FSA** is used in place of the general purpose Health Care FSA if the participant is enrolled in the CDHP with a Health Savings Account (HSA). The LHCFSA allows you to submit **eligible dental and vision expenses only**.

If you enroll in the Comprehensive Health or Premium Health plan, you may enroll in the HCFSA and/or the DCFSA.

If you enroll in the Consumer Driven Health Plan (CDHP) with HSA, you may enroll in the DCFSA and/or the LHCFSA, which covers only dental and vision benefits.

NOTE: The LHCFSA works the same way as the HCFSA, except that you can only submit claims for eligible dental and vision expenses, and you cannot have coverage under any other health plan or health insurer.

You may not enroll in the HCFSA if you are enrolled in the CDHP.

This year, the maximum amount you can contribute to the HCFSA or to the LHCFSA is $3,400.

The maximum amount you can contribute to the DCFSA is $7,500 per household ($3,750 if you are married and file a separate tax return). **Note:** The DCFSA has certain qualification rules. If you have any questions about the DCFSA, you should contact the Administrative Office.

How FSAs Work

To participate, you must enroll for an FSA each year. You must reenroll for 2026.

You'll be able to pay for eligible health care and dependent care expenses directly at the time of purchase by using the Benny™ Card, which will act like a bank debit card, except that it will be linked to your FSA. When you incur an eligible expense, you'll simply use the Benny Card to pay for it, and the merchant or health care provider will automatically be paid from your HCFSA. All merchants and medical providers who accept Mastercard should accept the Benny Card, including physicians, pharmacies, dental providers, vision providers, hospitals, discount stores, department stores, and supermarkets. If a merchant does not accept Mastercard, you'll have to pay for your products and services up front and submit a claim to the Administrative Office for reimbursement. **When using your LHCFSA or DCFSA you will need to fill out a paper reimbursement form.**

When you file a claim, you will be reimbursed differently under an HCFSA than you will under a DCFSA. With the HCFSA, the amount you elect for the year is available to you at any time during the year. With the DCFSA, you can only be reimbursed up to the amount you have in the DCFSA account as of the date of your claim.

Medications require a prescription in order to be eligible for reimbursement from an HCFSA.

You can use the funds in your HCFSA as reimbursement for over-the-counter (OTC) drugs and medicines that you purchase, like cough syrups, antacids, pain relievers, cough, cold and flu remedies, and smoking deterrents. However, you will need to have a doctor's prescription, an adequate receipt, and a completed claim form before OTCs qualify as an eligible expense.

Here are some of the OTC categories that may need a doctor's prescription:

- Acid controllers
- Allergy and sinus
- Antibiotic products
- Anti-diarrheals
- Anti-gas
- Anti-itch and insect bite
- Anti-parasitic treatments
- Baby rash
- Ointments or creams
- Cold sore remedies
- Cough, cold, and flu
- Digestive aids
- Feminine
- Anti-fungal or anti-itch
- Hemorrhoid preps
- Laxatives
- Motion sickness
- Pain relief
- Respiratory treatments
- Sleep aids and sedatives
- Stomach remedies

Contact the Administrative Office if you have any questions about what currently qualifies as an eligible FSA expense.

Determining the Amount You Want to Contribute to Your FSA

You will need to determine the amount you want to contribute to your FSA, up to $3,400 for the HCFSA or LHCFSA, and up to $7,500 per household for the DCFSA ($3,750 if you are married and file a separate tax return). It's up to you to estimate how much you expect to pay for eligible expenses in 2026. Make sure that an expected expense is eligible before you elect your contribution to an FSA. If you open a 2026 FSA, you will have until March 15, 2027, to incur any eligible expenses, and you will have 90 days after the end of the year (until March 31, 2027) to submit eligible claims for reimbursement. **Any money left in your account thereafter will be forfeited.**

Use the worksheet provided below to assist you in determining your usual annual expenses. Do not include insurance premiums. Be careful not to round the numbers up. Remember, certain OTC drugs are eligible for HCFSA reimbursement only with a doctor's prescription.

WORKSHEET: ESTIMATE YOUR FSA EXPENSES FOR 2026 HEALTH CARE			
HCFSA		**DCFSA**	
Deductibles or Copays	$	Child Care Expenses	$
Prescription Drugs	$	Elder Care Expenses	$
Shots, Allergy Tests	$	Other Eligible Expenses	$
Qualified OTC Drugs	$		
Glasses, Contact Lenses, etc.	$		
Hearing Aids and Batteries	$		
Dental Expenses	$		
Vision Expenses	$		
Other Eligible Expenses	$		
Total per Year*	**$**	**Total per Year***	**$**

* Enter this amount in the Flexible Spending Accounts section of the enrollment form.

The PacifiCorp Employee Benefits Department will divide your annual totals by 48 to determine your per-pay-period contribution. Use the following if you want to know what your per-pay-period amounts will be.

HCFSA / LHCFSA* of $_____ ÷ 48 = $ _____

DCFSA** Total of $_____ ÷ 48 = $ _____

* The LHCFSA may only be used for eligible dental and vision expenses.
** Dependent care includes child care and elder care.

FSAs are an excellent tax-saving method to pay for many of your out-of-pocket dependent care expenses and health care expenses.

If you wish to participate in one or both of the FSAs for 2026, you must enroll online by October 31, 2025.

LIFE AND AD&D INSURANCE

Life Insurance

The Fund has contracted with New York Life for the provision of life insurance coverage. As an employee, you are offered basic life and accidental death and dismemberment (AD&D), and supplemental life insurance for yourself. You can only purchase basic life insurance with AD&D for your spouse and basic life insurance for your dependent child(ren) if you elect basic life insurance for yourself.

You have a guaranteed issue during this initial enrollment for coverage closest to your previous coverage. If you want to elect a higher level of coverage, you must complete evidence of insurability as required by New York Life.

Basic Life and AD&D Insurance

- **For Active Employees.** The basic life insurance benefit for active members offers an amount equal to 2 times your base annual earnings. If you elected not to enroll in previous years and wish to enroll during this year's Open Enrollment, you will need to provide New York Life Insurance with evidence of insurability (proof of good health). PacifiCorp pays 50% of the cost for basic life and AD&D insurance, and you pay 50%. With your employee basic life insurance, you automatically receive basic AD&D coverage. Basic AD&D insurance gives you a benefit in the event of accidental death or certain dismemberment from an accidental injury. The severity of the loss determines the benefit amount paid. In the event you die from an accident, your beneficiary would receive your basic life benefit of 2 times your base annual earnings, plus the basic AD&D benefit of 2 times your base annual earnings, for a total of 4 times your base annual earnings. With the loss of use of one hand or foot, or sight in one eye, you get one-half the basic AD&D benefit. If you lose sight in both eyes, both hands or both feet, a hand and a foot, a hand and sight in one eye, or a foot and sight in one eye, you will receive the full basic AD&D benefit of 2 times your base annual earnings.
- **For Your Spouse.** You can purchase basic life insurance with AD&D for your spouse. You are automatically the beneficiary for this benefit. The coverage amounts available for your spouse are (1) $30,000/$30,000 AD&D, (2) 1 times/1 times AD&D or (3) 2 times/2 times AD&D your base annual earnings. If you increase spouse coverage for 2026, you are required to provide evidence of insurability. If required, you will receive a form in the mail.
- **For Your Dependent Child(ren) to Age 26.** The life insurance benefit for dependent children is $15,000 per eligible child. No matter how many children you cover, you pay $1.02 per month for this coverage. You may have insurance coverage for dependent children up to age 26. You are automatically the beneficiary for this benefit.

The amount you pay for supplemental life and AD&D insurance is based on age and how much coverage you elect. Carefully calculate the amount of coverage you want; then on your enrollment form, check the box that indicates that level of coverage.

When deciding how much insurance you need, consider what your family would need financially in the event you are no longer able to work.

If you go on long-term disability, the AD&D insurance is removed from your coverage. Your premium will be adjusted to exclude the AD&D coverage and premium while on LTD.

Any increase during Open Enrollment is subject to evidence of insurability.

Supplemental Life and AD&D Insurance

For Employees Only

If you want more life and AD&D insurance coverage than what your basic life benefit provides, you have the option of purchasing additional life and AD&D insurance. The supplemental and AD&D insurance benefit is provided by New York Life.

Supplemental insurance allows you to increase your life and AD&D insurance coverage by 1, 2, 3, or 4 times your base annual earnings. When you combine this with the basic coverage, you can get a total of 3, 4, 5, or 6 times your base annual earnings. For new enrollments or to increase your supplemental life and AD&D insurance amount, you must provide evidence of insurability. When you make your election in Benefitfocus, a pop-up screen will prompt you if you need to complete an evidence of insurability form. You need to click on the link, print out the form, complete it, and mail it to New York Life. This is the only notice you will receive to take action. Your request will be cancelled if approval is not received from New York Life before January 1.

Basic life with AD&D and supplemental life insurance with AD&D have certain limitations that you should be aware of and that are explained in the Summary Plan Description. You can also call the Administrative Office for more information.

ADDING UP YOUR LIFE AND AD&D COVERAGE	
In the event of death ***(not accidental)***	
Basic Life:	2 times your base annual earnings
+ Supplemental Life:	1, 2, 3, or 4 times your base annual earnings
Term Life Insurance	3, 4, 5, or 6 times your base annual earnings
–OR–	
In the event of ***accidental death***	
Basic Life:	2 times your base annual earnings
+ Basic AD&D:	2 times your base annual earnings
+ Supplemental Life and AD&D:	2, 4, 6, or 8 times your base annual earnings
Total Life and AD&D Benefit	6, 8, 10, or 12 times your base annual earnings

WHAT YOU PAY PER MONTH FOR LIFE INSURANCE FOR 2026	
Employee — Basic Life with AD&D	$0.111 per $1,000
Spouse — Basic Life with AD&D	$3.66 for the lump sum of $30,000 coverage
Dependent Child(ren) — Basic Life only	$1.02 for $15,000 coverage

Costs for Other Coverage Amounts	Employee Supplemental Life and AD&D	Spouse Basic Life and AD&D
Age as of 1/1/2026	You Pay per $1,000 of Coverage	
Under 30 years old	$0.09	$0.09
30 to 34 years old	$0.09	$0.09
35 to 39 years old	$0.12	$0.12
40 to 44 years old	$0.17	$0.17
45 to 49 years old	$0.29	$0.29
50 to 54 years old	$0.43	$0.43
55 to 59 years old	$0.70	$0.70
60 to 64 years old	$0.80	$0.80
65 to 69 years old	$1.37	$1.37
70 years and older	$2.05	n/a

IMPORTANT PLAN INFORMATION

Midyear Changes to Your Benefit Elections

IMPORTANT: After this Open Enrollment period is completed, generally, you will not be allowed to change your benefit elections or add or delete dependents until next year's Open Enrollment, unless you have a Special Enrollment event or a midyear change in status

Special Enrollment Event

Loss of Other Coverage Event: If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

You and your dependents may enroll in this Plan if you (or your eligible dependents) (1) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage and (2) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends or that you are determined to be eligible for such assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request Special Enrollment or to obtain more information, contact Employee Benefits.

Midyear Change-in-Status Events

The following events may allow certain changes in benefits midyear, as permitted by the IRS:

- Change in legal marital status (e.g., marriage, divorce or legal separation, dependent's death)
- Change in number or status of dependents (e.g., birth, adoption, dependent's death)
- Change in employee, spouse, or dependent's employment status, work schedule, or residence that affects their eligibility for benefits
- Coverage of a child due to a qualified medical child support order (QMCSO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Certain changes in the cost of coverage, composition of coverage, or curtailment of coverage of the employee's or spouse's plan
- Changes consistent with Special Enrollment rights and FMLA leaves

You must notify PacifiCorp Employee Benefits by creating a life event within Benefitfocus enrollment system with **31 days** of the midyear change-in-status event and provide supporting documentation. The Plan will determine if your change request is permitted, and, if so, changes become effective on the first day of the month following the approved change-in-status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Designation of a Primary Care Provider (PCP)

The Fund's medical plans generally allow the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of the participating primary care providers, contact the Administrative Office, or visit the Wellmark website listed on the inside cover of this Guide.

Direct Access to OB/GYN Providers

You do not need prior authorization (pre-approval) from the Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Administrative Office, or visit the Wellmark website listed on the inside cover of this Guide.

Important Reminder to Provide the Plan With Taxpayer Identification Number (TIN) or Social Security Number (SSN) of Each Enrollee in a Health Plan

Employers are required by law to collect the taxpayer identification number (TIN) or Social Security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a Social Security number, you can go to this website to complete a form to request an SSN: **socialsecurity.gov/online/ss-5.pdf**. Applying for a Social Security number is FREE. The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare & Medicaid Services (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the Social Security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact PacifiCorp Employee Benefits at **800-455-6363**.

COBRA Coverage Reminder

In compliance with a federal law called COBRA Continuation Coverage, this Plan offers its eligible members and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA Continuation Coverage when certain events occur, and, as a result of the event, coverage of that qualified beneficiary ends (together, the event and the loss of coverage are called a qualifying event). Qualifying events may include termination of employment, reduction in hours of work (making the employee ineligible for coverage), death of the employee, divorce or legal separation, or a child ceasing to be an eligible dependent child under terms of this plan, if a loss of coverage results. The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In addition to considering COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace. See **healthcare.gov**. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for Marketplace coverage or for the tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

In order to have the chance to elect COBRA Continuation Coverage after a divorce or legal separation or a child ceasing to be a dependent child under the Plan, you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs. That notice should be sent to Human Resources via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents). Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense. If you have questions about COBRA Continuation Coverage, contact the Administrative Office.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Administrative Office.

Medicare Notice of Creditable Coverage

If you or your eligible dependents are currently Medicare-eligible or will become Medicare-eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under our medical plans is or is not creditable with (as valuable as) Medicare's prescription drug coverage. To find out whether the prescription drug coverage under the medical plan options offered by the Trust Fund are or are not creditable, you should review the Plan's Medicare Part D Notice of Creditable Coverage which is being made available in your Enrollment packet. You can also receive a copy from the Administrative Office.

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 **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 **877-KIDS-NOW,** or visit **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 **askebsa.dol.gov**, or call **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 2025. Contact your state for more information on eligibility.

ALABAMA – Medicaid

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

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

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

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

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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

Health Insurance Premium Payment Program Website: https://www.in.gov/fssa/dfr
All other Medicaid Website: https://www.in.gov/medicaid/
Family and Social Services Administration Phone: 800-403-0864
Member Services Phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 800-338-8366
Hawki Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 800-657-3739

MISSOURI – Medicaid

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

MONTANA - Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – Medicaid and CHIP

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

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP

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

VERMONT– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

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

WISCONSIN – Medicaid and CHIP

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

WYOMING – Medicaid

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

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, menu option 4, ext. 61565

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

Privacy Notice Reminder

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own health care information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. The Notice has been revised to provide current information and is available on our website. You are provided a copy of this Notice when you enroll in the Plan, and you can get another copy from the Administrative Office.

Visit the Learning Library

The Learning Library has more information about your benefits. Visit **onlinelearninglibrary.com/ibew-west**, or scan the QR code.