Redwood Empire Electrical Workers Health & Welfare Trust Fund
2525 Cleveland Avenue, Suite C
Santa Rosa, CA 95403
(707) 526-1996

September 2024

TO: ACTIVE & RETIRED PARTICIPANTS

RE: ANNUAL NOTICES for Redwood Empire Electrical Workers Health and Welfare Plan ("PLAN")

This Notice includes Annual Notices the Plan is required to provide you with under the Affordable Care Act ("ACA") and other Federal Laws. **This Notice is intended for informational purposes only and to remind you of certain Plan rules. No action is necessary on your part. However, if you and/or your family members have any questions, please contact the Trust Fund office at the number above.**

YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE PLAN'S SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT (KNOWN AS THE "PLAN RULES").

A. HEALTH REIMBURSEMENT ACCOUNT ("HRA") – IMPORTANT REMINDERS!

As an important reminder, you may submit an HRA eligible claim to NAVIA Benefits to receive HRA reimbursements. If your claim expense is greater than your HRA account balance, you may only receive up to the funds available in your HRA account. Under the HRA Plan rules, you may be reimbursed for up to the balance in your account if you meet the eligibility requirements. Furthermore, the HRA claims for each eligible Participant and/or eligible Dependent must be for Qualifying Medical expenses (meaning any expense eligible for reimbursement under the HRA within the meaning of Internal Revenue Code Section 213(d)) incurred during a Covered Period and the claims must include receipts or documentation that the expense being incurred is eligible for reimbursement in order for you to claim a reimbursement. Please further note if you do NOT substantiate your HRA claims NAVIA Benefits, the Administrator for the HRA account, is permitted to deny your reimbursement claim or access to your HRA debit card including requiring you to repay the improper unsubstantiated claim, offset future claims until you repay the amount and/or withholding the improper payment from your wages or other compensation to the extent consistent with applicable law. **It is also important to note there are NO CASH benefits permitted under the HRA Plan. As such, you are encouraged to spend down your HRA account for Qualified Medical Expenses**. For more information, please refer to your copy of the HRA Plan Document.

Please contact NAVIA benefits for more information on your account balance either at 1-866-897-1996 or via their website ***www.naviabenefits.com***.

B. OPEN ENROLLMENT, REEW JOB ACCESS AND HEALTH AND WELFARE ELIGIBILITY – REMINDERS

Medical Open Enrollment: You are permitted to make your annual election to change your medical plan at any time during the year. However, once elected, you will not be able to change medical plans for a consecutive twelve-month period following the date of your election, unless you qualify for "Special Enrollment Rights" (See your copy of the Summary Plan Description for additional details on Page 25).

Dental Open Enrollment: You are permitted to make your annual election to change your dental plan at any time during the year. However, once elected, you will not be able to change dental plans for a consecutive twelve-month

period following the date of your election, unless you qualify for "Special Enrollment Rights" (See your copy of the Summary Plan Description for additional details on Page 25).

Online Job Access and Health and Welfare Eligibility: If you would like access to view your benefits and job history online, please request your username and password from the Administrative office.

C. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") AVAILABILITY OF THE NOTICE OF PRIVACY PRACTICES

The Board of Trustees of the Plan has adopted a Notice of Privacy Practices. The Notice of Privacy Practices describes the permitted ways that the Plan uses and discloses your Protected Health Information ("PHI"), your HIPAA privacy rights, and the Plan's legal responsibility regarding your PHI. You can contact the Trust Fund Office to request a paper copy of the Notice at any time. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice. **NOTE:** Depending on the insured coverage you are enrolled in, Kaiser HMO, Sutter Health Plus HMO, Western Health Advantage HMO and PPO, and United American Medical may also have its own HIPAA Notice of Privacy Practices and may also send you a copy of their own rules.

D. WOMEN'S HEALTH AND CANCEL RIGHTS ACT OF 1998

Under Federal Law, Group Health Plans, Insurers, and Health Maintenance Organizations ("HMO") (such as Kaiser Permanente, Sutter Health Plus, and Western Health Advantage) that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- 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 lymphedemas; in a manner determined in consultation with the attending physician and the patient.

This coverage is subject to the Plan's applicable (if any) annual deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). This Plan complies with these requirements. If you have any questions about whether your Plan covers mastectomies or reconstructive surgery, you may contact your selected Health Plan directly. The toll-free number for Kaiser Permanente is (800) 464-4000. The toll-free number for Sutter Health Plus HMO is (855) 315-5800. The toll-free number for Western Health Advantage HMO is (888) 563-2250. The toll-free number for Western Health Advantage PPO is (844) 783-0927. The toll-free number for United American Medical is (888) 344-2522.

E. NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under Federal Law, Group Health Plans, Health Insurance Issuers, and Health Maintenance Organizations may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or Issuer (ex. Kaiser Permanente or Sutter Health Plus or Western Health Advantage) may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

In addition, under Federal Law, Plans and Issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. A Plan or Issuer may not, under Federal Law, require that a physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

For information on precertification or if you have any questions about your Plan's coverage as it relates to childbirth or a newborn child, you may contact your selected Health Plan. The toll-free number for Kaiser Permanente is (800) 464-4000. The toll-free number for Sutter Health Plus HMO is (855) 315-5800. The toll-free number for Western Health Advantage HMO is (888) 563-2250. The toll-free number for Western Health Advantage PPO is (844) 783-0927. The toll-free number for United American Medical is (888) 344-2522.

F. AFFORDABLE CARE ACT – AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE ("SBC")

Group Health Plans, Insurers, and Health Maintenance Organizations ("HMOs") are responsible for providing an SBC annually to all eligible Participants as well as to all future eligible new Participants and their Dependents upon initial and special enrollment, as well as 60 days prior to a mid-year material modification of the SBC. The SBC provides a summary of what the Plan covers and what it costs and allows you to compare the Plan's benefit options (currently Kaiser Permanente HMO, Sutter Health Plus HMO, Western Health Advantage HMO and PPO) offered to you and/or your eligible Dependents. You have the right to request and receive within seven (7) business days an SBC for the Plan's benefits offered through each insured/HMO coverage. If you would like to receive a copy of the SBC and/or more details about your coverage, please contact the carriers directly.

G. 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 are eligible for health coverage from your employer, the State you reside in may have a Premium Assistance Program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these Premium Assistance Programs. **If you live in California, you can contact the California Department of Health Care services for further information on eligibility and premium assistance under the Health Insurance Premium Payment (HIPP) Program at: *www.dhcs.ca.gov* and E-mail at HIPP@dhcs.ca.gov/.**

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State that provides Premium Assistance, you can 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, you can contact your State Medicaid or CHIP office at **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored Plan.

If it is determined that you or your Dependents are eligible for Premium Assistance under Medicaid or CHIP, as well as eligible under the Plan rules, you may enroll in your employer Plan if you are not already enrolled. The employer cannot stop you from enrolling. 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, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling (866) 444-EBSA (3272).

If you live in a different state, to find out if the State you reside in provides assistance in paying your health plan premiums, please contact the Plan Office (at the number indicated below) for a list of participating States. To see if any more States have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, you can also contact either:

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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
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 more States have added a Premium Assistance Program since January 31, 2024, or for more information on special enrollment rights, you can also 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

H. DESIGNATION OF PRIMARY CARE PROVIDERS

Pursuant to the Patient Protection and Affordable Care Act and Consolidated Appropriations Act, the Plan (through its Insurers) generally allows the designation of a primary care provider including pediatrician and OBGYN care provider. You have the right to designate any primary care provider who participates in the PPO or HMO network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Kaiser HMO, Sutter Health Plus HMO, Western Health Advantage HMO and PPO, and United American Medical depending on the insured Plan option you are enrolled in.

You do not need prior authorization from Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the PPO or HMO network 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 Kaiser HMO, Sutter Health Plus HMO, Western Health Advantage HMO and PPO, and United American Medical depending on the insured Plan option you are enrolled in.

I. REMINDER NO SURPRISES ACT – YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS!

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your Plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your Plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your Plan's deductible or annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your Plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center.
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the Department of Health and Human Services at 1-800-985-3059 to submit a complaint regarding potential violations of the No Surprises Act for enforcement issues related to federally regulated plans such as self-funded plans. You may contact 1-888-466-2219 for enforcement issues related to state regulated plans such as fully-insured plans.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

You can find information about your rights under your state's law at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

For the State of California law information please visit www.HealthHelp.ca.gov.

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If you have any questions, please contact the Trust Fund Office at (707) 526-1996.