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 are 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

- ✓ **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.

2026 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 Plan Rx: Providence Health Plan Vision: VSP Dental: Trust Plan, Kaiser or Willamette Dental	$1,587	$0	$111	$190	$270
Kaiser Plan Option: Medical, Rx, & Vision: Kaiser Dental: Trust Plan, Kaiser or Willamette Dental	$1,572	$0	$110	$189	$267
Providence Plan Option: Medical & Rx: Providence Vision: VSP Dental: Trust Plan, Kaiser or Willamette Dental	$1,809	$0	$127	$217	$308

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. • Open Access Plus network 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 and 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**	**Plan Pays**	**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)	50% UCR* After Deductible
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 Covered Services	Trust Self-Funded Plan Plan Pays	Kaiser Permanente HMO Plan Pays	Providence Core Advantage 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 Covered Services	Trust Self-Funded Plan Plan Pays	Kaiser Permanente HMO Plan Pays	Providence Core Advantages 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 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).	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	80% UCR*	80%, after $10 copayment per visit	Participant Pays:
Lifetime maximum per person	$2,000	$2,000	$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	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.
	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**

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. 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
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.

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.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 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 (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, á'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.

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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**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ 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 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 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.
If you have a test	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——————
	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.

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. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). 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. If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay. Specialty drugs (listed in Tier 5 and Tier 6 on your formulary) can only be purchased at a participating specialty pharmacy (limited to 30days).
	Tier 2	$10 copay retail $30 copay mail order; deductible does not apply	Not covered	
	Tier 3	$40 copay retail $80 copay mail order; deductible does not apply	Not covered	
	Tier 4	$75 copay retail $150 copay mail order; deductible does not apply	Not covered	
	Tiers 5&6	50% coinsurance up to $300 retail; deductible does not apply	Not covered	
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——————

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	
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	——————none——————
	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.

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)	
	Habilitation 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.cciio.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.

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	$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**

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

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).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

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 asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

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

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 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).

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

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

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (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
HEALING FROM WITHIN

Different path. Different results.

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 Appointmer	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 4457-547-800 (TTY: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 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
និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែល
អាចចូលប្រើបានក៏អាចរកបានដោយឥតគិតថ្លៃដងដែរ។
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 นอกจากนี้ ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร 800-547-4457 (TTY: 711) หรือพูดคุยกับผู้ให้บริการของคุณ

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