HARRISON TRUST

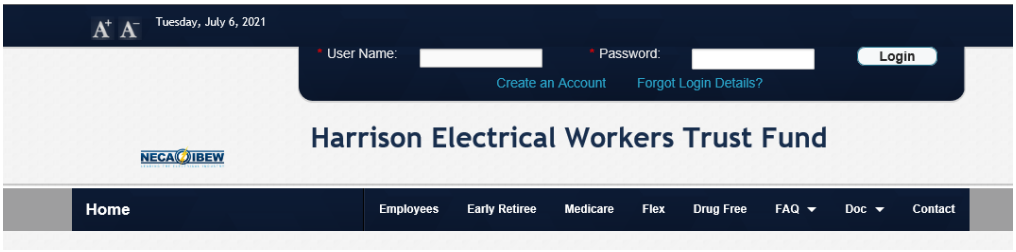
A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

July 2026

HARRISON FLEXIBLE BENEFITS PLAN
SEMI-ANNUAL ELECTION PERIOD – NOW ONLINE!!
July 15th – August 31st

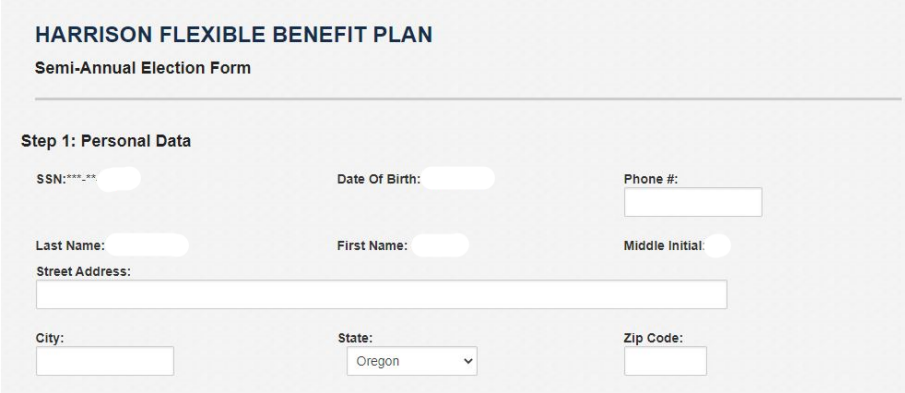
Dear Flex Participant:

It is time for the semi-annual Flex Plan election period which you can DO ONLINE! If you would like to make your election changes online, log into your Harrison Trust account at **www.harrisonbenefits.org,** otherwise please return the enclosed form. Also included in this mailing is the Flex direct deposit form and the opt-in form for automatic reimbursement from your Medical Reimbursement Account. The third page has instructions for electing direct deposit and automatic reimbursement. IF YOU DO NOT WISH TO MAKE ANY CHANGES TO YOUR ACCOUNT, then there is nothing that you need to do.



To Find the Election Form online follow the below steps:

- **Step 1** login to your account. If you have not established an online account, click on **Create an Account** and answer the question to set up your account.
- **Step 2** Click on the **Member Benefits** drop-down menu
- **Step 3** Click on **Flex Semi Annual Election**
- **Step 4** Verify that your phone and address are up to date



- **Step 5** Update your Election form
- **Step 6 Initial** and **SAVE**

The back of this letter includes instructions for filing out the form online or via paper.

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When completing the election form, you have three important decisions to make:

- On **Step 2** of the election form, you must indicate where you would like ***future*** employer contributions to be allocated. You may elect a percentage of future contributions to go to the Wage Replacement account and/or the Premium Reserve account.

- On **Step 3**, you can designate a percentage of your Premium Reserve account to move into Medical Reimbursement each MONTH. The money moved will be available for services the first day of the month after your employer is obligated to contribute to the plan (for example, if money is contributed September 20, it will be available for medical services provided on or after October 1).

- On **Step 4** of the election form, you must indicate how you want to distribute the funds in your **existing Premium Reserve** account. You may transfer a percentage of your existing Premium Reserve into Medical Reimbursement and/or Dependent Care, or you may leave money in the Premium Reserve account.

Please Note: Money can only move to the Medical Reimbursement account if you have medical insurance through Harrison**.** If you are a Traveler, your contributions will go to Wage Replacement.

If you are a Medicare Retiree and no longer receive health insurance through the Harrison Trust, you may move your money from Premium Reserve account to the Medical Reimbursement account, if you are able to provide proof of Medicare parts A & B and either a Supplemental plan or MedAdvantage plan.

Keep in mind that once funds are placed in the Wage Replacement, Medical Reimbursement, or Dependent Care accounts, they may not be transferred to other accounts. The only account from which you may transfer funds is the Premium Reserve account. If you request an automatic election by checking the box on Step 4 of the form (or if you requested an automatic election previously and have not completed a new election form), your funds will be transferred effective September 1, 2026. If you do not elect for an automatic election but are requesting funds to be transferred, the transfer will be effective the first day of the month following receipt of the form. **If you have not previously checked the automatic election box, or if you want to change a previous automatic election, you MUST complete the enclosed election form by August 31, 2026 to transfer funds from your premium reserve account or to change your allocations for future employer contributions.**

Included in the mailing is a paper copy of the election form. You only need to complete one option if you choose to make any changes to your flex elections. Fill out the form and return to the Trust office **OR** fill out the flex election on the Harrison website. **Again, if you do not want to make any election changes, there is nothing that you need to do.**

NOTE: You must have medical insurance coverage in effect for money to transfer to the **Medical Reimbursement**

HARRISON FLEXIBLE BENEFIT PLAN
Semi-Annual Election Form

Step 1. PERSONAL DATA
(Please print clearly)

_____
Social Security Number

_____
Last Name First Name MI

_____
Street Address

_____
City State Zip

Phone Number _____

Step 2. FUTURE CONTRIBUTIONS
Instructions: Choose how your **future** contributions will be allocated between accounts. I elect to allocate **future** contributions from my employer reports between the following account(s).

Wage Replacement _____%

Premium Reserve _____%

TOTAL MUST BE 100%

Step 3. MEDICAL REIMBURSEMENT- FUTURE CONTRIBUTIONS
Instructions: Choose the percentage of future contributions going into Premium Reserve above that you would like automatically moved **MONTHLY** into the Medical Reimbursement Account.

Medical Reimbursement (monthly) ___%

Step 4. SEMI-ANNUAL ELECTION TRANSFER

Instructions: Choose how your **existing** Premium Reserve balance will be allocated between the three accounts. (If no election is made, money will remain in the Premium Reserve Account.)
I elect to allocate my current Premium Reserve balance between the following account(s):

☐ **I want this election to happen every six months and to be effective March 1 & September 1 of each year.**

Premium Reserve _____%
(% to leave in Premium)

Medical Reimbursement _____%
(% to be transferred into Medical)

Dependent Care (Child Care) _____%
(% to be transferred into Dependent Care)

PERCENTAGES MUST TOTAL 100%

Step 5. SIGNATURE
I understand that all elections will be **EFFECTIVE THE FIRST OF THE MONTH FOLLOWING RECEIPT OF THIS FORM IN THE TRUST OFFICE.**

_____
Signature

_____
Date

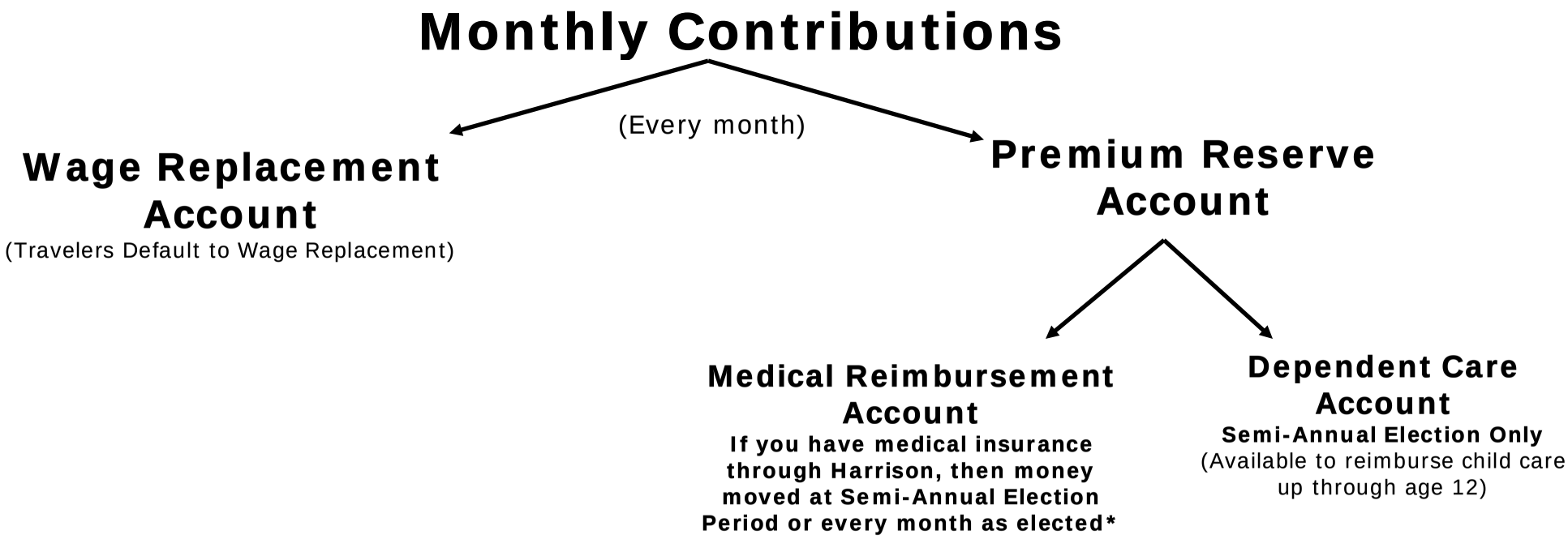
Step 6. RETURN BY 08/31/2026*
Return the white copy to:
Harrison Trust
5331 S Macadam Avenue, Suite #258
PMB #116
Portland, OR 97239
Phone: (503) 224-0048 X1681 Fax: (503) 208-9223 Email: pdxflexclaims@benesys.com

***If form is not returned, funds will continue to allocate and transfer based upon the last form on file.**

White: Harrison Flex Copy
Yellow: Member Copy

Money comes in each month you work and is deposited into your account. It is distributed between your Wage Replacement and Premium Reserve Accounts. The percentage deposited into each account is based on your last election form turned in. If you did not turn in a form and make an election, then all of your money has been deposited into the Premium Reserve Account. **Remember money needs to be in Premium Reserve to pay for Supplemental Life Insurance the end of each February.**

Twice a year, in January/February and July/August, you are given the opportunity to transfer funds already deposited into your Premium Reserve Account into your Dependent Care and Medical Reimbursement Accounts. **You must have Harrison medical coverage in effect for money to be transferred to Medical Reimbursement account. Money can only flow in the direction of an arrow. If you do not see an arrow going in that direction, your money will NOT go in that direction.**



***Note:** **Money will only be transferred to the Medical Reimbursement Account per your election, if you have medical insurance through the Harrison Trust (either the Trust, Kaiser, Providence or one of the retiree plans). If you do not have medical insurance through Harrison, funds elected to go to the Medical Reimbursement account will remain in or go to the Premium Reserve Account and remain there until the next semi-annual election period. If you are a Medicare Retiree and no longer receive health insurance through the Harrison Trust, you may move your money from Premium Reserve account to the Medical Reimbursement account, if you are able to provide proof of Medicare parts A & B and either a Supplemental plan or MedAdvantage plan.**

To: All Employees enrolled in the Harrison Electrical Workers Trust Fund Flexible Benefits Plan

From: Board of Trustees

Date: July 2026

Re: Summary of Material Modifications to Flex Plan Benefit Booklet

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Introduction

The June 2015 Benefit Booklet for the Flexible Benefits Plan is amended to increase the amount that can be allocated to the Dependent Care Reimbursement Plan. If you cannot locate your Benefit Booklet, call or write the Administrative Office.

Description of the Changes

1. Effective January 1, 2026, on page 16 of the booklet, Dependent Care Reimbursement Account (Non-Taxable Account), Section 4.a. and 4.b. are amended to read as follows*:*

4. The maximum payment that a Participant may receive from the Dependent Care Reimbursement Account for any calendar year is:

   a. In the case of a Participant who is not married at the close of the calendar year, the lesser of the Participant's earned income (as defined in Code Section 129(e)(2)) for the calendar year or $7,500;

   b. In the case of a Participant who is married at the close of the calendar year, the lesser of:

      (i) The Participant's earned income for the calendar year;

      (ii) The earned income of the Participant's spouse for the calendar year;

      (iii) $7,500 if the Participant and spouse file a joint federal income tax return; or

      (iv) $3,750 if the Participant and spouse file separate federal income tax returns. In the case of a spouse who is a full-time student at an

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educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income for such month of $250 if there is one person that qualifies for Dependent Care Expenses for whom the Participant seeks reimbursement from his Dependent Care Reimbursement Account or $500 if there is more than one person that qualifies for Dependent Care Expenses for whom the Participant seeks reimbursement from hisDependent Care Reimbursement Account.

Conclusion

If you have any questions concerning the changes in this notice, contact the Administrative Office. Please keep this notice with your June 2015 Benefit Booklet for the Harrison Electrical Workers Trust Fund Flexible Benefits Plan.

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DIRECT DEPOSIT AUTHORIZATION

The Harrison Electrical Trust Fund highly encourages you to have your Flex reimbursements electronically deposited into your bank, credit union or other financial institution. If you would like to have your Flex reimbursement deposited directly to your financial institution, please complete this form and sign below.

Name: _____ Last 4 of SSN: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ E-Mail: _____

The undersigned participant ("Participant") hereby authorizes and directs the Administrative Office for the Harrison Electrical Trust Fund ("Plan"), to transfer funds for benefit payments to which Participant may be entitled under the terms of the Plan as they become due and payable, and directly deposit said funds by electronic transfer to the account maintained by Participant at the financial institution identified below. Said funds shall be in full payment, satisfaction and discharge of amounts due Participant under the Plan. Participant authorizes and directs Financial Institution to refund any payments to the Plan to which Participant, or Participant's successors or estate, would not have been entitled under the Plan as a result of Participant's death or otherwise, and charge the same to the Participant's account designated below. Participant agrees on behalf of his or herself, any co-tenants, heirs, executors, successors and any trustee on his or her trust (if any) to reimburse the Plan for such payments.

☐ Checking Account (Attach a voided check or bank confirmation)
☐ Savings Account (Attach a deposit slip or bank confirmation)

Depository Name: _____
Bank, Credit Union, or Financial Institution

Street Address: _____

City: _____ State: _____ Zip: _____

ABA Routing#: _____ Account#: _____

If the bank identified above is a financial institution located outside of the United States or the funds deposited into the bank account identified above will be forwarded to, credited or otherwise handled by a financial institution located outside of the United States, I will immediately notify the Trust Office. This authority is to remain in full force and effect until the Harrison Electrical Trust Fund has received written notification from me of its termination in such time and in such manner as to afford the Harrison Electrical Trust Fund and the DEPOSITORY a reasonable opportunity to act upon it. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Signature_____Date_____

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Harrison Trust Flex Plan
Automatic Reimbursement from Medical Reimbursement Account Opt-In Form

The Harrison Electrical Trust Fund encourages you to opt-in for automatic reimbursement from your Flex Medical Reimbursement Account for medical and dental claims processed through the Harrison Trust Health insurance. By filling out and signing below you are authorizing the Trust to automatically request reimbursement from your Harrison Flex Medical Reimbursement Account. Funds will be mailed to you by check weekly, if you or your Dependents have had claims processed with out of pocket costs. If you want to further expedite the reimbursement process, please sign up for direct deposit.

Name: _____ Last 4 of SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ E-Mail: _____

☐ **By checking the box, you are opting into automatic reimbursement and confirm that you have no other insurance coverage outside of Harrison.**

The undersigned participant ("Participant") hereby authorizes and directs the Administrative Office for the Harrison Electrical Trust Fund Flex plan ("Plan"), to automatically process, weekly reimbursement from my Flex Medical Reimbursement Account. Said funds shall be in full payment, satisfaction, and discharge of amounts due Participant under the Plan.

This authority is to remain in full force and effect until the Harrison Electrical Trust Fund has received written notification from me of its termination in such time and in such manner as to afford the Harrison Electrical Trust Fund.

Signature _____ Date _____

Instructions for returning the form to the Trust office:

- Upload the signed form to the SECURE portal on the Harrison Trust website www.harrisonbenefits.org
  - Login with your unique ID and Password
  - Click on Member Benefit
  - Click on Documents to Submit
- Mail into the Trust
  PMB #116 5331 S Macadam Avenue, Suite 258
  Portland, OR 97239
- Fax to the Trust Office: 503-208-9223

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