REAL LIFE. *REAL BENEFITS.*

HARRISON ELECTRICAL WORKERS TRUST FUND

YOUR BENEFITS GUIDE

NECA IBEW
LEADING THE ELECTRICAL INDUSTRY

Prefund Early Retirees

WHAT'S *INSIDE*

Open Enrollment for 2027	2
About the Changes for 2027	3
Open Enrollment Meetings — Join us!	6
Using the Trust Self-Funded Plan	7
Medical, Prescription Drugs and Vision Benefits	8
Dental Benefits	12
Questions?	13

OPEN ENROLLMENT FOR 2027

NOVEMBER 1 - 30, 2026

Open Enrollment is your once-a-year opportunity to change your Harrison Electrical Workers Trust Fund benefit elections for the coming year, including adding or dropping dependents for any reason.

Effective January 1, 2027:

- Two medical plan options are available
- The Providence Health Plan will be discontinued – participants on Providence will be automatically moved to the Trust Self-Funded Plan
- Prescription drug benefits under the Trust Self-Funded Plan will be provided through Optum
- Improved massage therapy benefit under the Trust Self-Funded Plan
- Trust premiums will increase
- There are no changes to vision or dental benefits for 2027.

See pages 3 - 5 for more details.

JOIN US AT AN OPEN ENROLLMENT MEETING

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

See page 7 for dates, times and locations.

If You Are in the Providence Health Plan

If you are currently enrolled in the Providence Health Medical Plan, you and your enrolled dependents will automatically be moved to the Trust Self-Funded Plan. If you want to enroll on the Kaiser Permanente Plan, you need to complete an Enrollment Form during Open Enrollment (see instructions below).

See page 8 for a summary of the Trust Self-Funded Plan.

No Action Required, Unless...

You do not need to do anything during Open Enrollment unless you want to:

- Switch medical and/or dental plan elections
- Add or drop dependent coverage.

If you do nothing, your current benefit choices will continue except, if you are in the Providence Health Plan now, you will be moved to Trust Self-Funded Plan.

Submit Your Enrollment Form by November 30, 2026 if You Want to Make Changes for 2027

Enrollment forms are available online at **www.harrisonbenefits.org**. You have four 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**

Questions? Call **(503) 224-0048** or toll free **(800) 547-4457** ext. 1679

ABOUT THE CHANGES FOR 2027

Providence Health Plan Discontinued

As you likely heard in the news, the Providence Health Plan is shutting down at the end of this year.

The Trustees requested bids for a replacement plan from four insurance carriers, but they were all significantly more expensive. It simply made no sense economically to continue to offer a third plan—especially since the Trust Self-Funded Plan provides robust coverage, includes Providence providers and medical centers in the network, and has lower premiums than any new option would have had.

If you move to the Trust Self-Funded Plan and are in the middle of receiving care for a serious condition from an out-of-network provider, that care may be covered at the in-network level for up to 90 days to ensure no disruption. First, check to see if your provider is in the Cigna network (see page 8 for how to find network providers). If your provider is not in the Cigna network, you will need to complete a Transition of Care Request Form to apply (available from the Harrison Trust office).

You also have the option to choose the Kaiser Permanente HMO, if you live in the Kaiser network area.

If you do not return an enrollment form by November 30, 2026, you and your currently enrolled family members will be automatically enrolled in the Trust Self-Funded Plan.

ABOUT THE TRUST SELF-FUNDED PLAN

The Trust Self-Funded Plan is directed by the Harrison Trustees and managed by the Trust Office (BeneSys). That means the focus is 100% on providing comprehensive benefits for the good of members, in a way that is financially sustainable for the long-term health of the Plan.

Cigna does not make decisions about the Trust Self-Funded Plan. They provide certain necessary services that don't make sense for us to develop on our own including maintaining a provider network, conducting prior authorizations and case management, and providing health and wellness resources.

Optum Replaces Providence for Prescription Drugs

TRUST SELF-FUNDED PLAN

Currently the Trust Self-Funded Plan uses Providence to manage prescription drug benefits under the Plan. With the closure of the Providence Health Plan, we needed to select a new prescription benefit manager, and the Trustees have selected Optum.

For prescriptions filled through December 31, 2026: Your current coverage continues as usual, with no disruption. Continue to use your current Providence prescription ID card and contact Providence with any questions.

For prescriptions filled starting January 1, 2027: Use your new medical/prescription ID card and contact Optum with any questions.

What this change may mean for you:

- **New card:** You'll get a new medical/prescription plan ID card by the end of the year. When you fill a prescription in 2027, use your new card.
- **New prescription drug list:** Optum uses a different prescription drug list (also called a formulary) than Providence. Now through the end of the year, you can check where your medications are on the new list at **welcome.optumrx.com/premium**. Click on "Prescription drug list" at the top of the page then choose the 2027 formulary from the drop-down menu. Once you receive your new medical/prescription ID card, you can register on **optumrx.com** and/or the Optum Rx app.
- **Network pharmacies:** You must use a network pharmacy for coverage. Optum has a very large network, and the vast majority of pharmacies are included. Now through the end of the year, you can search the network pharmacy list at **welcome.optumrx.com/premium**. Once you receive your new medical/prescription ID card, you can register on **optumrx.com** and/or the Optum Rx app.
- **More locations to get a 90-day supply:** You will be able to fill up to a 90-day supply of maintenance medications at any network pharmacy.
- **Preauthorization:** If you have a prescription that was preauthorized by Providence, you should not need a new authorization for the refills you have left. But, when it's time for a new prescription, you'll need to get preauthorization from Optum.
- **Current prescriptions:** In 2027, if you have refills left, you should be able to get a refill at the pharmacy using your current prescription.
- **Mail order:** If you use mail order, you will need to get a new prescription before you order from Optum's Home Delivery Pharmacy.

Watch for more information about your prescription drug coverage and Optum later this year. In the meantime, if you have questions, you can contact the Harrison Trust Office.

MASSAGE THERAPY

TRUST SELF-FUNDED PLAN

Effective January 1, 2027, if you are enrolled in the Trust Self-Funded Plan, massage therapy will be covered at the same level whether you see an in-network provider or an out-of-network provider. Either way, the Plan will cover massage therapy at 80% after deductible, up to a maximum of $75 per visit. Keep in mind, there is a limit of 26 visits per calendar year for acupuncture and massage therapy combined.

NEW HEALTH COACHING PROGRAM

TRUST SELF-FUNDED PLAN

Starting January 1, 2027, the Harrison Trust is partnering with Evernorth Health Services to offer a new Health Coaching program to members enrolled in the Trust Self-Funded Plan—at no cost to you. The program includes:

- One-on-one virtual coaching visits
- Secure messaging and follow-up between visits
- Support for lifestyle goals and chronic conditions
- Health planning, goal setting, and progress tracking
- Group coaching and educational seminars
- And more!

Watch for more information later this year.

ID Cards

New ID cards are mailed in December.

MEDICAL AND PRESCRIPTION CARDS

If you are currently enrolled in the Trust Self-Funded Plan or Providence Health Plan, you will receive new medical/prescription plan ID cards for 2027. There will be one card for medical and prescription benefits. All cards will list only the Trust member's name (family members will not receive cards with their own names). If you enroll in the Kaiser Permanente HMO, you will receive new ID cards from Kaiser.

If you are currently enrolled in the Kaiser Permanente HMO, you will only receive new ID cards if you switch plans or add dependents.

2027 Harrison Trust Premiums

The Harrison Trustees work diligently to minimize rate increases in order to provide you and your family with a comprehensive benefits package.

If you are moving from the discontinued Providence Health Plan to either the Trust Self-Funded Plan or the Kaiser HMO, your premium share (if you have one) will be lower in 2027.

		2027 Cost per Person per Month			
		25+ years	20 yrs to 24 yrs & 11 months	15 yrs to 19 yrs & 11 months	10 yrs to 14 yrs & 11 months
Prefund Plan Option	**Cost of Benefits**	**Premium Share is 0% You Pay** (per person per month)	**Premium Share is 7% You Pay** (per person per month)	**Premium Share is 12% You Pay** (per person per month)	**Premium Share is 17% You Pay** (per person per month)
Trust Plan Option					
Medical: Trust Self-Funded Plan **Rx:** Optum **Vision:** VSP **Dental:** Trust Plan, Kaiser or Willamette	$1,637	$0	$115	$196	$278
Kaiser Permanente Option					
Medical/Rx/Vision: Kaiser **Dental:** Trust Plan, Kaiser or Willamette	$1,677	$0	$117	$201	$285

OPEN ENROLLMENT MEETINGS – *JOIN US!*

Learn more about the changes for 2027 and the options available to you at an open enrollment meeting. Representatives of the Trust as well as various carriers will share a presentation and be available to answer your questions. Spouses and covered domestic partners are welcome to attend.

Are you near early retirement or Medicare age and curious about other Plans? Then please attend any of the Retiree meetings.

Active and Early Retiree Participant Meetings

Date	Time	Place
Monday Nov. 16	4:00 p.m.	Join from a PC, Mac, iPad, iPhone or Android device: Please use this URL to join: **https://us02web.zoom.us/j/81858868543**
Tuesday Nov. 17	5:00 p.m.	Central Electrical Training Center 33309 HWY 99E, Tangent, Oregon
Wednesday Nov. 18	5:00 p.m.	NECA-IBEW Local 48 Training Center 16021 NE Airport Way, Portland, Oregon
Thursday Nov. 19	5:00 p.m.	Southern Oregon Labor Temple 4480 Rogue Valley Hwy, Suite 3, Central Point, Oregon
Friday Nov. 20	3:00 p.m.	IBEW Local 932 3427 Ash Street, North Bend, Oregon

Medicare Retiree Meetings

Date	Time	Place
Monday Nov. 16	1:00 p.m.	Join from a PC, Mac, iPad, iPhone or Android device: Please use this URL to join: **https://us02web.zoom.us/j/81928253944**
Tuesday Nov. 17	3:00 p.m.	Central Electrical Training Center 33309 HWY 99E, Tangent, Oregon
Wednesday Nov. 18	3:00 p.m.	NECA-IBEW Local 48 Training Center 16021 NE Airport Way, Portland, Oregon
Thursday Nov. 19	3:00 p.m.	Southern Oregon Labor Temple 4480 Rogue Valley Hwy, Suite 3, Central Point, Oregon
Friday Nov. 20	2:00 p.m.	IBEW Local 932 3427 Ash Street, North Bend, Oregon

MAKING THE TRANSITION FROM THE PROVIDENCE HEALTH PLAN?

This page gives you a quick start guide to using the Trust Self-Funded Plan. Please review these tips to help ensure a smooth transition to your new medical coverage.

USING THE TRUST SELF-FUNDED PLAN

The Trust Self-Funded Plan is managed through the Harrison Trust Office. So, when you have questions about your benefits or how the Plan works, you can get answers from the people who really know how the Trust works.

Cigna provides services to the Plan including conducting prior authorizations and case management, and providing health and wellness resources. So, you will visit the Cigna website to find providers and use MDLive virtual care. But, other than that, the Harrison Trust Office is your go-to source for information.

How to Find Network Providers

1. Go to **Cigna.com** and click on "Find a doctor" at the top of the page. Then, under "How are you covered?" select "Employer or School."
2. Enter your city/state or zip code. Then choose how you would like to search (doctor type, doctor name, or health facilities and group practices).
3. Select the plan: "Open Access Plus, OA Plus, Choice Fund OA Plus."

If you are already enrolled in the Trust Self-Funded Plan, you can register and log in at **MyCigna.com** and search the network.

Managing the Deductible

Most services, other than preventive care, are subject to the annual $500 per person / $1,000 per family deductible. In other words, you pay the first $500 per person (up to $1,000 per family) each year before the Plan starts to pay. But, don't let that stop you from seeing a provider!

- Preventive care is covered 100% with no deductible when you see in-network providers. Just make sure the visit stays focused on prevention. If you use that time to also talk about a medical issue you are having, it can change the visit from purely preventive to one that is subject to the deductible and coinsurance.
- Telehealth is a great option for non-emergency issues – and it's 100% free to you. MDLive is available for virtual health care with medical and mental health professionals for urgent care, primary care, mental health, and even dermatology. It is FREE. The only requirement is a $1 credit card hold per session.
- When you visit your provider, you don't have to pay upfront. Your provider's office will bill the Plan first. The Plan will then let the provider's office know that you still need to meet your deductible. At that point, your provider's office will send you a bill and you will pay it. So, you have some time.

Ask Your Doctor to Send You to a Participating Lab

When you need lab tests done, ask your doctor to send you to LabCorp or Quest. You can save up to 75%.

MEDICAL, PRESCRIPTION DRUG AND VISION BENEFITS

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 Benefits

Medical Plan Feature	Trust Self-Funded Plan	Kaiser Permanente HMO
Provider Choice	You may see any licensed provider, but your benefits are generally higher when you see an in-network provider. For a list of network providers, see **www.mycigna.com**.	Generally, you must receive care from Kaiser Permanente and affiliated providers. **www.kp.org**
Coverage Area	Anywhere with reimbursement at 60% of UCR (preferred providers reimbursed at 80%)	You must live within the Kaiser Service Area
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)
Medical Out-of-Pocket Maximum (includes deductible)	**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)
Prescription Drug Out-of-Pocket Maximum	$3,000 per person, $6,000 per family (2 or more persons)	No separate out-of-pocket maximum for prescriptions

Covered Services	Plan Pays		Plan Pays
	In-Network	Out-of-Network	In-Network
Doctor's Office Visits	80%	60% R&C*	100% after $5 copay first 3 visits, then $20 copay per visit for primary doctor 100% after $30 copay per visit for specialist
Hospital Services	80%	60% R&C*	80%
Maternity (Outpatient)	80%	60% R&C*	$0 for scheduled prenatal and postpartum visits
Emergency Room Care	80%	60% R&C*	80%
Preventive Care	100% (deductible does not apply)	Not covered	100%
Chiropractic Manipulation (26 visits per calendar year)	80%	60% R&C*	Not covered
Acupuncture Services (limited to 26 visits per calendar year for acupuncture and massage therapy combined)	80%	60% R&C*	Not covered
Massage Therapy (limited to 26 visits per calendar year for acupuncture and massage therapy combined)	80% (maximum benefit $75 per visit)		Not covered
X-ray and Lab	80%	60% R&C*	100% after $20 copay per visit (deductible does not apply)
Hi-Tech Imaging Services (PET, CT, MRI, etc.)	80%	60% R&C*	100% after $100 copay per visit (deductible does not apply)

*R&C stands for Reasonable and Customary Charge.

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

Prescription Drug Benefits

Refer to Plan Booklet for full benefit outline.

	Trust Self-Funded Plan*		Kaiser Permanente HMO
Participating pharmacies	**Up to 30 day supply**	**31- to 90-day supply**	**Up to 30-day supply**
Generic	$15 copay	$30 copay	$15 copay
Preferred Brand	$35 copay	$70 copay	$30 copay
Non-Preferred Brand	$70 copay	$140 copay	$50 copay
Specialty	$150 copay (must use Optum specialty pharmacy)	n/a	$50 copay
Mail Order		**31- to 90-day supply**	**31- to 90-day supply**
Generic	n/a	$30 copay	$30 copay
Preferred Brand	n/a	$70 copay	$60 copay
Non-Preferred Brand	n/a	$140 copay	$100 copay

*Trust Self-Funded Plan: You must use Optum network pharmacies.

Vision Benefits

Refer to Plan Booklet for full benefit description.

	Trust Self-Funded Plan (VSP)		Kaiser Permanente Plan	
How it works	Administered by VSP. You receive a higher level of coverage when you use a VSP provider.		Eyeglasses, contacts and visual aids must be provided by Kaiser to be covered, but they may be prescribed by a non-Kaiser provider.	
	VSP Network	**Non-Network**	**Kaiser Provider**	**Non-Kaiser**
Routine eye exam	Once every 12 months		Once every 12 months	
	100% after $15 copay; routine retinal screening covered up to $39	100% up to $50	**Age 19 or older:** 100% after $20 copay **Age 18 or younger:** 100%	Not covered
Prescription eyeglasses	**One pair every 12 months After $25 copay...**		**Age 19 or older:** 100% up to $150 per two-year period for: » Prescription eyeglasses » Conventional or disposable prescription contact lenses » Medically necessary contact lenses **Age 18 or younger:** 100% for: » **Standard eyeglasses** (limited to one pair per year) » **Elective contact lenses in lieu of eyeglasses** (limited to one pair per year for conventional contacts or a 12-month supply of disposable contacts per year) » **Medically necessary contact lenses** (limited to one pair per year for conventional contacts or a 12-month supply of disposable contacts per year; prior authorization required) » **Low vision aids** (limited to one device per year; prior authorization required)	
Lenses				
Single Vision	100%	100% up to $50		
Lined Bifocal	100%	100% up to $75		
Lined Trifocal	100%	100% up to $100		
Standard Progressive	100%	100% up to $75		
Premium Progressive	100% up to $80 - $90			
Custom Progressive	100% up to $120 - $160			
Frames				
Frames	100% up to $150	100% up to $70		
Featured Frame Brands	100% up to $170			
Walmart, Sam's Club or Costco	100% up to $80			
Contact lenses	**Once every 12 months in place of eyeglasses**			
Fit and Evaluation Exam	100% up to $60	Not covered		
Elective Contacts	100% up to $150 (no copay)	100% up to $105		
Medically Necessary Contacts	100%	100% up to $210		
Safety glasses (covered for employees only)	**One pair every 12 months After $15 copay...**			
Lenses (single vision, lined bifocal or lined trifocal)	100%	Not covered	Safety glasses provided through VSP as shown to the left. Contact the Trust Office for VSP access.	
Frames (ProTec Eyewear or Visionworks' safety frame collections)	100% **Other frames:** 100% up to $65	Not covered		

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

TAKE ADVANTAGE OF NO-COST CARE OPTIONS – *WHEREVER YOU MAY BE*

When you are enrolled in the Trust Self-Funded Plan, you have access to **free** resources:

1

MDLive

- 24/7/365 virtual care via video or phone
- Urgent care, primary care, mental health, dermatology
- No cost to you ($1 credit card hold to schedule an appointment)

2

Nurse Line

- Speak with a registered nurse 24/7/365
- No cost to you
- **(800) 768-4695**

3

Maternity Education – expert advice

- No cost to you
- **(800) 768-4695**

DENTAL BENEFITS

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.

No matter which medical plan option you choose, you can select any of the three dental plan options.

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 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	100%	100% after $10 copayment per visit	100% after $10 copayment per visit
Routine office Visits 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	80% UCR* $2,000 lifetime maximum per person	80%, after $10 copayment per visit $2,000 lifetime maximum per person	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.

QUESTIONS?

If you have questions, reach out to the Harrison Trust Office:

Local: (503) 224-0048

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

Email: harrison@benesys.com

For more information, visit **www.harrisonbenefits.org**.

This newsletter contains an overview of the Harrison Electrical Workers Trust Fund benefit program. Although we have made every effort to ensure this newsletter is accurate, provisions of the official plan documents and contracts will govern in the case of any discrepancy.

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HARRISON TRUST

A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Open Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ GENDER: (Circle One) Male Female

Other MOBILE NUMBER: _____ HOME NUMBER: _____

EMAIL: _____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL (CHOOSE ONE):**
☐ TRUST SELF-FUNDED PLAN ☐ KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST (**Active** Grp# 2454-10)	☐ TRUST SELF-FUNDED ☐ KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ☐ WILLAMETTE DENTAL **Note:** Choice of coverage is offered to new employees or during Open Enrollment

Note: IF YOU, YOUR SPOUSE, OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION** that applies: birth certificate(s), marriage certificate, adoption papers, guardianship papers, and divorce papers.)

FULL NAME	SSN	GENDER	DATE OF BIRTH	RELATIONSHIP

_____ _____

Signature Required for Kaiser Permanente Plan **Date**

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

MEMBER'S SIGNATURE _____ **DATE** _____

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

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 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 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 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 or retail). 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 or retail). 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 or retail). 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 Optum Specialty Pharmacy. Call (877) 838-2907 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	Coinsurance applies to provider delivery charges.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum of 100 visits per calendar year.
	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.

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	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 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 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 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**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2027-12/31/2027

KAISER PERMANENTE® : **HARRISON ELECTRICAL WORKERS - $500 Ded**

Coverage for: Individual / Family | Plan Type: EPO

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.
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.
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.
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.

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 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.
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

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 help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	130 visit limit / year. Prior authorization required.
	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.
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.cciio.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 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 (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-813-2000 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'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/onlineservices/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 ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። 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 (TTY (تلفن متنی): **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 Sprachassistenz 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. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ลาว (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ. 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 ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **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 ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี 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 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

Enthea
HEALING FROM WITHIN

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!

Questions? Call/Text: (617) 297-7237 or email: members@enthea.com

Enthea | Different path. Different results.

HEALING FROM WITHIN

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.**

Step 1 Find a Provider

Visit www.enthea.com > login > member login to browse in-network providers.

Login details:
Username/Email:
Enthea+HarrisonElectricalTrust@enthea.com
Password:
HarrisonBenefits!

✓ No referral needed — just let the provider know you're an Enthea member
✓ You, your covered spouse/domestic partner, & dependent children (18+) are eligible

Step 2 Screening & Medical Evaluation

You'll meet with a licensed provider who will:

- Ask about your history & symptoms
- Make sure this treatment is safe and appropriate for you

💡 Cost: You might owe a deductible or coinsurance. Your provider will let you know upfront.

Step 3 Approval & Authorization

If you're a good fit:

- Enthea handles the prior authorization
- Your provider will verify your coverage
- Your provider gets the green light to begin treatment

Step 4 Prep Sessions

Before your first medicine treatment session, you'll meet with a therapist to:

- Set intentions and goals
- Understand what to expect
- Build comfort and trust

Step 5 Medicine + Therapy Sessions

This is the core of your healing experience. You'll have:

- Up to 3 prep sessions
- 4 - 6 ketamine sessions
- Over 3-4 weeks
- Therapy integrated after each session

✓ You're Fully monitored by medical staff during every session.

Step 6 Integration & Additional Therapy

After the medicine sessions, you'll continue therapy to:

- Reflect on insights
- Build lasting change
- Stay grounded in your progress

Step 7 What You Might Pay (Out-of-Pocket Costs)

Here's how the benefit works:

Step	Covered by Your Fund	What You Might Owe
Screening Appointment	Yes	Deductible / Coinsurance
Treatment Sessions	Yes	Deductible / Coinsurance
Integration Therapy	Yes	Deductible / Coinsurance

- Your provider checks your benefits before you begin
- If there's a balance left, they may bill you later
- No surprise bills

Step 8 Support Doesn't End After Treatment

Your provider and Enthea are here to help with:

- Continued mental health support
- Follow-up questions
- Troubleshooting billing

NECA IBEW
LEADING THE ELECTRICAL INDUSTRY

You don't need to be in crisis to get help. If something feels off — stress, burnout, pain, or deep sadness — there's a path forward. And you don't have to walk it alone.

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

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. For new users, click 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: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Զանգահարեք 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 رایگان در دسترس هستند. با تماس 800-547-4457 (TTY: 711) بگیرید یا با ارائه دهنده خود صحبت کنید.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 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 ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 800-547-4457 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេង សេវាជំនួយភាសាឥតគិតថ្លៃអាចរកបានសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ទូរស័ព្ទទៅ 800-547-4457 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lwm hom lus, muaj kev pabcuam lus pub dawb rau koj. Cov kev pabcuam tsim nyog thiab cov kev pabcuam los muab cov ntaub ntawv hauv cov qauv siv tau kuj muaj pub dawb. Hu rau 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) หมายเหตุ: หากคุณพูดภาษาอื่น คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร 800-547-4457 (TTY: 711) หรือพูดคุยกับผู้ให้บริการของคุณ