Utah Pipe Trades Trust Funds

Pension
Health and Welfare

September 2026

RE: PLEASE REVIEW! IMPORTANT INFORMATION ENCLOSED

Dear Participant:

Enclosed with this letter, you will find four important items regarding the Utah Pipe Trades Welfare Trust Fund.

1. HIPAA Notice of Privacy Practices Notice – *Pages 3-7*
2. Summary Annual Notice – *Page 8-9*
3. Notice of Non-Discrimination – *Page 11*
4. Annual Women's Health Notice – *Page 12*
5. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) – *Pages 13-16*
6. The Medicare Part D Annual Notice – *Pages 17 - 20*
7. Utah Pipe Trades Health & Welfare Trust SMM September 2026 – *Pages 21 – 28*
8. Summary of Benefits and Coverage (SBC) for the upcoming 2027 plan year – *Pages 29 – 38*

If you wish to change your beneficiary for the Plan's life and AD&D insurance benefits, or have any questions regarding the enclosed notices, please contact the Trust Office at 877-416-8181.

Physical Address: 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566
Mailing Address: P.O. Box 1975, San Ramon, California 94583
Phone 925.398.7041 Toll Free 877.416.8181 Facsimile 925.462.0108
www.utpipetradesbenefits.org staff@utpipetradesbenefits.org

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Utah Pipe Trades Welfare Trust Fund

HIPAA NOTICE OF PRIVACY PRACTICES

The Utah Pipe Trades Welfare Trust Fund ("Plan") may use your health information, which may constitute protected health information ("PHI") as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). [1] The Plan has established policies and procedures to guard against unnecessary disclosure of your health information.

I. YOUR INDIVIDUAL RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

1. **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. The Plan is not required to agree to your request, and so the Plan may say "no" if it would affect your care.

2. **Right to Receive Confidential Communications.** You may ask us to contact you in a specific way. For example, you may ask that the Plan only communicate with you confidentially at a certain telephone number or by email or to send mail to a different address. The Plan must approve all reasonable requests for confidential communications.

3. **Right to Inspect and Copy Your Health Information.** You may inspect and copy your health information. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs, and postage—if applicable—associated with your request. The Plan may deny your request in limited situations.

4. **Right to Amend Your Health Information.** You may request that the Plan amend its records (e.g., if you think they are incomplete or inaccurate). The Plan may deny your request in certain instances—for example: (1) if you do not include a reason supporting the amendment; (2) if your health information records were not created by the Plan; (3) if the health information you are requesting to amend is not part of the Plan's records; (4) if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy; or (5) if the Plan determines the records containing your health information are accurate and complete.

5. **Right to an Accounting.** The Plan may share your health information—for example, see the permissible uses and disclosures discussed below. You may request a list (i.e., an "accounting") of the times the Plan shared your health information for six (6) years prior to the date you ask, including who we shared it with, and why. Your request for an accounting must specify the period

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

for which you are requesting the information and cannot be for a period older than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge, but additional accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

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

II. USE AND DISCLOSURE OF HEALTH INFORMATION

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

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

1. **To Make or Obtain Payment.** The Plan may use or disclose your health information to pay or collect payment from third parties, such as providers, related to the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

2. **To Conduct Health Care Operations.** The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. For example, the Plan may use your health information to conduct case management, quality improvement, and utilization review; for provider credentialing activities; or to engage in customer service and grievance resolution activities.

3. **For Treatment.** The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the Plan may disclose that you are eligible for benefits to a health care provider contacting the Plan to verify your eligibility. This may also include using your health information to inform you about or recommend possible treatment options or alternatives, as well as health-related benefits or services that may be of interest to you.

4. **To Business Associates.** The Plan may share your health information with its Business Associate (as defined in HIPAA) as part of a contract or agreement for the Business Associate to perform services for the Plan, but only after the Business Associate has agreed in writing to implement appropriate safeguards regarding your PHI.

5. **For Public Health Risks.** The Plan may disclose your health information for public health activities, in certain situations, such as:

    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence, if authorized or required by law, or if you have consented to such disclosure

- Preventing or reducing a serious threat to anyone's health or safety by sharing this information with someone reasonably able to help prevent or lessen the threat

6. **For Underwriting and Related Purposes.** The Plan may use or disclose your health information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of health insurance, but your genetic information will not be used or disclosed for such purposes.

7. **In Connection with Judicial and Administrative Proceedings.** As permitted or required by state law, the Plan may disclose your health information in response to a court or administrative order, or in response to a subpoena, but only if certain conditions are satisfied—such as providing notice to you or obtaining certain assurances from the requesting party.

8. **For Law Enforcement, Worker's Compensation, and Other Government Requests.** As permitted or required by state law, the Plan may use or share health information about you:

    - For workers' compensation claims.
    - For law enforcement purposes or with a law enforcement official, in certain situations.
    - With health oversight agencies for activities authorized by law. (However, the Plan may not disclose your health information if you are subject to an investigation which does not arise out of or is not directly related to your receipt of health care or public benefits.)
    - For special government functions such as military, national security, and presidential protective services.

9. **When Legally Required.** The Plan may disclose your health information when required by federal or state law.

10. **To Coroners, Medical Examiners and Funeral Directors.** The Plan may share health information with a coroner, medical examiner, or funeral director when an individual dies.

11. **Organ and Tissue Donation.** The Plan may share health information about you with organ procurement organizations.

12. **Family, Friends, and others.** The Plan may disclose your health information to a family member, friend, or other person involved in your health care if you are present and do not object to the sharing of PHI, or in the event of an emergency. You may also appoint a personal representative to access your health information, such as through a medical power of attorney form. If this appointment is sufficient under state (or other applicable) law, your personal representative may generally act on your behalf regarding the health information described in this Notice, including accessing and authorizing the Plan's use or disclosure of your health information.

ADDITIONAL RESTRICTIONS FOR CERTAIN INFORMATION

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

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

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

III. THE PLAN'S DUTIES

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

IV. COMPLAINTS

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

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

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

V. CONTACT

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

Michael Jokela
c/o BeneSys Inc.
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

877-416-8181
925-462-0108
staff@utpipetradesbenefits.org

VI. EFFECTIVE DATE

This Notice is effective beginning February 16, 2026.

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

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-416-8181 (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 877-416-8181 (TTY: 711) o hable con su proveedor.

中文 (Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 877-416-8181 文本电话： 711）或咨询您的服务提供商。

Tiếng Việt (Vietnamese) LƯU Ý: Nếu bạn nói một ngôn ngữ khác, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Gọi 877-416-8181 (TTY: 711)hoặc nói chuyện với nhà cung cấp của bạn.

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format.
Tumawag sa 877-416-8181 (TTY: 711) o makipag-usap sa iyong provider.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 877-416-8181 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք այլ լեզվով, ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Զանգահարեք 877-416-8181 (TTY: 711) կամ խոսեք ձեր մատակարարի հետ

فارسی (Persian) توجه :اگر به زبان دیگری صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است .خدمات کمکی و کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند .با 877-416-8181 (TTY: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-416-8181 (TTY: 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) 注意: 別の言語を話す場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助手段やサービスも無料でご利用いただけます。877-416-8181（TTY: 711）に電話するか、プロバイダーにお問い合わせください。

العربية (Arabic)
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 877-416-8181 (711) أو تحدث إلى مقدم الخدمة.

ਗੁਰਮੁਖੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 877-416-8181 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖
ប្រសិនបើអ្នកនិយាយភាសាផ្សេង
សេវាជំនួយភាសាឥតគិតថ្លៃអាចរកបានសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។
ទូរស័ព្ទទៅ 877-416-8181 (TTY: 711)
ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lwm hom lus, muaj kev pabcuam lus pub dawb rau koj. Cov kev pabcuam tsim nyog thiab cov kev pabcuam los muab cov ntaub ntawv hauv cov qauv siv tau kuj muaj pub dawb. Hu rau 877-416-8181 (TTY: 711) lossis tham nrog koj tus kws kho mob.

हिंदी (Hindi) ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 877-416-8181 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ภาษาไทย (Thai) หมายเหตุ: หากคุณพูดภาษาอื่น คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร 877-416-8181 (TTY: 711)) หรือพูดคุยกับผู้ให้บริการของคุณ

SUMMARY ANNUAL REPORT

FOR UTAH PIPE TRADES WELFARE TRUST FUND

This is a summary of the annual report of the Utah Pipe Trades Welfare Trust Fund, E.I.N. 87-6128290, Plan No. 501, for the year ended September 30, 2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with The Union Labor Life Insurance Company and Blomquist Hale to provide certain benefits incurred under the terms of the plan. The total premiums paid for the plan year ended September 30, 2025 was $410,126.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $14,602,236 as of September 30, 2025, compared to a balance of $16,576,356 as of October 1, 2024. During the plan year, the plan experienced a decrease in its net assets of $1,974,120. This decrease includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. During the plan year, the plan had total income of $20,722,968 including employer contributions of $18,556,130, participant contributions of $612,273, and earnings from investments of $1,554,565.

Plan expenses were $22,697,088. These expenses included $746,295 in administrative expenses and $21,950,793 in benefits paid to or for participants and beneficiaries.

Your Rights to Additional Information

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

1. An independent auditor's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. transactions in excess of 5% of the plan assets; and

5. insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of BeneSys Administrators, who is the contract administrator, 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566, (925) 398-7060. The charge to cover copying costs will be 25 cents per page for any part thereof.

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

You also have the legally protected right to examine the annual report at the main office of the plan (7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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NOTICE OF NONDISCRIMINATION

Discrimination is Against the Law

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

The Health Plan:

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

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

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

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Health Plan at 877-416-8181.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at the Health Plan's website: www.utpipetradesbenefits.org.

ANNUAL NOTIFICATION WOMEN'S HEALTH AND CANCER-RIGHTS ACT OF 1998

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

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, as requested by the patient in consultation with the attending physician for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

This coverage is subject to the Plan's deductibles, coinsurance, or co-payment provisions.

If you have any questions about your Plan's coverage for mastectomies or reconstructive surgery, please contact the Trust Fund Office at (925) 398-7041.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Your Health and Welfare Plan requires group coverage to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after delivery by cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate. If you are discharged earlier, your physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care.

If you have any questions about your Plan's coverage, please contact the Trust Fund Office at (925) 398-7041.

Thank you.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

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

Utah Pipe Trades Trust Fund

Pension
Health and Welfare

September 2026

Important Notice from
Utah Pipe Trades Welfare Trust Fund
about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with Utah Pipe Trades Welfare Trust Fund and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

Utah Pipe Trades Welfare Trust Fund has determined that the prescription drug coverage under the Fund's Medical Plan is "creditable."

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan noted above is, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Fund's Medical Plan and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

> If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.
>
> For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with the Utah Pipe Trades Welfare Trust Fund, and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through the Fund's Medical Plan. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th - December 7th of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	You can select or keep your current medical and prescription drug coverage with the Utah Pipe Trades Welfare Trust Fund and also enroll in a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under this Trust Fund. That is because prescription drug coverage is part of the entire medical plan. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.
Option 3	**If you are currently participating in the Fund by making Self-Payment contributions**, you can drop your current medical and prescription drug coverage with the Utah Pipe Trades Welfare Trust Fund and instead enroll in a Medicare prescription drug plan.	• If you drop coverage for yourself, you will lose ALL coverage, including medical plan coverage for your spouse and dependents. • **If you drop coverage, you can never come back into this plan.**

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

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

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact the Administrative Office at:

BeneSys Administrators
P.O. Box 1975
San Ramon, CA 94583
Phone 925·398·7041 or Toll Free 877-416-8181
www.utpipetradesbenefits.org

As in all cases, the Utah Pipe Trades Welfare Trust Fund reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated November 2022) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

This document has been uploaded and is available on the participant website at www.utpipetradesbenefits.org

SUMMARY OF MATERIAL MODIFICATIONS
September 2026

This Notice, called a summary of material modifications ("SMM"), advises you of certain changes that have been made to the Plan Document/Summary Plan Description for the Utah Pipe Trades Welfare Trust Fund dated January 1, 2026 ("SPD"). These changes are effective January 1, 2027. Please be sure that you and your covered family members read this notice carefully. It should be kept with your SPD (including the Cigna benefits booklet that is part of the SPD), prior SMMs, and the Plan's annual Summary of Benefits and Coverage ("SBC") notices for future reference.

Addition of Health Reimbursement Arrangement

The Trustees are pleased to announce that effective January 1, 2027, the Plan will provide a Health Reimbursement Arrangement ("HRA") for all Active Employee and Flat-Rate Employee Participants. Your HRA account will be funded solely by employer contributions made on your behalf based on your Covered Hours worked. Employers began contributing to the HRA for work performed on or after August 1, 2025, and so you will begin with an HRA balance equal to the contributions received on your behalf thus far. The HRA contribution rate was $0.30 per Covered Hour worked from August 1, 2025 – July 31, 2026, and increased to $0.60 per Covered Hour worked on or after August 1, 2026. The contribution rate is established in the applicable collective bargaining agreements and may change from time to time.

Your HRA balance may be used to reimburse out-of-pocket medical expenses for you and your Covered Dependents, so long as the expense qualifies as a tax-deductible medical care expense under Internal Revenue Code Section 213(d), is not reimbursable from other sources, and is incurred on or after January 1, 2027. To request reimbursement from your HRA, you must file a claim form with the Administrative Office within 12 months after the expense was incurred and include documentation substantiating the medical expense. (Note that an expense is "incurred" at the time the service or supply is furnished, not necessarily at the time of payment.)

For additional details, please see the attached Appendix A, which sets forth the specific terms and provisions of the new HRA benefit.

Termination of Temporary Dental and Vision Care Benefits.

The Plan currently offers a temporary dental and vision care benefit, which provides reimbursement of up to $1,500 per covered family for eligible dental and/or vision claims incurred per calendar year. Given the new HRA benefit, this benefit will end on December 31, 2026 and will not be available for reimbursement of any dental or vision claims incurred after that date. You may still receive reimbursements under this benefit for eligible dental and/or vision claims incurred during the 2026 calendar year, even if the claim for reimbursement is received after December 31, 2026, so long as it is received within 12 months of the date of service. Note that many dental and vision expenses are eligible for reimbursement under the new HRA benefit, subject to rules stated in Appendix A.

Temporary Hour Bank Loan Policy

As described on pages 13-14 of the SPD, the Plan generally requires that a member work 300 Covered Hours to be eligible for coverage under the Plan. Coverage then begins on the first day of the month after completing this requirement. However, the Trustees may, from time to time and in their sole discretion, adopt policies under which hours may be advanced for newly dispatched members, and this notice is to advise you of a temporary hour bank loan policy that was recently adopted by the Trustees to address a labor shortage involving the specialized needs of Contributing Employers.

For certain new members 300 hours will be advanced to their hour bank (an "hour bank loan") in their first month of work. In order to qualify, the member must meet the following requirements:

- Be dispatched to work in the jurisdiction of the Plan by Local 140 to a Contributing Employer between March 1, 2026 and December 31, 2027;
- Not have any Covered Hours under or participated in the Plan in the 12 months prior to dispatch; and
- Be a plumber licensed in Utah or be a pipefitter and pass Local 140's skills test and requirements for a classification of 5th Step Apprentice or higher, by the end of the month employment began, and be designated by Local 140 as eligible for this hour bank loan policy based on the member's level of industry knowledge and experience as related to the Contributing Employer's specialized labor needs (a "Loan Eligible Member").

Coverage will then begin the first of the month following the month employment began.

Example: Jim, a journeyman pipefitter first dispatched by Local 140 to a Contributing Employer on May 15, 2026, is designated as a Loan Eligible Member by Local 140 due to his level of industry knowledge and experience and otherwise meets the requirements stated above. Jim receives an hour bank loan of 300 hours, and so is eligible for coverage on June 1, 2026. His hour bank is reduced by 140 hours to provide the June coverage, leaving Jim with 160 hours in his bank. Each month, any hours worked will be applied first toward the minimum 140 hours required to maintain eligibility. Any excess will be applied to repay the hour bank loan. Members receive credit for hours worked once the Administrative Office receives contributions.

If the hour bank loan is not fully repaid after 12 months, then the obligation to repay the hour bank loan will end and any remaining hour bank loan hours will be cancelled. At that point, the member must satisfy the continuing eligibility requirements under the Plan in order to continue coverage. If, during the first 12 months of coverage, a member loses Plan coverage and has an outstanding hour bank loan, the loan and banked hours will be cancelled. In order to have coverage reinstated, the member must reestablish Initial Eligibility by working at least 300 Covered Hours within no more than five consecutive months — and the Plan's regular rules on restoring lost coverage within 4 months do not apply.

All other provisions of the Plan, including those on establishing and continuing eligibility, continue to apply. The Board of Trustees reserves the right to extend or terminate this hour bank loan policy at any time.

Should you have any questions regarding the benefit changes described above, please contact the Administrative Office (BeneSys) at 877-416-8181.

Note: Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Administrative Office. *This document has been uploaded and is available on the participant website at www.utpipetradesbenefits.org.*

Appendix A
Health Reimbursement Arrangement
Utah Pipe Trades Welfare Trust Fund

This document forms part of the Plan Document/Summary Plan Description ("SPD") for the Utah Pipe Trades Welfare Trust Fund (the "Plan") and sets forth the Plan's Health Reimbursement Arrangement ("HRA"), which is effective January 1, 2027. Under the HRA, contributions on your behalf will accumulate in an HRA account, which you can access for tax-free reimbursement of certain out-of-pocket medical expenses. The HRA is subject to all of the terms, conditions, and definitions of the Plan, except where the HRA-specific rules in this Appendix provide otherwise, and is integrated with the medical and prescription drug benefits provided under the Plan. The HRA is intended to qualify as a "health reimbursement arrangement" as that term is defined in IRS Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code ("Code") and will be interpreted at all times in a manner consistent with that intent.

1. **Eligibility.** If you are an Active Employee or Flat-Rate Employee Participant, you are eligible for reimbursements from your HRA once you have met the applicable Initial Eligibility Requirements for coverage as described in Section II the SPD, but no earlier than January 1, 2027. Below are two examples:

   Example #1 – Current Participant: If you are a currently-eligible Plan Participant as of January 1, 2027, you are eligible for HRA reimbursements beginning effective January 1, 2027, which will be based on the employer HRA contributions that have been received on your behalf through that date.

   Example #2 – New Active Employee Participant: If you first begin work for a Contributing Employer in work covered by a Collective Bargaining Agreement starting in January 2027 and you work at least 300 Covered Hours during the months of January – March 2027, you will be eligible for Plan coverage generally and also HRA reimbursements effective beginning April 1, 2027. Your initial HRA balance will equal the employer HRA contributions received on your behalf through the date of your initial eligibility.

2. **Source of HRA Contributions.** Employers make specified "HRA contributions" to the Fund pursuant to applicable collective bargaining agreements and other written agreements for Covered Hours worked on and after August 1, 2025. The HRA contributions made on your behalf are allocated to an "HRA account" in your name, provided you have met the eligibility requirements described above. No other types of contributions to the HRA are permitted – for example, you cannot make self-payments to your HRA account. The hourly HRA contribution amounts that apply at a given time are established in the applicable collective bargaining agreements.

3. **HRA Account Balances.** HRA accounts are recordkeeping accounts established for the purpose of tracking each Participant's available HRA reimbursements at a given time. Your HRA account balance is the amount of employer HRA contributions actually made and allocated to your HRA account, less any payments of HRA benefits you have already received. HRA accounts are not credited with interest or any investment gains or losses. HRA benefit payments are limited to the balance of your account. If you submit a claim for reimbursement that exceeds your available account balance, your application will be denied for the portion of the expense exceeding your HRA account balance, though you may later file

a new claim for reimbursement of this excess amount once your account has sufficient funds. Unused HRA balances from one year carry over to future years and remain available for HRA reimbursements until used up, subject to the termination and forfeiture rules described in this Appendix.

4. **Administrative Expenses.** As currently designed, the Trust Fund will pay all expenses associated with administration of the HRA and no administrative expenses will be charged to participant HRA accounts.

5. **How HRA Benefits Work.** As you incur eligible medical expenses that are not paid or reimbursable by the Plan or another resource you might have, you may request reimbursement from the balance in your HRA account up to the amount of the expense. However, the HRA can only provide reimbursements for "Eligible Medical Expenses" (as defined below) that you or your Covered Dependents incur on or after the date you first became eligible for the HRA (and no earlier than January 1, 2027). *An expense is "incurred" at the time the service is rendered or the supply is obtained—not necessarily at the time of payment.*

   Note that you may never cash out or roll over your HRA account.

6. **Eligible Medical Expenses.** "Eligible Medical Expenses" are medical care expenses as defined in Section 213(d) of the Code – in other words, tax deductible medical expenses. See IRS Publication 502 for IRS guidance on tax-deductible medical expenses. Common examples include:

   - COBRA or Retiree self-pay premiums to the Plan for continuation of your Plan coverage after your retirement or other loss of eligibility,
   - payments towards your Plan out of pocket amounts (deductibles, copays and coinsurance for covered medical and prescription drug benefits),
   - prescription drugs,
   - over-the-counter medicines and drugs (e.g., ibuprofen, allergy medications, heartburn relief, cold/flu medication, skin treatments, and sleep aids),
   - over-the-counter medical products and supplies (e.g., first aid supplies, blood pressure monitors, etc.),
   - chiropractic care,
   - physical therapy,
   - acupuncture,
   - vision care, including glasses, contact lenses and exams,
   - dental care, including medically necessary orthodontics, and
   - hearing aids.

7. **Ineligible Medical Expenses.** Amounts that do not qualify as medical care expenses under Code Section 213(d) are not eligible for reimbursement from your HRA, including the following examples: wage replacement/cash, tuition, long-term care services, funeral and burial expenses, household or domestic help, most cosmetic procedures, toiletries (toothpaste, cosmetics, etc.), non-FDA-approved drugs, treatments or drugs that are not legal under applicable law, drugs obtained outside the U.S., and expenses for which you have no payment responsibility or that are otherwise reimbursable from other sources. In addition, the HRA cannot reimburse you for health insurance premiums for another plan or individual coverage, COBRA premiums for another plan, or premiums for Medicare. Also, you may not

take an HRA reimbursement and claim a federal income tax deduction for the same medical expense.

8. **Reimbursement Procedures for HRA Benefits.** A request for reimbursement from your HRA must be received by the Administrative Office within 12 months after the date the expense was incurred, unless you establish it was not reasonably possible to do so. A request for reimbursement must include a properly completed HRA claim form, plus written statements and/or bills from an independent third party describing the service or product, the amount of the expense, and the date of the service or sale. An HRA claim form is available from the Administrative Office or via the Trust Fund website. Depending on the circumstances, the substantiating documents may include an invoice, prescription, affidavit, and/or other documentation required by the Administrative Office. Cash register receipts are not, alone, an acceptable form of substantiation, except for purchases of over-the-counter medicines, drugs, products, or supplies, in which case the receipt must be itemized. (Further details about required documentation are on the claim form.)

   If your claim for reimbursement is approved, a check will be issued to you for the approved reimbursement amount. Alternatively, you may sign up for direct deposit and receive reimbursement directly to your bank account.

   If your claim for reimbursement is denied, the Plan's Claims Procedures apply, which are set forth in Section XI of the SPD. For this purpose, the Administrative Office is the Claims Administrator with respect to HRA benefits and also decides first-level appeals, and the Board of Trustees is the Claims Fiduciary with respect to second-level appeals.

9. **Reciprocity.** If you travel to another United Association (UA) local's geographic area and have contributions sent to this Plan as your "home" trust, a portion of these reciprocated contributions may be applied to your HRA account, according to the following rules: (a) if the hourly contribution rate in the other area is the same or less than the current hourly contribution rate to this Plan (disregarding the separate HRA contribution rate), all of the reciprocated contributions are applied to your hour bank according to the rules described in Section II of the SPD (i.e., the reciprocated contributions are divided by the current hourly contribution rate to this Plan (disregarding the separate HRA contribution rate)) and no amount is applied to your HRA account, and (b) if the hourly contribution rate in the other area is more than the current hourly contribution rate to this Plan (disregarding the separate HRA contribution rate), an amount equal to that excess rate (but limited to the current HRA contribution rate) times the actual number of hours worked in the other area will be allocated to your HRA account and remaining amount of reciprocated contributions will be allocated to your hour bank as described above (i.e., the remaining reciprocal contributions are divided by the current hourly contribution rate to this Plan (disregarding the separate HRA contribution rate)). If you are working in the geographic area covered by this Plan but have elected to have contributions sent to another plan as your "home" trust, the HRA contributions made on your behalf will be included in the amount reciprocated to your home trust.

10. **Termination and Forfeiture.** You may continue to access your HRA for up to 24 months after your Plan coverage terminates or, if later, for up to 24 months after the latest transaction involving your HRA account (contribution or reimbursement) occurs. After 24 months without Plan coverage, contributions, or reimbursements, you will permanently forfeit any remaining HRA balance.

Please note the Plan must report that you are receiving Minimum Essential Coverage on a Form 1095 for each month in which you have an HRA balance after your regular Plan coverage has terminated. Having Minimum Essential Coverage may make you ineligible for the Affordable Care Act's Premium Tax Credit when purchasing exchange coverage through the Health Insurance Marketplace. If you wish to avoid this, you may opt out of further HRA coverage after your regular Plan coverage ends, as described at the end of this Appendix in Section 16.

If you continue or resume earning Covered Hours following termination of coverage under the Plan, any HRA contributions received on your behalf for this period of non-coverage will *not* be attributed to your account unless and until you restore your Plan coverage before otherwise forfeiting the whole balance of your HRA account under these forfeiture provisions.

Notwithstanding the forgoing, your HRA balance will immediately be permanently forfeited upon the occurrence of either of the following events:

- If your Employer's Bargaining Unit ceases participation in the Plan, or
- If you work for an employer that has no obligation to contribute to the Plan or any reciprocal plan for your work that, regardless of geographic area, is in the same industry, trade, or craft covered by a Collective Bargaining Agreement.

Once your HRA balance is permanently forfeited, it cannot be reinstated, even if you subsequently return to covered employment and re-establish Initial Eligibility under the Plan.

Also, please note that the benefits under the Plan, including your HRA, are not vested and may be changed or eliminated by the Trustees at any time.

11. **Death.** If you die, your surviving spouse (if they are a Covered Dependent) may use your remaining HRA balance to pay for Eligible Medical Expenses, including Self-Pay premiums for COBRA or Retiree coverage under the Plan.

12. **COBRA.** If you have a COBRA Qualifying Event that causes you to lose coverage under the Plan you will have an opportunity to elect to continue your Plan coverage, with or without your HRA. You must notify the Administrative Office in writing if you wish to use your HRA to pay the monthly contributions required for COBRA.

13. **Retirement.** You may use your HRA balance to pay for Retiree Self-Pay coverage. If you wish to do so, you must notify the Administrative Office in writing.

14. **Overpayments and Fraud.** If it is determined that an incorrect payment was made to you from your HRA account, you will be required to repay the Plan. If you do not refund the overpayment, the Plan may offset future Plan benefit payments or report the incorrect payment that was made to you as taxable income. For more information, see the provisions in the SPD on overpayments, subrogation and reimbursement rights, and fraudulent or false claims. The HRA is governed by IRS rules, which the Trustees have no power to change.

15. **Online Access and Mobile App.** Beginning January 1, 2027, you can access your HRA account online at www.utpipetradesbenefits.org. Once logged in, you can view your HRA account balance and claims payment history, submit claims, sign up for text notifications, and direct deposit reimbursement. Also, if you own an iPhone or Android, you can download the mobile app. Search for "BeneSys Inc HRA" in the Apple App Store or Google Play Store. You can upload a receipt from your phone, file a claim, and view your HRA account balance 24/7.

16. **Opt-out.** You may permanently opt out of your HRA at any time, in which case no further HRA reimbursements will be available to you. You may not opt out of employer contributions to the HRA. You may obtain an opt-out form from the Trust's website at www.utpipetradesbenefits.org, or by calling the Administrative Office at 877-416-8181.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $450/individual or $900/family For out-of-network providers: $900/individual or $1,800/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, office visits, emergency room visits, urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $35 for out-of-network outpatient hospital visit and $500 per admission for out-of-network hospital stay There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: For in-network providers: $3,000/individual or $6,000/family. For out-of-network providers: Unlimited/individual or Unlimited/family. Outpatient Prescription Drugs (in-network): $2,600/individual or $5,200/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Medical: Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, outpatient prescription drugs and health care this plan doesn't cover. Outpatient Prescription Drugs: premiums, balance-billing charges, out-of-network prescription drugs, and medical expenses.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay, plus 20% coinsurance/visit Deductible does not apply	$35 deductible, plus 40% coinsurance/visit Deductible does not apply	None
	Specialist visit	$35 copay, plus 20% coinsurance/visit Deductible does not apply	$35 deductible, plus 40% coinsurance/visit Deductible does not apply	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening**	Not covered/visit Not covered/screening	None None
		No charge/immunizations**	Not covered/immunizations	None
		**Deductible does not apply		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay, plus 20% coinsurance/x-ray 20% coinsurance/blood work 20% coinsurance/independent lab	$35 deductible, plus 40% coinsurance/x-ray $35 deductible, plus 40% coinsurance/blood work 40% coinsurance/independent lab	None
	Imaging (CT/PET scans, MRIs)	$35 copay, plus 20% coinsurance	$35 deductible, plus 40% coinsurance	$750 penalty for no out-of-network precertification.
If you need drugs to treat your illness or condition: More information about prescription drug coverage is available at www.express-scripts.com or 1-855-596-4432	Generic drugs	Retail Pharmacy for 30-day supply: $8 copayment per prescription; Mail Order for 90-day supply: $15 copayment per prescription. No charge for FDA-approved generic contraceptives.	If you fill a prescription at an Out-of-Network pharmacy, you pay 100% for the drug at the time of purchase and can file a claim with Express Scripts for reimbursement. The Plan reimburses no more than it would have paid had you used a Network pharmacy.	• Deductible does not apply. • Some prescriptions are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription • Specialty drugs require preauthorization (to avoid non-payment) by calling Accredo at 1-800-803-2523
	Preferred brand drugs	Retail Pharmacy for 30-day supply: 30% coinsurance; Mail Order for 90-day supply: $45 copayment per prescription. No charge for FDA approved brand name contraceptives if a generic is medically inappropriate or unavailable.		
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 50% coinsurance; Mail Order for 90-day supply: $60 copayment per prescription.		
	Specialty drugs	You pay 50% coinsurance up to $60 for up to a 30-day supply.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay/visit, plus 20% coinsurance	$35 deductible/visit, plus 40% coinsurance	$750 penalty for no out-of-network precertification. Per visit copay/ deductible is waived for non-surgical procedures.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	Medical/Surgical: 20% coinsurance; after Deductible Mental Health/Substance Use Disorder Services: No charge (0% coinsurance; Deductible does not apply)	Medical/Surgical: 20% coinsurance; after Deductible Mental Health/Substance Use Disorder Services: No charge (0% coinsurance; Deductible does not apply)	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	$40 copay/visit, plus 20% coinsurance Deductible does not apply	$40 copay/visit, plus 20% coinsurance Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission, plus 20% coinsurance	$500 deductible/admission, plus 40% coinsurance	$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay, plus 20% coinsurance/office visit** 20% coinsurance/all other services **Deductible does not apply	$35 deductible, plus 40%coinsurance/office visit** 40% coinsurance/all other services **Deductible does not apply	$750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	$250 copay/admission, plus 20% coinsurance	$500 deductible/admission, plus 40% coinsurance	$750 penalty for no out-of-network precertification.
If you are pregnant	Office visits	20% coinsurance	$35 deductible, plus 40% coinsurance/visit Deductible does not apply	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250 copay/admission, plus 20% coinsurance	$500 deductible/admission, plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification. 16 hour maximum per day
	Rehabilitation services	20% coinsurance/visit** $35 copay, plus 20% coinsurance/PCP visit for Chiropractic care services** $35 copay, plus 20% coinsurance/ Specialist visit for Chiropractic care services** **Deductible does not apply	40% coinsurance/visit	$750 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation and Cardiac rehab services; 30 days for Chiropractic care services. Limits are not applicable to mental health conditions

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				for Physical, Speech and Occupational therapies.
	Habilitation services	20% coinsurance/visit Deductible does not apply	40% coinsurance/visit	$750 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	$750 penalty for no out-of-network precertification.
	Hospice services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	Not covered/inpatient services 40% coinsurance/outpatient services	$750 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	No charge when obtained during a preventive care office visit	Not covered	Covered for children up to 19 years. Adults pay 100% of these expenses. Vision expenses are reimbursable through the HRA.
	Children's glasses	Not covered	Not covered	You pay 100% of these expenses. Vision expenses are reimbursable through the HRA.
	Children's dental check-up	Not covered		Dental expenses are reimbursable through the HRA.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids, except bone-anchored hearing aids (BAHAs).
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric Surgery (in-network only Surgeon Charges Lifetime max $10,000)
- Chiropractic care (30 days)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$450
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$3,080

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

The plan's overall deductible	$450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$4,920

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

The plan's overall deductible	$450
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$450
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$1,060

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

Discrimination is against the law.

Medical coverage

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

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

cigna healthcare

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, **800.537.7697 (TDD)**

Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).