

Harrison Electrical Workers Trust Fund

Open Enrollment Booklet

2026 PLAN YEAR

OPEN ENROLLMENT: NOVEMBER 1 – November 30, 2025

WHAT YOU NEED TO DO...

➤ **REVIEW THE 2026 BENEFITS IN THIS BOOKLET**

- Invitation to Open Enrollment meetings; in-person and virtual
- Plan Options and Hour Requirements
- The Medical and Dental Benefit Comparison
- Important Changes

➤ **DECIDE IF YOU WANT TO MAKE A CHANGE FOR 2026— THIS IS YOUR CHANCE!**

- To change your medical and dental plan elections
- Add or remove dependents
- **If you do not wish to make any changes to your coverage, no action is required**

- The **DEADLINE** to submit your enrollment form is **November 30th!** All changes effective January 1st.

WAYS TO SEND YOUR COMPLETED ENROLLMENT FORM TO HARRISON TRUST:

Online: www.harrisonbenefits.org – go paperless!

MAIL: PMB #116, 5331 S Macadam Ave., Suite 258, Portland, OR 97239

FAX: (503) 228-0149

EMAIL: harrison@benesys.com

Enrollment forms can be found online at www.harrisonbenefits.org

Local: (503) 224-0048

Toll Free: (800) 547-4457 ext.1679



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- ✓ **Keeping your costs down.** The Harrison Trustees work diligently with the health plans to minimize rate increases in order to provide you and your family with a comprehensive benefits package.
- ✓ **Reminder:** If you have other health insurance, fill out the Coordination of Benefits form and return to the Trust office. Forms are located on the Trust website.
- ✓ **Have your beneficiaries changed?** If yes, please complete and submit a beneficiary form. Forms are located on the Trust website.

Please come to one of the open enrollment meetings to have your questions answered. Spouses are welcome to attend. Representatives of the Trust as well as the various carriers will present the benefit options available to you.

Are you near early retirement or Medicare age and you would like more information on other Plans? Then please attend any of the Retiree meetings.

ACTIVE & EARLY RETIREE PARTICIPANT MEETINGS

DATE	TIME	PLACE
Monday Nov 17, 2025	5 pm	Central Electrical Training Center 33309 HWY 99E - Tangent, Oregon
Tuesday Nov 18, 2025	4 pm	Join from a PC, Mac, iPad, iPhone or Android device: Please click this URL to join. https://us02web.zoom.us/j/88507964585
Wednesday Nov 19, 2025	5 pm	NECA-IBEW Local 48 Training Center 16021 NE Airport Way - Portland, Oregon
Thursday Nov 20, 2025	5 pm	Southern Oregon Labor Temple 4480 Rogue Valley Hwy Ste 3- Central Point, Oregon
Friday Nov 21, 2025	4 pm	IBEW Local 932 3427 Ash Street - North Bend, Oregon

MEDICARE RETIREE MEETINGS

DATE	TIME	PLACE
Monday Nov 17, 2025	3 pm	Central Electrical Training Center 33309 HWY 99E - Tangent, Oregon
Tuesday Nov 18, 2025	1 pm	Join from a PC, Mac, iPad, iPhone or Android device: Please click this URL to join. https://us02web.zoom.us/j/83837952142
Wednesday Nov 19, 2025	3 pm	NECA-IBEW Local 48 Training Center 16021 NE Airport Way - Portland, Oregon
Thursday Nov 20, 2025	3 pm	Southern Oregon Labor Temple 4480 Rogue Valley Hwy Ste 3- Central Point, Oregon
Friday Nov 21, 2025	2 pm	IBEW Local 932 3427 Ash Street - North Bend, Oregon

Harrison Trust premiums will see an increase for the 2026 plan year. Please note the rates below.

PLAN OPTION	EMPLOYER PAID	HOURS PER MONTH (approximately)	COBRA SELF-PAY	COBRA SELF-PAY
	<i>Monthly Deduction</i>	<i>(Bargaining Unit Employees)</i>	<i>Medical /Rx</i>	<i>Medical/Rx Dental, Vision</i>
Trust Medical, VSP, and Dental - Trust, Kaiser or Willamette	\$1,405	143	\$1,355	\$1,405
KAISER Medical/Vision/Rx, Dental - Trust, Kaiser or Willamette	\$1,470	149	\$1,420	\$1,470
Providence Medical and Rx, VSP, Dental - Trust, Kaiser or Willamette	\$1,575	160	\$1,525	\$1,575

BENEFIT MODIFICATIONS FOR 2026

TRUST SELF-FUNDED PLAN

- No Benefit Changes for 2026. Enclosed find a newsletter outlining some benefit clarifications and improvements made in the last year.

KAISER

- No Benefit Changes

PROVIDENCE HEALTH PLAN: Due to the continued increase in the cost of healthcare, there will be some changes to the Providence Health Plan effective January 1, 2026. These adjustments are necessary to help maintain the long-term sustainability of our health benefits program while continuing to provide quality coverage to all participants. **Detailed below are the major plan changes for 2026:**

- The deductible will increase from \$500 to \$750 per individual coverage and \$1000 to \$1500 per family
- Copay for office visits will increase from \$20 to \$30
- Copay for in network specialist office visit, urgent care and occupational therapy will increase from \$30 to \$50
- Out of network coinsurance increase from 40% to 50%. This means if you go to an out of network provider, you will pay 50% of the cost instead of 40%
- Emergency Room copay increased from \$250 after deductible to \$500 after deductible unless admitted
- Routine Vision Exam removed. This benefit is still available under Vision Service Plan (VSP).

We understand that any change to your benefits can have an impact, and we are committed to ensuring you have the information and support needed to make the most of your coverage.

Additional details and updated plan documents are included in the Open Enrollment materials.

What do I need to know on the Trust Self-Funded Plan?

Doctors and Facilities	• In-Network care provided through Cigna's nationwide network of physicians, hospitals, and other medical providers. • <u>Open Access Plus network</u> has over 1 million providers nationwide. • Find a provider on myCigna.com
Virtual Care – MDLive	• Whenever – 24/7/365, including holidays and weekends for medical; appointments scheduled in minutes for behavioral care.

	• Wherever – at home, at work, or on the go. • However – via video or phone. Access through myCigna.com, mobile app or telephone. • Whomever – adult and pediatric care for medical. • Whyever – care for minor medical conditions and behavioral/mental health needs. *There is a \$1 credit card hold to schedule an appointment*
New 24/7 FREE Nurse Call Line (800) 768-4695	• Nurse Line and Health Information Line available Free 24/7/365 • Speak with a registered nurse. Get answers to your questions for FREE! • Put the phone number in your cell phone. (800) 768-4695
myCigna.com	• Find doctors, hospitals, labs & specialists in one place • Network Information to find a nearby doctor or immediate care • Quality of Care with Cigna Care Designation • Spanish Language Functionality • Snapshot of your health with the online health assessment. • Built in search engine with a cost estimator. • Mobile Access
Mobile App and Mobile site 	• Mobile site and myCigna app deliver information on the go • All customers can access myCigna via a mobile device using an internet browser or • Utilize myCigna mobile app for iOS and Android devices for tools and resources in a simple to use tool.
National Labs LabCorp or Quest	• Stick with lower cost labs. National Labs; Quest Diagnostics® or Laboratory Corporation of America (LabCorp) can save you up to 75%. • Ask your doctor to send labs to LabCorp or Quest for extra savings.
Enthea	• Ketamine-Assisted Therapy (KAT). KAT combines low-dose ketamine treatments with talking to a mental health professional to help break old patterns that cause depression, anxiety, PTSD and emotional pain.
FREE Maternity Education (800) 768-4695	• A member of our team will help you understand any health issues that could affect your baby. • You can ask your own questions and get information to help you make informed choices about your pregnancy.

Harrison Electrical Workers Trust Fund 2026 Medical Options

All information contained in this benefit comparison is in summary and does not fully describe your benefit coverage. For specific information about your medical options, refer to your benefits booklet, or you may obtain a benefits packet for the plan of your choice from the Trust Office. You may also contact the health plan's Customer Service for further assistance. If there is any conflict between this summary and the SPD, the SPD prevails.

Medical Plan Feature		Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Option Advantage
Provider Choice		Any provider. In Oregon and SW Wash.: For a list of network providers , see www.mycigna.com .	Except for emergencies, you must receive care from Kaiser Permanente and affiliated providers. www.kp.org	Refer to the Providence Provider Directory Provider list can be viewed at www.providence.org/health_plans (Click on Signature Network option)
Coverage Area		Anywhere with Reimbursement at 60% of UCR (Preferred providers reimbursed at 80%)	You must live or work within the Kaiser Service Area	OREGON: all counties. WASHINGTON: Clark, Skamania and Klickitat counties
Annual Deductible		\$500 per person, \$1,000 per family (2 or more persons)	\$500 per person/\$1,500 per family (3 or more persons) (office visits not subject to deductible)	\$750 per person, up to \$1,500 (2 or more persons). (Waived for many outpatient services from participating providers)
Medical Out-of-Pocket Maximum (includes deductible) (Coinsurance)		In-Network: \$3,000 per person, \$6,000 per family (2 or more persons) Out-of-Network: \$3,000 per person, \$6,000 per family (2 or more persons)	\$6,000 per person/\$12,000 per family (2 or more persons) (not all copays apply to this limit)	\$6,000 per person, up to \$12,000 (2 or more persons). (Some services do not apply to maximums) Many services require prior authorization If you do not obtain prior authorization for services from a non-participating provider, a 50% penalty, not to exceed \$2,500 will apply to each covered service
Rx Out-of-Pocket Maximum		\$3,000 per person, \$6,000 per family (2 or more persons)	No separate out-of-pocket maximum for Rx	No separate out-of-pocket maximum for Rx
Covered Services		Plan Pays		
		IN-NETWORK		OUT-OF-NETWORK
Doctor's Office Visits		80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after you pay \$5 co-pay first 3 visits then \$20 co-pay per visit for primary doctor/ \$30 co-pay per visit for specialist	100% after \$30 co-pay per visit (Deductible does not apply)
Hospital Services		80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	80%	80% (including maternity and newborn nursery care) (Deductible does not apply to newborn nursery care)
				50% UCR* After Deductible

Harrison Electrical Workers Trust Fund 2026 Medical Options

Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Core Advantage	
Covered Services	Plan Pays	Plan Pays	Plan Pays	
			IN-NETWORK	OUT-OF-NETWORK
Maternity - Outpatient	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	\$0 for scheduled prenatal and postpartum visits. Inpatient hospital 80%	80% Prenatal office visits covered in full	50% UCR* After Deductible
Emergency Room Care	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	80%	80% after \$750/\$1500 deductible and \$500 co-pay (Copay waived if admitted within 24 hours)	50% after deductible and \$500 co-pay (Copay waived if admitted within 24 hours)
Preventive Care	In Network Providers: 100% (deductible does not apply) Out-of-Network Providers: Not covered	100%	100%	50% UCR* Deductible does not apply for most services
Chiropractic Manipulation	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers (26 visits per calendar year)	Physician referred chiropractic are no longer covered.	20 chiropractor visits per member per calendar year.	Not Covered
Acupuncture Services and Massage Therapy	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers (Combination of 26 visits per calendar year total)	Physician referred acupuncture are no longer covered.	12 acupuncture visits per member per calendar year.	Not Covered
X-ray and Lab	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after \$20 co-pay per visit (deductible does not apply)	80% First \$500 covered in full, co-payment waived	50% UCR* After Deductible
Hi-Tech Imaging Services (PET, CT, MRI, etc)	80% In-Network Preferred Providers 60% UCR* Out-of-Network Providers	100% after \$100 co-pay per visit (deductible does not apply)	80%	50% UCR* After Deductible

*Benefits paid at UCR (Usual, customary and reasonable charges)

Harrison Electrical Workers Trust Fund 2026 Medical Options

Medical Plan Feature		Trust Self-Funded Plan	Kaiser Permanente HMO	Providence Core Advantages
Covered Services	Plan Pays	Plan Pays	Plan Pays	Plan Pays
Prescription Drugs Refer to Plan Booklet for full benefit outline.	Providence participating pharmacies (up to 30 day supply): Generic: \$15 copay Preferred Brand: \$35 copay Non-Preferred Brand: \$70 copay Specialty: \$150 copay Providence Mail Order (90-day supply): Generic: \$30 copay Preferred Brand: \$70 copay Non-Preferred Brand: \$140 copay Prescriptions by Mail: You may obtain a 90-day supply (two copayments will apply) Costco Home Delivery, Postal Prescription Services or 90-day supply at Fred Meyer, Walgreens or Providence pharmacies.	Kaiser Formulary Rx; (non-formulary medications are not covered): Generic: \$15 copay (up to 30-day supply) Preferred Brand: \$30 copay (up to 30-day supply) Non-Preferred Brand: \$50 copay (up to 30-day supply) Specialty medications: \$50 copay up to 30-day supply Mail Order for maintenance medications: 90-day supply for 2 copays	Preferred Generic: \$0 copay for a 30-day supply purchased at a participating retail pharmacy Non-Preferred Generic Drugs: \$10 copay for a 30-day supply purchased at a participating retail pharmacy Preferred Brand-Name: \$40 copay for a 30-day supply purchased at a participating retail pharmacy Non-Preferred Brand-Name: \$75 copay for a 30-day supply purchased at a participating retail pharmacy Specialty and Compound Medications: 50% coinsurance up to a \$300 retail Prescriptions by Mail: You may obtain a 90-day supply (two copayments will apply) of each maintenance drug through Costco Home Delivery, Postal Prescription Services or 90-day at Fred Meyer, Walgreens or Providence pharmacies. Use of Non-Participating Pharmacies: Reimbursement subject to review	
Vision Benefits provided by the Trust through Vision Service Plan. (Except Kaiser participants) Refer to Plan Booklet for full benefit description.	In-Network VSP Provider: Exam: You pay \$25 copayment Glasses: You pay \$25 copayment and any non-covered any non-covered services Frames are covered once every 12 months with a \$150 allowance and 20% off out-of-pocket above that amount. Lenses are covered every 12 months (single vision or lined trifocal).	Kaiser Permanente Plan provider: Exam: You pay \$20 copayment per visit, no limit on number of visits. Glasses or contact lenses: You pay balance after a credit of \$150 once every two years	In-Network VSP Provider: Exam: You pay \$25 copayment Glasses: You pay \$25 copayment and any non-covered services Frames are covered once every 12 months with a \$150 allowance and 20% off out-of-pocket above that amount. Lenses are covered every 12 months (single vision, lined bifocal or lined trifocal).	

*Benefits paid at UCR (Usual, customary and reasonable charges)

Harrison Electrical Workers Trust Fund 2026 Medical Options

Benefit Questions?		
Harrison Trust Office:	(503) 224-0048, ext. 1679	(800) 547-4457, ext. 1679
Kaiser Permanente Membership Services:	(503) 813-2000	(800) 813-2000 (Refer to Group #2454)
Providence Health Plan:	(503) 574-7500	(800) 878-4445 (Refer to Group #105122)

*Benefits paid at UCR (Usual, customary and reasonable charges)

Harrison Electrical Workers Trust Fund

2026 Active Plan Dental Options

The following chart shows key features of your dental options. For more information about your dental options refer to your benefit booklet, or you may obtain a Kaiser or Willamette dental benefits packet from the Trust Office. If there is any conflict between this summary and the SPD, the SPD prevails.

Dental Plan Feature		Trust Self-Funded Dental Plan		Kaiser Dental		Willamette Dental	
Provider Choice		Any Provider		Kaiser Providers		Willamette Dental Providers	
Coverage Area		Anywhere		You must live or work within the Kaiser Service Area		Anywhere in Willamette Dental Service Area (Western & Central Oregon, Washington, Idaho)	
Annual Deductible		None		None		None	
Annual Maximum Benefit		\$2,000 per person		\$2,000 per person		No annual maximum	
Covered Services		Plan Pays		Plan Pays		Plan Pays	
Preventive Care							
Routine office Visits		100%		100% after \$10 copayment per visit		100% after \$10 copayment per visit	
Cleaning		100%		100% after \$10 copayment per visit		100% after \$10 copayment per visit	
Routine Oral exam		100%		100% after \$10 copayment per visit		100% after \$10 copayment per visit	
Basic Services							
Routine fillings and simple extractions.		70% UCR*		80%, after \$10 copayment per visit		100% after \$10 copayment per visit	
Oral Surgery		70% UCR*		80%, after \$10 copayment per visit		Participant Pays: \$100	
Root Canal		70% UCR*		80%, after \$10 copayment per visit		Participant pays: \$75-\$125, depending on tooth	
Non-routine Oral exam		70% UCR*		100% after \$10 copayment per visit		100% after \$10 copayment per visit	
X-rays		70% UCR*		100% after \$10 copayment per visit		100% after \$10 copayment per visit	
Major Services: (Crowns, inlays, onlays, bridges, dentures)		50% UCR*		50% after \$10 copayment per visit		Participant Pays: Crowns: \$150 Upper or Lower Denture: \$200 Bridge (per tooth): \$150	
Orthodontia Lifetime maximum per person		80% UCR* \$2,000		80%, after \$10 copayment per visit \$2,000		Participant Pays: \$1,500 for Comprehensive Orthodontia.	

* Usual, customary and reasonable

This is just a summary of benefits. Please refer to Trust Plan Booklet or Carrier Benefit Booklets for a complete description.

PMB #116 • 5331 S Macadam Avenue • Suite 258, Portland, OR 97239
(503) 224-0048 (800) 547-4457 Fax (503) 228-0149

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.harrisonbenefits.org or call in Portland (503) 224-0048 or toll-free 1-800-547-4457. 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 www.cciio.cms.gov or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 person/\$1,000 family (2 or more persons) If elected, Flexible Benefits Plan may be used for reimbursement of your deductible.	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. Most network provider preventive care services are covered before you meet your deductible .	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?	No.	
What is the out-of-pocket limit for this plan ?	For network providers or out-of-network providers : • \$3,000 person/\$6,000 family for medical in-network • \$3,000 person/\$6,000 family for medical out-of-network • \$3,000 person/\$6,000 family for prescriptions If elected, your Flexible Benefits Plan may be used for reimbursement of your out-of-pocket expenses.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. For a list of network providers , see www.mycigna.com , or call 1-800-547-4457.	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 permission from this plan.

 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
		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 (including virtual visits)	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	None
	Preventive care/screening/immunization	No charge	Not covered	Deductible does not apply. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.harrisonbenefits.org	Preferred and non-preferred generic drugs	Retail: \$15 copay /prescription; Mail order: \$30 copay /prescription	Not covered except for urgent or emergency situations.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If elected, your Flexible Benefits Plan may be used for reimbursement of prescription drug co-payments.
	Preferred brand drugs	Retail: \$35 copay /prescription; Mail order: \$70 copay /prescription	Not covered except for urgent or emergency situations.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a brand with generic equivalent is selected, the cost difference between the two will be added to the member copay. Unless the prescriber writes on the prescription "dispense as written".
	Non-preferred brand drugs	Retail: \$70 copay /prescription; Mail order: \$140 copay /prescription	Not covered except for urgent or emergency situations.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a brand with generic equivalent is selected, the cost difference between the two will be added to the member copay. Unless the prescriber writes on the prescription "dispense as written".
	Specialty drugs	\$150 copay /prescription	Not covered	Must use Credena Health. Call (503) 962-1700 for more information. Maximum 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	\$250 copay if not admitted except for certain medical conditions.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	Limited to the U.S. and Canada.
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization recommended except in an emergency. See your plan document for details.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	See your plan document for details.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization recommended except in an emergency. See your plan document for details.
If you are pregnant	Office visits	No charge	40% coinsurance after deductible	
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum of 100 visits per calendar year.
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Routine custodial care excluded. Limitations apply – See your plan document.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Equipment purchase requires review for medical necessity.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$25 copay /visit	100% of cost in excess of \$50	Limited to 1 exam every 12 months.
	Children's glasses	Frames covered up to \$150.	Various reimbursement amounts. Refer to Plan Document.	Limited to every 12 months for lenses, 12 months for frames.
	Children's dental check-up (Trust Dental)	No charge	No charge	2 exams per calendar year
	Children's dental check-up (Kaiser Dental)	\$10 copay /visit	Not covered	Question? In Portland (503) 813-2000 or toll-free 1-800-813-2000
	Children's dental check-up (Willamette Dental)	\$10 copay /visit	Not covered	Question? Toll-free 1-855-433-6825

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 .)	
- Cosmetic Surgery is general excluded except as required by Women's Health and Cancer Rights Act, due to an accidental bodily injury, or due to a birth defect. - Habilitation Services - Infertility Treatment	- Long Term Care - Non-emergency care when traveling outside the U.S. - Private Duty Nursing - Weight Loss Programs - Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
- Acupuncture Services - Bariatric Surgery - Dental Care	- Chiropractic Care - Hearing Aids - Naturopathic Services - Most coverage provided outside the United States. See www.harrisonbenefits.org.

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <http://www.cciio.cms.gov>. 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 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: Harrison Electrical Workers Trust Fund administrative office at (503) 224-0048 or 1-800-457-4457. 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.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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](#).

_____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](#) \$500
- [Specialist copayment](#) \$0
- [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	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$2,460
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$2,960

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$0
- [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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,380
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,880

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$500
- [Specialist copayment](#) \$0
- [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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$280
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$780



All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest

 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 see <https://kp.org/plandocuments> or call 1-800-813-2000 (TTY: 711). 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 www.healthcare.gov/sbc-glossary/ or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions		Answers	Why this Matters:
What is the overall deductible ?		\$500 Individual / \$1,500 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. Preventive care and services indicated in chart starting on page 2.	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?		No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?		\$6,000 Individual / \$12,000 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 ?		Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?		Yes. See www.kp.org or call 1-800-813-2000 (TTY: 711) for a list of Participating 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.

Important Questions		Answers	Why this Matters:
Do you need a referral to see a specialist ?	Yes, but you may self-refer to certain specialists .		This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit, deductible does not apply	Not covered	\$5 / visit, deductible does not apply for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Specialist visit	\$30 / visit, deductible does not apply	Not covered	None
	Preventive care/screening/immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: \$20 / visit, deductible does not apply. Lab tests: \$20 / visit, deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRI's)	\$100 / visit, deductible does not apply	Not covered	Some services may require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	\$15 (retail) & \$30 (mail order) / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines.
	Preferred brand drugs	\$30 (retail) & \$60 (mail order) / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$50 (retail) & \$100 (mail order) / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail) & up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through exception process.
	Specialty drugs	\$50 (retail) / prescription , deductible does not apply	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$40 / visit, deductible does not apply	Not covered	Non-Participating Providers covered when temporarily outside the service area: \$40 / visit, deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fee	20% coinsurance	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit, deductible does not apply	Not covered	\$5 / visit, deductible does not apply for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Inpatient services	20% coinsurance	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge, deductible does not apply	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
	Home health care	20% coinsurance	Not covered	130 visit limit / year. Prior authorization required.
If you need help recovering or have other special health needs	Rehabilitation services	Outpatient: \$30 / visit, deductible does not apply Inpatient: 20% coinsurance .	Not covered	Outpatient: 20 visit limit / therapy / year. Prior authorization required. Inpatient: Prior authorization required.
	Habilitation services	\$30 / visit, deductible does not apply	Not covered	20 visit limit / therapy / year. Prior authorization required.
	Skilled nursing care	20% coinsurance	Not covered	100 day limit / year. Prior authorization required.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines. Prior authorization required.
	Hospice service	No charge, deductible does not apply	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider (You will pay the least)	What You Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge for refractive exam, deductible does not apply	Not covered	None
	Children's glasses	No charge, deductible does not apply	Not covered	Limited to one pair of select frames and lenses or contact lenses / 12 months.
	Children's dental check-up	Not covered	Not covered	None

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 • Chiropractic care • Cosmetic surgery	• Dental care (Adult & Child) • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • 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 • Hearing aids (Under age 26: 1 aid / ear / 36 months)	• Infertility treatment • Routine eye care (Adult)

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 shown in the chart below. 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-813-2000 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.ccio.cms.gov
Oregon Department of Insurance	1-888-877-4894 or https://dfr.oregon.gov/
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.gov

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 1-800-813-2000 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-813-2000 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griegie in Deitsch, ruf 1-800-813-2000 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711)

CAROLINIAN (Kapasa|Falawasch): ngere aukke ghut alillis reel kapasa|Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-813-2000 (TTY: 711)

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](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other (blood work) [copayment](#) \$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	\$500
Copayments	\$100
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,260

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other (blood work) [copayment](#) \$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	\$0
Copayments	\$800
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$810

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other (x-ray) [copayment](#) \$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	\$500
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser 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, such as large print, audio, braille, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

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
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members:

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/online-services/cc/pub/complaintinformation.aspx>.

This notice is available at <https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice>

Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call 1-800-813-2000 (TTY: 711).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆኑ ለሆኑ ረዳት መርሻዎችን እና አገልግሎቶችን ጨምሮ የአድራሻ እርዳታ አገልግሎቶች በ 1-800-813-2000 ይደውሉ (TTY: 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم 1-800-813-2000 (TTY: 711).

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 1-800-813-2000 (TTY: 711)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با 1-800-813-2000 تماس بگیرید (تلفن منتهی): 711.

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le 1-800-813-2000 (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie 1-800-813-2000 an (TTY: 711).

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。1-800-813-2000 までお電話ください (TTY: 711)。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់: បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសមស្រប ដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ 1-800-813-2000 (TTY: 711)។

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. 1-800-813-2000로 전화해 주세요 (TTY: 711).

ລາວ (Laotian) ເຂົາໃຈໃສ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການປຶກສາການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການປຶກສາການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-813-2000 (TTY: 711).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. 1-800-813-2000 irratti bilbilaa (TTY:- 711)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਰਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ 1-800-813-2000 (TTY:- 711)।

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la 1-800-813-2000 (TTY: 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру 1-800-813-2000 (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al 1-800-813-2000 (TTY: 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером 1 800 813 2000 (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. 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 www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$750/per person \$1,500/per family (2 or more).	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. Office visits, most preventive care , emergency and urgent care services.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network : \$6,000/per person \$12,000/per family (2 or more). Out-of-Network : \$6,000/per person \$12,000/per family (2 or more).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above Usual, Customary and Reasonable (UCR) .	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See ProvidenceHealthPlan.com/findaprovider or call 1-800-878-4445 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
		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	First 3 visits \$5 copay /visit; deductible does not apply then \$30 copay /per in-person visit; deductible does not apply or \$10 copay /per virtual visit; deductible does not apply/visit	50% coinsurance ; deductible does not apply	Some services such as lab and x-ray will include additional member costs.
	Specialist visit	\$50 copay /visit; deductible does not apply	50% coinsurance ; deductible does not apply	Some services such as lab and x-ray will include additional member costs. Virtual visits are covered at the same cost-share as office visits.
	Preventive care/screening/immunization	No charge; deductible does not apply	50% coinsurance	Not all preventive services are required to be covered in full by the ACA. For more information on preventive services that are covered in full see: ProvidenceHealthPlan.com/PreventiveCare . 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.
	Diagnostic test (x-ray, blood work)	20% coinsurance . Covered in full for the first \$500 of services per calendar year, deductible does not apply	50% coinsurance	_____none_____
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.

For more information about limitations and exceptions, see the plan or policy document at [www.ProvidenceHealthPlan.com](#)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProvidenceHealthPlan.com	Tier 1	No charge; deductible does not apply	Not covered	ACA Preventive drugs are covered in full in-network .
	Tier 2	\$10 copay retail \$30 copay mail order; deductible does not apply	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Tier 3	\$40 copay retail \$80 copay mail order; deductible does not apply	Not covered	Prior authorization may apply. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Tier 4	\$75 copay retail \$150 copay mail order; deductible does not apply	Not covered	If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay .
	Tiers 5&6	50% coinsurance up to \$300 retail; deductible does not apply	Not covered	Specialty drugs (listed in Tier 5 and Tier 6 on your formulary) can only be purchased at a participating specialty pharmacy (limited to 30days).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: 10% coinsurance Hospital-based facility: 20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	\$500 copay	\$500 copay	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	_____none_____

For more information about limitations and exceptions, see the plan or policy document at www.ProvidenceHealthPlan.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	\$50 copay /visit; deductible does not apply	50% coinsurance ; deductible does not apply	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: First 3 visits \$5 copay /visit; deductible does not apply then \$30 copay /per in-person visit; deductible does not apply or \$10 copay /per virtual visit; deductible does not apply All other services: 20% coinsurance	Office visit 50% coinsurance ; deductible does not apply All other services: 50% coinsurance	All services except provider office visits may require prior authorization . If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. See your benefit summary for Applied Behavioral Analysis (ABA) services.
	Inpatient services	20% coinsurance	50% coinsurance	
	Office visits	No charge; deductible does not apply	50% coinsurance	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	_____none_____
	Rehabilitation services	Outpatient services \$50 copay /visit; deductible does not apply All other services: 20% coinsurance	50% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.

For more information about limitations and exceptions, see the plan or policy document at www.ProvidenceHealthPlan.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habituation services	Outpatient services \$50 copay /visit; deductible does not apply All other services: 20% coinsurance	50% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	20% coinsurance	50% coinsurance	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. Coverage is limited to 60 days per calendar year.
	Durable medical equipment	Diabetic Supplies: 20% coinsurance ; deductible does not apply All other equipment: 20% coinsurance	50% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.
	Hospice services	No charge; deductible does not apply	No charge; deductible does not apply	_____none_____
Children's eye exam	Children's eye exam	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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 .)	
• Abortion • Bariatric surgery • Cosmetic surgery (with certain exceptions) • Dental care (Adult)	• Dental check-up (Child) • Infertility treatment • Long-term care • Massage therapy • Private-duty nursing • Routine foot care (covered for diabetics) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture (12 visits) • Chiropractic care (20 visits)	• Hearing Aids (one per ear every 3 calendar years) • Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com • Routine eye exam (Adult)

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:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or <http://www.ProvidenceHealthPlan.com>.
- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or <https://dfr.oregon.gov> regarding their possible rights to continuation coverage under State law.

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:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or <http://www.ProvidenceHealthPlan.com>.
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or <https://dfr.oregon.gov>

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 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](#).

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

For more information about limitations and exceptions, see the plan or policy document at www.ProvidenceHealthPlan.com



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](#) \$750
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal 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	\$750
Copayments	\$0
Coinsurance	\$1,950
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	
\$2,660	

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$750
- [Specialist copayment](#) \$50
- 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	\$750
Copayments	\$0
Coinsurance	\$850
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	
\$1,520	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$750
- [Specialist copayment](#) \$50
- 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	\$750
Copayments	\$0
Coinsurance	\$350
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	
\$1,000	

Non-Discrimination Statement:

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide 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)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance 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 with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. 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, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

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УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistentă lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្មើស គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYEEFFANNA: Afaan dubbattu Oroomiffa, taajaala gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bililaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

با باشد می ف (TTY: 711) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرد تماس 1-800-878-4445

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษา^๑ไทยคุณสามารถใช้บริการช่วยเหลือทางภาษา^๑ได้ฟรี โทร 1-800-878-4445 (TTY: 711)

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HARRISON ELECTRICAL WORKERS TRUST FUND

www.harrisonbenefits.org

November 2025

What's New in Healthcare and Insurance Benefits

The Harrison Electrical Workers Trust Fund Active Employee Plan has been amended since the Summary Plan Description/Benefit Booklet was printed in 2016. This newsletter summarizes updates to the Plan from recently approved Amendments 17, 18, and 19.

Time Loss Benefit Updates

Eligibility For Time Loss Benefits

Time loss benefits can provide you with a short-term, weekly income if you become disabled and cannot work due to your non-occupational illness, injury, or pregnancy. The amount and duration of the benefit can vary, depending on the disability. See the Benefit Booklet for details.

To be eligible for time loss benefits, at the time your disability starts you must be eligible for Harrison Trust coverage as an active employee.*

If you are a newly covered employee, or if you have had lapses in Harrison Trust coverage during the prior 36 month period, you will be eligible for time loss benefits for disabilities that start after you have been covered by the Harrison Trust for 6 consecutive months. However, the 6-month waiting period will be waived if you have time loss coverage under another health and welfare plan and you had no more than a 90-day gap between your previous coverage and Harrison Trust coverage.

Amendment 18 (effective 1/1/2024), increased the allowable gap between prior time loss coverage and Harrison Trust coverage from 63 to 90 days.

*This does not include coverage under COBRA.

Certification of Disability for Time Loss Benefits

To receive time loss benefits, a doctor, physician assistant, or nurse practitioner must certify your total disability. You need not be confined to your home, but you must be unable to work in your normal job because of your non-occupational illness, injury or pregnancy and you must be under the care of a doctor, physician assistant or nurse practitioner.

Amendment 18 (effective 1/1/2025), expanded covered providers by permitting physician assistants and nurse practitioners (in addition to doctors) to certify your total disability and supervise your care.

Trust Medical Plan Updates

Gender Affirming Care

Because the Trust Medical Plan covers gender affirming care, Amendment 17 (effective 1/1/2024), removed the exclusion of services related to gender-reassignment procedures and complications.

Coordination of Benefits

If you are covered by two medical, dental or vision plans (such as both yours and your spouse's employer plan), rather than getting full benefits from both plans, the plans work together to **coordinate benefits** so the total payment from both plans equals the total benefits from the plan with the higher benefits.

The plan that covers you as an employee will be primary and the other plan (the secondary plan) will pay only if it covers a higher benefit. For example, if your employer plan covers 80% and the other plan covers 90%, your employer's plan will pay 80% and the other plan will pay 10%. If both plans cover 80%, the other plan pays 0%.

Amendment 19 (effective 1/1/2024), removed a \$10,000 limit on payments when the Trust Medical Plan was the secondary plan.

The [Benefit Booklet](#) is the official summary plan description (SPD) of your Harrison Electrical Workers Trust Fund Active Trust Plan. This newsletter is a summary of material modifications that describe amendments to the Benefit Booklet/SPD you previously received. Keep this newsletter with your Benefit Booklet/SPD. This summary of material modifications is being furnished to you in accordance with Sections 102 and 104 of the Employee Retirement Income Security Act of 1974 (ERISA). Unless otherwise specified, the changes described in this newsletter replace the corresponding section in the Benefit Booklet/SPD. Changes described in this newsletter are effective as of the date noted.

Harrison Trust

BeneSys, Inc.

5331 S Macadam Ave

Suite 258 PMB #116

Portland OR 97239



The Harrison Electrical Workers Trust Fund is proud to announce a **NEW** mental health benefit!

KETAMINE-ASSISTED THERAPY (KAT)

When traditional therapy and medications haven't been enough, KAT offers a different way forward.

What is Ketamine-Assisted Therapy (KAT)?

Ketamine is a safe, FDA-approved anesthetic that has been used in hospitals and medical settings **for over 50 years**. At low doses, it helps your brain **break old patterns that cause depression, anxiety, PTSD, and emotional pain**.

KAT combines **low-dose ketamine treatments with talking to a mental health professional** to help you heal from the inside out — **even when nothing else has worked**.



Creates new brain pathways for healing



Helps you process what's been bottled up



Often works when traditional therapies fall short

How It Works

- 1 Screening & Medical Evaluation**
A licensed provider evaluates your health and determines if KAT is a good fit.
- 2 Preparation**
You meet with a therapist to set goals before starting.
- 3 Ketamine Sessions**
You receive ketamine which is administered by a health professional in a relaxing, monitored environment.
- 4 Integration Therapy**
After each session, you meet with your therapist to process and apply what surfaced.

Typical Plan: 4–6 sessions over 3–4 weeks

Who Might Benefit?

- Depression
- PTSD (work, life, or military trauma)
- Anxiety and constant stress
- Substance use dependency
- Suicidal thoughts
- Burnout and emotional exhaustion

Is It Safe?

- **Yes**, used safely in hospitals for decades
- Careful screening to ensure KAT is appropriate
- Given at much lower doses for therapy
- Side effects are mild (you might feel a little tired, dizzy, or emotional for a bit)

You're fully monitored by medical staff during every session and work with a trained therapist after each session.

Why It Works

Instead of numbing the symptoms, KAT:

- Boosts your brain's ability to create new, healthier pathways
- 65% of patients with hard-to-treat depression see real improvement
- Backed by Johns Hopkins, Yale, NIH, and FDA-approved research

**Ready To Learn More?
Access Your Member Portal:**



To search for a provider & more:

www.enthea.com > login > member login email:

**Enthea+HarrisonElectricalTrust@enthea.com
password: **HarrisonBenefits!****

Your Ketamine-Assisted Therapy Journey through Enthea

You've tried the usual stuff — pills, talk therapy, or nothing at all. If it's not working, you're not out of options. Small steps. Big change. **Start here.**



Member email: members@enthea.com
Support: call/text: 617-297-7237

EAP Summary of Services

The Employee Assistance Program (**EAP**) is a **FREE** and **CONFIDENTIAL** benefit for you and your family members provided by **Harrison Electrical Workers Trust**

Counseling

Six (6) sessions in-person, on the phone or virtually for concerns such as:

- Depression
- Anxiety
- Relationships and family
- Workplace challenges
- Stress management
- Alcohol or substance misuse
- Grief and loss
- Professional development

Resources for Life

Assistance in finding childcare, adult care, caregiving resources, and more.

Legal Consultations/Mediation

Free 30-minute consultation and a 25% discount on services thereafter.

Financial Coaching

Unlimited guidance to improve spending, debt reduction, credit enhancement, savings, and retirement planning.

Identity Theft

60-minute consultation with a Fraud Resolution Specialist™ to restore identity and credit.

Home Ownership and Housing Support

Aid and discounts for home transactions and housing assistance resources.

Coaching

Three (3) phone or video sessions with a Coach for goal setting, healthy habits, and personal development.

Pet Parent Resources

Information, support, and discounts for pet owners.

Wellbeing Tools

Fertility health support, wellness resources, and gym discounts.

Member Site

Personal and professional development videos, webinars, self-assessments, online legal tools and more at **my.canopywell.com**. Log-in or register as a new user with organization name: **Harrison Electrical Workers Trust**

Canopy EAP App

Download the app by searching for “**Canopy EAP**” in Google Play or the App Store.

Self-Scheduling Portal

Register with your work email or personal email + code for online provider search and appointment management. Code: **POWER**

Canopy is committed to creating a safe, inclusive, and equitable society for all.

“Crisis Counselors are available by phone 24/7/365”



800-433-2320



503-850-7721



my.canopywell.com

BeneSys Now Mobile App!

The Board of Trustees of the Harrison Electrical Workers Trust is pleased to present a mobile application, BeneSys Now. Navigating healthcare is tough! Make it easier by taking advantage of our mobile app. The mobile app is designed for easy access to your Health Plan info!

Download the free “**BeneSys Now**” mobile app from your Apple or Google Play Store!



Features include:

- ✓ Biometric login using facial recognition or fingerprint
- ✓ User-friendly menu for easy navigation
- ✓ Secure messaging
- ✓ Download frequently requested forms and documents



Eligibility & Medical ID Cards

- View dependent enrollment information
- Check current Eligibility status, as well as one year of history
- Have an electronic Trust Plan Medical ID card

Contributions

- See your last 12 months of contributions to Harrison.

Claims Information*

- Track your family's annual deductibles
- Individual accumulator information for each family member
- Access 12 months of Explanation of Benefits (EOB)
- Twelve (12) months of claims history and payment status

Benefits

- Access to key documents and forms

If you have questions or need assistance with the application, please contact the Trust Office at (503) 224-0048

*Family members age 18 and over must register individually.

Take Advantage of Our Online Services!

Navigating healthcare is tough. Make it easier by taking advantage of our online services. Register at **www.harrisonbenefits.org**. This website provides you with an effective way to access and manage your benefits.

Registration is Easy!

1. From your computer or mobile device go to www.harrisonbenefits.org.
2. As a new user by clicking the Create an Account link to get started.
3. Enter your name, date of birth, SSN or Alternate ID and zip code.
4. Make sure what you enter matches our records!
5. Provide your email address and create a password.

What You Will Find

- ✓ Eligibility, including future eligibility
- ✓ Dependent info
- ✓ Your Dollar Bank Reserve Account info
- ✓ Claims history & EOBs
- ✓ Work history for the Harrison Trust, Cornell-Hart and Cascade Pension Plans
- ✓ Flex Plan transactions and balances
- ✓ Where to go to get a drug test for the DFWP program
- ✓ Contact info for the nurseline and employee assistance program
- ✓ Benefit books
- ✓ Forms

Please note: Only one username and password are permitted per email address. If more than one person in your family requires website access, each must use a different email address. Every member, spouse, and dependent over the age of 18 must create their own login to access to their Protected Health Information (PHI).

Questions? Use the “Contact Us” section of the website.

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 800-547-4457 (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 800-547-4457 (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 800-547-4457 (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 800-547-4457 (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 800-547-4457 (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. 800-547-4457 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք այլ լեզվով, ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ: Անվճարի ձևաչափերով տեղեկատվություն տրամադրվում է համար համապատասխան օժանդակ օժանդակ միջոցներով ու ծառայություններով նույնպես հասանելի են անվճար: Չանգահարեք 800-547-4457 (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 تماس (TTY: 711) رایگان در دسترس هستند. 800-547-4457

بیگریڈ 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 800-547-4457 (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。800-547-4457 (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 800-547-4457 (TTY: 711) أو تحدث إلى مقدم الخدمة.

ਗੁਰਮੁਖੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਦੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। 800-547-4457 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖
ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយភាសាគតិកត្តាអាចរកបានសម្រាប់អ្នក។
ជំនួយ
និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែល
អាចចូលប្រើបានក៏អាចរកបានដោយគតិកត្តាផ្តល់ផងដែរ។
ទូរស័ព្ទទៅ 800-547-4457 (TTY: 711)
ឬនិយាយទៅកាន់អ្នកផ្តល់សេវាបស់អ្នក។

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 800-547-4457 (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। 800-547-4457 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ภาษาไทย (Thai) หมายถึง: หากคุณพูดภาษาอื่น คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร 800-547-4457 (TTY: 711) หรือพูดคุยกับผู้ให้บริการของคุณ

Welcome to your 2026 benefits.
Wishing you good health for the upcoming year!