HARRISON ELECTRICAL WORKERS TRUST FUND

ACTIVE EMPLOYEE PLAN

September 1, 2016
with Amendments 1-16

TABLE OF CONTENTS

INTRODUCTION

The Board of Trustees is pleased to issue this new Benefit Booklet effective September 1, 2016. This Benefit Booklet and the Trust Agreement are intended to meet the requirements of Section 402(b) of the Employee Retirement Income Security Act for the Harrison Electrical Workers Trust Fund Active Employee Plan.

This Benefit Booklet summarizes the Active Employee Plan's requirements relating to:

- Eligibility to participate in the Active Employee Plan;
- The circumstances that may result in termination of eligibility to participate in the Active Employee Plan;
- The benefits provided by the Active Employee Plan;
- Appeal rights if Your claim is denied; and
- Your rights under the Employee Retirement Income Security Act of 1974.

Three medical plans are available to You and Your Dependents. You and Your Dependents can have medical benefits provided by Providence Health Plan, Kaiser Permanente, or the Active Employee Plan benefits described in this Benefit Booklet. Three dental plans are available to You and Your Dependents. You and Your Dependents can have dental benefits provided by Kaiser Permanente, Willamette Dental, or the Active Employee Plan benefits described in this Benefit Booklet. You and Your Dependents will have the vision benefits described in this Benefit Booklet, unless You have elected Kaiser Permanente for Your medical benefits, in which case Kaiser Permanente provides vision benefits.

Regardless of the medical and dental plans You choose, You and Your Dependents will have the employee assistance benefits described in this Benefit Booklet. The Employee will have the time loss benefits, life insurance benefits and accidental death and dismemberment benefits described in this Benefit Booklet.

The benefits provided by the Harrison Trust are not vested. Although the Board of Trustees intends to continue to provide health and welfare benefits for You and Your Dependents, unforeseen circumstances may make it inadvisable to continue the Active Employee Plan, Providence Health Plan, Kaiser Permanente, and Willamette Dental in their present form. The Board of Trustees reserves the right to amend, change or terminate the Active Employee Plan, Providence Health Plan, Kaiser Permanente, and Willamette Dental, including the right to change the eligibility rules, change or reduce benefits and require or increase payments.

The Board of Trustees has discretionary authority to interpret all provisions of this Benefit Booklet including, but not limited to, eligibility to participate, eligibility for benefits and the amount of benefits, if any, to be paid. No Trustee, Union representative, Employer representative or employee of the Trust Office is authorized to interpret this Benefit Booklet for the Board of Trustees. The Board of Trustees has authorized employees of the Trust Office to respond informally to written or oral inquiries on an informal basis. However, the written and oral answers are not binding upon the Board of Trustees.

There is a website for the Harrison Trust. The website provides online access to eligibility, paid claims information, enrollment applications, claim forms, a copy of this Benefit Booklet, updates to this Benefit Booklet and links to Harrison Trust Providers such as the PPO networks, Providence Health Plan, Kaiser Permanente, Willamette Dental and Vision Service Plan. The website address is www.harrisonbenefits.com. To access eligibility status and claims information, go to the Access My Account icon and follow the prompts.

Terms and phrases that have capital letters are defined terms. See the Definition of Terms section starting on page 155.

If You would like further information or assistance, please call or write the Trust Office:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland OR 97239
In Portland: (503) 224-0048, ext. 1679
Outside Portland: (800) 547-4457, ext. 1679
www.harrisonbenefits.com

HARRISON ELECTRICAL WORKERS TRUST FUND

Timothy Gauthier *Management Trustee*	Garth Bachman *Union Trustee*
Todd Mustard *First Management Trustee*	Diana Winther *First Alternate Union Trustee*
Patrick Maloney *Second Alternate Management Trustee*	Trillium Ward *Second Alternate Union Trustee*

Temporary COVID-19 Measures

Effective March 23, 2020 and continuing until the declared end of the COVID-19 National Emergency or such earlier date determined by the Trustees, the Trustees may take such actions as they deem reasonable and necessary to allow benefits that would not otherwise be paid under the Plan for the purpose of providing Employees and Dependents coverage that might not be available due to the National Emergency, or to address needs caused by the National Emergency. In addition, the Trustees will implement any legally required provision that has been issued by the federal government as a result of the National Emergency. Any such benefits are temporary and will cease automatically at the declared end of the National Emergency unless the Trustees set an earlier expiration time, or the Trustees determine it is advisable to continue such temporary benefit to a specified time.

ELIGIBILITY AND ENROLLMENT PROCEDURES

Eligibility for Category I Bargaining Unit Employees

A Category I Employee works under a collective bargaining agreement between an employer and certain local unions of the I.B.E.W. (48, 280, 659, or 932). Employers who have a collective bargaining agreement with these local unions of the I.B.E.W. will pay the hourly contribution stipulated in the collective bargaining agreement to the Harrison Trust for each hour of service an Employee performs. All hours, for the purpose of calculating contributions, are treated as straight-time hours.

All employer contributions paid to the Harrison Trust are credited (in dollars) to Your Reserve Account up to the maximum amount You are allowed to accumulate. See page 5 for the maximum amount. You may call the Trust Office or go to the Harrison Trust's website at www.harrisonbenefits.com to determine Your current and future eligibility.

To become eligible for health and welfare coverage and to maintain health and welfare coverage, You must have sufficient credits in Your Reserve Account in any qualifying Month to meet the required charge for coverage in the coverage Month, as shown below.

SUFFICIENT CREDITS IN YOUR RESERVE ACCOUNT IN THE QUALIFYING MONTH OF…	PROVIDES COVERAGE FOR THE CORRESPONDING MONTH OF…
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

As long as You have sufficient credits in Your Reserve Account and comply with paragraphs 1, 2, 3, 4, or 5 on page 4, Your benefits will be continued.

If You do not have sufficient credits in Your Reserve Account and return to work and accumulate the required credits in Your Reserve Account, Your benefits will be automatically reinstated as of the first day of the coverage Month corresponding to the qualifying Month as described on page 3.

Partial Self-Payments

If You are a Category I Employee, You may maintain coverage by making timely self-payments in the amount equal to the required Monthly charge less the credit in Your Reserve Account. Your required self-payment must be received by the 15th day of the Month for which You are self-paying the premium unless the 15th day of the month is a national holiday or weekend. In this case, the required self-payment must

be received by the first business day after the national holiday or weekend. For example, a partial self-payment for April coverage must be made by April 15 (assuming April 15 is not a national holiday or weekend). You must meet the requirements of rule 1, 2, 3, 4, or 5 on page 4, to make a partial self-payment.

There are three ways to make a self-payment:

1. Mail your check to the following address:
   Harrison Electrical Workers Trust Fund
   5331 Southwest Macadam Avenue
   Suite 258, PMB #116
   Portland, OR 97239

2. Deliver your check to the following address:
   Harrison Electrical Workers Trust Fund
   5331 Southwest Macadam Avenue, Suite 220
   Portland, OR 97239

3. Make a payment by debit card or credit card. Call the Trust Office for instructions *at* (503) 224-0048, ext. 1679 or (800) 547-4457, ext. 1679.

To make a partial self-payment there must not be a lapse in coverage and You must have had coverage in the Month immediately preceding the Month for which You want to make a partial self -payment. The prior Month's coverage must not have been provided through COBRA self-payment. If You do not make a partial self-payment to continue coverage, You will not be eligible to make future partial self-payments until Your Reserve Account has enough credits to pay for a Month of coverage.

Requirements to Make a Partial Self-Payment, Use Your Reserve Account, and Obtain a Disability Waiver of Health and Welfare Premiums

To be eligible to make a partial self-payment, use Your Reserve Account, or obtain a disability waiver of health and welfare premiums, You must meet one of the following:

1. Work for a Contributing Employer in a bargaining unit position or in a non-bargaining unit position provided the Contributing Employer is a party to a Category II Agreement;

2. Available for immediate dispatch to a Contributing Employer by being registered on the appropriate local union's out-of-work list; and You are not working in Restricted Non-Covered Employment in the Electrical Industry. **IF YOU ARE WORKING IN RESTRICTED NON-COVERED EMPLOYMENT, YOU MUST NOTIFY THE TRUST OFFICE. IF YOU FAIL TO NOTIFY THE TRUST OFFICE AND CONTINUE TO RECEIVE HEALTH AND WELFARE COVERAGE, THE HARRISON TRUST WILL HOLD YOU RESPONSIBLE FOR ANY HEALTH INSURANCE PREMIUMS PAID AND HEALTH AND WELFARE CLAIMS PAID FOR THE MONTH(S) YOU WERE INELIGIBLE TO USE YOUR RESERVE ACCOUNT. INFORMATION FOR NOTIFYING THE TRUST OFFICE IS:**

3. Work for a Contributing Employer that contributes to another trust that is a party to a reciprocity agreement with the Harrison Trust;

4. Eligible to receive, currently receiving or have received an I.B.E.W. pension and not working in the Electrical Industry; or

5. Be disabled.

Forfeiture of Your Reserve Account

If You fail to qualify under one of the above paragraphs for twelve (12) consecutive months, at the end of the 12th month, Your Reserve Account will be forfeited and the credits will be transferred to the general fund of the Harrison Trust.

If You Move from One Contributing Employer to Another

Your benefits will continue, provided You maintain the necessary credits in Your Reserve Account as of the first of each Month. If You transfer from one Contributing Employer to another, Your Reserve Account will be maintained, and You will not lose any coverage. You should make sure Your new Employer is contributing to the Harrison Trust for You.

The Maximum Accumulation in Your Reserve Account

The maximum amount of credits You are allowed to accumulate in Your Reserve Account is set by the Board of Trustees. The Board of Trustees reserve the right to increase or decrease the maximum amount of credits You are allowed to accumulate in Your Reserve Account. The maximum amount of credits is equal to the cost of twelve (12) months of health and welfare coverage (medical, dental, vision, time loss, life and accidental death and dismemberment insurance) You have selected as established by the Board of Trustees. You may not elect to receive any portion of the credits in Your Reserve Account in cash. Your Reserve Account may only be used to obtain health and welfare coverage through the Harrison Trust. You may check with the Trust Office to determine the amount of credits in Your Reserve Account and the maximum amount of credits You may accumulate in Your Reserve Account.

In the event You have a full Reserve Account at the end of each Month in a calendar quarter, the Harrison Trust will deposit $100 into an individual account for You. For example, if You have a full Reserve Account at the end of January, February, and March, the Harrison Trust will deposit $100 into Your individual account at the end of March. Your individual account may only be used to obtain health and welfare coverage through the Harrison Trust.

Reserve Account Sharing Policy

The Board of Trustees has a Reserve Account Sharing Policy whereby an Employee can transfer credits from his/her Reserve Account to another Employee's Reserve Account. The minimum amount of credits that may be transferred is equal to forty (40) hours of contributions to the Harrison Trust. The credits transferred will permanently reduce the maximum amount of credits an Employee may accumulate in his/her Reserve Account. Contact the Trust Office to obtain a copy of the Reserve Account Sharing Policy.

Employee Contributions to an Individual Account

If You are a Category I Employee or You have a frozen Reserve Account and participate as a Category II Employee, You have the option of making after-tax contributions to the Harrison Trust in order to pay for future health and welfare coverage after Your Reserve Account has been depleted. In order to make an after-tax contribution, You must meet one of the criteria to make a partial self-payment, use Your Reserve Account, or obtain a disability waiver as described on page 4 of the Benefit Booklet. A separate account will be established in Your name. This account will not earn interest. The maximum accumulation in this account is equal to the cost of six Months of health and welfare coverage. If You wish to take advantage of this option, contact the Trust Office for a form that must accompany Your payment.

Once a payment is made to the individual account, it cannot be withdrawn for any reason other than to purchase Harrison health and welfare coverage for You and Your Dependents after Your Reserve Account has been depleted. In the event You die, Your Dependents can use the money in the account to purchase Harrison health and welfare coverage.

Special Contribution Formula for Category I Employees

An employer and a local union may request permission from the Board of Trustees to negotiate a flat Monthly contribution rate in lieu of a contribution rate based on hours of service. The Board of Trustees will allow a flat contribution rate only for non-construction bargaining units where Employees work a steady number of hours each Month and there is little Employee turnover. The Board of Trustees will determine the flat Monthly contribution rate. The Board of Trustees has sole discretion to determine whether a bargaining unit is eligible for the flat Monthly contribution rate.

Advance of Harrison Trust Health and Welfare Coverage for New Journeypersons

In order to avoid a hardship for journeypersons who have begun to work for a Contributing Employer and may have to wait several Months for Harrison Trust health and welfare coverage under the Active Employee Plan's lag Month eligibility system, the Harrison Trust will advance up to two Months of Harrison Trust health and welfare coverage under the terms set forth below.

1. The applicant must be a journeyperson who has started to work for a Contributing Employer;

2. The applicant must not have had contributions made on his/her behalf to the Harrison Trust in the five years preceding the application;

3. The applicant must provide proof of group health and welfare coverage for the Month immediately before the Month Harrison Trust health and welfare coverage will start. If the

journeyperson has Dependents, he/she must provide proof that his/her Dependents were enrolled in group health and welfare coverage for the Month immediately before the Month Harrison Trust health and welfare coverage will start; and

4. An application must be submitted to the Trust Office and the application must be approved by the Trust Office or the Board of Trustees.

If the application is approved, the journeyperson and his/her Dependents will be provided up to two consecutive Months of Harrison Trust health and welfare coverage without meeting the Eligibility Criteria for Category I Bargaining Unit Employees as described on page 3 of the Benefit Booklet. The Harrison Trust health and welfare coverage will start the first day of the Month after the journeyperson's application has been approved and the journeyperson has started to work for a Contributing Employer. After up to two consecutive Months of Harrison Trust health and welfare coverage have been provided, the journeyperson must meet the Harrison Trust's eligibility rules in order to continue Harrison Trust health and welfare coverage.

Each journeyperson who takes advantage of the advance of up to two Months of Harrison Trust health and welfare coverage must repay the cost of the Harrison Trust health and welfare coverage advanced as follows:

1. All contributions made by a Contributing Employer to the Harrison Trust for the journeyperson above the minimum amount necessary to qualify for a Month of Harrison Trust health and welfare coverage which would normally accumulate in the journeyperson's Reserve Account will be applied to offset the initial cost of Harrison Trust health and welfare coverage advanced. Once the cost of health and welfare coverage advanced by the Harrison Trust has been recouped, health and welfare contributions made to the Harrison Trust for the journeyperson above the minimum amount necessary to qualify for health and welfare coverage will accumulate in the journeyperson's Reserve Account.

A journeyperson can take advantage of the advance of up to two Months of Harrison Trust health and welfare coverage only once.

Eligibility for Category II Non-Bargaining Employees

An employer required to contribute to the Harrison Trust for Category I (bargaining unit) Employees may sign a Category II Agreement that allows coverage for non-bargaining Employees subject to the following rules:

1. The employer must have a Collective Bargaining Agreement with I.B.E.W. Local No. 48, 280, 659 or 932 (the Harrison Unions) that requires the employer to make a contribution to the Harrison Trust for Category I (bargaining unit) Employees;

2. If the employer has its principal place of business within the geographic jurisdiction of the Harrison Unions, it may elect to cover its non-collectively bargained Employees at all U.S. locations or elect to cover its non-collectively bargained Employees whose principal work location is within the geographic jurisdiction of the Harrison Unions;

3. If the employer's principal place of business is outside the geographic jurisdiction of the Harrison Unions but the employer has a place of business within the geographic jurisdiction of the Harrison Unions, the employer may elect to cover its Category II Employees whose principal work location is within the geographic jurisdiction of the Harrison Unions;

4. New Employees, during their first full or partial Month of employment, can be excluded;

5. A part-time Employee who works twenty (20) hours or less per week can be excluded;

6. An Employee hired as summer help (working less than 500 hours between May 1 and September 30) can be excluded;

7. In addition to the exclusions in paragraphs 4 through 6, an employer can exclude a limited number of non-bargaining unit Employees from coverage pursuant to a schedule obtainable from the Trust Office;

8. A health and welfare contribution is not allowed for a non-bargaining unit Employee who is not employed on the last day of the Month; and

9. The Board of Trustees retains the authority to accept or reject a Category II Agreement on a case by case basis.

If the employer intends to exclude Employees from coverage under paragraph 7 above, the employer must send a written notice, including the excludable Employee's name(s), to the Trust Office. Once an Employee is excluded from coverage under paragraph 7 above, the employer will not be allowed to provide coverage for the Employee and Dependents under the Category II Agreement for twelve (12) Months unless the Employee or Dependent qualifies for Special Enrollment Rights as described under the heading Special Enrollment Rights on page 10. The excluded Employee must sign a form provided by the Trust Office acknowledging that the Employee and Dependents will not have health and welfare coverage through the Harrison Trust for a minimum of twelve (12) Months absent Special Enrollment Rights.

The Monthly contribution amount for Employees covered by a Category II Agreement is determined by the Board of Trustees. Contact the Trust Office for a copy of the Category II Agreement, which spells out the rules in more detail.

Disability Waiver for Category I and Category II Employees

If You become Totally Disabled due to an occupational or non-occupational Illness or Injury, You have health and welfare coverage on the date of Total Disability and Your Total Disability continues for at least one calendar Month, You may apply to the Trust Office to have the amount charged for coverage waived during Your Total Disability. Your Reserve Account will be frozen and the waiver begins on the first day of the Month You qualify for the disability waiver.

The disability waiver is allowed for six (6) Months in a lifetime. In order to qualify for a waiver, You must obtain a statement from Your Physician describing the nature of Your Total Disability, the date Your Total Disability started, and the date You expect to return to work. This information must be provided on an

application form that is available from the Trust Office and on the Trust's website at www.harrisonbenefits.com. You must also meet one of the criteria on page 4.

Dependents – Eligibility

An Employee's Dependents are defined in the Definition of Terms section of the Benefit Booklet.

Dependents will be eligible for health and welfare coverage on the date the Employee becomes eligible or, if later, the date the individual becomes a Dependent of the Employee. For example, a new spouse will become a Dependent on the date of marriage, a new child will become a Dependent on the date of birth, adoption or placement in the Employee's home pending adoption, and a Domestic Partner or a Domestic Partner's children will become Dependents at the time detailed on page 15. In order for a Dependent to be eligible for health and welfare coverage, an Employee must enroll his/her Dependent within one-hundred twenty (120) days after the Employee became eligible for health and welfare coverage or, if later, within one- hundred twenty (120) days of the date of marriage, birth of a child, adoption or placement of a child in the Employee's home pending adoption or establishment of a domestic partnership.

A Dependent's coverage will terminate on whichever of the following dates is applicable:

1. The first day of the Month following the date he or she no longer qualifies as a Dependent. For example, divorce, legal separation, dissolution of a domestic partnership or a child who no longer meets the definition of Dependent due to age. In the case of a Domestic Partner and a Domestic Partner's children who do not qualify as Dependents of the Employee for federal income tax purposes under Section 152 of the Internal Revenue Code, coverage will terminate on the date the federal and, if applicable, state taxes are not paid to the Trust by the due date; or

2. The date the Employee's health and welfare coverage ends.

Dependent Verification Process

Upon request from the Trust Office, the Board of Trustees, or their designee, an Employee, COBRA enrollee, or Dependent must provide documents to establish to the satisfaction of the Trust Office, the Board of Trustees, or their designee that an individual enrolled for Harrison health and welfare coverage as a Dependent meets the definition of Dependent in the Benefit Booklet. Absent satisfactory documentation provided within the required time frame, Harrison health and welfare coverage for the individual will be terminated.

If satisfactory documentation is provided that the individual meets the definition of Dependent in the Benefit Booklet, but after the date Harrison health and welfare coverage has terminated, Harrison health and welfare coverage will be reinstated as follows:

1. If satisfactory documentation is received by the Trust Office within 90 days after Harrison health and welfare coverage terminated, Harrison health and welfare coverage will be reinstated for the Dependent retroactive to the termination date; or

2. If satisfactory documentation is received by the Trust Office more than 90 days after Harrison health and welfare coverage terminated, Harrison health and welfare coverage will be reinstated for the Dependent effective the first day of the month in which satisfactory documentation is received by the Trust Office. For example, if satisfactory documentation is received by the Trust Office on December 28, health and welfare coverage will be reinstated for the Dependent effective December 1.

Special Enrollment Rights

Employees and Dependents have special enrollment rights in this Plan as well as the Providence Health Plan and the Kaiser Permanente if the Employee or Dependent did not enroll when first eligible and the criteria set forth below are met.

Late Enrollees

A late enrollee is an Employee or Dependent who did not enroll in this Plan, the Providence Health Plan, or Kaiser Permanente, when first eligible for coverage and does not qualify as a special enrollee. A late enrollee may enroll during the next Open Enrollment Period.

Special Enrollee

A special enrollee is an Employee or Dependent that is allowed to enroll in this Plan, the Providence Health Plan, or Kaiser Permanente after initial eligibility for coverage and before the next Open Enrollment Period because of a loss of other group health coverage, a change in family status or enrollment rights under the Children's Health Insurance Coverage Act.

Special Enrollees Who Have Lost Other Group Health Coverage

If the Employee did not enroll himself or a Dependent for Harrison Trust coverage because other group health coverage was in effect, the Employee may enroll himself or a Dependent for Harrison Trust coverage within thirty (30) days after the other group health coverage ends, so long as the following conditions are met:

1. The person to be enrolled was covered under another group health plan at the time Harrison Trust coverage was previously offered;

2.

    a. COBRA continuation coverage under another group health plan was exhausted. Failure to pay the premium or premature termination of COBRA continuation coverage does not satisfy this requirement; or

    b. Coverage under another group health plan was terminated as the result of loss of eligibility for reasons such as legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment (failure to pay the premium does not satisfy this requirement); or

c. Employer contributions toward the premium for other group health coverage was terminated; and

3. The person must request Harrison Trust coverage not later than thirty (30) days after the date the other group health coverage ends. Contact the Trust Office for the enrollment form or go to www.harrisonbenefits.com.

Coverage under this Plan, the Providence Health Plan, or Kaiser Permanente will become effective on the first day of the month following the Trust Office's receipt of the enrollment form and payment of the required premium. If the Trust Office does not receive the enrollment form within thirty (30) days after the date the other group health coverage ended, You will be considered a late enrollee.

Special Enrollees Who Have a Change in Family Status

Employees who declined enrollment in this Plan, the Providence Health Plan, or Kaiser Permanente and who have since had a change in family status may be eligible to enroll as a special enrollee. Marriage, establishment of a domestic partnership, adoption, placement for adoption, or birth of a child are considered a change in family status. The Employee must request enrollment for himself/herself and/or the newly acquired Dependent within one hundred twenty (120) days of the marriage, establishment of the domestic partnership, adoption, placement for adoption, or birth of a child. In the case of marriage or establishment of a domestic partnership, coverage will become effective on the day of the event. In the case of the birth of a child, coverage will become effective on the date of birth. In the case of adoption or placement for adoption, coverage will become effective on the date of the adoption or placement for adoption. If the Trust Office does not receive the enrollment form within one hundred twenty (120) days of the date of the change in family status, You or Your Dependent will be considered a late enrollee. Contact the Trust Office for the enrollment form or go to www.harrisonbenefits.com.

Special Enrollment Rights Under the Children's Health Insurance Coverage Act

An Employee or Dependent who is eligible to enroll for Harrison Trust coverage but did not enroll under either of the following circumstances will have special enrollment rights.

1. The Employee or Dependent is covered under Medicare or a state's Children's Health Insurance Program and coverage for the Employee or Dependent is terminated as a result of a loss of eligibility for such coverage; or

2. The Employee or Dependent becomes eligible for a premium assistance subsidy from Medicare or a state's Children's Health Insurance Program to help pay the cost of Harrison Trust coverage.

If either of these circumstances occur, the Employee or Dependent will have a sixty (60) day period to enroll for Harrison Trust coverage. If the Trust Office does not receive the enrollment form within sixty (60) days after loss of coverage or the date of eligibility for premium assistance, You will be considered a late enrollee. Contact the Trust Office for the enrollment form or go to www.harrisonbenefits.com.

Family and Medical Leave

If You are a Category I or Category II Employee and leave work temporarily for Family and Medical Leave, the Harrison Trust will pay up to three (3) Months of health and welfare coverage for You and Your Dependents (or up to six (6) Months of health and welfare coverage for You and Your Dependents if the Family and Medical Leave is to care for a covered service member) if You meet certain criteria. If You are a Category I Employee and the reason for Your leave is Your own pregnancy, the Harrison Trust will pay for health and welfare coverage for You and Your Dependents for up to thirteen (13) weeks prior to your verified expected due date for delivery, and up to thirteen (13) weeks after Your delivery (and any such leave shall count toward the three (3) Months described in the preceding sentence). The maximum number of weeks provided will be twenty-six (26). If You qualify, You and Your Dependents will receive the same coverage You had before taking Family and Medical Leave.

Prerequisites for Coverage Under Family And Medical Leave

1. You must be actively employed by a Contributing Employer at the time You take Family and Medical Leave;

2. You must have worked for one (1) or more Contributing Employers for at least twelve (12) Months (not consecutive) before the Family and Medical Leave;

3. You must have worked for one (1) or more Contributing Employers at least 750 hours during the twelve (12) Months before the Family and Medical Leave;

4. The Family and Medical Leave must be for one of the following reasons:

    a. Birth of a child or placement of a child for adoption or foster care;

    b. To care for a spouse, child or parent with a "serious health condition";

    c. Your own "serious health condition";

    d. To care for a spouse, child, parent, or next of kin who is a covered service member who is undergoing medical treatment, recuperation, or therapy; who is in out-patient status; or is on a temporary disability list for a serious Injury or Illness; or

    e. To deal with a qualifying exigency arising because a spouse, child, or parent is on active duty or has been called to active duty in the armed forces.

5. A "serious health condition" is an Illness, Injury or impairment involving:

    a. Inpatient treatment;

    b. Absence from work or school for three or more days with continuing treatment by a Health Care Provider;

c. Continuing treatment by a Health Care Provider for a condition that is incurable or serious enough to result in three or more days of incapacity; or

d. Prenatal care.

6. You must intend to return to work for Your Employer after the Family and Medical Leave; and

7. You may use the Family and Medical Leave benefit once per twelve (12) consecutive Months.

The Family and Medical Leave Benefit

If You qualify for the Family and Medical Leave benefit as a Category I Employee, Your Reserve Account will be frozen at the end of the Month that You leave work for the Family and Medical Leave. If You qualify for the Family and Medical Leave benefit as a Category II Employee, Your Employer will pay the health and welfare premium for the Month You last worked before taking the Family and Medical Leave. The Harrison Trust will pay for health and welfare coverage during the Family and Medical Leave. After Family and Medical Leave coverage is exhausted, You are responsible for payment of health and welfare coverage out of Your Reserve Account or by COBRA payment.

Application Process

If You think You qualify for Family and Medical Leave, call the Trust Office or go to www.harrisonbenefits.com to obtain an application form. You need to complete the application form and return it to the Trust Office. You will be notified whether You qualify for this benefit.

Harrison Trust paid health and welfare coverage will stop before the third Month or sixth Month if You return to work or otherwise terminate Your Family and Medical Leave.

Military Service

If You or a Dependent join the Armed Forces of the United States or are called to active duty for more than thirty (30) days, health and welfare coverage for You or Your Dependent will end on the date You or Your Dependent enters full-time active duty.

The Federal Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA) provides certain rights that include:

1. Your Reserve Account will be preserved for a maximum of five years. However, You may use Your Reserve Account to provide coverage for Your Dependents.

2. There will be COBRA-type continuation coverage rights for Your Dependents to extend health and welfare coverage for a maximum of twenty-four (24) Months from the date military leave began. See the COBRA section on page 20 or contact the Trust Office for more information. This right applies only to Dependents covered by the Plan at the time of military service.

3. USERRA provides that if an Employee leaves work for military service for less than thirty-one (31) days, his employer or the Harrison Trust may be required to continue to make the hourly

contribution that the Employee would have had paid to the Harrison Trust but for the military service. The Harrison Trust has agreed to assume this obligation. If You think that You qualify for continued contributions to the Harrison Trust under USERRA, contact the Trust Office.

4. In order to qualify for the continued contributions under USERRA, You must comply with the notice requirements of USERRA, which include notifying Your employer of the expected military leave and return to employment within the time frame established by USERRA.

5. When Your military service ends, any eligibility waiting period cannot be applied to You and Your Dependents unless the waiting period was established after You left for military service and the new waiting period applies to all Employees. When returning from military service, You cannot be required to satisfy any preexisting condition exclusion, unless the preexisting condition exclusion applies to all Employees. This rule does not apply to service related Injuries or Illnesses.

If You have questions concerning Your rights under USERRA, contact Your employer or the Trust Office.

Reciprocal Agreements

The Harrison Trust is a party to the Electrical Industry Health and Welfare Reciprocal Agreement. If You want to have health and welfare contributions sent from the Harrison Trust to Your home fund or from the health fund where You are working to the Harrison Trust, contact the Trust Office for instructions. You will need to register on the Electronic Reciprocity Transfer System before health and welfare contributions can be transferred.

There is usually a lag of at least thirty (30) days before the Harrison Trust receives reciprocal contributions, which may result in an interruption in coverage and a possible COBRA notice. Coverage months based on reciprocal contributions are determined in accordance with normal rules. A delay in receiving reciprocal contributions therefore may result in retroactive coverage.

DOMESTIC PARTNER COVERAGE, RULES, AND PROCEDURES

The Harrison Trust and its insured plans (this Plan, Kaiser Permanente, Providence Health Plan, and the Willamette Dental Plan) offer health and welfare coverage to an Employee's Domestic Partner and the Domestic Partner's Dependent children subject to the rules set forth below, in other sections of this Benefit Booklet and in the Kaiser Permanente, Providence, and Willamette Dental booklets.

See the Definition of Terms section of the Benefit Booklet for the definition of “Domestic Partner”.

An Employee may enroll a Domestic Partner and the Domestic Partner's Dependent children for health and welfare coverage during the following times:

1. Within one-hundred twenty (120) days after the Employee becomes eligible for employer paid health and welfare coverage;

2. Within one-hundred twenty (120) days after the Domestic Partnership relationship is established;

3. Within one-hundred twenty (120) days after the Domestic Partner has a new child (enrollment for the child only if the Domestic Partner is already enrolled for coverage);

4. During Special Enrollment Rights periods described on page 10; and

5. During the Open Enrollment Period established by the Board of Trustees.

Contact the Trust Office for enrollment forms or go to www.harrisonbenefits.com.

If an Employee enrolls a Domestic Partner and a Domestic Partner’s Dependent children for health and welfare coverage and allows the health and welfare coverage for the Domestic Partner and a Domestic Partner’s Dependent children to lapse (for example does not pay the federal and, if applicable, state taxes) while health and welfare coverage is maintained for the Employee, the Employee will not be allowed to re-enroll his/her Domestic Partner and Domestic Partner’s Dependent children for health and welfare coverage until the next Open Enrollment Period unless there is an enrollment right under the Special Enrollment Rights section on page 10.

Federal law requires that the value of employer paid health and welfare coverage provided to a Domestic Partner and the Domestic Partner's Dependent children are taxable income to the Employee unless the Employee certifies that the Domestic Partner and/or the Domestic Partner's Dependent children are claimed as "dependents" of the Employee for federal income tax purposes under Section 152 of the Internal Revenue Code. An Employee who elects to provide health and welfare coverage for a Domestic Partner and the Domestic Partner's Dependent children as a result of employer paid health and welfare coverage, absent a certification of dependent status satisfactory to the Board of Trustees, will be required to pay the federal and, if applicable, state income taxes associated with the value of employer paid health and welfare coverage for the Domestic Partner and the Domestic Partner's Dependent children by the date established by the Board of Trustees or the coverage for the Domestic Partner and the Domestic Partner's children will terminate. The Board of Trustees determine the value of the health and welfare coverage for the Domestic Partner and, if applicable, the Domestic Partner's Dependent children. Contact

the Trust Office for the current information. The Employee will receive a W-2 form from the Harrison Trust at the end of each year in an amount equal to the value of the employer paid health and welfare coverage provided to the Domestic Partner and, if applicable, the Domestic Partner's Dependent children.

Payment to the Harrison Trust to cover the federal taxes must be paid by the 20th day of the Month preceding the coverage Month. For example, payment of federal taxes must be made by June twenty (20) in order for Your Domestic Partner to have July health and welfare coverage. If the Employee fails to make a timely payment, health and welfare coverage for the Domestic Partner and, if applicable, the Domestic Partner's Dependent children will end and the Employee will not be allowed to re-enroll the Domestic Partner and, if applicable, the Domestic Partner's Dependent children until the next Open Enrollment Period unless there is an enrollment right under the Special Enrollment Rights section on page 10.

If an Employee elects to provide health and welfare coverage for a Domestic Partner and, if applicable, the Domestic Partner's Dependent children, and certifies that the Domestic Partner and/or Dependent children are claimed as "dependents" of the Employee for federal income tax purposes under Section 152 of the Internal Revenue Code, the Employee will not receive a W-2 form from the Harrison Trust for the value of the employer paid health and welfare coverage and will not be subject to the pre-payment of federal taxes detailed in the preceding paragraph. In order to avoid receipt of a W-2 form and the pre-payment of federal taxes, the Employee must sign a certificate regarding "dependent" status of the Domestic Partner and, if applicable, the Domestic Partner's children prior to the first Month in which health and welfare coverage is provided to the Domestic Partner and, if applicable, the Domestic Partner's Dependent children and before January 1 of each subsequent year. Contact the Trust Office for the certification or go to www.harrisonbenefits.com.

If a Domestic Partner has health and welfare coverage through the Active Employee Plan and his/her own health and welfare coverage, the benefits provided by the Active Employee Plan will be secondary with respect to payment of the Domestic Partner's health and welfare claims. If the Domestic Partner has health and welfare coverage through the Active Employee Plan and his/her own health and welfare coverage and the Domestic Partner has Dependent children that the Employee does not claim as "dependents" on his/her federal income tax return, the Active Employee Plan will be secondary with respect to payment of the Dependent children's health and welfare claims.

BOTH THE EMPLOYEE AND DOMESTIC PARTNER HAVE AN OBLIGATION TO NOTIFY THE TRUST OFFICE IN WRITING WITHIN THIRTY (30) DAYS AFTER THEY NO LONGER QUALIFY AS DOMESTIC PARTNERS. THE ADDRESS OF THE TRUST OFFICE IS:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland OR 97239

If either the Employee or Domestic Partner makes a false statement or representation regarding their status as Domestic Partners in the enrollment form or fail to notify the Trust Office in writing within thirty (30) days after they no longer qualify as Domestic Partners and the Harrison Trust suffers any financial loss as a result thereof, the Harrison Trust or the Board of Trustees may bring a civil action against either or both the Employee and the Domestic Partner to recover any losses incurred by the Harrison Trust including reasonable attorney's fees and court costs. The Board of Trustees may also offset prospective

benefits payable to the Employee, Domestic Partner or either of their Dependent children in order to recover the Harrison Trust's loss. The Board of Trustees may also withdraw credits from the Employee's Reserve Account in order to recover the Harrison Trust's loss.

PLAN OPTIONS

An Employee participating in the Harrison Trust has the option of enrolling in one of three medical and prescription drug plans: the Active Employee Plan's medical and prescription drug benefits described in this Benefit Booklet, Providence Health Plan or Kaiser Permanente. You also have the option of enrolling in one of three dental plans: the dental benefits described in this Benefit Booklet, the Kaiser Permanente Dental Plan, or the Willamette Dental Plan. The Providence Health Plan, the Kaiser Permanente Medical and Dental Plans, and the Willamette Dental Plan are available only for Employees who reside in certain geographic areas. Check with the Trust Office for the geographic areas served by Providence Health Plan, Kaiser Permanente Medical and Dental Plans and the Willamette Dental Plan. **Because the cost of each Plan is different, check with the Trust Office to determine the current Monthly cost.**

You may change Your medical, prescription drug and/or dental coverage choice during the Open Enrollment Period. For example, You can switch from Providence Health Plan or Kaiser Permanente to the Active Employee Plan or from the Active Employee Plan to Providence Health Plan or Kaiser Permanente. You can also switch from the Active Employee Dental Plan to either the Kaiser Permanente Dental Plan or the Willamette Dental Plan or vice versa.

If You are considering Providence Health Plan, Kaiser Permanente or the Willamette Dental Plan, You should refer to their benefit booklets for the schedule of benefits, exclusions and the claim appeal procedures. Contact the Trust Office for a Benefit Booklet.

Active Employee Plan

If You select the Active Employee Plan the following benefits are described in this Benefit Booklet:

1. Medical;
2. Prescription drug;
3. Dental;
4. Vision;
5. Employee assistance;
6. Accidental death and dismemberment;
7. Life insurance; and
8. Time loss.

Providence Health Plan

If You select Providence Health Plan, Your medical and prescription drug benefits are described in a separate Benefit Booklet prepared by Providence Health Plan. Your vision, employee assistance, accidental death and dismemberment, life insurance and time loss benefits are described in this Benefit

Booklet. You have the option of dental benefits through Kaiser Permanente, Willamette Dental or the dental benefits described in this Benefit Booklet.

Kaiser Permanente

If You select Kaiser Permanente, Your medical, prescription drug and vision benefits are described in a separate Benefit Booklet prepared by Kaiser Permanente. Your employee assistance, accidental death and dismemberment, life insurance and time loss benefits are described in this Benefit Booklet. You have the option of dental benefits through Kaiser Permanente, Willamette Dental or the dental benefits described in this Benefit Booklet.

COBRA – CONTINUATION OF COVERAGE

This section is applicable to all Employees and their Dependents regardless of whether You are enrolled in the Active Employee Plan, Providence Health Plan, Kaiser Permanente, or Willamette Dental.

Introduction

This section contains important information about Your right to COBRA continuation coverage, which is a temporary extension of medical and prescription drug coverage or medical, prescription drug, dental and vision coverage. COBRA continuation coverage can become available to You and Your Dependents who are covered under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) when You or Your Dependents would otherwise lose Your group health and welfare coverage. This section explains COBRA continuation coverage, when it may become available, and what You need to do to preserve Your right to COBRA continuation coverage.

There may be other coverage options available to You and Your Dependents. You and Your Dependents may be able to buy medical and prescription drug coverage through the Health Insurance Marketplace. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. If You have terminated employment, being eligible for COBRA does not limit Your ability for a tax credit through the Marketplace. If You are an Employee or if You choose to elect COBRA coverage, then Your eligibility for the tax credit may be affected. Additionally, You may qualify for a special enrollment opportunity with another group health plan for which You are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if You enroll within thirty (30) days.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health and welfare coverage that would otherwise end because of a life event known as a qualifying event. Qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose health and welfare coverage because of a qualifying event. Depending on the type of qualifying event, Employees, and Dependents may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders may also be qualified beneficiaries. This is discussed in more detail below. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You will lose Your coverage under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) because either of the following qualifying events happen:

1. Your hours of employment are reduced; or

2. Your employment ends for any reason.

If You are the spouse or Domestic Partner of an Employee, You will become a qualified beneficiary if You lose Your coverage under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) because any of the following qualifying events happen:

1. Your spouse or Domestic Partner dies;

2. Your spouse's or Domestic Partner's hours of employment are reduced;

3. Your spouse's or Domestic Partner's employment ends for any reason;

4. Your spouse or Domestic Partner becomes enrolled in Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from Your spouse or the Domestic Partner relationship ends. If an Employee cancels coverage for his or her spouse or Domestic Partner in anticipation of a divorce, legal separation or dissolution of the Domestic Partner relationship and a divorce, legal separation or dissolution of the Domestic Partner relationship later occurs, then the divorce, legal separation or dissolution of the Domestic Partner relationship will be considered a qualifying event even though the ex-spouse or ex-Domestic Partner lost coverage earlier. If the ex-spouse or ex-Domestic Partner provides written notice to the Trust Office within sixty (60) days after the divorce, legal separation or dissolution of the Domestic Partner relationship and can establish that the Employee canceled the coverage earlier in anticipation of the divorce, legal separation or dissolution of the Domestic Partner relationship, then COBRA continuation coverage may be available for the period after the divorce, legal separation or dissolution of the Domestic Partner relationship.

Dependent children will become qualified beneficiaries if they lose coverage under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) because any of the following qualifying events happen:

1. The parent-Employee dies;

2. The parent-Employee's hours of employment are reduced;

3. The parent-Employee's employment ends for any reason;

4. The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced, legally separated or the Domestic Partner relationship ends; or

6. The child is no longer eligible for coverage because he or she no longer qualifies as a "Dependent child."

Special Second Election Period

Certain Employees and former Employees who are eligible for federal trade adjustment assistance or alternative trade adjustment assistance are entitled to a second opportunity to elect COBRA for themselves and their Dependents (if they did not already elect COBRA) during a special second election

period of sixty (60) days or less (but only if the election is made within six (6) Months after coverage under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) is lost). If You are an Employee or former Employee and You qualify for federal trade adjustment assistance or alternative trade adjustment assistance, contact the Trust Office after qualifying for federal trade assistance or alternative trade adjustment assistance or You will lose any right that You may have to elect COBRA during a special second election period.

Notices and Elections of COBRA Continuation Coverage

Under this Plan and an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental), Your spouse's or Domestic Partner's coverage ends the last day of the Month that a divorce, legal separation or dissolution of a Domestic Partnership relationship occurs and a Dependent child's coverage ends on the last day of the Month in which the Dependent child no longer qualifies as a Dependent.

Important

For the following qualifying events (divorce, legal separation, dissolution of a domestic partnership, or a Dependent child who no longer qualifies as a Dependent child), You, Your spouse, Domestic Partner or Dependent child must notify the Trust Office **in writing** within sixty (60) days after the divorce, legal separation, dissolution of the domestic partnership or child losing Dependent status using the procedures specified under the heading Notice Procedures. If the notice is not provided in writing to the Trust Office during the 60-day notice period, Your spouse, Domestic Partner or Dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT COBRA CONTINUATION COVERAGE.

Notice Procedures

Any notice You provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or deliver Your written notice to the Trust Office at this address:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland OR 97239

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the Trust name (Harrison Electrical Workers Trust Fund), the name and address of the Employee covered by the Harrison Trust and the name(s) and address(es) of the qualified beneficiary(ies) who will lose coverage due to a qualifying event. The notice must also state the qualifying event (divorce, legal separation, dissolution of a Domestic Partnership, or a child who no longer qualifies as a Dependent) and the date the qualifying event happened. If the qualifying event is a divorce, Your notice must include a copy of the divorce decree. If the qualifying event is the dissolution of a domestic partnership, Your notice must provide the date the dissolution occurred.

If the Trust Office receives timely written notice that one of the four qualifying events (divorce, legal separation, dissolution of a domestic partnership or child losing Dependent status) has happened, the Trust Office will notify the family member of the right to elect COBRA continuation coverage. You, Your spouse, Domestic Partner or Dependent child will also be notified of the right to elect COBRA continuation

coverage automatically (without any action required) when coverage is lost because Your employment ends, hours of employment are reduced, You die or become enrolled in Medicare (Part A, Part B or both).

You, Your spouse, Domestic Partner, or Dependent child must elect COBRA continuation coverage within sixty (60) days of receiving the COBRA election form or, if later, sixty (60) days after coverage ends by completing and returning the election form to the Trust Office. Each qualified beneficiary has a right to elect COBRA continuation coverage. **If You, Your spouse, Domestic Partner, or Dependent child does not elect COBRA continuation coverage within the 60-day election period, the qualified beneficiary(ies) will lose the right to elect COBRA continuation coverage.** The election to accept COBRA continuation coverage is effective on the date the election is mailed to the Trust Office. A qualified beneficiary may change a prior rejection of COBRA continuation coverage to acceptance at any time until the election period expires.

In considering whether to elect COBRA continuation coverage, You should take into account that You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within thirty (30) days after Your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if You get COBRA continuation coverage for the maximum time available.

Benefits Available under COBRA Continuation Coverage

You, Your spouse, Domestic Partner and each Dependent child has the right to elect COBRA continuation coverage for medical and prescription drug coverage only, or for medical, prescription drug, dental and vision coverage. Any other benefits provided to You or Your family such as time loss benefits, life insurance and accidental death and dismemberment benefits are not available by electing COBRA continuation coverage. COBRA continuation coverage is identical to the medical, prescription drug, dental and vision coverage available to similarly situated Employees and Dependents. If the medical, prescription drug, dental and vision coverage is modified, COBRA continuation coverage will be modified in the same way. All family members must select the same coverage.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of health and welfare coverage.

When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare benefits (Part A, Part B or both), divorce, legal separation, dissolution of a domestic partnership or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to thirty-six (36) Months.

When the qualifying event is the Employee's termination of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) Months. There are several ways in which this eighteen (18) months of COBRA continuation coverage can be extended.

Medicare Entitlement Extension of Eighteen (18) Month period of COBRA Continuation Coverage

When the qualifying event is the Employee's termination of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) Months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee can last up to thirty-six (36) Months after the date of Medicare entitlement. For example, if an Employee became entitled to Medicare eight (8) Months before the date his coverage terminates because of a reduction of hours of employment, COBRA continuation coverage for his Dependents can last up to thirty-six (36) Months after the date of Medicare entitlement, which is equal to twenty-eight (28) Months after the date of the qualifying event (thirty-six (36) Months minus eight (8) Months).

Disability Extension of Eighteen (18) Month period of COBRA Continuation Coverage

If You or a qualified beneficiary covered is determined by the Social Security Administration to be disabled and You notify the Trust Office in a timely fashion, You and Your Dependents may be entitled to receive up to an additional eleven (11) Months of COBRA continuation coverage, for a maximum of twenty-nine (29) Months. The disability must have to have started at a time before the 60th day of COBRA continuation coverage and must last at least until the end of the eighteen (18) Month period of COBRA continuation coverage. You must make sure that the Trust Office is notified **in writing** of the Social Security Administration's disability determination within sixty (60) days after the date of the determination and before the end of the eighteen (18) Month period of COBRA continuation coverage. You must follow the procedures under the heading "Notice Procedures" on page 22. In addition, Your written notice must include the name of the disabled person, the date that he or she became disabled, the date that the Social Security Administration made its determination and must include a copy of the Social Security Administration's disability determination. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED IN WRITING TO THE TRUST OFFICE WITHIN THE REQUIRED TIME, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, You must notify the Trust Office in writing within thirty (30) days after the Social Security Administration's determination.

Second Qualifying Event Extension of Eighteen (18) Month period of COBRA Continuation Coverage

If a Dependent experiences another qualifying event while receiving eighteen (18) Months of COBRA continuation coverage, the Dependent can get up to eighteen (18) additional Months of COBRA continuation coverage, for a maximum of thirty-six (36) Months. Notice of the second qualifying event must be given in a timely manner to the Trust Office. This extension may be available to the Dependents receiving COBRA continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (Part A, Part B, or both), gets divorced, legally separated, the domestic partnership dissolves or if the Dependent child no longer qualifies as a Dependent child but only if the event would have caused the Dependent to lose coverage had the first qualifying event not occurred. In all these cases, the Dependent must make sure that the Trust Office is notified **in writing** of the second qualifying event within sixty (60) days of the second qualifying event. The Dependent must follow the procedures under the heading "Notice Procedures" on page 22. Your written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce, Your notice must include a copy of the divorce decree. If the second qualifying event is the dissolution of a domestic partnership, Your notice must state the date the domestic partnership dissolved. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED IN WRITING TO THE TRUST OFFICE WITHIN THE REQUIRED 60-DAY

PERIOD, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

How Much COBRA Continuation Coverage Costs

A qualified beneficiary who elects COBRA continuation coverage will be required to pay the cost of COBRA continuation coverage. The cost may not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the group health plan for coverage of a similarly situated Employee or Dependent who is not receiving COBRA continuation coverage.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance. Under the Trade Act of 2002, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health coverage, including COBRA continuation coverage. If You have questions about the Trade Act of 2002, You may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

When and How Payment for COBRA Continuation Coverage must be Made

First payment for COBRA Continuation Coverage

If You elect COBRA continuation coverage, You do not have to send a payment with the election form. However, You must make Your first payment for COBRA continuation coverage no later than forty-five (45) days after the date of Your election. This is the date the election form is postmarked, if mailed. If You do not make Your first payment for COBRA continuation coverage in full no later than forty-five (45) days after the date of Your election, You will lose all COBRA continuation coverage rights.

Your first payment must cover the cost of COBRA continuation coverage from the time Your coverage under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) would have otherwise terminated up to the time You make the first payment. You are responsible for making sure that the first payment is enough to cover the entire cost. You may contact the Trust Office to confirm the correct amount of Your first payment.

Your first payment for COBRA continuation coverage should be sent to:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

Monthly payments for COBRA Continuation Coverage

After You make Your first payment for COBRA continuation coverage, You are required to pay for COBRA continuation coverage for each subsequent Month of coverage. The Monthly payments are due by the first day of the Month. If You make a Monthly payment on or before the first day of the Month, Your coverage will continue for that coverage period without any break. **The Trust Office will not send notices of payments due for these coverage periods.**

Monthly payments for COBRA continuation coverage should be sent to:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

Grace Period for Monthly Payments

Although Monthly payments are due by the first day of the Month, You have a grace period of thirty (30) days to make each Monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, if You pay a Monthly payment later than the first day of the Month but before the end of the grace period, Your coverage will be suspended as of the first day of the Month and then retroactively reinstated (going back to the first day of the Month) when the Monthly payment is received. This means that any claim You submit for benefits while Your coverage is suspended may be denied and may have to be resubmitted once Your coverage is reinstated. **If You fail to make a Monthly payment by the end of the grace period, You will lose all rights to COBRA continuation coverage.**

Termination of COBRA Continuation Coverage before the End of the Maximum Period

COBRA continuation coverage will automatically end (before the end of the maximum coverage period) if:

1. The premium is not paid by the end of the grace period;

2. After electing COBRA continuation coverage, You, Your spouse, Domestic Partner or Dependent child becomes enrolled in Medicare benefits (Part A, Part B or both);

3. After electing COBRA continuation coverage, You, Your spouse or Domestic Partner or Dependent child becomes covered under another group health plan;

4. The Harrison Trust no longer provides group health coverage for any of its participants;

5. Your last employer stops contributing to the Harrison Trust and makes a group health plan available for its Employees formerly covered under the Harrison Trust. In this situation, the group health plan maintained by Your last employer has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving COBRA coverage under the Harrison Trust on the day before the cessation of contributions by the employer and whose last employment prior to the qualifying event was with the employer; or

6. During a disability extension period (explained on page 24), the disabled person is determined by the Social Security Administration to no longer be disabled. In this circumstance, COBRA continuation coverage will be terminated for any qualified beneficiary who is receiving extended COBRA continuation coverage under the disability extension as of the later of (i) the first day of the Month that is more than thirty (30) days after the final determination by the

Social Security Administration that You, Your spouse or Domestic Partner or Dependent child is no longer disabled; or (ii) the end of the coverage period that applies without regard to the disability extension.

You, Your spouse or Domestic Partner and/or Dependent child must notify the Trust Office in writing within thirty (30) days if, after electing COBRA continuation coverage, You, Your spouse or Domestic Partner or Your Dependent child becomes entitled to Medicare (Part A, Part B or both), becomes covered under another group health plan, or You, Your spouse or Domestic Partner or Dependent child is determined by the Social Security Administration to no longer be disabled. Follow the "Notice Procedures" on page 22.

Automatic COBRA Continuation Coverage for Your Spouse or Your Domestic Partner and Dependent Children in Certain Circumstances

When You elect COBRA continuation coverage, coverage for Your Dependents who had coverage immediately before the qualifying event will continue automatically unless a Dependent independently declines COBRA continuation coverage. If You choose not to elect COBRA continuation coverage, Your Dependents who had coverage immediately before the qualifying event may still elect COBRA continuation coverage. Of course, in all circumstances, anyone electing COBRA continuation coverage must pay the required premium.

Transfer Rights to Another Plan

If You are covered by Providence Health Plan, Kaiser Permanente, or Willamette Dental that covers a limited geographic area and relocate to another area where employers contributing to the Harrison Trust have an active workforce, You may be entitled to elect coverage available to other Employees working in that area. If You find Yourself in this situation, call or write the Trust Office. Under no circumstance would such a transfer prolong Your maximum COBRA continuation coverage.

More Information about Individuals Who may be Qualified Beneficiaries

A child born to, adopted by or placed for adoption with an Employee during a period of COBRA continuation coverage is considered a qualified beneficiary provided the Employee has elected COBRA continuation coverage. The child's COBRA continuation coverage begins when the child is born and it lasts as long as COBRA continuation coverage lasts for other family members of the Employee. To be enrolled in this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental), the child must satisfy the otherwise applicable eligibility requirements (for example, age).

A child of an Employee who is receiving benefits under this Plan or an insured plan (Providence Health Plan, Kaiser Permanente, or Willamette Dental) pursuant to a Qualified Medical Child Support Order is entitled to the same rights under COBRA as a Dependent child of the Employee, regardless of whether that child would otherwise be considered a Dependent.

More Information about COBRA Continuation Coverage

Questions concerning Your COBRA continuation coverage rights should be addressed to the Trust Office. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability

and Accountability Act and other laws affecting group health plans, contact the nearest Regional or District office of the US Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the website.

Are there Coverage Options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options available to qualified beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Keep the Trust Office Informed of Address Changes

In order to protect Your family's rights, You should keep the Trust Office informed of any changes in the addresses of family members. You should keep a copy of any notices You send to the Trust Office.

OREGON PORTABILITY HEALTH INSURANCE PLANS

This section of the Benefit Booklet applies only if You reside in Oregon and Your medical and prescription drug benefits are provided by Providence Health Plan or Kaiser Permanente.

Oregon law requires some insurance companies and HMO's that previously provided You and Your Dependents group health insurance benefits to provide a choice of two health insurance plans when group health insurance coverage ends.

Eligibility Requirements for Portability Health Benefit Plans

To enroll in one of the portability plans, You or Your Dependent must:

1. Have ended coverage or lost eligibility under the Providence Health Plan or Kaiser Permanente.

2. Have been continuously enrolled with Providence Health Plan or Kaiser Permanente, or Providence Health Plan or Kaiser Permanente and one or more other Oregon group health plans (including any continuation coverage under COBRA) for at least one-hundred eighty (180) days prior to the loss of coverage under the Providence Health Plan and/or Kaiser Permanente.

3. Be a resident of Oregon.

4. Apply for portability coverage not later than the 63rd day after termination of Your group health insurance coverage.

5. Not be eligible for Medicare.

How to Apply for a Portability Health Benefit Plan

In order to exercise the right to enroll in one of the portability health benefit plans, You or Your Dependents must:

1. Submit a written application to Providence Health Plan or Kaiser Permanente.

2. Apply for individual coverage within sixty-three (63) days after You lose Your group health insurance coverage or after Your COBRA coverage expires.

3. Be responsible for paying the cost of the individual insurance coverage.

If eligible, You have the choice of two portability health benefit plans:

1. A prevailing cost plan, which includes benefit coverage and premiums that are prevalent in the Oregon group health insurance/Providence Health Plan and/or Kaiser Permanente marketplace; and

2. A low cost plan, which emphasizes affordability.

If You would like more information about the portability health benefit plans, contact Providence Health Plan or Kaiser Permanente.

The Portability Plan is a new plan and not a continuation of Your terminated group health insurance plan. The Portability Plan's benefits and premiums may differ from Your group health insurance plan.

MEDICAL BENEFITS

Medical Benefits

DEDUCTIBLE – EMPLOYEE OR DEPENDENT	$500 per calendar year
DEDUCTIBLE – FAMILY	$1,000 per calendar year
PREFERRED PROVIDER PERCENTAGE	80% of the negotiated rate for Covered Charges
NON-PREFERRED PROVIDER PERCENTAGE	60% of Reasonable and Customary Covered Charges

The Medical Benefits portion of this Benefit Booklet provides that all Covered Charges (other than for prescription drugs, dental, and vision), after satisfying the Deductible, will be payable at 60% of the Reasonable and Customary Charge for a non-Preferred Provider and 80% of the negotiated rate for a Preferred Provider until the out-of-pocket maximum has been met. The following are exceptions to the higher co-payment for non-Preferred Provider services:

1. If there are fewer than two Preferred Provider Primary Care Physicians within a thirty (30) mile radius of Your primary residence, Medical Benefits (but not Hospital charges) from a non-Preferred Provider will be paid at 80% of the Reasonable and Customary Charge;

2. If You utilize a Preferred Provider (e.g., physician or hospital) but your Preferred Provider uses a non-Preferred Provider for your services (e.g., lab services, anesthesiologist, radiologist), Your share of the cost of services will be treated as if a Preferred Provider had performed such services, provided you did not direct your Preferred Provider to use a non-Preferred Provider.

3. If You utilize a Preferred Provider (e.g., physician or hospital) and such Preferred Provider leaves the network, and you meet the requirements of a being a "continuing care patient", Your share of the cost of continuing services shall be the same as if the services were delivered by a Preferred Provider for 90 days after the provider leaves the network (or 90 days from the date You are no longer a "continuing care patient"). With respect to a provider that leaves the network, a continuing care patient is one who is: (a) being treated for a serious and complex condition; (b) being treated in an in-patient or institutional facility; (c) scheduled for nonelective surgery; (d) is pregnant; or (e) terminally ill. You will be sent a notification and must return the required form in order to be considered a continuing care patient.

4. If You utilize air ambulance services of a non-Preferred Provider, Your share of the cost of the services will be treated as if a Preferred Provider had performed the services.

Out-of-Pocket Maximum for Medical Benefits

During a calendar year, Your out-of-pocket maximum for in-network (Preferred Provider) charges, including the Deductible for Medical Benefits, is $3,000 per person or $6,000 per family (excluding prescription drug charges). There is a separate out-of-pocket maximum for Your out-of-network (non-Preferred Provider) charges. After the in-network (Preferred Provider) out-of-pocket maximum has been met, all Covered Charges for Medical Benefits (excluding prescription drug charges) provided by a Preferred Provider will be paid at 100% of the negotiated rate for the remainder of the calendar year

except for those Medical Benefits (excluding prescription drug charges) that have lower maximums or other limitations.

During a calendar year, Your out-of-pocket maximum for out-of-network (non-Preferred Provider) charges, including the Deductible for Medical Benefits, is $3,000 per person or $6,000 per family (excluding prescription drug charges). After the out-of-network (non-Preferred Provider) out-of-pocket maximum has been met, all Covered Charges for Medical Benefits (excluding prescription drug charges) provided by a non-Preferred Provider will be paid at 100% of the Reasonable and Customary Charge for the remainder of the calendar year except for those Medical Benefits (excluding prescription drug charges) that have lower maximums or other limitations.

During a calendar year, the out-of-pocket maximum for prescription drug copayments is $3,000 per person or $6,000 per family. If the out-of-pocket maximum for prescription drug charges has been met, prescription drug charges covered by the Plan for the remainder of the calendar year will be paid at 100% except for those prescription drug benefits that have lower maximums or other limitations.

Deductible

Many of the Medical Benefits are subject to a calendar year Deductible. The per person Deductible is $500 of Covered Charges in a calendar year. The family Deductible is $1,000 of Covered Charges in a calendar year. Once the $1,000 family Deductible has been met during a calendar year, no other family member must satisfy the Deductible for the remainder of the calendar year.

Any Covered Charges incurred during the last three Months of the calendar year and applied to the Deductible will apply toward the Deductible in the next calendar year.

If a single accident causes injuries to two or more members of a family, only one Deductible will apply to the family for Covered Charges incurred during that calendar year that result from such injuries. In no event will a lesser amount be paid than would be payable if this single Deductible did not apply.

Benefit Period

A Benefit Period begins in a calendar year when You have incurred Covered Charges that exceed the Deductible amount. Included will be Covered Charges incurred in October, November and December of the preceding calendar year for which no benefits were paid because such charges were applied to the Deductible amount.

A Benefit Period ends on the earliest of the following:

1. The last day of the calendar year in which it was established; or

2. The day coverage provided under this Plan ends; or

3. The day the maximum benefit is paid.

Determination of Benefits

Benefits to be paid will be determined by multiplying the benefit percentage by the amount of Reasonable and Customary Covered Charges or negotiated Covered Charges in the case of a Preferred Provider in a Benefit Period that exceed the Deductible. For example:

HOSPITAL VISIT YOU ARE CHARGED	COVERED CHARGES	DEDUCTIBLE (YOU PAY)	PLAN PAYS 80% PREFERRED PROVIDER 60% NON-PREFERRED PROVIDER	YOU PAY
$1,000	$1,000	$500	$500 x 80% = $400 $500 x 60% = $300	$100 $200

Covered Charges

A Covered Charge, except preventative care, must be Medically Necessary in order to be eligible for payment. Covered Charges are:

1. Office visits (including telemedicine visits), inpatient and outpatient Hospital visits and home visits with a Provider except where otherwise limited by the Plan (for example, a yearly limit on the number of chiropractic and naturopathic visits per calendar year).

2. Semi-private room and board and routine nursing for confinement in a Hospital.

3. Semi-private room and board and routine nursing for confinement in a Skilled Nursing Facility (not to exceed the average semi-private Hospital room rate). Confinement must commence within fourteen (14) days after discharge of three (3) or more days in an acute care Hospital.

4. Intensive nursing care for each day of confinement in a Hospital as follows:

    a. For Hospitals which make a separate charge for intensive nursing care, the Hospital's specific charge for intensive nursing care is covered;

    b. For Hospitals that make a combined charge for room and board and intensive nursing care, the part of the combined charge that is in excess of the Hospital's prevailing semi-private room and board rate will be the Covered Charge for intensive nursing care.

5. Medical services and supplies furnished by a Hospital.

6. Anesthetics and their administration.

7. Medical treatment given by or at the direction of a Doctor, if such treatment is administered by a Provider.

8. Services of a RN or LPN for private duty nursing services in a Hospital.

9. Services of a licensed physiotherapist.

10. Charges by a Doctor or speech therapist for rehabilitative speech therapy that is necessary because of an Illness (other than a functional nervous disorder), or is necessary because of surgery on account of an Illness. Charges by a Doctor or speech therapist for speech therapy that is necessary as the result of Down Syndrome. Charges by a speech therapist for a child under age six (6) for speech therapy that is necessary as the result of developmental delay and is not rehabilitative in nature (restoring developmental skills that were lost or impaired due to an Illness). If the speech therapy is necessary because of a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

11. X-rays (other than dental), lab tests and other diagnostic services.

12. X-ray and radiation therapy.

13. Charges for the repair of sound, natural teeth (including their replacement) required as a result of and performed within twenty-four (24) Months of an Accidental Bodily Injury.

14. Emergency medical transportation within the United States and Canada to and/or from a Hospital or care center. Transportation must be by state certified ambulance or by certified air ambulance transportation. Benefits are provided to the nearest facility capable of providing the necessary care. However, if the nearest facility is a non- Preferred Provider, benefits will still be provided if transportation is to the nearest Preferred Provider facility capable of providing the necessary care. If the emergency medical transportation service is a non-Preferred Provider, benefits for such transportation services will be paid at 80% of the usual, customary and reasonable (UCR) charge.

15. Medical supplies and appliances as follows:

    a. Drugs that require a written prescription from a Doctor and must be dispensed by a licensed pharmacist or Doctor;

    b. Blood and other fluids to be injected into the circulatory system;

    c. Lens, each eye, immediately following and because of cataract surgery;

    d. Casts, splints, trusses, braces, crutches and surgical dressings;

    e. Purchase or rental of Hospital-type equipment for kidney dialysis for Your personal and exclusive use. The total purchase price, if allowed, will be paid on a Monthly pro rata basis during the first twenty-four (24) Months of ownership, but only so long as dialysis treatment continues to be Medically Necessary. Also covered are supplies, materials and repairs necessary for the proper operation of such equipment and also reasonable and necessary expenses for the training of a person to operate and maintain the equipment for Your personal and exclusive use. No benefits are paid on or after the day You are entitled to benefits under Medicare;

f. Rental of Hospital-type medical equipment up to purchase price for other than kidney dialysis, including wheelchair, Hospital bed, equipment for the treatment of respiratory paralysis and equipment for the use of oxygen;

g. Purchase of Durable Medical Equipment when required for the standard treatment of an Illness or Injury. The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase price of a new piece of equipment or device. The Trust Office or Board of Trustees may authorize the purpose of an item (prorated over twelve (12) Months) if it is determined the cost of purchasing an item would be less than the overall cost of rental of the item;

h. Prosthesis;

i. Surgically implantable contraceptive devices, intrauterine devices (IUDs), diaphragms, Depo-Provera and other non-self administered contraceptives; and

j. Other Medically Necessary supplies and appliances as ordered by Your Provider.

16. Maternity expenses for an Employee or Dependent are covered on the same basis as any other Illness, whether or not the pregnancy commences while the Employee or Dependent is covered under the Plan, except as described below. Covered services include prenatal care by Your Provider, delivery at an approved facility or Birthing Center, post-natal care, including complications of pregnancy and delivery. Prenatal office visits with a Preferred Provider are preventive care services and are covered at 100% of the Negotiated Rate with no Deductible or co-payment. Your Dependent child's newborn child will be covered under the Plan for thirty-one (31) days following birth. After the thirty-one (31) day period, the newborn child will remain covered under the Plan only if the newborn child qualifies as the Employee's Dependent.

17. Preventive care services from a Preferred Provider are covered at 100% of the negotiated rate for a Preferred Provider. You do not have to satisfy the Deductible. There is no coverage for preventive care services obtained from a non-Preferred Provider except as provided in Section 18. Preventative care services are:

    a. Items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force. Examples of preventive care services include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.

    b. Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

    c. For infants, children, and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

d. For women, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by HRSA. Examples of covered services include annual well-women visits, contraceptive methods and counseling, and breastfeeding support.

e. The complete list of preventive services covered by this Plan if a Preferred Provider is used is available at www.hhs.gov/healthcare/prevention and is subject to change. This Plan covers a new guideline or recommendation effective with the calendar year that begins on or after one (1) year from the date the new recommendation or guideline is issued or adopted, as applicable. This Plan does not cover any preventive care item or service after the date it is no longer included in the applicable recommendation or guideline, unless such coverage is provided for elsewhere in this Plan.

This Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in this section to the extent not specified in the applicable recommendation or guideline.

18. Preventive Care Services from a non-Preferred Provider. Preventive care services obtained from a non-Preferred Provider are excluded except for the following preventive care services:

a. Immunizations for children (over age three), adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at 60% of the Reasonable and Customary Charge after the Deductible has been met.

b. Annual pap, pelvic, breast, and mammogram examinations are covered at 60% of the Reasonable and Customary Charge after the Deductible has been met.

c. Annual prostate examination for men are covered at 60% of the Reasonable and Customary Charge after the Deductible has been met.

d. Well baby visits (including Medically Necessary immunizations) for the first three (3) years of a child's life are covered at 60% of the Reasonable and Customary Charge. This benefit is not subject to the Deductible.

b. A colonoscopy is allowed once every ten (10) years if You are over age fifty (50). A colonoscopy will be allowed before age fifty (50) or more often than once every ten (10) years if the colonoscopy is Medically Necessary. A colonoscopy will be paid at 60% of the Reasonable and Customary Charge after the Deductible has been met.

19. Birthing Center: Charges made for services and supplies furnished by a Birthing Center for prenatal care, delivery of a child and postpartum care rendered within twenty-four (24) hours after delivery.

20. Benefit for Donors: Medical services incurred by a donor in connection with a covered transplant when You are the recipient of the transplant.

21. Formula and related supplies if the formula is supplying 100% of the individual's nutritional intake; for example, the individual must be fed through a tube.

22. Bariatric surgical procedures including gastric-bypass and laparoscopic procedures but only if surgery is preapproved in writing by a medical review agency selected by the Board of Trustees using its most stringent Medical Necessity review criteria.

23. Yearly limitation on Chiropractic and Naturopathic services: twenty-six (26) visits per calendar year maximum for chiropractic services and twenty-six (26) visits per calendar year maximum for naturopathic services. The number of visits for which You will receive benefit payment will be reduced if these services are used to meet part or all of Your calendar year Deductible.

24. Acupuncture services provided by an MD, DO, or Licensed Acupuncturist, and massage therapy provided by a licensed massage therapist. Benefits are limited to twenty-six (26) visits per calendar year. Payment not to exceed $75.00 per visit.

25. Diabetic Training: one session or one treatment plan per lifetime.

26. Services of a Doctor or an occupational therapist for rehabilitation services provided to restore fully developed skills that were lost or impaired due to an Injury or Illness.

27. The following replacement of organ and tissue:

    a. Cornea transplants;

    b. Artery or vein transplants;

    c. Kidney transplants;

    d. Joint replacements;

    e. Heart valve replacements;

    f. Implantable prosthetic lenses in connection with cataracts;

    g. Prosthetic bypass or replacement vessels;

    h. Bone marrow transplants;

    i. Heart transplants;

    j. Heart and lung transplants; and

    k. Liver transplants.

28. Clinical Trial Benefits as follows:

    a. This Plan will not discriminate against a person who is qualified to participate in an approved clinical trial (defined in paragraph c below); deny his or her right to participate in that approved clinical trial; or deny, limit, or impose additional conditions on the coverage of routine patient costs (defined in paragraph e below) for items and services furnished in connection with participating in the approved clinical trial.

    b. A person covered by this Plan is "qualified" to participate in an approved clinical trial if he or she is eligible according to the trial's protocol for the treatment of cancer or other life-threatening condition (defined in paragraph d below) and either (i) the referring health care professional is a Preferred Provider who concluded that the person's participation would be appropriate, or (ii) the person provides the Board of Trustees or their designee with medical and scientific information establishing, to their satisfaction, that his or her participation in the approved clinical trial would be appropriate.

    c. An "approved clinical trial" is a Phase I, II, III, or IV clinical trial conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening conditions and is (i) approved or funded by one or more of the federal entities listed in the Public Health Service Act Section 2709(d); (ii) conducted in connection with an investigational new drug application reviewed by the U.S. Food and Drug Administration; or (iii) exempt from investigational new drug application requirements.

    d. A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

    e. "Routine patient costs" include items and services typically provided under the Medical Benefits portion of the Plan for a person who is not enrolled in an approved clinical trial, except it does not include (i) the investigational item, device, or service itself; (ii) items and services not included in the direct clinical management of the person but that, instead, are provided in connection with data collection analysis; or (iii) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

    f. The Plan may require a person to use a Preferred Provider participating in the clinical trial if the Preferred Provider will accept the person as a trial participant, but the limitations in paragraph a apply when a qualified person participates in an approved clinical trial that is conducted outside the person's state of residence.

29. Hospital Emergency Room Services: If You receive treatment at a Hospital emergency room for an Illness or Injury that a prudent layperson would not consider to be an Emergency Medical Condition, You must pay the first $250 of the emergency room visit. The $250 payment is in addition to any Deductible that You must meet under the Plan. The Plan will pay 80% of the negotiated charge for a Preferred Provider and 80% of the Reasonable and Customary Charge for a non-Preferred Provider after the Deductible and $250 payment, if applicable, are met. There is no requirement for prior authorization before seeking treatment for an Emergency

Medical Condition in a Hospital emergency room. Examples of an Emergency Medical Condition which a prudent layperson would consider an emergency are:

- Severe chest pain;
- Uncontrolled bleeding;
- Loss of consciousness;
- Severe shortness of breath;
- Poisoning;
- Sudden onset of paralysis and/or slurred speech;
- Severe burns;
- Broken bones; and
- Acute abdominal pain.

30. All claims related to dialysis, including related products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis, shall be paid at the lesser of the Preferred Provider negotiated rate, the billed amount or at 150% of the Medicare rate for such services. A person who requires dialysis is required to become covered by Medicare at the earliest eligibility time and the Plan will reimburse such person for the cost of the Medicare Part B premiums (please contact the Trust Office for information).

31. Charges for cochlear implants are covered when Medically Necessary for severe to profound hearing loss due to Illness or Injury after preapproval in writing by a medical review agency selected by the Board of Trustees. Covered Charges include implant surgery, pre-implant testing, post-implant follow up, speech therapy, programming and associated supplies (such as transmitter cable and batteries).

CHEMICAL DEPENDENCY BENEFITS

How Much the Active Employee Plan Pays

Benefits are provided for Chemical Dependency services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment of other medical conditions.

All Covered Charges will be reimbursed at 60% (80% for a Preferred Provider), subject to Your annual Deductible. All Covered Charges must be Medically Necessary and provided by a Provider that is acting within the scope of his/her license.

If Your treatment program requires an inpatient stay, the facility must be a licensed Health Care Facility.

What is not Covered

1. Charges resulting from educational programs for drinking drivers or from volunteer mutual support groups.

2. Treatment solely for detoxification or primarily for maintenance care (providing an environment without access to drugs or alcohol).

Important Points to Remember

1. You must be covered under the Active Employee Plan to be eligible for Chemical Dependency benefits. If You are covered by Kaiser Permanente or Providence Health Plan, Your benefits will be paid in accordance with those Plans.

2. All Covered Charges are reimbursed at 60% (80% for a Preferred Provider) and are subject to the annual Deductible.

3. The services You receive must be Medically Necessary and provided by a Provider who is acting within the scope of his or her license. If inpatient care is needed, the facility must be a licensed Health Care Facility.

4. The Chemical Dependency benefits shall be interpreted in a manner that complies with the Federal Mental Health Parity and Addiction Equity Act of 2008.

MENTAL ILLNESS BENEFITS

How Much the Active Employee Plan Pays

Benefits are provided for Mental Illness services at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for Medically Necessary treatment of other medical conditions.

All Covered Charges will be reimbursed at 60% (80% for a Preferred Provider), subject to Your annual Deductible. All Covered Charges must be Medically Necessary and provided by a Provider that is acting within the scope of his/her license.

If Your treatment program requires an inpatient stay, the facility must be a licensed Health Care Facility.

Important Points to Remember

1. You must be covered under the Active Employee Plan to be eligible for Mental Illness benefits. If You are covered by Kaiser Permanente or Providence Health Plan, Your benefits will be paid in accordance with those Plans.

2. All Covered Charges are reimbursed at 60% (80% for a Preferred Provider) and are subject to the annual Deductible.

3. The services You receive must be Medically Necessary and provided by a Provider who is acting within the scope of his or her license. If inpatient care is needed, the facility must be a licensed Health Care Facility.

4. The Mental Illness benefits shall be interpreted in a manner that complies with the Federal Mental Health Parity and Addiction Equity Act of 2008.

HOMEMAKER SERVICES

This benefit is available when You are physically unable to perform daily household tasks and noother household member is able to perform these tasks. The annual Deductible is waived for this benefit. The Covered Charge for homemaker services is 80% of the Reasonable and Customary Charge, to a maximum of $500 per week. A week commences the first day charges for homemakerservices are incurred. Lifetime maximum benefit for these services is $5,000.

To be eligible for this benefit You must meet the following guidelines:

1. You must apply to the Trust Office and demonstrate both cause and need; and

2. Services cannot be rendered by a family member.

INPATIENT CUSTODIAL CARE

Inpatient care that is custodial in nature is reimbursed at 100% of the Reasonable and Customary Charge to a maximum of $100 per day for the first twenty (20) days of confinement and $78.50 per day for an additional eighty (80) days. The annual Deductible is waived for this benefit. The lifetime maximum benefit for these services is 10,000. For example:

INPATIENT CUSTODIAL CARE YOU ARE CHARGED	COVERED CHARGES	DEDUCTIBLE (YOU PAY)	PLAN PAYS 80% UP TO LIFETIME MAXIMUM OF $5,000	CO-PAY (YOU PAY)
$100 per day for twenty (20) days	$100 per day for twenty (20) days	$0	$100 x twenty (20) days = $2,000	$0.00
$100 per day for five (5) days	$78.50 per day for five (5) days	$0	$78.50 x 5 days = $392.50	$107.50

To be eligible for this benefit, You must meet the following guidelines:

1. You must apply to the Trust Office and demonstrate both cause and need;

2. This benefit is not available if the Provider is eligible for payment under the skilled nursing provision of the Plan; and

3. The service must be provided by a state licensed inpatient care facility.

HOSPICE BENEFIT

Covered Charges

The Hospice benefit covers the services and supplies listed below when they are included in the Hospice Treatment Plan and provided and billed by an Approved Hospice. Covered Charges include the following:

1. Inpatient confinement at an Approved Hospice;

2. Skilled nursing services (by an RN or LPN);

3. Diagnostic services;

4. Physical, speech and inhalation therapy;

5. Medical supplies, equipment and appliances;

6. Counseling services (except bereavement counseling);

7. Prescription drugs obtained from the Approved Hospice; and

8. Charges for Respite Care provided when You require continuous attention. Charges by a non-professional Provider may be covered by Respite Care if approved by the Trust Office or Board of Trustees in advance.

Hospice Exclusions

In addition to the exclusions listed elsewhere in the Benefit Booklet, charges for the following services and supplies are not covered:

1. Services provided for bereavement counseling for family members;

2. Pastoral and spiritual counseling;

3. Funeral arrangements;

4. Financial or legal counseling;

5. Services performed by family members or volunteer workers; and

6. Homemaker or housekeeping services, except as allowed by the Home Health Care and Homemaker Services sections of the Benefit Booklet.

HOME HEALTH CARE

Home health care benefits provide payment of 60% of Reasonable and Customary Charges (80% of negotiated rates for Preferred Providers) of eligible home health care charges for a single visit. These benefits are payable up to a maximum of 100 visits during a calendar year.

Covered Charges

Charges are covered for Illness or Accidental Bodily Injury:

1. That do not arise out of or in the course of any employment; and

2. For which You are not entitled to benefits under any workers' compensation law.

The charges must meet the following requirements:

1. The charges must be Medically Necessary for Your treatment, You are Totally Disabled and, in the opinion of Your Doctor, would otherwise be confined as a registered bed patient in a Hospital or Skilled Nursing Facility and:

    a. You are under the direct care of a Doctor;

    b. The plan of treatment covering home health care is established in writing by Your Doctor prior to commencement of such treatment;

    c. The plan of treatment is reviewed and updated in writing by Your Doctor at least once every Month; and

    d. You are examined by Your Doctor at least once every sixty (60) days.

2. The charges that are provided by a home health agency must meet the following requirements:

    a. It is primarily engaged in and is federally certified as a home health agency and is licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services (as listed in this section);

    b. Its professional service policies are established by a professional group association with such agency or organization, including at least one Doctor and at least one registered nurse, to govern the services provided;

    c. It provides for full-time supervision of home health care service by a Doctor or by a registered nurse;

    d. It maintains a complete medical record for each patient; and

    e. It has an administrator.

3. Charges must be incurred for one or more of the following, unless the charges are Covered Charges under the Medical Benefits portion of this Benefit Booklet:

    a. Part-time or intermittent nursing care by a licensed practical nurse;

    b. Service by a registered nurse;

    c. Skilled Nursing Care including but not limited to:

        i. Giving of injections, including IVs;

        ii. Changing and irrigating urinary catheters;

        iii. Drawing blood for testing;

        iv. Taking of blood pressure;

        v. Giving insulin shots;

        vi. Use of oxygen and breathing machines;

        vii. Treatment of bed sores and other skin problems; and

        viii. Bandaging surgical incisions.

    d. Speech language therapy for lost communication skills (loss due to an accident or Illness) including but not limited to:

        i. Teaching communication skills;

        ii. Alternate means of expression; and

        iii. Help with choking or swallowing problems.

    e. Physical therapy including but not limited to:

        i. Planning an exercise program;

        ii. Teaching balance and coordination skills; and

        iii. Easy approach to getting in and out of a wheelchair or bed.

Home Health Care Exclusions

1. Charges for services for which You are not, in the absence of this coverage, legally required to pay;

2. Charges for services performed by Your immediate family or any person residing with You;

3. Charges for general housekeeping services (except as specified under Home Maker Services Benefit); and

4. Charges for services for Custodial Care (except as specified under Inpatient Custodial Care Benefit).

HEARING AID BENEFIT

This benefit is available if You are covered under this Plan, Providence Health Plan or Kaiser Permanente. The following guidelines must be met:

1. This benefit is for hearing aids and devices which means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachment or accessory for the instrument or device.

2. The hearing aids and devices must be ordered by a Doctor, certified audiologist or licensed hearing aid dealer.

3. Covered Charges for hearing aids and devices are not subject to the Deductible and the first $400 will be paid at 100%. After the first $400, the Trust will pay 50% of the Covered Charges for hearing aids and devices up to an additional payment of $3,000. The maximum benefit is $3,400. For example:

HEARING AID DEVICES YOU ARE CHARGED	COVERED CHARGES	DEDUCTIBLE (YOU PAY)	PLAN PAYS 100% FIRST $400 50% UP TO $1,500	YOU PAY
$500	$500	$0	$400 x 100% = $400 $100 x 50% = $50.00	$50.00

4. This benefit renews every thirty-six (36) Months.

5. Benefits will not be paid for batteries and for ancillary equipment that are not obtained upon purchase of the hearing aids and devices, and benefits will not be paid for repairs, servicing or alteration of hearing aids and devices.

6. If You are covered by this Plan, there is a separate medical benefit for a Medically Necessary cochlear implant.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program is also available to Employees and Dependents enrolled in Kaiser Permanente and Providence Health Plan.

The Employee Assistance Program (EAP) is a FREE and CONFIDENTIAL benefit that can assist You and Your Dependents with personal problems, large or small, such as:

Marital conflict	Stress management	Alcohol or drug abuse
A conflict at work	Family relationships	Grieving a loss
Depression or anxiety	Financial/legal/consumer concerns	Career development services

Personal Consultation with an EAP Counselor. Each family has access up to three counseling sessions, face-to-face, over the phone, or online per unrelated incident per year (November 1 through October 31) with an EAP counselor. An EAP counselor will help identify problems, establish goals, make recommendations, and develop action plans.

How to Use the EAP

1. Call (800) 443-2320 and identify Yourself as an Employee or Dependent of the Harrison Electrical Workers Trust Fund.

2. Make an appointment with a counselor or ask that a counselor call You.

3. Meet confidentially with a counselor. The counselor will assist in evaluating the problem, provide short-term counseling, and, if needed, offer referrals to professional help beyond the scope of the EAP. You are responsible for any fees charged by the professional to which the EAP counselor refers You unless those fees are covered by another portion of the Benefit Booklet.

4. Remember that the EAP provides up to three paid counseling sessions per unrelated incident for each family unit at no charge.

Confidentiality

Anything You discuss with the EAP counselor remains strictly confidential, except as required to be disclosed by law. Any questions regarding confidentiality should be discussed with Your EAP counselor.

Crisis Counseling

Available twenty-four hours per day, seven days a week. Call (800) 433-2320.

Work/Family/Life

The EAP will do the research for You. The EAP will help locate resources and information related to elder care, child care, or anything else You may need.

Legal Consultations/Mediation

The EAP will provide a thirty-minute office or telephone consultation at no cost with a network attorney/mediator. If You decide to retain the attorney/mediator after the initial consultation, a 25% discount from the attorney's/mediator's normal hourly rate is available.

Financial Coaching

Coaches will provide thirty consecutive days of unlimited financial coaching, developing a needs analysis and an online written action plan to help develop better spending habits, reduce debt, improve credit, increase savings, and plan for retirement.

Identity Theft

This service provides up to a sixty (60) minute free consulting with a highly trained fraud resolution specialist who will conduct emergency response activities and assist You and Your Dependents with restoring Your identity, good credit, and dispute fraudulent debts.

Home Ownership Program

If You are planning to buy, sell, refinance, or invest in a home, this program offers a network of prescreened service providers that offer free consultations. Also available are pre-negotiated discounts for selected services. To access this service or for more information, call (866) 505-3244.

Legal Tools

Free online legal forms for areas such as creating a will, financial power of attorney, living will, or final arrangements. Complete instructions on the proper signing and specific witness requirements are provided. To access this service: (i) go to www.cascadecenters.com; (ii) hover on the Employee Assistance tab and click Legal Tools; (iii) click Visit Legal/Financial Library; and (iv) click on Legal Tools.

Cascade Personal Advantage

Free innovative educational tools allowing You to manage Your stress and improve quality of life. Chat live with an EAP counselor, take self-assessments, view videos, access personal growth courses, download documents, and more. To access Cascade Personal Advantage: (i) go to www.cascadecenters.com; (ii) click "Member Log-In"; (iii) register as a new user; and (iv) enter Harrison Electrical Workers.

PREFERRED PROVIDER PROGRAM

As part of the Harrison Trust's voluntary Preferred Provider program, You can receive substantial savings on a wide variety of health care services offered by the Harrison Trust's two Preferred Provider networks. When You choose a Provider or facility who is a Preferred Provider, Covered Charges paid by the Harrison Trust are usually at a higher percentage and You pay less out of pocket. This is because Preferred Providers have contracted to provide services at negotiated rates. Bills from Preferred Providers are paid at 80% of the negotiated rate after the Deductible has been satisfied rather than 60% of the Reasonable and Customary Charge after the Deductible has been satisfied for a non-Preferred Provider. There are three exceptions as follows:

1. If there are fewer than two Preferred Provider Primary Care Physicians within a thirty (30) mile radius of Your primary residence, Medical Benefits (but not Hospital charges) from a non-Preferred Provider will be paid at 80% of the Reasonable and Customary Charge;

2. If Your Physician is a Preferred Provider and uses a pathology facility that is a non-Preferred Provider, the pathology facility's Medically Necessary Covered Services will be paid at 80% of the Reasonable and Customary Charge; and

3. If You have an inpatient or outpatient surgical procedure and Your Physician and Hospital are Preferred Providers, but the anesthesiologist, radiologist, and/or assistant surgeon is a non-Preferred Provider, the anesthesiologist, radiologist, and/or assistant surgeon's Medically Necessary Covered Charges will be paid at 80% of the Reasonable and Customary Charge.

4. If you go to a Hospital emergency room for an Emergency Medical Condition and are immediately admitted to that Hospital as an inpatient and the Hospital is not a Preferred Provider, the Hospital's Medically Necessary Covered Charges will be paid at 80% of the Reasonable and Customary Charge.

The Providence Preferred Provider Network

Anytime You need to see a Provider or need to be admitted to a Hospital or clinic in Oregon or Southwest Washington (Clark, Cowlitz, Klickitat, Skamania and Wahkiakum Counties), consult the Providence Preferred Provider Directory for a list of Providers, Physicians, Hospitals and clinics that are members of the Providence Preferred Provider Network. You can review the list of Preferred Providers, Hospitals, and clinics by telephoning Providence at (800) 793-9338 or using the Providence website. If You use the Providence website, follow these directions:

1. Go to www.providence.org/Health_Plans/Members/directories.htm

2. Select "Provider Directories"

3. In the first step "Select Your Plan or Provider Group" select "Providence Preferred Providers (PPO)"

4. You can run Your search based on Provider type, specialty, facility, location, gender of Doctor, etc. The website also contains basic information about the Doctor such as medical school attended.

The Multiplan Preferred Provider Network

Any time You need to see a Provider, or need to be admitted to a Hospital or clinic outside Oregon and Southwest Washington (Clark, Cowlitz, Klickitat, Skamania and Wahkiakum Counties), consult the Multiplan Preferred Provider Network for a list of Providers, Physicians, Hospitals and clinics that are members of the Multiplan Preferred Provider Network. You can review the list of Preferred Providers, Physicians, Hospitals and clinics at www.multiplan.com/search or by telephoning (800) 464-0292.

How to Get the Most Out of the Preferred Provider Network

The following are a few helpful hints when using the Providence Preferred and Multiplan Preferred Provider Networks:

1. When You seek medical services, identify Yourself as a member of the Providence Preferred or Multiplan Preferred Provider Network and present Your identification card.

2. If Your Doctor is not a member of the Preferred Provider Network, You can still save money by asking Your Doctor to refer You to a Preferred Provider Hospital, clinic, or specialist.

Additional Provider Discounts

The Harrison Trust has an arrangement with organizations that attempt to obtain discounts for Your medical bills even if the Provider, Hospital, or clinic is not a member of the Preferred Provider network. For example, assume You have met Your Deductible for the year and saw a non-Preferred Provider who charged $100. Under normal circumstances, You would pay 40% of the bill ($40.00) and the Harrison Trust would pay 60% of the bill ($60.00). On occasion, the Harrison Trust may be able to obtain a discount from the non-Preferred Provider who would, for example, agree to accept $80.00 in full payment of the charge. Under this scenario, You would pay 40% of the discounted bill ($32.00) and the Harrison Trust would pay 60% of the discounted bill ($48.00).

PREADMISSION REVIEW PROGRAM, CASE MANAGEMENT SERVICES, DISEASE MANAGEMENT PROGRAM AND HEALTHY MOTHER BABY PROGRAM

Preadmission Review Program

Preadmission Review is a program that reviews the necessity and quality of inpatient stays for Hospitalization, Chemical Dependency and Mental Illness. This program is provided by Innovative Care Management, Inc.

Authorization given by Innovative Care Management, Inc., for an inpatient stay for Hospitalization, Chemical Dependency or Mental Illness is only for the purpose of reviewing whether the admission is necessary for the care and treatment of an Illness or Injury. It does not guarantee that all charges are covered by the Plan. All charges submitted for payment are subject to all terms and conditions of the Plan, regardless if preadmission authorization is received from Innovative Care Management, Inc.

You and Your Doctor have the final decision regarding Hospitalization and medical treatment.

Contacting Innovative Care Management for Preadmission Review

For all inpatient Hospital stays, except childbirth, and all inpatient stays for the treatment of Chemical Dependency and Mental Illness, You, a family member, Your Doctor or Hospital should contact Innovative Care Management, Inc., prior to admission. The telephone numbers for Innovative Care Management, Inc., are (800) 862-3338 and (503) 654-9447 in the Portland area. The information You will need to provide to Innovative Care Management, Inc., is:

1. Trust Name: Harrison Electrical Workers Trust Fund;

2. Employee's name and identification number;

3. Name, date of birth and address of person being admitted;

4. Family contact and telephone numbers;

5. Admitting Doctor's name and telephone number;

6. Hospital name, address and telephone number;

7. Date of admission; and

8. Diagnosis, surgery or procedure to be performed.

Innovative Care Management, Inc. provides a preadmission evaluation for each inpatient Hospitalization, except childbirth, and all inpatient stays for the treatment of Chemical Dependency and Mental Illness.

1. **Non-Emergency Hospitalization and Inpatient Stay for the Treatment of Chemical Dependency and/or Mental Illness**: Before admission to a Hospital as an inpatient for any reason except childbirth and before an inpatient stay for the treatment of Chemical Dependency and/or Mental Illness, You, a family member, Your Doctor or Hospital should notify

Innovative Care Management, Inc., at least ten (10) days prior to the scheduled Hospitalization or inpatient stay to determine whether the Hospital stay is Medically Necessary.

2. **Urgent Hospitalization and Inpatient Stay for the Treatment of Chemical Dependency and/or Mental Illness**. An urgent Hospitalization or inpatient stay for the treatment of Chemical Dependency and/or Mental Illness occurs when the condition is not life threatening but requires an admission of less than ten (10) days notice. In this situation, You, a family member, Your Doctor or Hospital should notify Innovative Care Management, Inc., prior to the scheduled Hospitalization or inpatient stay. If You, a family member, Your Doctor or Hospital do not have time to notify Innovative Care Management, Inc., before admission, You, a family member, Your Doctor or Hospital should call Innovative Care Management, Inc., within forty-eight (48) hours of the admission.

3. **Emergency Hospitalization and Inpatient Stay for the Treatment of Chemical Dependency and/or Mental Illness.** An emergency Hospital admission or inpatient stay for the treatment of Chemical Dependency and/or Mental Illness occurs as the result of an unforeseen condition requiring immediate medical attention and does not require preadmission certification. However, Innovative Care Management, Inc., should be notified by You, a family member, Your Doctor or Hospital within 48 hours of the admission.

Concurrent Review

After admission to a Hospital or inpatient stay for the treatment of Chemical Dependency and/or Mental Illness, Innovative Care Management, Inc., will evaluate Your progress through concurrent review that monitors the length of stay. If Innovative Care Management, Inc., disagrees with the length of stay recommended by Your Doctor, or determines the continued confinement is no longer necessary, You and Your Doctor will be consulted. You and Your Doctor have the final decision regarding Hospital confinement and medical treatment.

Hospital Discharge Planning

During Your Hospital stay or inpatient stay for treatment of Chemical Dependency and/or Mental Illness, Innovative Care Management, Inc., will monitor Your progress. Timely discharge planning will help You return home at the earliest date.

Case Management Services

When You need intensive, chronic or expensive care, Innovative Case Management, Inc. health care professionals guide You through the complex health care system.

Innovative Care Management, Inc. nurses work with You, Your family and Your Doctor to help find appropriate Providers, and determine the right care and equipment for Your specific needs. They:

1. Support You and Your Doctor in Your plan of care and help You avoid delays or complications.

2. Provide support and education if You or a family member is living with diabetes, heart disease or respiratory disease.

3. Help You evaluate clinical, economic and humanistic outcomes.

4. Encourage You to take an active role in Your health care.

Case management services are voluntary. If You call for pre-certification or You have a number of claims that indicate You will need extensive or chronic care, the Harrison Trust will refer You to Innovative Care Management, Inc. If Innovative Care Management, Inc. agrees that You could benefit from case management, an Innovative Care Management, Inc. representative will contact You and ask You if You want the assistance of an Innovative Care Management, Inc. health care professional.

If You, the case manager and the Trust Office agree on care not covered by the Benefit Booklet that can reasonably be expected to offer a cost effective result without a sacrifice to the quality of Your care, the Board of Trustees has the right to allow the care even though the care is not covered by the Benefit Booklet.

Disease Management Program

Innovative Care Management, Inc. provides a voluntary disease management program for You and Your Dependents afflicted with coronary heart disease, congestive heart failure, asthma, diabetes and chronic obstructive pulmonary disease.

The purposes of the Disease Management Program include:

1. Early detection and management of the diseases identified above;

2. Encourage the patient to take an active role in the management of his/her medical condition;

3. Provide education about the medical condition; and

4. Encourage the patient to follow through with his/her treatment plan.

If You have been diagnosed with one of the diseases identified above, You may receive a brochure from Innovative Care Management, Inc. concerning Your specific disease and a telephone call concerning how the Disease Management Program can benefit You.

Healthy Mother Baby Program

The Health Mother Baby Program is designed to inform and assist expectant mothers in avoiding risks during their pregnancies and promoting the health of their babies at no cost. Though not intended as a replacement for the care a Doctor will provide, the program provides information and support and services valuable to expectant mothers. As part of the program, an expectant mother can expect:

1. Health screening;

2. Counseling and pregnancy education;

3. Free educational materials;

4. Monthly nurse contact; and

5. Follow up well baby and preventive care.

To access the Healthy Mother Baby Program call Innovative Care Management at (800) 862-3338 or (503) 654-9447 in the Portland area.

NURSE HELP LINE

The Nurse Help Line helps You obtain reliable personal advice about Your health so You can make good health care decisions.

The Nurse Help Line is a toll-free phone service staffed by registered nurses. No phone trees or automated information - but real medical professionals to help You get answers to Your health care questions. It's available 24 hours a day, seven days a week.

Using Physician-approved guidelines, the Nurse Help Line's registered nurses help You sort through symptoms to find out what kind of help or information You need or what You need to do. Call when:

- You aren't sure how serious the symptoms are and need help to decide whether to go to the emergency room now or the Doctor's office later;
- You want to know more about a medical test Your Doctor ordered;
- You want to know more about a medical condition;
- You have a question, but don't want to call Your Doctor;
- You would like the nurse to send health care information from their health education library.

For help, call (800) 971-2680. Registered nurses will answer Your call. The nurse will ask Your name, address and the telephone number. If the connection is lost, the nurse can call You back. The nurse will listen to Your questions and work through the details with You until You get the advice You need.

The nurse may send information, may suggest a home remedy, or may suggest that You go to the Doctor's office, an urgent care center or the emergency room. If You think You have a life-threatening emergency, do not call the Nurse Help Line. Call 911 or go to the emergency room right away.

TELEPHONIC/VIDEO PHYSICIAN OR DERMATOLOGIST VISIT AND SMOKING CESSATION BENEFIT THROUGH TELADOC

The Teladoc benefit allows You to consult with a Primary Care Physician, pediatrician, or family medicine physician licensed in Your state by telephone or video conference from Your home or while traveling for non-emergency issues including:

- Cold and flu symptoms.
- Allergies.
- Sinus problems.
- Sore throat.
- Respiratory infection.
- Brochitis.
- Pink eye.
- Urinary tract infection.
- Ear infection.

The physician will diagnose the problem and recommend treatment. A prescription will be ordered for You when appropriate. Physicians will not order diagnostic testing, but will refer You to Your Primary Care Physician if that level of care is needed. Teladoc physicians can advise You whether You should see a specialist and the type of specialist You should see. Prior to speaking with a Teladoc physician, You need to create a Teladoc account including a medical history disclosure which is similar to the information You complete in a Primary Care Physician's office during an initial visit. To get started, visit the Teladoc website, click "set up account" and then follow the instructions. Contact information for the Teladoc program is (800) 835-2362 or Teladoc.com.

Teladoc also has a dermatology program that offers access to dermatologists. You can upload photographs of Your dermatological condition to licensed dermatologists who provide treatment and prescription medication when appropriate. In order to participate in the dermatology program, You must complete Teladoc's medical history, if You have not previously done so, as well as a comprehensive dermatology intake form, prior to the consultation. In addition, You must upload at least three (3) images of Your condition prior to communicating with a dermatologist.

The Teladoc smoking cessation program includes access to nurses who are trained to provide smoking and tobacco products cessation coaching and counseling. Teladoc physicians are available to prescribe FDA approved drugs including Chantix, Zyban, and nicotine replacement therapies if necessary. You will receive information about the tobacco cessation program from a Teladoc physician during a consultation under the telephonic/video physician program if You indicate on Your medical history disclosure form that You are a smoker or tobacco user. If You decide to enroll in the tobacco cessation program, You will receive educational material and a physician may prescribe a FDA-approved drug. You will also be assigned a tobacco cessation coach who will follow up with You at regular intervals.

The Teladoc programs are provided at no cost to You. There is no Deductible or co payment.

PRESCRIPTION DRUG BENEFITS

You are eligible to use this prescription drug program if You are enrolled in the Active Employee Plan. If You are enrolled in the Kaiser Permanente Medical Plan, Your prescription drug benefits are provided by Kaiser Permanente. If You are enrolled in the Providence Health Medical Plan, Your prescription drug benefits are provided by the Providence Health Medical Plan.

Prescription drug benefits under the Active Employee Plan are provided by the Trust in cooperation with Providence Health Plan.

Providence Resources

We want You to understand how to use Your pharmacy benefits. Providence Customer Service is available to assist You in understanding Your benefits and resolving any problems You may have about Your pharmacy benefits.

Contacting Providence Pharmacy Customer Service

Customer Service representatives are available by phone from 8 a.m. to 6 p.m., Monday through Friday, (excluding holidays):

- In the Portland-metro area, please call 503-574-7400.
- In all other areas, please call toll-free 877-216-3644.
- If You are hearing impaired, please call the TTY line 711.

You may access claims and benefit information 24 hours a day, seven days a week through Your myProvidence account.

Registering for a MyProvidence Account

You can create a myProvidence account online. A myProvidence account enables You to view Your prescription drug benefit information, claims history, and benefit payment information. You can register for a myProvidence account by visiting Providence Health Plan's website at: http://providencehealthplan.com/Harrison.

Your Providence Identification Card

You will receive an Identification Card from Providence Health Plan. Your Identification Card lists information about Your prescription drug coverage, including:

- Your identification number and group number
- Important phone numbers

The Identification Card is issued by Providence Health Plan for identification purposes only. It does not confer any right to services or benefits under the Plan.

When receiving pharmacy services, identify Yourself as Providence Health Plan participant, present Your Identification Card, and pay Your copayments.

Please keep Your Identification Card with You and use it when contacting Your pharmacy or Providence Customer Service.

Your Responsibilities

It is Your responsibility to verify whether or not a pharmacy is in the Providence Health Plan, and whether the pharmacy care is covered by the Plan, even if You have been directed or referred to a pharmacy by a Provider.

If You are unsure about a pharmacy's participation in the Providence Health Plan, please visit the Provider Directory, available online at https://phppd.providence.org/, before You obtain services. You can also call Providence Customer Service to get information about pharmacies that participate in the Providence Health Plan.

A printable directory of Network Pharmacies is also available at https://phppd.providence.org/. If You do not have Internet access or would like a hard copy of a Pharmacy Provider Directory, You may contact Providence Customer Service for assistance.

All pharmacy services are subject to the provisions, limitations, and exclusions that are specified in the Benefit Booklet. You should read the provisions, limitation, and exclusions before seeking services because not all pharmacy services are covered by this Plan.

Prescription Drug Definitions

The following are considered "prescription drugs":

1. Any medicinal substance which bears the legend, "RX only" or "Caution: federal law prohibits dispensing without a prescription";
2. Any medicinal substance of which a least one ingredient is a federal or state legend drug in a therapeutic amount; and
3. Any medicinal substance which has been approved by the Oregon Health Resources Commission as effective for the treatment of a particular indication.

Prescription Drug Benefits

This Plan provides benefits for prescription drugs which are Medically Necessary for the treatment of an Illness or Injury, and which are **dispensed by a Providence Health Plan Network Pharmacy** pursuant to a prescription ordered by a Provider for use on an outpatient basis, subject to the Plan's benefits, limitations, and exclusions.

This Plan also provides benefits for prescription drugs that are preventive care prescription drugs covered by the Patient Protection and Affordable Care Act (ACA) including contraceptives. ACA preventive care prescription drugs are listed on the Providence formulary and do not require a copayment when dispensed by a Providence Health Plan Network Pharmacy pursuant to a prescription ordered by a

Provider for use on an outpatient basis, subject to the Plan's benefits, limitations and exclusions. Over the counter ACA preventive care prescription drugs cannot be covered in full without a written prescription from a Provider.

Both generic and brand-name drugs are covered subject to the terms of the Benefit Booklet. In general, generic drugs are subject to lower copayments than brand-name drugs. Please refer to this section for Your copayment information.

If You request a brand-name drug when a generic is available, You will be responsible for the difference in cost between the brand-name and generic drug in addition to Your brand-name drug copayment, unless Your Provider writes "dispense as written" on the prescription. This cost difference does not apply to Your out-of-pocket maximum.

Providence Health Plan Network Pharmacies maintain all applicable certifications and licenses necessary under state and federal law of the United States and have an agreement with Providence Health Plan to provide prescription drug benefits pursuant to this Plan.

Using Your Prescription Drug Benefit

Important information about Your prescription drug benefits are:

- If You request a brand-name drug when a generic is available, You will be responsible for the difference in cost between the brand-name drug and the generic drug in addition to Your brand-name drug copayment, unless Your Provider writes "dispense as written" on the prescription. This cost difference does not apply to Your out-of-pocket maximum. Network Pharmacies may not charge more than Your copayment. Please contact Providence Customer Service if You are asked to pay more, or if You or the pharmacy have questions about Your prescription drug benefit or need assistance processing Your prescription.
- Copayments are due at the time of purchase. If the cost of Your prescription drug is less than Your copayment, You will only be charged the cost of the prescription drug.
- You may be assessed multiple copayments for multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- Diabetes supplies including glucometers, test strips, lancets, and syringes and inhalation extender devices may be obtained at a Network Pharmacy. These items are covered under Your Plan. Diabetes supplies do not include insulin pump devices, which are covered under the Durable Medical Equipment benefit of your Medical Plan.
- Self-administered drugs, including injectables and self-administered chemotherapy drugs, are covered under this Prescription Drug Benefit.
- Some prescription drugs require prior authorization or an exception to the formulary in order to be covered. These may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in the Providence Health Plan Prescription Drug Formulary available at http://providencehealthplan.com/Harrison.

Prescription Drug Formulary

The Providence Health Plan formulary is a list of Food and Drug Administration (FDA)-approved prescription generic, brand, and specialty drugs. It is designed to offer drug treatment choices for covered

medical conditions. Formulary status is given to drugs which meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage over non-formulary alternatives.

The formulary can help You and Your Provider choose effective medications that are less costly and minimize Your out-of-pocket expense. There are effective generic drug choices to treat most medical conditions. The formulary is available at http://providencehealthplan.com/Harrison.

Not all FDA-approved drugs are added to the formulary. Non-formulary drug requests require a formulary exception, must be FDA-approved, Medically Necessary, and require by law a prescription to dispense.

Newly approved FDA drugs will be reviewed by the Oregon Region Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, Providence Health Plan may authorize the use of a newly approved FDA drug during its review period, so You do not go without Medically Necessary treatment.

Summary of Your Prescription Drug Copayment Obligations

	Schedule of Copayments		
Drug Coverage Category	**All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)**	**All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)**	**All Participating Specialty Pharmacies (for up to a 30-day supply of specialty drugs)**
Preferred generic drug	$15	$30	N/A
Non-preferred generic drug	$15	$30	
Preferred brand-name drug	$35	$70	
Non-preferred brand-name drug	$70	$140	
Specialty drug	N/A	N/A	$150

Out-Of-Pocket Maximum

During a calendar year, the maximum amount of money You will pay for copayments for prescription drugs covered by the Plan is $3,000, and the maximum amount of money a family will pay for copayments for prescription drugs covered by the Plan is $6,000. Once You or Your family meet the out-of-pocket maximum, the Plan will pay 100% for covered prescription drugs for the remainder of the calendar year, subject to any Plan limitations and exclusions. You will still be responsible for the difference in cost between the brand name and generic drug after meeting the out of pocket maximum unless the Provider writes “dispense as written” on the prescription.

Using Network Pharmacies

Pharmacies are designated as Network retail, preferred retail, specialty, and mail-order pharmacies. **You must obtain prescription drugs from Providence Health Plan Network Pharmacies**, except in the case of an urgent or emergency situation. You may obtain a list of Providence Health Plan Network Pharmacies at: https://phppd.providence.org/ or by contacting the Providence Customer Service Team at the telephone number listed on Your Member Identification Card. There are approximately 36,000 Providence Health Plan Network Pharmacies nationwide, including Walgreens, Costco, Fred Meyer, Safeway, Albertson's, CVS, Rite Aid, and Bi-Mart.

Non-specialty prescription drugs are available at the following Network Pharmacies:

1. Providence Health Plan Standard Retail Network Pharmacy – 30 day supply only.
2. Providence Health Plan Preferred Retail Network Pharmacy – up to a 90 day supply.
3. Mail Order Network Pharmacy – up to a 90 day supply.

All covered prescription drugs are subject to the copayments and benefit maximums listed in this section. Copayments are due at the time of purchase. Network Pharmacies may not charge You more than the specified Copayment or Coinsurance amount. Members should contact their Customer Service Team if they are asked to pay more or if they or the pharmacy have questions about these prescription drug benefits or need assistance processing a prescription.

You must present Your Identification Card to the Network Pharmacy when You obtain prescription drugs.

Urgent or Emergency Situations – Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, You may need to use an out-of-network pharmacy. If this happens, You will need to pay full price for the prescription at the time of purchase. You may be reimbursed by the Plan upon submission of a Prescription Drug Reimbursement form, which can be obtained from the Providence website or by contacting Providence Customer Service. You must include any itemized pharmacy receipts, along with this form and an explanation as to why You used an out-of-network pharmacy. Once received, the claim will be reviewed (submission of a claim does not guarantee payment). If the claim is approved, You will be reimbursed the cost of the prescription, subject to the terms of these coverage provisions, less the applicable copayment.

International prescription drug claims will only be covered when prescribed for emergency conditions and will be subject to other limitations and exclusions in the Benefit Booklet.

Using Mail-Order and Preferred Retail Pharmacies

You may purchase up to a 90-day supply of maintenance drugs (drugs you have been on for at least 30 days and that you anticipate continuing on in the future) at one time using a Mail Order Network Pharmacy or a Providence Health Plan Retail Preferred Network Pharmacy. Not all drugs are covered for more than a 30-day supply, including compounded medications, drugs obtained from specialty pharmacies, and limited distribution pharmaceuticals.

To purchase prescriptions by mail, your physician or provider can call in the prescription or you can mail your prescription along with your Providence Health Plan Member ID number to one of our Network mail-order Pharmacies, subject to the following specific provisions:

1. Your medical provider has written a prescription for a 90 day supply.
2. Qualified drugs under this program will be determined by Providence Health Plan. (Not all prescription drugs are available through mail-order pharmacy.)
3. Not all maintenance prescription drugs are available in 90-day allotments.
4. Copayment(s) will be applied to the quantity stated on your Benefit Summary. (Some quantity limitations and Copayments for unit of use packaging may apply.)

When using a mail-order pharmacy, Your copayment is required prior to processing you Your order. If there is a change in our Network mail-service or preferred retail Pharmacies, you will be notified of the change at least 30 days in advance.

To order a prescription by mail order, have Your Provider send a prescription electronically, via phone or fax to one of the Mail Order Network Pharmacies listed at https://phppd.providence.org/.

The Specialty Pharmacy Program

Specialty drugs are self-administered injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through a Providence Health Plan designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty drugs are listed in the formulary. They are used to treat complex health conditions such as:

Cancer	Organ transplants
Crohn's Disease	Osteoporosis
Growth Hormone Deficiency	Psoriasis
Hepatitis C	Rheumatoid Arthritis

Your prescription drug program requires You to use a Providence Health Plan designated specialty pharmacy to obtain medications on the Providence Specialty Drug List. The Providence Health Plan designated specialty pharmacy is listed in the Plan's provider directory. In order to determine whether a prescription drug must be obtained from a specialty pharmacy, refer to the Plan's formulary or call Providence Health Plan and speak to a pharmacy benefits specialist who will verify eligibility and coverage of the requested medication and assist in locating a specialty pharmacy to meet your prescription needs.

Some medications are considered limited access drugs, which are medications that may have special dosing or monitoring requirements or used on specific patient populations. Because of this, the manufacturer chooses to limit the distribution of their drug to only a few pharmacies. Whenever a drug is only available via limited access from a pharmaceutical company, Providence Health Plan will work with You and Your Provider to obtain this medication through an alternative specialty pharmacy to meet your healthcare needs.

You are required to pay Your specialty drug copayment of $150 until You or Your family has reached the out-of-pocket maximum for prescription drugs.

Compound Prescription Drugs - Prior Authorization May Be Required

A compound prescription drug is custom prepared by a licensed pharmacy, a Doctor, or a person under the supervision of a licensed pharmacist. Compound prescription drugs are a combination of two or more ingredients (excluding water) and must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount.

If the cost of the compound prescription drug exceeds $150 for a thirty (30) day supply or $450 for a ninety (90) day supply, Your Provider must obtain prior authorization from Providence before the Plan will pay for the compound prescription drug. Prior authorization request forms may be downloaded from https:ljProvidenceHealthPlan.com/priorauth, or requested by calling Providence Health Plan Pharmacy Customer Service at (503) 574-7400 or toll-free at (877) 216-3644. Completed forms may be faxed to Providence Health Plan at (503) 574-8646. The prior authorization procedure is as follows:

- Take the prescription to the pharmacy which will submit it to Providence electronically;
- If the compound prescription drug cost exceeds $150 for a thirty (30) day supply or $450 for a ninety (90) day supply, the compound prescription drug will be rejected;
- Upon rejection, the Provider who issued the prescription must request and submit a prior authorization form to Providence;
- The completed prior authorization form is faxed by the Provider to the Providence clinical pharmacy team for review; and
- Providence then faxes the Provider its determination.

The copayment for a compound prescription drug is the same as the copayment for a thirty (30) day or ninety (90) day prescription drug obtained from the Providence retail pharmacy network.

Prescription Drug Quantity Limits

Prescription dispensing limits, including refills, are as follows:

1. topicals, up to 60 grams;
2. liquids, up to eight ounces;
3. tablets or capsules, up to 100 dosage units;
4. multi-use or unit-of-use, up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less;
5. FDA-approved women's prescription contraceptives: up to 3-Months initial dispensing, then up to 12-Months subsequent dispensing at Providence Network Pharmacies; and
6. opioids are limited to a seven-day supply for an initial prescription if You have not previously obtained a prescription for opioid medication within 108 days of the date the pharmacy fills the prescription. If there is Medical Necessity to prescribe opioids for longer than a seven-day supply, a prior authorization can be submitted or the Provider can write a second prescription as subsequent fills will not be limited to seven days.

Other dispensing limits may apply to certain medications requiring limited use, as determined by Providence medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits. Examples of such limited use medications include, but are not limited to, Viagra, Cialis, and Levitra (3 tablets per week or 12 tablets per 30 day period).

Prescription Drug Limitations

Prescription drug limitations are as follows:

1. All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary or Affordable Care Act preventive care drugs and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market formulary consideration.
2. Certain drugs require prior authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses Providence pharmacy claims history to confirm if certain drugs have been tried first by You. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, prior authorization is required. For some drugs, Providence Health Plan limits the amount of the drug the Plan will cover. You or Your Provider can contact Providence Health Plan directly to request prior authorization. If You have questions regarding a specific drug, please call Providence Customer Service.
3. Medications, drugs, or hormones prescribed to stimulate growth are not covered, except when there is a laboratory-confirmed diagnosis of growth hormone deficiency for children through 18 years of age and when prescribed for the treatment of documented pituitary destruction in adults.

Prescription Drug Exclusions

No coverage will be provided under this section for:

1. Drugs or medicines delivered, injected or administered for You by a Provider or another trained person;
2. Amphetamines and amphetamine derivatives except when used in the treatment of narcolepsy or hyperactivity in children and adults;
3. Drugs prescribed that do not relate to the prevention or treatment of an Illness or Injury except Affordable Care Act prescription drugs;
4. Drugs used for the treatment of fertility/infertility;
5. Fluoride, for persons over the age of 16 years old;
6. Drugs that are not provided in accordance with the Providence formulary management program;
7. Drugs used in the treatment of fungal nail conditions;
8. Over-the-counter (OTC) drugs or vitamins, that may be purchased without a Provider's written prescription and prescription drugs that are available in an OTC therapeutically similar form, except as required by federal law;
9. Drugs dispensed from pharmacies outside the United States, except when prescribed for urgent care and Emergency Medical Conditions or as required by federal law;
10. Drugs placed on a prescription-only status as required by state or local law;

11. Replacement of lost or stolen medication;
12. Drugs used in the treatment of drug-induced fatigue, general fatigue and idiopathic hypersomnia;
13. Drugs dispensed or compounded by a pharmacist that do not have at least one FDA-approved medication in therapeutic amount;
14. Drugs used for weight loss or for cosmetic purposes;
15. Drug kits, unless the product is available solely as a kit. Kits typically contain a pre-packaged drug along with items associated with the administration of the drug (e.g., gloves, shampoo);
16. Prenatal vitamins that contain docosahexaenoic acid (DHA); and
17. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs).

Disclaimer

Providence Health Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this Plan.

Claims Administration

This section explains how the Plan treats various matters having to do with administering the pharmacy benefits and/or pharmacy claims.

Time Limit for Submitting Claims

The Plan will make no payments for claims received more than one year after the date of service.

Payment of Claims

The Plan's payments for most covered services are made directly to the pharmacy or provider of services. Except as otherwise specifically provided in this section, if You are billed directly and pay for a prescription drug which is covered by this section (for example, a prescription drug obtained from an out-of-network pharmacy due to an urgent or emergency situation), reimbursement from the Plan will be made only upon Your written notice to Providence on a prescription drug reimbursement receipt form. Payment will be made to You.

Prescription drug reimbursement request forms can be obtained at:
http://ProvidenceHealthPlan.com/rxform. Please send all claim forms to:

Providence Health Plan
Attn: Claims Dept.
P.O. Box 3125
Portland, OR 97208-3125

Claim forms must be submitted within one year from the date of service to be eligible for payment.

CHARGES FOR MEDICAL BENEFITS AND PRESCRIPTION DRUGS THAT ARE NOT COVERED

1. Charges that are, after professional medical review, deemed not Medically Necessary to the care or treatment of an Injury or Illness, except for preventative care services.

2. Charges that would not have been made if no Plan existed.

3. Charges that You are not legally obliged to pay if You did not have Plan coverage.

4. Charges that are in excess of the Reasonable and Customary Charges for services and material.

5. Charges for treatment by a Provider that is not within the scope of his or her license.

6. Charges for which benefits are not provided in this Plan.

7. Charges for dental services or supplies for treatment of the teeth, gums or alveolar processes. Except the Plan will pay for:

    a. Hospital charges if You are a bed patient; or

    b. Any dental charges covered under the Medical Benefits portion of the Plan.

8. Charges for eye glass lenses or contact lenses and the fitting of them. Except the Plan will pay for charges covered under the Medical Benefits portion of the Plan following cataract surgery.

9. Charges for confinement in a Skilled Nursing Facility, unless such confinement:

    a. Starts within fourteen (14) days after You have been confined for at least three days in a Hospital for which room and board charges were paid;

    b. Is for treatment of the Illness causing the Hospital confinement;

    c. Is for which a Doctor visits at least once every thirty (30) days; and

    d. Is not routine custodial-type care.

10. Charges for treatment for cosmetic purposes or for Cosmetic Surgery. Except the Plan will pay for reconstructive treatment or surgery for the following:

    a. Solely due to an Accidental Bodily Injury;

    b. Solely due to surgical removal of all or a part of the breast tissue as the result of an Illness; or

    c. Solely due to a birth defect.

11. Charges for services provided by a person who usually lives in the same household as You, or who is a member of Your immediate family.

12. Charges for services or supplies furnished by any plan or program established by an agency of the United States Government or foreign government agency, unless such exclusion is prohibited by law.

13. Charges for necessary care and treatment of Temporomandibular Joint Syndrome and associated myofascial pain are limited to a maximum benefit payment of $3,000 lifetime outpatient care and $10,000 lifetime for surgeons' charges for surgical care. Hospital charges associated with surgical care are payable as any other Illness.

14. Charges for corrective shoes or arch supports.

15. Charges for in-Hospital medical or surgical care for conditions that do not generally require Hospitalization.

16. Charges for services and supplies for weight loss or obesity, except for surgical procedures that are allowed under the section **Covered Charges** on page 37, paragraph 22, and for services and supplies allowed as preventive care services. See page 36, paragraph 18.

17. Charges for non-medical self-help or training, such as programs for weight control, and general fitness or exercise programs. Educational programs to which drivers are referred by the judicial system and volunteer mutual support groups.

18. Charges for drugs and medicines that can be obtained without a Provider's prescription, including vitamins, dietary supplements and other non-prescription supplements.

19. Charges for counseling or treatment in the absence of Illness, including individual or family counseling or treatment for marital, behavioral, family, occupational, religious or educational problems or treatment of normal transitional response to stress. There may, however, be limited coverage under the Employee Assistance Program described on page 49.

20. Charges for services related to sex change procedures and complications except as required by Section 1557 of the Affordable Care Act.

21. Charges for psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, image therapy, sensory movement groups and sensitivity training.

22. Charges for family planning, including services and supplies for artificial insemination, in-vitro fertilization or surgery to reverse elective sterilization are not covered.

23. Charges for Radial Keratotomy and LASIK surgery.

24. Charges for services or purchases before covered by the Plan. Charges for services or purchases will be deemed to have been incurred on the date the services were performed or the date the purchase occurred.

25. All charges not specifically listed as Covered Charges.

26. Charges for Experimental or Investigational Services, which means treatment, procedures, equipment, drugs, devices or supplies that are, in the Board of Trustees' judgment, experimental or investigational. Services are considered experimental or investigational if:

    a. They require, but have not received, approval of the US Food & Drug Administration;

    b. They have not been the subject of a favorable study published in peer review medical literature. Peer review medical literature means a U.S. scientific publication that requires that manuscripts be submitted to acknowledged experts inside and outside the editorial office before publication for their considered opinions or recommendations regarding publication of the manuscript; or

    c. They are determined by the Board of Trustees, after consultation with a medical advisor, to be in research status and not accepted as a proper course of treatment.

EXCLUSIONS, LIMITATIONS AND NON-COVERED CHARGES

The following exclusions, limitations and non-Covered Charges apply to all benefits provided by the Active Employee Plan except the Life Insurance and Accidental Death and Dismemberment Benefit:

No benefits are provided for:

1. Any Injury or Illness that arises out of or in the course of any employment for wage or profit or with an employer for which You could receive benefits under any workers' compensation law or occupational disease law, or You receive any settlement from a workers' compensation carrier except as allowed by the Subrogation and Reimbursement Obligations section of the Benefit Booklet. See page 123.

2. Losses that are due to war or any act of war, whether declared or undeclared.

3. Charges incurred or disability claimed while You are not under the direct care of a Doctor.

4. Telephone consultations, missed appointments and completion of claim forms.

DENTAL BENEFITS

Dental Benefit Options

When You become eligible for dental benefits, the Harrison Trust makes three options available to You and Your Dependents. The options are:

1. The Active Employee Plan's dental benefits described in this Benefit Booklet.

2. Kaiser Permanente dental benefits. You do not have to be enrolled in the Kaiser Permanente medical and prescription drug plan to select Kaiser Permanente dental benefits. The Kaiser Permanente dental benefits are described in a separate benefit booklet that is available by contacting the Trust Office.

3. Willamette Dental. The Willamette Dental benefits are described in a separate benefit booklet that is available by contacting the Trust Office.

You must live within certain geographic areas to enroll in the Kaiser Permanente Dental Plan and the Willamette Dental Plan. Contact the Trust Office. You may change dental plans during the open enrollment period determined by the Board of Trustees.

A summary of the dental benefits provided by the Active Employee Plan is:

DENTAL MAXIMUM PER PERSON PER CALENDAR YEAR	$2,000 for all persons except Dependent Children under age nineteen (19). There is no calendar year dental maximum, except for the orthodontia lifetime maximum benefit, for Dependent Children under age nineteen (19). You cannot use or borrow another family member's dental maximum.
DENTAL BENEFITS AT 100%	Covered dental charges for routine exams and prophylaxis (cleaning and scaling of teeth by a dentist or dental hygienist) but no more than twice during a calendar year
DENTAL BENEFITS AT 70%	Covered dental charges other than those payable at 100% and 50%.
DENTAL BENEFITS AT 50%	Covered dental charges for dentures, gold fillings, crowns, inlays, onlays and bridgework.
ORTHODONTIC LIFETIME MAXIMUM BENEFIT	Orthodontic benefits are paid at 80% up to a lifetime maximum of $2,000.

Covered Dental Charges

The dental charge must be incurred for dental procedures necessary to Your care and treatment and performed by or under the direct supervision of a dentist.

The charge for a dental procedure is incurred on the day the procedure is performed. If a procedure is not completed in one day, the day that the procedure is completed is the incurred day for any charges in connection with such procedure.

In the event that more than one dentist furnishes services or materials for one dental procedure, the Plan will pay no more than its obligation had one dentist furnished the services or materials.

The following dental charges are covered:

1. Charges for any Accidental Bodily Injury:

    a. That does not arise out of or in the course of any employment for wage or profit; and

    b. That You are not entitled to benefits under any workers' compensation law.

2. Charges for any sickness not entitling You to benefits under any workers' compensation or occupational disease law.

3. Dental x-rays:

    a. Full mouth set of x-rays, including panoramic (one set or panoramic in each period of three (3) consecutive years); and

    b. Bite wing x-rays, two (2) sets per calendar year.

4. Charges that are incurred for dental services, supplies and X-ray examinations that are not excluded dental charges and are not otherwise excluded from coverage by the terms of the Plan and are performed by or under the direct supervision of a dentist.

5. Charges that do not exceed the Reasonable and Customary Charges for the procedures performed or materials furnished.

6. Fluoride treatments are allowed twice per calendar year.

7. Sealants for Dependents under the age of nineteen (19). This benefit applies to permanent teeth. This benefit renews every calendar year and the maximum annual payment is $100.

Dental Charges not Covered

The following dental procedures and charges are not covered:

1. Charges for services or materials for which You are not, in the absence of this coverage, legally required to pay.

2. Charges for services or materials received from a dental or medical department maintained by an employer, a mutual benefit association, a labor union or a health benefit plan, or for services or materials furnished by or at the direction of the US government or any state, province or other political subdivision, unless You would be required to pay such charges in the absence of this Plan.

3. Charges for dental procedures You have incurred for the repair of sound natural teeth (including their replacement) required as a result of, and within twenty-four (24) Months of an Accidental Bodily Injury can be considered for benefit payment under medical expense benefits.

4. Charges for services or materials for cosmetic purposes, except for cosmetic dental procedures incurred within twenty-four (24) Months of an Accidental Bodily Injury.

5. Charges for facings on crowns, or pontics, posterior to the second bicuspid and/or bonding.

6. Charges due to war or any act of war, whether declared or undeclared.

7. Charges for any portion of a dental procedure performed before the effective date of or after the termination of Your coverage for dental benefits, except eligible dental charges incurred for dental care furnished within thirty (30) days after termination of coverage for dental benefits will be considered eligible for payment if:

    a. The service involves an appliance, or modification of an appliance, for which the impression was taken prior to the termination of coverage;

    b. The service involves a crown, bridge or gold restoration for which the tooth was prepared prior to the termination of coverage;

    c. The service involved root canal therapy for which the pulp chamber was opened prior to the termination of Your coverage; or

    d. The procedure is completed within thirty (30) days after termination of coverage and You are not otherwise entitled to payment under any other like dental coverage of any type or source.

8. Charges for periodic oral examination and/or prophylaxis performed in excess of two procedures in any calendar year.

9. Charges for replacement of lost or stolen appliances, dentures, or bridgework.

10. Charges for dental appointments that are not kept.

11. Charges for any service or material not furnished by a dentist or Denturist, except a service performed by a licensed dental hygienist or licensed professional authorized to perform dental services under the supervision of a dentist, or an X-ray ordered by a dentist.

12. Charges for the replacement of a prosthesis within five (5) years after it was first placed. This exclusion does not apply to the following:

    a. A crown which is needed for restoration only;

    b. Replacement which is needed because of the first time replacement of an opposing full denture or the extraction of natural teeth;

    c. A permanent prosthesis which replaces a stayplate or other temporary prosthesis; and

    d. Replacement of a prosthesis which, while in the mouth, has been damaged beyond repair as a result of an accident which occurs while covered by the Plan. Charges for prosthesis reline no more often than every thirty-six (36) Months.

TMJ – Temporomandibular Joint Syndrome

Charges for necessary care and treatment of Temporomandibular Joint Syndrome and associated myofascial pain are covered as a medical benefit but are limited. See page 69, paragraph 13.

Denturists

Payment will be made for services that are within the lawful scope of practice of a Denturist. No payment will be made for services rendered by a Denturist unless:

1. The Denturist has successfully completed a course in advanced oral pathology as prescribed by the Health Division and has received a certificate of completion; or

2. You have received a statement, dated within thirty (30) days prior to the date of treatment, signed by a dentist, or a Doctor, that Your oral cavity is substantially free from disease.

VISION CARE BENEFITS

This is Your Vision Plan if You are enrolled in the Active Employee Plan or Providence Health Plan. If You are enrolled in Kaiser Permanente, Your vision benefits are provided by Kaiser Permanente.

Vision Benefits

The vision benefits are provided by a group contract between the Harrison Trust and Vision Services Plan. The terms of the group contract are summarized below. In the event of a conflict between this summary and the group contract, the terms of the group contract will control. If You would like a copy of the group contract, please contact the Trust Office.

You and Your Dependents are eligible for an eye exam and lenses every twelve (12) Months and a frame every twenty-four (24) Months. Contact lenses are allowed every twelve (12) Months. Twelve (12) Months after You obtain Your contact lenses, You are eligible for the frame and lens benefit.

How to Use the Vision Plan

1. You can obtain vision benefits from a Vision Service Plan (VSP) network provider or an out-of-network provider. In most cases, You will have lower out-of-pocket costs by using a VSP network provider. See **Summary of Your Vision Benefits** below.

2. To find a VSP network provider, call VSP at (800) 877-7195, or visit its website at www.vsp.com.

3. If You use a VSP network provider, identify Yourself as a VSP member. Your VSP network provider will handle the rest.

4. You do not have to use a VSP network provider. You may use the vision care provider of Your choice.

Summary of Your Vision Benefits

Copayments

When You choose a VSP network provider or an out-of-network provider, You pay these copayments:

Exam	$15.00
Materials (lens and frames, but not elective contact lens)	$25.00
Elective Contact Lens Exam (fitting and evaluation)	Up to $60.00

Type of Vision Service	VSP Network Payment Amount after Copayment	Out-of-Network Maximum Payment Amount after Copayment	Frequency of Service
Examination	Paid in Full	Up to $50.00	Once every twelve (12) Months

Type of Vision Service	VSP Network Payment Amount after Copayment	Out-of-Network Maximum Payment Amount after Copayment	Frequency of Service
Frames	Up to $150.00	Up to $70.00	Once every twenty-four (24) Months
Single Lens	Paid in Full	Up to $50.00	Once every twelve (12) Months
Bifocal Lined Lens	Paid in Full	Up to $75.00	Once every twelve (12) Months
Trifocal Lined Lens	Paid in Full	Up to $100.00	Once every twelve (12) Months
Standard Progressive Lens	Paid in Full	Up to $75.00	Once every twelve (12) Months
Lenticular	Paid in Full	Up to $150.00	Once every twelve (12) Months
Elective Contact Lens (only covered in lieu of lens and frame)	Up to $130.00	Up to $105.00	Once every twelve (12) Months
Necessary Contact Lens*	Paid in Full	Up to $210.00	Once every twelve (12) Months

* Necessary contact lenses are a Plan benefit when specific criteria are satisfied and when prescribed by Your VSP network provider or out-of-network provider. Prior review and approval by VSP are required to be eligible for the necessary contact lens benefit.

Discounts and Savings when using a VSP Network Provider

1. 20% off an additional pair of glasses and sunglasses.

2. Up to 35-45% savings on non-covered lens options, such as scratch resistant and anti-reflective coatings and progressives.

Procedure if You use an Out-of-Network Provider

1. Obtain Your exam and any necessary eyewear (lenses, frame or contacts) and pay the bill in full. Remember to get an itemized receipt.

2. Mail the itemized receipt to:

   VSP
   PO Box 997105
   Sacramento CA 95899-7195

   When mailing the receipt, be sure to identify the Plan as Harrison Electrical Workers Trust Fund and include the following information:

   a. Employee's name;

   b. Address;

   c. Personal identification number;

   d. Patient's name;

e. Date of birth of patient; and

f. Patient's relationship to the Employee.

VSP will reimburse You according to the an out-of-network provider reimbursement schedule on page 76 and 77.

3. You must submit a copy of the itemized receipt to VSP within six (6) Months of the date of service.

4. If You have Internet access, sign on to www.vsp.com, select the Out-of-Network Reimbursement Form and follow the directions.

What is Covered and What is Not Covered

Services Covered

1. Vision exam: includes a refraction test to determine the need for glasses, analysis for binocularity, and testing of the overall health of the eyes and related optic structures. This benefit is available once every twelve (12) Months from the last exam.

Eyewear Covered

1. Frames and lenses: lenses are available once every twelve (12) Months from the last date of service. Frames are available once every twenty-four (24) Months from the last date of service.

2. Contacts: when You choose contacts instead of glasses, You must pay up to a $60.00 copayment for Your elective contact lens exam (fitting and evaluation). This benefit is available once every twelve (12) Months from the last date of service. Twelve (12) months after the last date of service You are eligible for the frame and lens benefit in paragraph 1 above.

Services and Materials Not Covered

There is no benefit for professional services or materials connected with:

1. Orthopedics or vision training and any associated supplemental testing;

2. Plano lenses (less than + 0.50 diopter power);

3. Two pair of glasses instead of bifocals;

4. Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available;

5. Medical or surgical treatment of the eyes;

6. Corrective vision treatment of an experimental nature;

7. Costs for services and/or materials above the Plan allowances; and

8. Services and/or materials not indicated in the Vision Care Benefits section of the Benefit Booklet.

Limitations of Vision Benefits

The Vision Care Benefits are designed to cover visual needs rather than cosmetic materials. When You select any of the following extras, the Vision Care Benefits will pay the basic cost of the allowed lenses and You will pay the additional cost for the following options:

1. Optional cosmetic processes;

2. Anti-reflective coatings, color coatings, mirror coatings, or scratch coatings;

3. Blended lenses, cosmetic lenses, laminated lenses, oversize lenses, progressive multi focal lenses, photochromic lenses (covered for employee only), tinted lenses except pink #1 and pink #2 (covered for employee only), or UV (ultraviolet) protective lenses;

4. Certain limitations on low vision care;

5. A frame that costs more than the Plan allowance; and

6. Contact lenses (except as noted elsewhere in the Vision Care Benefits section of the Benefit Booklet).

Special Conditions

If You need an eye exam or new eyeglasses before Your twelve (12) or twenty-four (24) Month period is completed because of a medical condition, You should have Your Doctor submit an authorization and a request for payment to VSP. If approved by the Board of Trustees, VSP may authorize services under the Plan.

Use of an Out-Of-Network Ophthalmologist

In the event You have a vision exam performed by an out-of-network ophthalmologist, the Trust will pay 80% of the Reasonable and Customary Charges for the exam. This benefit is available once every twelve (12) Months from the last date of service, and applies only to an out-of-network ophthalmologist. This benefit DOES NOT apply to an out-of-network optometrist. Mail a copy of the ophthalmologist's itemized bill to:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

Include the following information:

1. Employee's name;
2. Address;
3. Personal identification number;
4. Patient's name;
5. Patient's date of birth; and
6. Patient's relationship to Employee

Retinal Examination

The Retinal Examination produces a digital image of almost the entire retina. It allows ophthalmologists and optometrists to obtain an extended view of Your retina (200 degrees) and facilitates the early detection of disorders and diseases evidenced in the retina.

The Retinal Examination is not covered by VSP. If Your eye care professional recommends an Retinal Examination, the Trust will pay for the cost of the examination up to $25.00. This benefit is available once every twelve (12) Months from the date of the last Retinal Examination. There is no Deductible.

In order to obtain reimbursement (up to $25.00) for the Retinal Examination, mail a copy of Your eye care professional's billing for the Retinal Examination to:

Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

Include the following information with the billing:

1. Employee's name;
2. Address;
3. Personal identification number;
4. Patient's name;
5. Patient's date of birth; and
6. Patient's relationship to Employee.

Safety Eyewear Benefit For Employees Only

Copayments

When You choose a VSP network provider or an out-of-network provider, You pay a $15.00 copayment.

Type of Vision Service	VSP Network Payment Amount after Copayment	Out-of-Network Maximum Payment Amount after Copayment	Frequency of Service
Examination	Paid in Full	Up to $8.00	Once every twelve (12) Months
ProTech Safety Frames	Paid in Full	Up to $25.00	Once every twenty-four (24) Months

Type of Vision Service	VSP Network Payment Amount after Copayment	Out-of-Network Maximum Payment Amount after Copayment	Frequency of Service
Single Lens	Paid in Full	Up to $35.00	Once every twelve (12) Months
Bifocal Lined Lens	Paid in Full	Up to $65.00	Once every twelve (12) Months
Trifocal Lined Lens	Paid in Full	Up to $65.00	Once every twelve (12) Months
Lenticular	Paid in Full	Up to $90.00	Once every twelve (12) Months

How to Use the Safety Eyewear Benefit

1. You can obtain safety eyewear from a VSP network provider or an out-of-network provider. In most cases, You will have a lower out-of-pocket costs by using a VSP network provider.

2. To find a VSP network provider, call VSP at (800) 877-7195 or visit its website at www.vsp.com. If You use a VSP network provider, identify Yourself as a VSP member. Your VSP network provider will handle the rest.

3. If You obtain Your safety eyewear benefit from an out-of-network provider, follow the procedures on page 77 under the heading **Procedure if You use an Out-of-Network Provider** to receive reimbursement for a portion of the cost.

Claim Appeal Procedure for Vision Care Benefits

1. *Complaints and Grievances.* You should report any complaints and/or grievances to VSP at the address or telephone number below. Complaints and grievances are disagreements regarding access to care, quality of care, treatment, or services. Complaints and grievances may be submitted to VSP verbally or in writing. You may submit written comments and supporting documents concerning Your complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt unless special circumstances require an extension. In that case, resolution shall be achieved as soon as possible but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, it will notify You of the expected resolution date. Upon final resolution, VSP will notify You of the outcome in writing. In the event of a conflict between this summary and the group policy, the terms of the group policy will control. If You would like a copy of the group policy, please contact the Trust Office.

2. *Appeal of a Denied Claim.* If a claim is denied in whole or in part, a request may be submitted to VSP for a full review of the denial.

   Initial Appeal. The appeal must be filed within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the person for whom the claim was denied, including the Employee's name, VSP member identification number, date of birth, the provider of services, and the claim number. You may review, during normal working hours, or receive by mail any documents held by VSP pertinent to the denial. You may also submit written comments or supporting documents concerning the claim to assist in VSP's review.

VSP's response to the initial appeal, including specific reasons for the decision, shall be provided within thirty (30) calendar days after receipt of a request for review.

Second Level Appeal. If You disagree with the response to the initial appeal, You have the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, You may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to You in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies. When You have completed the appeal process stated above, additional voluntary alternative dispute resolution options may be available including mediation or arbitration. You may contact the Trust Office or VSP for details. Additionally, under Section 502(a)(1)(B) of the Employee Retirement Income Security Act, You have the right to bring a civil action when all available levels of review have been completed, the claim was not approved, and You disagree with the outcome.

Time of Action. No lawsuit shall be brought against VSP until You have exhausted Your grievance rights and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with VSP. No action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoice was submitted to VSP.

Contact information for VSP grievances and appeals is as follows:

Vision Service Plan Insurance Company
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
T: (800) 877-7195

LIFE INSURANCE

For Employees Only

Life insurance benefits are provided to Employees only. Retired Employees and those making payments under COBRA are not eligible for life insurance benefits. Life insurance is provided through a group policy with Standard Insurance Company (Standard).

Amount of Insurance

$10,000

Reduction in Insurance Due to Age

Your life insurance amount will be reduced based on Your age, as shown below:

AGE	BENEFIT
65 through 69	$6,500
70 through 74	$5,000
75 or more	$3,500

When Life Insurance Begins

Your life insurance begins on the date You qualify for Harrison group health and welfare benefits.

When Life Insurance Ends

Your life insurance ends on the earliest of:

1. The date the last period ends for which a required premium is made on Your behalf to Standard by the Harrison Trust;

2. The date the group policy terminates;

3. The date You cease to be eligible for the Active Employee Plan due to the lack of employer, or a combination of employer and Employee contributions for health and welfare benefits. A self-payment under COBRA WILL NOT extend Your life insurance benefits; or

4. The date You become a full-time member of the armed forces of any country (except as provided under the Uniformed Services Employment and Reemployment Act).

Waiver of Premium

Life insurance will continue without premium payment while You are Totally Disabled if:

1. You become Totally Disabled while insured under the group policy prior to age sixty (60);

2. You remain Totally Disabled for at least one-hundred eighty (180) days;

3. Satisfactory proof of Total Disability is furnished to Standard Insurance Company no later than eighteen (18) Months after You become Totally Disabled.

Totally Disabled means that, as a result of sickness, accidental Injury or pregnancy, You are unable to perform, with reasonable continuity, the material duties of any gainful occupation for which You are reasonably qualified by training, education or experience.

Premium payment must continue to be made during the first one-hundred eighty (180) days of Total Disability. If You qualify for the Waiver of Premium Benefit, those premiums will be refunded to the Trust.

The amount of life insurance continued under the Waiver of Premium Benefit will be the amount of Your life insurance in effect on the day preceding Total Disability, subject to reductions in insurance due to age. If You receive an Accelerated Benefit, the life insurance amount will be reduced according to the Accelerated Benefit provision.

All insurance under this Waiver of Premium Benefit will end on the earliest of:

1. The date the You are no longer Totally Disabled;

2. Ninety (90) days after the date Standard mails a request for additional proof of Total Disability, if satisfactory proof is not given;

3. The date You fail to attend an examination or cooperate with the examiner;

4. The effective date of an individual life insurance policy, if You have converted under Right to Convert; or

5. The date You attain age sixty-five (65).

Accelerated Benefit

1. *Qualifying for an Accelerated Benefit*

   If You qualify for a Waiver of Premium Benefit and You have a Qualifying Medical Condition You have the option of accelerating the life insurance benefit payment. Standard will pay an accelerated benefit, after receiving satisfactory proof of a Qualifying Medical Condition. Qualifying Medical Condition means that You are Terminally Ill with a life expectancy of less than twelve (12) Months.

2. *Application for Accelerated Benefit*

   You must have at least $10,000 of insurance in effect to be eligible.

You must apply for an Accelerated Benefit. To apply You must give Standard satisfactory proof of loss on its form. Proof of loss must include a statement from a Physician that You have a Qualifying Medical Condition.

Standard may have You examined at its expense in connection with Your claim for an Accelerated Benefit. Any examination will be conducted by one or more Physicians of its choice.

3. *Amount of Accelerated Benefit*

You may receive an Accelerated Benefit of up to 75% of Your life insurance. The minimum Accelerated Benefit is $5,000.

If the amount of Your insurance is scheduled to reduce within twenty-four (24) Months following the date You apply for the Accelerated Benefit, Your Accelerated Benefit will be based on the reduced amount.

If Your insurance is scheduled to end within twenty-four (24) Months following the date You apply for the Accelerated Benefit, You will not be eligible for the Accelerated Benefit.

You may elect an Accelerated Benefit once. The Accelerated Benefit will be paid to You in a lump sum. If You recover from Your Qualifying Medical Condition after receiving an Accelerated Benefit, Standard will not ask You for a refund.

The amount of Your life insurance after payment of the Accelerated Benefit will be:

a. The amount of Your life insurance as if no Accelerated Benefit had been paid; minus

b. The amount of the Accelerated Benefit; minus

c. An interest charge calculated as follows:

   A × B × C ÷ by 365 = interest charge.

   A = The amount of the Accelerated Benefit.

   B = The Monthly average of Standard's variable policy loan interest rate.

   C = The Number of days from payment of the Accelerated Benefit to the earlier of:

      i. The date You die, or

      ii. The date You have a right to convert.

However, Your life insurance will not be reduced to less than 10% of Your original amount.

4. *Exclusions*

No Accelerated Benefit will be paid if:

a. All or part of Your insurance must be paid to Your child(ren), or Your spouse or former spouse as part of a court approved divorce decree, separation maintenance agreement, or property settlement agreement;

b. You are married and live in a community property state, unless You give Standard a signed written consent from Your spouse;

c. You have filed for bankruptcy, unless You give Standard written approval from the Bankruptcy Court for payment of the Accelerated Benefit;

d. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement; or

e. You have previously received an Accelerated Benefit under the group policy.

Right to Convert to an Individual Policy

1. *Right to Convert*

You may buy an individual policy of life insurance from Standard without submitting evidence of insurability if:

a. Your life insurance, whether under the Group Policy or continued under Waiver of Premium, ends or is reduced for any reason except failure to make a required premium or payment of an accelerated benefit; and

b. You apply in writing and pay Standard the first premium during the conversion period, which is the thirty-one (31) days after Your life insurance ends or is reduced.

Except as limited under *2. Limits on Right to Convert*, the maximum amount You have a right to convert is the amount of Your insurance that ended.

2. *Limits on Right to Convert*

If Your insurance ends or is reduced because of termination or amendment of the group policy, the following applies:

a. You may not convert insurance which has been in effect for less than five (5) years.

b. The maximum amount You have a right to convert is the amount of Your insurance immediately prior to Your termination of coverage under this group policy, minus any other group life insurance for which You become eligible during the thirty-one (31) days after termination of this group policy.

3. *The Individual Policy*

You may select any form of individual life insurance policy Standard issues to persons of Your age, except:

a. A term insurance policy;

b. A universal life policy;

c. A policy with disability, accidental death, or other additional benefits; or

d. A policy in an amount less than the minimum amount Standard issues for the form of life insurance You select.

The individual policy of life insurance will become effective on the day after the end of the conversion period. Standard will use its published rates for standard risks to determine the premium.

4. *Death During the Conversion Period*

If You die during the conversion period, Standard will pay a death benefit equal to the maximum amount You had a Right To Convert, whether or not You applied for an individual policy. The benefit will be paid according to the **Benefit Payment and Beneficiary Provisions**.

Filing a Life Insurance Claim

1. *Filing a Claim*

Claims should be filed on Standard forms. You may obtain a claim form by calling the Trust Office.

2. *Time Limits for Filing Proof of Loss*

Proof of loss must be provided within ninety (90) days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that ninety (90) day period.

Proof of Loss for **Waiver of Premium** must be provided within eighteen (18) Months after the date of Total Disability. Further proof of loss will be required at reasonable intervals, but not more often than once a year after You have been continuously Totally Disabled for two years.

If proof of loss is filed outside these time limits, the claim will be denied. These limits will not apply while You or Your beneficiary lacks legal capacity.

3. *Proof of Loss*

Proof of loss means written proof that a loss occurred:

a. For which the group policy provides benefits;

b. That is not subject to any exclusions; and

c. That meets all other conditions for benefits.

Proof of loss includes any other information which may reasonably be required in support of a claim. Proof of loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until Standard receives proof of loss.

4. *Investigation of Claim*

Standard may have You examined at its expense at reasonable intervals. Any examination will be conducted by specialists of its choice. Standard may have an autopsy performed at its expense, except where prohibited by law.

5. *Time of Payment*

Benefits will be paid within sixty (60) days after proof of loss is satisfied.

6. *Notice of Decision on Claim*

Standard will evaluate a claim for benefits promptly after receipt. For all claims except Waiver of Premium claims, within ninety (90) days after Standard receives the claim, it will send the claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional ninety (90) days.

For Waiver of Premium claims, within forty-five (45) days after Standard receives the claim, it will send the claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional thirty (30) days.

Before the end of the extension for a Waiver of Premium claim, Standard will send the claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional thirty (30) days.

If an extension is due to the claimant's failure to provide information necessary to decide a Waiver of Premium claim, the extended time for deciding the claim will not begin until the claimant provides the information or otherwise responds.

If Standard extends the time to decide a claim, Standard will notify the claimant of the following:

a. The reason(s) for the extension;

b. When Standard expects to decide the claim;

c. An explanation of the standards on which entitlement to benefits is based;

d. The unresolved issues preventing a decision; and

e. Any additional information Standard needs to resolve the claim.

If Standard requests additional information, the claimant will have forty-five (45) days to provide the information. If the claimant does not provide the requested information within forty-five (45) days, Standard may decide the claim based on the information it has received.

If Standard denies any part of the claim, it will send the claimant a written notice of denial containing:

a. The reason(s) for Standard's decision;

b. Reference to the part(s) of the group policy on which the decision is based;

c. Reference to any internal rule or guideline relied upon in deciding a Waiver of Premium claim;

d. A description of any additional information needed to support the claim;

e. Information concerning the claimant's right to review Standard's decision; and

f. Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act if the claim is denied on review.

7. *Review Procedure*

If all or part of a claim is denied, the claimant may request a review. The claimant must request review in writing within the following time frames:

a. Within one-hundred eighty (180) days after receiving notice of denial of a claim for Waiver of Premium;

b. Within sixty (60) days after receiving notice of denial of any other claim.

The claimant may send to Standard written comments or other information to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for the copies. Standard's review will include any written comments or other information the claimant submits to support the claim.

Standard will review the claim after it receives the request for review. For all claims except Waiver of Premium claims, within sixty (60) days after Standard receives the request for review, it will send the claimant:

a. A written decision on review; or

b. A notice that Standard is extending the review period for sixty (60) days.

For Waiver of Premium claims, within forty-five (45) days after Standard receives the request for review, it will send the claimant:

a. A written decision on review; or

b. A written notice that Standard is extending the review period for forty-five (45) days.

If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If Standard extends the review period, it will notify the claimant of the following:

a. The reason(s) for the extension;

b. When it expects to decide the claim on review; and

c. Any additional information it needs to decide the claim.

If Standard requests additional information, the claimant will have forty-five (45) days to provide the information. If the claimant does not provide the requested information within forty-five (45) days, Standard may conclude its review of the claim based on the information it has received.

With respect to Waiver of Premium claims, the person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the initial denial decision was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person. The claimant may request the names of the medical or vocational experts who provided advice to Standard about a claim for Waiver of Premium.

If Standard denies any part of the claim on review, the claimant will receive a written notice of denial containing:

a. The reason(s) for Standard's decision;

b. Reference to the part(s) of the group policy on which the decision is based;

c. Reference to any internal rule or guideline relied upon in deciding a Waiver of Premium claim;

d. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim; and

e. Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act.

The group policy does not provide voluntary alternative dispute resolution options. However, You may contact the local office of the United States Department of Labor or Your state insurance commissioner for assistance.

Benefit Payment and Beneficiary Provisions

1. *Payment of Benefits*

Benefits payable because of Your death will be paid to the beneficiary You name. Beneficiary means a person You name to receive death benefits.

2. *Naming a Beneficiary*

You may name one or more beneficiaries. Two or more surviving beneficiaries will share equally, unless You specify otherwise. You may name or change beneficiaries at any time without the consent of a beneficiary.

You must name or change beneficiaries in writing. Your beneficiary designation:

a. Must be dated and signed by You;

b. Must be delivered to the Trust Office during Your lifetime;

c. Must relate to the insurance provided under the group policy; and

d. Will take effect on the date it is delivered to the Trust Office.

You may obtain a beneficiary designation form by calling the Trust Office.

3. *Simultaneous Death Provision*

   If a beneficiary dies on the same day You die, or within fifteen (15) days thereafter, benefits will be paid as if that beneficiary had died before You, unless proof of loss with respect to Your death is delivered to Standard before the date of the beneficiary's death.

4. *No Surviving Beneficiary*

   If You do not name a beneficiary, or if You are not survived by a beneficiary, benefits will be paid in equal shares to the first surviving class of the classes below:

   a. Your spouse or Domestic Partner. Domestic Partner means an individual recognized as such under applicable law;

   b. Your children;

   c. Your parents;

   d. Your brothers and sisters;

   e. Your estate.

5. *Methods of Payment*

   Benefits will be paid to the recipient (person who is entitled to benefits under this Benefit Payment and Beneficiary Provisions section) in a lump sum.

   To the extent permitted by law, the amount payable to the recipient will not be subject to any legal process or to the claims of any creditor.

Allocation of Authority

Standard has full and exclusive authority to control and manage the group policy, to administer claims, to interpret the group policy and resolve all questions arising in the administration, interpretation and application of the group policy.

Standard's authority includes, but is not limited to:

1. The right to resolve all matters when review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the group policy and any claim under it; and

3. The right to determine:

   a. Your eligibility for insurance;

b. Your entitlement to benefits;

c. The amount of benefits payable; and

d. The sufficiency and the amount of information Standard may reasonably require to determine a, b, or c, above.

Subject to the review procedures of the group policy, any decision Standard makes in the exercise of its authority is conclusive and binding. Upon final resolution, VSP will notify You of the outcome in writing. In the event of a conflict between this summary and the group policy, the terms of the group policy will control. If You would like a copy of the group policy, please contact the Trust Office.

Time Limits for Legal Actions

No action at law or in equity may be brought until sixty (60) days after Standard has been given proof of loss. No such action may be brought more than three years after the earlier of:

1. The date Standard Insurance Company receives proof of loss; and

2. The time within which proof of loss is required to be given.

Address and Telephone Number of Standard Insurance Company

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1093
(800) 628-8600

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

For Employees Only

Accidental Death & Dismemberment (AD&D) insurance benefits are provided to Employees only. Retired Employees and those making payments under COBRA are not eligible for AD&D benefits. AD&D benefits are provided through a group policy with Standard Insurance Company (Standard).

Summary of the Insurance Benefit

AD&D insurance provides benefits for dismemberment or death resulting from accidental bodily injury. The AD&D insurance is summarized below.

1. *When Benefits are Payable*

   If You have an accident while insured for AD&D insurance, and the accident results in a loss, Standard will pay benefits according to the terms of the group policy after satisfactory proof of loss is received.

2. *Definition of Loss for AD&D Insurance*

   Loss means loss of life, hand, foot or sight, that:

   a. Is caused solely and directly by an accident;

   b. Occurs independently of all other causes; and

   c. Occurs within 365 days after the accident.

   With respect to a hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, loss means entire and irrevocable loss of sight.

3. *Amount of Insurance*

   The amount payable is:

LOSS	AMOUNT
Life	$10,000
One hand, one foot, or sight of one eye	$5,000
Two or more of the above losses	$10,000

   No more than 100% of Your AD&D insurance will be paid for all losses resulting from one accident.

4. *Seat Belt Benefit*

   The amount of the seat belt benefit is $10,000.

Standard Insurance Company will pay a seat belt benefit if:

a. You die as the result of an automobile accident for which the AD&D insurance benefit is payable; and

b. You were wearing a seat belt at the time of the accident, as evidenced by a police accident report.

i. **Seat belt** means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

ii. **Automobile** means a motor vehicle licensed for use on public highways.

5. *AD&D Insurance Exclusions*

No AD&D insurance is payable if the loss is caused or contributed to by any of the following:

a. War or act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;

b. Suicide or other intentionally self-inflicted Injury, while sane or insane;

c. Committing or attempting to commit assault or a felony, or actively participating in a violent disorder or riot. Actively participating does not include being at a scene of a violent disorder or riot while performing Your official duties;

d. The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a Physician;

e. Sickness or Pregnancy existing at the time of the accident;

f. Heart attack or stroke;

g. Medical or surgical treatment for any of the above.

6. *When AD&D Insurance Begins*

Your AD&D insurance begins on the date You qualify for Harrison group health and welfare benefits.

7. *When AD&D Insurance Ends*

Your AD&D insurance ends on the earliest of:

a. The date the last period ends for which a required premium is made on Your behalf to Standard by the Harrison Trust;

b. The date the group policy terminates;

c. The date You cease to be eligible for the Active Employee Plan due to a lack of employer, or a combination of employer and Employee contributions for the health and welfare benefits. A self-payment under COBRA WILL NOT extend Your AD&D Insurance benefit; or

d. The date You become a full-time member of the armed forces of any country (except as provided under the Uniformed Services Employment and Reemployment Act).

Filing Accidental Death & Dismemberment Claims

1. *Filing a Claim for Benefits*

Claims should be filed on Standard claim forms. You may obtain a claim form by calling the Trust Office.

2. *Time Limit for Filing Proof of Loss*

Proof of loss must be provided within ninety (90) days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after the ninety (90) day period.

If proof of loss is filed outside of these time limits, the claim will be denied. These limits will not apply while You or Your beneficiary lacks legal capacity.

3. *Proof of Loss*

Proof of loss means written proof that a loss occurred:

a. For which the group policy provides benefits;

b. That is not subject to any exclusions; and

c. That meets all other conditions for benefits.

Proof of loss includes any other information Standard may reasonably require in support of a claim. Proof of loss must be written and must be provided at the expense of You or Your beneficiary. No benefits will be provided until Standard receives proof of loss.

4. *Investigation of Claim*

Standard may have You examined at its expense at reasonable intervals. Any such examination will be conducted by specialists of its choice.

Standard may have an autopsy performed at its expense, except where prohibited by law.

5. *Time of Payment*

Benefits will be paid within sixty (60) days after proof of loss is satisfied.

6. *Notice of Decision on Claim*

Standard will evaluate a claim for benefits after receipt. Within ninety (90) days after Standard receives the claim, it will send the claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional ninety (90) days.

If Standard extends the time to decide the claim, Standard will notify the claimant of the following:

a. The reason(s) for the extension;

b. When Standard expects to decide the claim;

c. An explanation of the standards on which entitlement to benefits is based;

d. The unresolved issues preventing a decision; and

e. Any additional information Standard needs to resolve the claim.

If Standard requests additional information, the claimant will have forty-five (45) days to provide the information. If the claimant does not provide the requested information within forty-five (45) days, Standard may decide the claim based on the information it has received.

If Standard denies any part of the claim, it will send the claimant a written notice of denial containing:

a. The reason(s) for Standard's decision;

b. Reference to the part(s) of the group policy on which the decision is based;

c. A description of any additional information needed to support the claim;

d. Information concerning the claimant's right to review Standard's decision; and

e. Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act if the claim is denied on review.

7. *Review Procedure*

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within sixty (60) days after receiving notice of denial of the claim.

The claimant may send to Standard written comments or other information to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for the copies. Standard's review will include any written comments or other information the claimant submits to support the claim.

Standard will review the claim promptly after it receives the request for review. Within sixty (60) days after Standard receives the request for review, it will send the claimant:

a. A written decision on review; or

b. A notice that Standard is extending the review period for sixty (60) days.

If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If Standard extends the review period, it will notify the claimant of the following:

a. The reason(s) for the extension;

b. When it expects to decide the claim on review; and

c. Any additional information it needs to decide the claim.

If Standard requests additional information, the claimant will have forty-five (45) days to provide the information. If the claimant does not provide the requested information within forty-five (45) days, Standard may conclude its review of the claim based on the information it has received.

If Standard denies any part of the claim on review, the claimant will receive a written notice of denial containing:

a. The reason(s) for Standard's decision;

b. Reference to the part(s) of the group policy on which the decision is based;

c. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim; and

d. Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act.

The group policy does not provide voluntary alternative dispute resolution options. However, You may contact the local office of the United States Department of Labor or Your state insurance commissioner for assistance.

Benefit Payment and Beneficiary Provisions

1. *Payment of Benefits*

   Benefits payable because of Your death will be paid to Your beneficiary. Beneficiary means the person You name to receive Your benefits. Dismemberment benefits will be paid to You if You are living. Any dismemberment benefits which are unpaid at Your death will be paid to Your beneficiary.

2. *Naming a Beneficiary*

   The beneficiary(ies) You name for life insurance will be Your beneficiary for AD&D benefits. You may name one or more beneficiaries. Two or more surviving beneficiaries will share equally, unless You specify otherwise. You may name or change beneficiaries at any time without the consent of a beneficiary.

   You must name or change beneficiaries in writing. Your beneficiary designation:

   a. Must be dated and signed by You;

   b. M**u**st be delivered to the Trust Office during Your lifetime;

   c. Must relate to the insurance provided under the group policy; and

   d. Will take effect on the date it is delivered to the Trust Office.

   You may obtain a beneficiary designation form by calling the Trust Office.

3. *Simultaneous Death Provision*

   If a beneficiary dies on the same day You die, or within fifteen (15) days thereafter, benefits will be paid as if that beneficiary had died before You, unless proof of loss with respect to Your death is delivered to Standard before the date of the beneficiary's death.

4. *No Surviving Beneficiary*

   If You do not name a beneficiary, or if You are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below:

   a. Your spouse or Domestic Partner. Domestic Partner means an individual recognized as such under applicable law;

   b. Your children;

c. Your parents;

d. Your brothers and sisters;

e. Your estate.

5. *Methods of Payment*

Benefits will be paid to the recipient (person who is entitled to benefits under this Benefit Payment and Beneficiary Provisions section) in a lump sum.

To the extent permitted by law, the amount payable to the recipient will not be subject to any legal process or to the claims of any creditor.

Allocation of Authority

Standard has full and exclusive authority to control and manage the group policy to administer claims, and to interpret the group policy and resolve all questions arising in the administration, interpretation and application of the group policy.

Standard's authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the group policy and any claim under it; and

3. The right to determine:

   a. Your eligibility for insurance;

   b. Your entitlement to benefits;

   c. The amount of benefits payable; and

   d. The sufficiency and the amount of information Standard may reasonably require to determine, a, b or c, above.

   Subject to the review procedures of the group policy, any decision Standard makes in the exercise of its authority is conclusive and binding.

Time Limits for Legal Actions

No action at law or in equity may be brought until sixty (60) days after Standard has been given proof of loss. No such action may be brought more than three years after the earlier of:

1. The date Standard receives proof of loss; and

2. The time within which proof of loss is required to be given.

Address and Telephone Number of Standard Insurance Company

Standard Insurance Company
900 SW 5th Avenue
Portland, OR 97204-1093
(800) 628-8600

TIME LOSS BENEFITS

For Employees Only

New Employees

If You have not been eligible for health and welfare coverage through the Harrison Trust in any of the previous thirty-six (36) consecutive Months, You will be eligible for Time Loss benefits in the event of Total Disability as the result of a non-occupational Illness or Injury occurring after six (6) Months of health and welfare coverage under the Harrison Trust.

If You have not had health and welfare coverage through the Harrison Trust in any of the previous thirty-six (36) consecutive Months, the six (6) Months of health and welfare coverage through the Harrison Trust before Time Loss benefits become effective will be waived if You had previous time loss coverage under a prior health and welfare plan so long as there is not a gap of more than 63 days between the date Your time loss coverage under the prior health and welfare plan ended and the date health and welfare coverage under the Harrison Trust begins.

Employees must have Harrison Trust health and welfare coverage (other than COBRA coverage) at the time of Total Disability to be eligible for this benefit. Dependents are not eligible for this benefit.

Maximum Payment and Length of Payment

Time Loss benefits are available only in the event of Total Disability as the result of a non-occupational Illness or Injury or for you own pregnancy.

For a Total Disability the time loss benefit is a Weekly Benefit of $400 for up to fifty-two (52) weeks. Payment will commence on the first day of an Accidental Bodily Injury and the eighth day of Illness due to a non-occupational Illness or Injury that results in Total Disability. Payment will also commence on the first day of an Illness in the event of Hospitalization. The Total Disability must be certified by a Doctor. You need not be confined to Your home, but You must unable to work in Your normal job because of an Illness or Accidental Bodily Injury and under the care of a Doctor. If You return to full-time work for a continuous period of at least two weeks, any subsequent disability will be deemed to be a new disability regardless of its cause.

For your own pregnancy the time loss benefit is a Weekly Benefit of $800 for up to thirteen (13) weeks prior to your verified expected due date for delivery, and up to thirteen (13) weeks after Your delivery. The maximum number of weeks provided at $800 a week is twenty-six (26) weeks. The pregnancy time loss benefit for such time period is in lieu of a Total Disability time loss benefit if you qualify for both benefits, but if the Total Disability continues after the pregnancy benefit ends, You would be eligible for Total Disability benefits for the remainder of the fifty-two (52) weeks.

Your Time Loss benefits are subject to federal income tax and, if applicable, state income tax. The Trust Office will mail a W-2 form for Time Loss benefits paid during the year to Employees by January 31st of the following year.

Filing a Claim for Time Loss Benefits

Contact the Trust Office or go to the Harrison website at www.harrisonbenefits.com for the forms for Time Loss benefits.

Prior to the payment of Time Loss benefits, the Board of Trustees reserves the right to have an independent medical exam performed.

ADMINISTRATION OF THE PLAN AND CLAIM APPEAL PROCEDURES

The day-to-day administrative details of the Harrison Trust are handled by the Trust Office:

BeneSys, Inc.
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239
In Portland: (503) 224-0048, ext. 1679
Outside Portland: (800) 547-4457, ext. 1679
www.harrisonbenefits.com

If You have any questions regarding the Active Employee Plan, please contact BeneSys, Inc.

Claims (Other than Life and Accidental Death & Dismemberment Insurance)

Claim forms must be completed in order to receive benefits. Claim forms may be obtained by calling or writing the Trust Office or on the web at www.harrisonbenefits.com. After completing the claim form, mail or bring it, together with the itemized billing from the Provider to the Trust Office for processing.

Claims will be Paid In The Following Manner

1. Vision claims are processed and paid by:

   Vision Service Plan
   PO Box 997100
   Sacramento CA 95899-7100
   (800) 877-7195
   TDD/Hearing Impaired (800) 735-2922

2. For Providence Health Plan enrollees, present Your ID card to Your Provider at the time of service and make sure Your Provider bills Providence Health Plan directly.

3. For Kaiser Permanente enrollees, present Your ID card at Your Kaiser Permanente facility for services and prescription drugs.

Claim Filing Requirements

1. *Time Requirements*

   a. Proof of claim for Hospital confinement must be given to the Trust Office within ninety (90) days after release from the Hospital. Proof of claim for any other service, supply or treatment must be given to the Trust Office within ninety (90) days after the service or treatment.

   b. If proof of any claim is not given within ninety (90) days, the claim will not be denied or reduced if the proof of the claim is given as soon as reasonably possible. **However, no**

claim will be paid if submitted to the Trust Office more than one year after date of release from the Hospital or the date of service or treatment.

"Proof" means proof satisfactory to the Board of Trustees.

2. *Examination*

   a. The Board of Trustees, at the expense of the Harrison Trust, has the right to have You examined by a Provider, as often as required whenever Your Illness or Injury is the basis of a claim.

   b. The Board of Trustees has the right to require an autopsy, if not prohibited by law. A disputed Illness is a basis for this requirement.

Payment of Claims

All medical and dental claim payments will be paid to the Employee unless the claim has been assigned to a Hospital or Provider in writing or unless the Trust Office or Board of Trustees determines that the Employee is not legally able to complete a binding receipt or payment should be made to another person or entity.

If the Trust Office or Board of Trustees determines that the Employee is not legally able to receive such payment, the Board of Trustees may pay the Hospital or Provider, Your estate or a relative. Any payment made under this option will discharge the Harrison Trust and Board of Trustees from further obligation for such payment.

The Board of Trustees reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to You and to any assignees. Such actions will be binding on You and on Your assignees.

Return of Overpayment

If the Harrison Trust, Board of Trustees or Trust Office mistakenly pays a claim for which You are not entitled or makes a payment to a person, Hospital or Provider who is not entitled to the payment, or You do not make a required subrogation or reimbursement payment, the Board of Trustees has the right to recover the payment from the person, Hospital or Provider paid or anyone else who benefited from it. The Board of Trustees' right to recover includes the right to deduct the amount paid by mistake or not paid via subrogation or reimbursement from future Covered Charges of You or any family member or from Your Reserve Account.

Claims Appeal Procedure

If You have a claim concerning benefits provided by Providence Health Plan, Kaiser Permanente, Willamette Dental, Vision Service Plan or Standard Insurance Company, the claim should be filed with that organization in accordance with its claims appeal procedures.

If You have a claim concerning the denial of a time loss benefit, or a disability waiver of health and welfare premiums, refer to the next section of the Benefit Booklet entitled *Claims Appeal Procedure for Time Loss Benefits and Waiver of Health and Welfare Premium Claims* on page 115.

If You have a claim concerning eligibility for coverage (such as insufficient money in Your Reserve Account or a late self-payment), or whether a person qualifies as a Dependent, You may file an appeal pursuant to paragraph 3 on page 109.

If You have a claim for benefits that involves the Active Employee Plan (such as a medical, prescription drug or dental benefit), the procedures outlined below apply.

1. *Denial of a Claim by the Trust Office*

   a. **Timeframe for Initial Decision by Trust Office**. A decision will be made on a claim as soon as practicable and the Trust Office or the Board of Trustees' authorized representative will communicate that decision in writing to You.

      The time in which an initial decision will be made depends on the type of claim submitted as follows:

Medical and prescription drugs (post-service claims)	30 days
Dental	30 days
Eligibility, a late self-payment, coverage for a Dependent, a COBRA issue, or a rescission of coverage issue	90 days

      The time for providing a decision begins when the claim is filed in accordance with the Plan's procedures, without regard to whether all the information necessary to make a decision accompanies the filing.

   b. **Medical and Prescription Drug Claims**. The Trust Office or the Board of Trustees' authorized representative is responsible for reviewing medical and prescription drug claims. You will be notified in writing whether Your claim is approved or denied. The timeframe in which a decision is made is based on the type of claim You have submitted.

      i. **Urgent Care Claim.** An urgent care claim is where the terms of the Plan require prior authorization before medical care or treatment can be obtained and a delay in obtaining the medical care or treatment could:

         I. Seriously jeopardize Your life or health or Your ability to regain maximum function; or

         II. In the opinion of a Provider with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the medical care or treatment.

      In the event there is an urgent care claim, the Trust Office or the Board of Trustees' authorized representative will provide notice of the benefit determination

(whether approved or denied) within seventy-two (72) hours after receipt of the claim unless insufficient information is provided to determine whether, or to what extent, benefits are covered or payable by the Plan. In such a case, the Trust Office or the Board of Trustees' authorized representative shall notify You as soon as possible but not later than twenty-four (24) hours after receipt of the claim and identify the specific information necessary to complete review of the claim. You shall have at least forty-eight (48) hours to provide the requested information. You will be notified of the decision as soon as possible but not later than forty-eight (48) hours after either receipt of the information or the end of the additional time period, whichever is earlier. You may appeal an adverse benefit determination to the Board of Trustees and they or their authorized representative will act on the appeal within seventy-two (72) hours after receipt.

ii. **Pre-Service Claim.** A pre-service claim is where the terms of the Plan require prior authorization before medical care or treatment can be obtained. Unlike an urgent care claim, Your health is not in serious jeopardy at the time the pre-service claim is submitted. In the event there is a pre-service claim, the Trust Office or the Board of Trustees' authorized representative shall provide notice of the benefit determination (whether approved or denied) within a reasonable period of time but not later than fifteen (15) days after receipt of the claim. The time may be extended up to an additional fifteen (15) days for matters beyond the control of the Trust Office or the Board of Trustees' authorized representative, but You will be notified of the extension before the end of the initial fifteen (15) day period. The notice will identify the circumstances requiring the extension and the date by which the Trust Office or the Board of Trustees' authorized representative expects to issue a decision. If the extension is necessary because You did not submit necessary information, the notice will describe the information required and give You an additional period of at least forty-five (45) days to furnish the information. You may appeal an adverse benefit determination to the Board of Trustees and they or their authorized agent will act on the appeal within thirty (30) days after receipt.

iii. **Concurrent Claim.** A concurrent claim is a claim that is reconsidered after initial approval of an ongoing course of treatment and results in a reduction or termination of benefits before the end of the approved course of treatment. An example is an inpatient Hospital stay, originally approved for five (5) days that is subsequently shortened to three (3) days. In the event of reconsideration, You must be notified so that You can appeal the decision and obtain a decision on appeal before the course of treatment is reduced or terminated. An appeal to extend a course of treatment for a claim involving urgent care must be acted on within twenty-four (24) hours after receipt of the appeal but only if the appeal is received at least twenty-four (24) hours before the expiration of the approved course of treatment. Coverage for the ongoing course of treatment will be continued pending the outcome of an appeal.

iv. **Post-Service Claim.** A post-service claim is a claim for benefits after the care or treatment has been provided. An example is the amount of a Provider's bill that will be paid. The Trust Office or the Board of Trustees' authorized agent will provide

notice of the benefit determination (whether approved or denied) within a reasonable period of time but not later than thirty (30) days after receipt of the claim. The time may be extended up to an additional fifteen (15) days for matters beyond the Trust Office's or the Board of Trustees' authorized representative's control but You will be notified of the extension before the end of the thirty (30) day period. The notice will identify circumstances requiring an extension of time and the date by which the Trust Office or the Board of Trustees' authorized agent expects to issue the decision. If the extension is necessary because You did not submit necessary information, the notice will describe the information needed and give You an additional period of at least forty-five (45) days to furnish the information. You may appeal an adverse benefit determination to the Board of Trustees and they or their authorized agent will act on the appeal within the time limit specified in the **Decision by the Board of Trustees** section.

c. **Dental Claims**. The Trust Office or the Board of Trustees' authorized representative is responsible for reviewing dental claims. You will be notified in writing whether Your claim is granted or denied within a reasonable period of time but not later than thirty (30) days after receipt of the claim. The time period may be extended up to an additional fifteen (15) days for matters beyond the Trust Office's or the Board of Trustees' authorized agent's control but You will be notified of the extension before the end of the thirty (30) day period. The notice will identify circumstances requiring an extension of time and a date by which the Trust Office expects to issue the decision. If the extension is necessary because You did not submit necessary information, the notice will describe the information needed and give You an additional period of at least forty-five (45) days to furnish the information. You may appeal an adverse benefit determination to the Board of Trustees and they or their authorized agent will act on the appeal within the time limit specified in the **Decision by the Board of Trustees** section.

d. **Eligibility Claims**. The Trust Office or the Board of Trustees' authorized representative is responsible for reviewing claims concerning eligibility-type issues such as ineligibility to enroll, a late self-payment, coverage for a Dependent, COBRA coverage issues, and rescission of coverage issues. A rescission of coverage is a cancellation or discontinuation of medical, prescription drug, dental, or vision coverage that has a retroactive effect and is not due to a failure to timely pay the required contribution. You will be notified in writing of an eligibility decision. The written decision will normally be provided within ninety (90) days after receipt of Your written notice concerning an eligibility issue. You may appeal an adverse eligibility decision to the Board of Trustees and they or their authorized agent will act on the appeal within the time limits specified in the **Decision by the Board of Trustees** section.

e. **Independence of Decision Makers**. Throughout the claims and appeals process, the Plan will insure that all claims and appeals are adjudicated in a manner designed to insure the independence and impartiality of the persons involved in making the decision. The Plan will not provide bonuses to individuals or organizations based on the number of denials made by the claims adjudicator or the entity employing the claims adjudicator. The Plan will not contract with a medical expert based on the expert's reputation for outcomes in

contested cases. Rather, the Plan will contract with medical experts based on each expert's professional qualifications.

2. *Content of Initial Adverse Benefit Determination and Eligibility Determination Notice*

   a. If Your claim is denied, the adverse determination will be in writing and will provide:

      i. The specific reason(s) for the adverse benefit determination;

      ii. Reference to the specific Plan provision(s) on which the adverse benefit determination is based;

      iii. A description of any additional material or information necessary to perfect the claim and an explanation why such material or information is necessary;

      iv. A description of the Plan's review procedure, the time limits applicable to such procedures, and Your right to bring a civil lawsuit for the benefit after an adverse determination by the Board of Trustees or their designee;

      v. If the adverse benefit determination is based upon an internal rule, guideline, protocol or similar criterion, You will be notified of Your right to receive the document free of charge upon request; and

      vi. If the adverse benefit determination is based upon a decision involving Medical Necessity, experimental treatment or other similar exclusions or limitations, You will be notified of Your right to receive a statement of the scientific or clinical reason for the decision free of charge upon request.

3. *Appeal of an Adverse Benefit Determination and Eligibility Determination*

   a. If You disagree with the initial adverse benefit or eligibility determination, You or Your authorized representative may file a written appeal within one-hundred eighty (180) days following receipt of the adverse benefit or eligibility determination. The written appeal must be filed as follows:

      Harrison Electrical Workers Trust Fund
      Attn: Appeals Board
      5331 S Macadam Avenue
      Suite 258, PMB #116
      Portland, OR 97239

   b. Upon written request, You will be provided free of charge reasonable access to and copies of all non-privileged documents, records and other information relevant to Your appeal. Whether a document, record or other information is relevant is determined in accordance with 29 C.F.R. § 2560.503-1(m)(8).

c. In conjunction with Your appeal, You or Your authorized representative may submit written comments, documents, records or other information relating to Your claim to the Board of Trustees.

d. If You or Your authorized representative request to appear at a hearing before the Board of Trustees at the time Your appeal is filed, You will be notified of the time, date and place of the hearing by regular mail at the return address shown on Your request for review. You may be represented at the hearing by an attorney or other authorized representative of Your choice at Your cost and expense.

4. *Decision by the Board of Trustees or Designee*

a. Upon receipt of an appeal, the Board of Trustees or designee will review the claim de novo (meaning without deference to the initial decision). The Board of Trustees or designee will review all relevant information regardless of whether the information was previously submitted. If the appeal involves issues of medical judgment such as whether a particular treatment, drug or other procedure is experimental, investigational or Medically Necessary, the Board of Trustees or designee will consult a health care professional who has appropriate training and experience in the appropriate field of medicine. If the Board of Trustees or designee consults a health care professional, he/she will be identified regardless of whether the Board of Trustees or designee relies on his/her opinion. If the Board of Trustees or designee consults a health care professional, he/she will be different than the health care professional previously consulted and will not be a subordinate of the health care professional previously consulted.

b. A decision will be made by the Board of Trustees or designee at the Board of Trustees' next regularly scheduled meeting following receipt of the appeal unless the appeal is received less than thirty (30) days prior to the meeting. If this is the case, the Board of Trustees or designee will review the appeal no later than the date of the subsequent Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees or designee requires an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

c. The decision of the Board of Trustees or designee will be in writing and sent within five (5) days after the decision is reached.

d. If the Board of Trustees or designee deny Your benefit appeal, the adverse benefit determination will include the following:

i. The specific reason(s) for the adverse benefit determination;

ii. Reference to the specific Plan provision(s) on which the decision is based;

iii. A statement that, upon written request, You will be provided free of charge reasonable access to and copies of all documents, records and other information

relevant to Your claim. Whether a document, record or information is relevant is determined in accordance with 29 C.F.R. § 2560.503-1(m)(8);

iv. A statement of Your right to bring a civil lawsuit for the benefit under ERISA;

v. A statement that any internal rule, guideline, protocol or similar criterion used as a basis for the adverse benefit determination will be available free of charge upon written request; and

vi. A statement that if the adverse benefit determination was based on Medical Necessity, experimental, investigational or other similar exclusions or limitations, You will be notified of Your right to receive a statement of the scientific or clinical reason for the decision free of charge upon request.

e. If the Board of Trustees or designee deny Your eligibility appeal, the decision will include the following:

i. The specific reason(s) for the decision;

ii. Reference to the specific Plan provision(s) on which the decision is based; and

iii. A statement of Your right to bring a civil lawsuit under ERISA.

f. You are required to use the procedures set forth above before bringing a civil lawsuit for the benefit or eligibility under ERISA.

g. The Board of Trustees or designee has the full and exclusive authority to administer the Active Employee Plan, interpret the Active Employee Plan, determine eligibility questions, determine eligibility for benefits, and resolve all questions arising in the administration, interpretation and application of the Active Employee Plan. The Board of Trustees' or designee's authority includes, but is not limited to:

i. The right to resolve all matters when review has been requested;

ii. The right to establish and enforce rules and procedures for the administration of claims so long as the rules and procedures are consistent with ERISA;

iii. The right to construe and interpret the Active Employee Plan and determine eligibility for benefits; and

iv. The exercise of the aforementioned powers and authorities by the Board of Trustees or designee will be given the fullest deference allowed by law.

5. *External Review Process*

External review is available for adverse benefit determinations that involve medical judgment (as determined by the external reviewer) and rescission of coverage decisions. Examples of claims that involve medical judgment are:

a. Appropriateness of health care setting (e.g., inpatient or outpatient);

b. Medical Necessity or appropriateness of treatment;

c. Experimental or investigational treatment; and

d. Whether the treatment involved an Emergency Medical Condition.

If You disagree with the adverse benefit determination made by the Board of Trustees or designee that involves medical judgment or the rescission of coverage, You or Your authorized representative may file a written appeal within four (4) months after the date of receipt of the adverse benefit determination. The written appeal must be filed as follows:

Harrison Electrical Workers Trust Fund
ATTN: External Review
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

The written appeal must describe the adverse benefit determination that is being appealed.

The cost of the external review process will be paid by the Plan.

Preliminary Review. Within five (5) business days after receipt of the appeal to external review, the Trust Office will make a preliminary review of the appeal which will include:

a. A determination whether the claimant is covered by the Plan at the time the health care item or service was requested or in the case of a post-service claim was covered by the Plan at the time the health care item or service was provided;

b. A determination whether the appeal involves medical judgment or rescission of coverage;

c. A determination whether the claimant has exhausted the internal claims review procedures or whether exhaustion is not required; and

d. A determination whether the claimant has provided all forms and information required to process the appeal.

Within one business day after completing the preliminary review, the Trust Office will notify the claimant in writing whether the appeal is eligible for external review. If the appeal is not complete, the claimant will be notified of the additional information or materials that are

required and that it must be received within the four (4) month period for requesting external review or, if later, forty-eight (48) hours after receipt of the notice that the submission is incomplete. If the Trust Office determines the appeal is complete but not eligible for external review, the reasons will be provided and the claimant will be provided contact information for the Employee Benefits Security Administration.

The Plan or its designee will contract with at least three (3) independent review organizations (IROs) that are accredited by URAC or a similar nationally-recognized accrediting organization. The IRO will decide the appeal. The appeal will be submitted to an IRO on a random or rotating basis. The IRO will not receive a financial incentive for a decision that upholds an adverse benefit determination.

Referral to IRO. The Plan or its designee will provide the IRO with all documents and information considered by the Board of Trustees or designee related to the appeal within five (5) business days of the referral of the appeal to the IRO. If the Plan fails to timely provide documents and information to the IRO, the IRO can terminate the external review and make a decision to reverse the adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the claimant and Plan.

If the IRO receives new information or documentation from the claimant, the IRO must notify the Plan within one (1) business day of receipt. Thereafter, the Board of Trustees may, but is not required to, reconsider the adverse benefit determination in light of the new information or documentation. Reconsideration by the Board of Trustees will not delay the IRO review. If the Board of Trustees decides to reverse the prior adverse benefit determination, the claimant and the IRO will be notified within one (1) business day after the decision is made.

The IRO will review all information and documents timely received. The IRO will decide the appeal on a *de novo* basis, meaning without deference to any decisions or conclusions reach by the Board of Trustees or designee.

In addition to the documents and information provided by the Plan and claimant, the IRO may consider the following in reaching its decision:

a. The claimant's medical records;

b. The claimant's health care professional's recommendation;

c. Reports from health care professionals and other documents submitted by the Plan, claimant or the claimant's health care professional;

d. The terms of the Plan;

e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

f. Any applicable clinical review criteria developed and used by the Plan unless the criteria are inconsistent with the terms of the Plan or applicable law; and

g. The opinion of the IRO's clinical reviewer after considering relevant information and documents.

Decision by the IRO. The IRO must provide a written decision to the claimant and Plan within sixty (60) days from receipt of the request for external review. The decision of the IRO should include, to the extent relevant, the following:

a. A general description of the reason for the appeal, including information sufficient to identify the appeal, the diagnosis code and meaning, the treatment code and meaning and the reason for the denial that is subject to appeal;

b. The date the IRO received the appeal and the date of decision;

c. Reference to evidence or documents considered in reaching the decision including, if applicable, the claimant's medical reports, the recommendations and reports of the claimant's health care professional, clinical review criteria developed and used by the Plan, the applicable terms of the Plan and appropriate practice guidelines, including the applicable evidence-based standards;

d. A discussion of the principal reason(s) for the decision, including any evidence-based standards relied upon;

e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the claimant or the Plan;

f. A statement that judicial review may be available to the claimant; and

g. Contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Service Health Act.

If the IRO reverses the decision of the Board of Trustees or designee, the Plan must provide benefits pursuant to the decision without delay unless or until there is a judicial decision reversing the IRO decision.

Expedited Review by the IRO. The Plan will allow a claimant to make a request for expedited external review at the time the claimant receives:

a. An initial adverse benefit determination (i.e., the Plan's first level of review) and the claimant filed a request for expedited review under the Plan's appeal procedures but the claim involves a medical condition for which the time frame for completion of the expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

b. The claimant has received an adverse benefit determination from the Board of Trustees or designee and the claimant has a medical condition where the time frame for completion of the appeal process to the IRO would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function or the appeal concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services but has not been discharged from a facility.

Upon receipt of a request for expedited external review, the Trust Office or the Board of Trustees' designee will immediately make a preliminary determination if the appeal is eligible for the expedited external review under the standards detailed above. The Plan will notify the claimant in writing whether the appeal is eligible for an expedited decision by the IRO.

Upon a determination that a request is eligible for expedited external review, the Plan will transmit all necessary documents and information to the IRO electronically or by any other expeditious method.

The IRO must consider the information and documents provided to it, to the extent it considers them appropriate. In reaching a decision, the IRO will review the appeal on a *de novo* basis, meaning without deference to any decisions or conclusions reached during the earlier stages of the Plan's review procedures.

The IRO will issue a decision as expeditiously as possible but in no event more than seventy-two (72) hours after the IRO receives the request for expedited external review. If the decision of the IRO is verbal, it must, within forty-eight (48) hours of providing the verbal decision, provide written confirmation of the decision to the claimant and the Plan.

Claims Appeal Procedure for Time Loss Benefit and Waiver of Health and Welfare Premium Claims

This Claims Appeal Procedure is applicable for the denial, reduction or termination of a time loss benefit and the denial or termination of a claim for waiver of health and welfare premiums.

1. *Denial of a Time Loss Benefit or a Waiver of Health and Welfare Premium Claim by the Trust Office*

   a. The Trust Office is responsible for reviewing an application for time loss benefits and waiver of the health and welfare premiums. If such a claim is denied, You will be notified in writing. The written notice of denial will normally be provided within forty-five (45) days after receipt of a completed application for time loss benefits or waiver of health and welfare premiums. If the Trust Office determines an extension of time is necessary to complete review because of matters beyond its control, the forty-five (45) day period may be extended for up to thirty (30) days provided the Trust Office notifies You of the extension of time during the initial forty-five (45) day period. If, prior to the end of the first thirty (30) day extension, the Trust Office determines that a further extension of time is necessary to complete review of the claim because of matters beyond its control, the thirty (30) day extension period may be extended for up to an additional thirty (30) days provided that the Trust Office notifies You of the extension before the end of the first

thirty (30) day extension period. If an extension of time is required by the Trust Office, You will be notified in writing and the notice will specify the reason(s) for the extension, the unresolved issue(s), if any, preventing a decision, additional information, if any, needed to resolve the issue(s) and the date a decision is expected.

2. *Content of the Denial Notice*

   a. If Your claim is denied, the denial notice will be in writing and will provide:

      i. The specific reason(s) for the decision.

      ii. Reference to the specific Plan provision(s) on which the denial is based;

      iii. A description of any additional material or information necessary to perfect the claim and an explanation why such material or information is necessary;

      iv. A description of the Plan's review procedures, the time limits applicable to such procedures, Your right to relevant documents, records and information, the time limits applicable to such procedures and Your right to bring a civil lawsuit for the benefit after an adverse benefit determination by the Board of Trustees or their designee; and

      v. If the decision is based on an internal rule, guideline, protocol or other similar criterion, the internal rule, guideline, protocol or similar criterion will be described or provided to You free of charge upon request.

3. *Appeal Procedure*

   a. If a claim for time loss benefits or claim for waiver of health and welfare premiums has been denied or partially denied, You may appeal the denial to the Board of Trustees.

   b. You or Your representative have one-hundred eighty (180) days following receipt of the denial notice to file an appeal with the Board of Trustees. The appeal must be in writing and mailed or delivered as follows:

      Harrison Electrical Workers Trust Fund
      Attn: Appeals Board
      5331 S Macadam Avenue
      Suite 258, PMB #116
      Portland, OR 97239

   c. Upon written request, You will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to Your claim. Whether a document, record or other information is relevant to a claim will be determined in accordance with ERISA regulation 29 C.F.R. § 2560.503-1(m)(8).

d. In conjunction with Your appeal, You or Your representative may submit written comments, documents, records and other information relating to Your claim to the Board of Trustees.

e. If You or Your authorized representative request to appear at the hearing before the Board of Trustees at the time Your appeal is filed, You will be notified of the time, date and place of the hearing by regular mail at the return address shown on Your request for review. You may be represented at the hearing before the Board of Trustees by an attorney or other representative of Your choice at Your cost and expense.

4. *Decision by the Board of Trustees or Designee*

a. Upon receipt of an appeal, the Board of Trustees or designee will review the claim de novo (meaning without deference to the decision). The Board of Trustees or designee will review all relevant information regardless of whether the information was submitted. If the appeal involves issues of medical judgment, the Board of Trustees or designee will consult a health care professional who has appropriate training and experience in the appropriate field of medicine. If the Board of Trustees or designee consult a medical or vocational expert, he/she will be identified regardless of whether the Board of Trustees or designee rely on his/her opinion. If the Board of Trustees or designee consults a health care professional, he/she will be different than the health care professional previously consulted and will not be a subordinate of the health care professional previously consulted.

b. A decision will be made by the Board of Trustees or designee at the Board of Trustees' next regularly scheduled meeting following receipt of the appeal unless the appeal is received less than thirty (30) days prior to such meeting. If this is the case, the Board of Trustees or designee will review the appeal not later than the date of the next Board of Trustees meeting. If, due to special circumstances, the Board of Trustees or designee require an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

c. The decision of the Board of Trustees or designee will be in writing and sent within five (5) days after the decision is reached.

d. If the Board of Trustees or designee deny Your appeal, the decision will include the following:

i. The specific reason(s) for the decision;

ii. Reference to the specific Plan provision(s) on which the denial is based;

iii. A statement that, upon written request, You will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to Your claim. Whether a document, record or other information is relevant to a claim will be determined in accordance with 29 C.F.R. § 2560.503-1(m)(8);

iv. A statement of Your right to bring a lawsuit for the benefit under ERISA; and

v. A statement that if the decision is based on an internal rule, guideline, protocol or other similar criterion, the internal rule, guideline, protocol or similar criterion will be described or provided to You free of charge upon request.

e. You are required to use the procedures set forth above before bringing a lawsuit for time loss benefits or waiver of health and welfare premiums under ERISA.

f. The Board of Trustees or designee has the full and exclusive authority to administer time loss claims and waiver of health and welfare claims, interpret the Active Employee Plan as it relates to time loss benefits and waiver of health and welfare premiums, determine eligibility for time loss benefits and waiver of health and welfare premiums and resolve all questions arising in the administration, interpretation and application of the Active Employee Plan that concerns time loss benefits and waiver of health and welfare premiums. The Board of Trustees' or designee's authority includes, but is not limited to:

i. The right to resolve all matters when review has been requested;

ii. The right to establish and enforce rules and procedures for the administration of time loss benefits and waiver of health and welfare premiums and any claim concerning time loss benefits and waiver of health and welfare premiums so long as the rules and procedures are consistent with ERISA;

iii. The right to construe and interpret the Active Employee Plan and determine eligibility for time loss benefits and waiver of health and welfare premiums; and

iv. The exercise of the aforementioned powers and authorities by the Board of Trustees or designee will be given the fullest deference allowed by law.

COORDINATION OF MEDICAL, DENTAL AND VISION BENEFITS

This Coordination of Medical, Dental and Vision Benefits section arises when You or a Dependent have health and welfare coverage under more than one health and welfare plan. When a husband and wife or Domestic Partners work, each may have a family health and welfare plan provided at his or her place of employment. If each spouse or Domestic Partner has a health and welfare plan for the other and/or for their children, questions arise as to which health and welfare plan should pay what amount in the event an Illness or Injury occurs. Coordination of benefits is a method for determining which health and welfare plan has primary responsibility to pay for benefits in a given situation and which health and welfare plan has secondary responsibility. Coordination of Benefits does not apply to prescription drug or time loss benefits.

Definitions

The following definitions apply to this section of the Benefit Booklet:

Plan - means any of the following coverages which provide benefit payments or services to an Employee, Dependent or Domestic Partner for Medical, Dental and/or Vision Benefits:

1. Group or blanket insurance (except student accident insurance);

2. Group BlueCross and/or BlueShield and other pre-payment coverage on a group basis, including HMOs;

3. Coverage under a labor-management trusted plan, a union welfare plan, an employer organization plan or an employee benefit plan;

4. Coverage under governmental plans, other than Medicaid, and any other coverage required or provided by law;

5. Group or individual "no fault" coverage; and

6. Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type Hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceed $100 per day.

Claimant - means the person for whom the claim for Medical, Dental and/or Vision Benefits is made.

Claim Period - means part or all of a calendar year during which the Employee, Dependent or Domestic Partner is covered by this Plan.

Covered Charge - means the Reasonable and Customary Charges for any Medically Necessary medical care, service or supply or preventive care, dental or vision benefit that is covered at least in part by any of the Plans involved during a Claim Period. Where a Plan provides Medical, Dental or Vision Benefits in the form of services or supplies rather than cash payments, the reasonable cash value of the service or supply during a Claim Period will also be considered a Covered Charge. The difference in cost of a private Hospital

room and a semi-private Hospital room is not considered a Covered Charge unless the Employee's, Dependent's or Domestic Partner's stay in a private Hospital room is considered Medically Necessary by at least one of the Plans involved.

Coordination of Benefits

If an Employee, Dependent or Domestic Partner is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pays.

1. The Primary Plan (which is the Plan that pays benefits first) pays all the benefits that would be payable under its terms in the absence of this provision.

2. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the Primary Plan will not exceed the greater of:

    a. 100% of the Covered Charge; or

    b. The amount of Covered Charge it would have paid had it been the Primary Plan.

If this Plan's payment obligation (as the Secondary Plan) for Covered Charges for an Illness, Injury or sickness would exceed $10,000, then it shall never pay more than the amount of money paid by the Primary Plan for the same Illness, Injury or sickness.

Order of Benefit Determination Rules

If the COB provision applies, the order of benefit determination rules set forth below control and determine which Plan is primary and which Plan(s) is secondary.

When another Plan does not have a COB provision, that Plan is the Primary Plan.

When another Plan does have a COB provision, the first of the following rules which apply determine which Plan is the Primary Plan:

1. If a Plan covers the Claimant as an Employee, member or non-Dependent, then that Plan is the Primary Plan;

2. If the Claimant is a Dependent child whose parents are not divorced or separated, then the Plan of the parent whose birthday is earlier in the calendar year is the Primary Plan except:

    a. If both parents' birthdays are on the same day, rule (4) below will apply.

    b. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a COB rule based on the gender of the parent, then that Plan's COB rule will determine which Plan is the Primary Plan.

3. If the Claimant is a Dependent child whose parents are divorced or separated, the following rules will apply:

    a. The Plan which covers a child as a Dependent of the parent who by court decree must provide health coverage will be the Primary Plan; and

    b. When there is no court decree that requires a parent to provide health coverage to a Dependent child, the following rules will apply:

        i. When a parent who has custody of a child has not remarried, that parent's Plan will be the Primary Plan; and

        ii. When a parent who has custody of a child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second and by the Plan of the parent without custody third.

4. If none of the above rules apply, the Plan that has covered the Claimant for the longest period of time will be the Primary Plan except when:

    a. One Plan covers the Claimant as a laid-off or retired Employee (or a Dependent of such Employee); and

    b. The other Plan includes this COB rule for laid-off or retired Employees (or is issued by a state that requires this COB rule by law) then the Plan that covers the Claimant as other than a laid-off or retired Employee (or Dependent of such an Employee) will pay first.

Right to Receive and Release Necessary Information

In order to receive benefits, the Claimant must give the Plan any information that is needed to coordinate benefits. This Plan may release to or collect from any other person or organization any needed information about the Claimant.

Facility of Payment

Any payment made by another Plan may include an amount that should have been paid by this Plan. If so, this Plan may pay that amount to the Plan that made the payment. That amount will then be treated as though it was a benefit paid by this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this Plan is more than should have been paid under this COB section, this Plan may recover the excess from one or more of the following:

1. Any person or organization to whom payment was made;
2. Any Plan or other organization that should have made payment; or

3. The Claimant.

If You, Your Dependent or Domestic Partner have other health and welfare coverage and this Plan is secondary, You will receive faster claims service if You submit the claim to the Primary Plan first and attach a copy of its explanation of benefits form and an itemized bill showing the services received to Your claims submission to this Plan.

SUBROGATION AND REIMBURSEMENT OBLIGATIONS

The following definitions apply to this section of the Benefit Booklet:

1. *Covered Person* - means an individual covered by this Plan as well as the estate, heirs, guardian and/or conservator of a Covered Person. Covered Person also includes any trust established for the purpose of receiving Recovery Funds and/or paying future income, care or medical expenses to or for a Covered Person as the result of a Third Party Claim.

2. *Recovery Funds* - means any amount recovered by or for a Covered Person from a Third Party as the result of a Third Party Claim.

3. *Third Party Claim* - means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action by or for a Covered Person against a Third Party (or any right to assert the foregoing) alleging or claiming the Third Party may be responsible (from a liability and/or financial standpoint) for the Injury or Illness of a Covered Person for which Covered Charges are paid or may be paid by the Trust.

4. *Third Party* - means any individual or entity who may be fully or partially responsible (from a liability and/or financial standpoint) for the Injury or Illness of a Covered Person for which Covered Charges are paid or may be paid by the Trust. Third Party includes an insurer of such individual or entity and includes all types of liability insurance as well as other forms of insurance (including insurance coverage of the Covered Person or a family member) that may pay money to or on behalf of a Covered Person including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection coverage and worker's compensation coverage.

Subrogation Rights

Upon payment of Covered Charges for an Injury or Illness of a Covered Person that are related to a Third Party Claim, the Trust and its Board of Trustees shall be subrogated to all a Covered Person's rights of recovery against the Third Party and the Covered Person shall do whatever is necessary to secure such rights and do nothing to prejudice them.

The Trust or its Board of Trustees may pursue the Third Party to recover the Covered Charges for an Injury or Illness that are paid or may be paid by the Trust that are related to the Third Party Claim in the Trust's name or in the name of a Covered Person. The Trust and its Board of Trustees are entitled to all subrogation rights and remedies of a Covered Person under common law and statutory law as well as under the Benefit Booklet.

Right of Recovery

In addition to the Trust's subrogation rights, the Trust and its Board of Trustees require the Covered Person and his/her attorney, if any, to protect the Trust's reimbursement rights. The following rules apply:

1. A Covered Person agrees to hold any Recovery Funds in a trust or escrow account for the Trust up to the amount of Covered Charges the Trust paid or may pay for his/her Injury or Illness that are related to the Third Party Claim. The Trust shall be paid first from the Recovery Funds.

2. A Covered Person grants the Trust an equitable lien and/or constructive trust to all Recovery Funds up to the amount of Covered Charges the Trust paid or may pay for his/her Injury or Illness that are related to the Third Party Claim. If the Covered Person is represented by an attorney, all Recovery Funds shall be deposited in the attorney's trust account. No portion of the Recovery Funds shall be paid to the Covered Person, the attorney or anyone other than the Trust until the Trust's right to reimbursement in paragraph (3) has been fully satisfied.

3. The Trust is entitled to a first priority recovery from the Recovery Funds for the full amount of Covered Charges it has paid or may pay for the Injury or Illness of a Covered Person that are related to the Third Party Claim. However, if the Covered Person has employed an attorney who assisted in obtaining the Recovery Funds, the Board of Trustees will allow no more than a 25 percent reduction in the repayment of Covered Charges. The repayment obligation exists regardless of whether: (i) a Covered Person has been made whole; (ii) the Third Party admits liability or asserts that a Covered Person is also at fault; (iii) a Covered Person only sought the recovery of non-economic damages; or (iv) a worker's compensation claim has been resolved through a disputed claims settlement where the parties agree the Injury or Illness is not work-related.

4. The Board of Trustees reject the make whole, collateral source and common fund theories and the Trust's rights shall not be affected by similar doctrines or rules, whether established at common law or statute, that would reduce the Trust's right to full recovery under this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet.

5. The Trust may require a Covered Person and his/her attorney to sign an agreement to abide by this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet as a prerequisite to paying for Covered Charges.

6. A Covered Person and his/her attorney shall do nothing to prejudice the Trust's right of recovery under this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet.

7. The Board of Trustees, in their discretion, may suspend payment or deny payment of Covered Charges for an Injury or Illness of a Covered Person related to the Third Party Claim if a Covered Person and/or his/her attorney fail to cooperate and/or perform all acts required by this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet or the Board of Trustees has a reasonable basis to believe a Covered Person and/or his/her attorney will not honor all of his/her obligations under this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet.

Additional Obligations of a Covered Person and Rights of the Trust and the Board of Trustees

In connection with the Trust's right to subrogation and reimbursement, a Covered Person shall do the following as applicable and agrees that the Trust and the Board of Trustees may do one or more of the following at the Board of Trustees' discretion:

1. If a Covered Person seeks payment for Covered Charges for an Injury or Illness for which there may be a Third Party Claim, he/she shall notify the Trust Office of the potential Third Party Claim. A Covered Person has this responsibility even if the first request for payment of Covered Charges is a bill or invoice submitted to the Trust by a Provider.

2. Upon request from the Trust Office, a Covered Person shall provide the Trust Office with all available information relating to the potential Third Party Claim.

3. A Covered Person shall immediately disclose to the Trust Office all Recovery Funds and all settlements of any kind that have been obtained that are related to the Third Party Claim.

4. By accepting payment of Covered Charges relating to an Injury or Illness for which there may be a Third Party Claim, a Covered Person agrees that the Trust and its Board of Trustees have the right to intervene in any lawsuit, mediation or arbitration filed by or on behalf of a Covered Person seeking Recovery Funds from a Third Party.

5. A Covered Person agrees that the Trust Office, Trust, Board of Trustees, or its representative may notify any Third Party or Third Party's representative or insurer of the Trust's recovery rights set forth in this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet.

6. This **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet applies regardless of whether a Covered Person's Injury or Illness for which there may be a Third Party Claim occurred before the Covered Person became enrolled in the Plan.

7. If any term, provision, agreement or condition of this **SUBROGATION AND REIMBURSEMENT OBLIGATIONS** section of the Benefit Booklet is held by a Court to be invalid or unenforceable, the remainder of the section shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

8. The Board of Trustees has the authority to compromise subrogation and reimbursement claims on a case by case basis depending on the facts and circumstances.

LEGAL RIGHTS, NOTICES AND DISCLOSURES

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require a Provider obtain authorization from the plan or the issuer for prescribing length of stay not in excess of 48 hours (or 96 hours).

Womens' Health & Cancer Rights Act

If following a mastectomy You elect breast reconstruction in connection with such mastectomy, the following charges will be covered:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce symmetric appearance; and

3. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation between You and Your attending Physician.

This benefit is subject to the annual Deductible and copayments.

Qualified Medical Child Support Orders

The Board of Trustees will recognize and be bound by Qualified Medical Child Support Orders. You may contact the Trust Office to obtain, without charge, the procedure the Board of Trustees will follow when a Medical Child Support Order is received.

Disclosure of Grandfathered Health Plan Status

The Active Employee Plan, the Providence Health Plan, the Kaiser Permanente Plan, and the Willamette Dental Plan are not grandfathered health plans under the Affordable Care Act.

State Benchmark Plan for determining Essential Health Benefits

The Board of Trustees has adopted the Utah benchmark plan for determining essential health benefits for the Active Employee Plan.

Notice Regarding Nondiscrimination and Accessibility Requirements

The Harrison Trust and the Active Employee Plan comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex, and do not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Harrison Trust and the Active Employee Plan provide free aids and services to people with disabilities to allow them to communicate effectively with the Trust Office, such as: qualified sign language interpreters; and written information in other formats (large print, audio, accessible electronic formats, and other formats). In addition, for people whose primary language is not English, the Harrison Trust and Active Employee Plan provide free language services, such as qualified interpreters and information written in other languages. If you need these services, contact the Harrison Trust at:

5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239
In Portland: (503) 224-0048, ext. 1679
Outside Portland: (800) 547-4457, ext. 1679

If You believe the Harrison Trust and Active Employee Plan have 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 civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through its Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail or telephone at:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 547-4457, ext. 1679.

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 547-4457, ext. 1679.

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 (800) 547-4457, ext. 1679.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 547-4457, ext. 1679.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 547-4457, ext. 1679 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (800) 547-4457, ext. 1679.

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。(800) 547-4457, ext. 1679 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 (800) 547-4457, ext. 1679.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (800) 547-4457, ext. 1679.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 547-4457, ext. 1679.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 547-4457, ext. 1679.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 547-4457, ext. 1679.

4457-547) 800(با .توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد, ext. 1679 تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 547-4457, ext. 1679.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 547-4457, ext. 1679.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 547-4457, ext. 1679.

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 547-4457, ext. 1679.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (800) 547-4457, ext. 1679 'ਤੇ ਕਾਲ ਕਰੋ।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 547-4457, ext. 1679.

Notice of Privacy Practices of the Harrison Trust and Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If You have health and welfare coverage provided by Providence, Kaiser, or Willamette Dental, these plans have their own notice of privacy practices to protect Your medical information.

This notice describes the legal obligations of the Plan and Your legal rights regarding Your Protected Health Information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Among other things, this notice describes how Your Protected Health Information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain medical information known as Protected Health Information. Generally, Protected Health Information is health information, including demographic information, collected from You or created or received by a Provider, a health care clearinghouse, a health plan, or this Plan, from which it is possible to individually identify You and that relates to:

- Your past, present, or future physical or mental health condition;
- The provision of health care to You; or
- The past, present, or future payment for health care services provided to You.

If You have any questions about this notice or about the Plan's privacy practices, please contact the Plan's HIPAA Client Service Representative whose address and telephone number are listed on page 138.

The Plan's Responsibilities

The Plan is required by law to:

- Maintain the privacy of Your Protected Health Information;
- Provide You with certain rights with respect to Your Protected Health Information;
- Give You this notice which describes the Plan's legal duties and privacy policies regarding Your Protected Health Information; and
- Follow the terms of this notice until modified.

The Board of Trustees reserves the right to change the terms of this notice and to make new provisions regarding the use and disclosure of Your Protected Health Information that the Plan maintains, as allowed or required by law. If there are material changes to this notice, You will be provided with a revised notice mailed to Your last known address.

How the Plan May Use and Disclose Protected Health Information about You

Under the law, the Plan may use and disclose Your Protected Health Information under certain circumstances without Your permission. The following paragraphs describe different ways the Plan may use and disclose Your Protected Health Information. Each paragraph will explain what is meant and may present examples. Not every use or disclosure in a paragraph will be listed. However, all of the ways the Plan is permitted to use and disclose Your Protected Health Information will fall within one (1) of these paragraphs.

1. *To Make or Obtain Payment*. The Plan may use and disclose Your Protected Health Information to determine Your eligibility for benefits, to facilitate payment for the treatment and services You receive from Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell Providers about Your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary, or to determine whether the Plan will cover the treatment. The Plan may share Your Protected Health Information with a utilization review or precertification service provider. The Plan may also share Your Protected Health Information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

2. *To Facilitate Treatment*. The Plan may use and disclose Your Protected Health Information to facilitate treatment or services by Providers. The Plan may provide medical information about You to Providers, including Doctors, nurses, and hospital personnel who are involved in Your care. For example, the Plan may disclose Protected Health Information about You to Providers who are treating You.

3. *For Health Care Operations*. The Plan may use and disclose Your Protected Health Information to facilitate the administration of the Plan. These uses and disclosures are necessary to run the Plan. Health care operations include activities such as:

    a. Quality assessment and improvement activities;

    b. Activities designed to improve health or reduce health care costs;

    c. Clinical guideline and protocol development, case management and care coordination;

    d. Contacting Providers and participants with information about treatment alternatives and other related functions;

    e. Health care professional competence or qualification review and performance evaluation;

    f. Accreditation, certification, licensing and credentialing activities;

    g. Underwriting, including stop-loss underwriting, premium rating and related functions to create, renew or replace health insurance or health benefits. However, Your genetic information will not be used for underwriting purposes;

h. Review and auditing, including compliance reviews, medical reviews, legal services, fraud and abuse detection and compliance programs;

i. Business planning and development, including cost management and planning related to analyses and formulary development; and

j. Business management and general administration activities of the Plan, including customer service and resolution of appeals and grievances.

4. *When Required by Law*. The Plan will disclose Protected Health Information about You when required to do so by federal, state or local law. For example, the Plan may disclose Protected Health Information when required by a court order in a lawsuit such as a medical malpractice case.

5. *To Avert a Serious Threat to Health or Safety*. The Plan may use and disclose Protected Health Information about You when necessary to prevent a serious threat to Your health and safety, to the health and safety of the public or another person. Any disclosure, however, will only be made to someone able to help prevent the threat. For example, the Plan may disclose Protected Health Information about You in a proceeding regarding the licensure of a physician.

6. *Military.* If You are a member of the armed forces, the Plan may disclose Protected Health Information about You as required by military command authorities. The Plan may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.

7. *For Treatment Alternatives*. The Plan may use and disclose Your Protected Health Information to send You information about or recommend possible treatment options or alternatives that may be of interest to You.

8. *For Disclosure to the Board of Trustees*. The Plan may disclose Your Protected Health Information to another health plan maintained by the Harrison Trust or to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Plan. In addition, the Plan may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan may also disclose to the Board of Trustees information whether You are participating in the Plan. Your Protected Health Information cannot be used for employment purposes without Your specific authorization.

9. *Spouse, Family Members, and Close Personal Friends.* The Plan may make Your Protected Health Information known to a spouse, family member, or close personal friend. Disclosure of Your Protected Health Information will be determined based on how involved the person is in Your health care or payment of Your health claims. For example, the Plan will normally provide information to a spouse or family member confirming eligibility for health coverage or if a health claim was paid but not the specific treatment or diagnosis or the reason the Provider was consulted. The Plan may release Protected Health Information to parents or guardians, if allowed by law. If You are not present or able to agree to these disclosures of Your Protected Health Information, the Plan, through the Trust Office or Board of Trustees, may use professional judgment to determine whether the disclosure is in Your best interest. If You do

not want Your Protected Health Information disclosed to a spouse, family member, or close personal friend as outlined in this paragraph, You must notify the Plan as described in the Right to Request Restrictions section on page 135.

With only limited exceptions, the Plan will send all mail to the Employee. This includes mail related to the Employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the Employee, spouse, and other family members and information on the denial of any Plan benefits involving the Employee, spouse, and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications and the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

10. *Personal Representative*. The Plan will disclose Your Protected Health Information to individuals authorized by You, or to an individual designated as Your personal representative, attorney-in-fact, etc., so long as You provide written notice/authorization and any supporting documents (for example, power of attorney). Even if You designate a personal representative, federal law permits the Plan to elect not to treat the person as Your personal representative if the Plan has a reasonable belief that:

    a. You have been, or may be, subject to domestic violence, abuse or neglect by such person;

    b. Treating such a person as Your personal representative could endanger You; or

    c. Plan representatives determine, in their professional judgment, that it is not in Your best interest to treat the person as Your personal representative.

11. *Business Associates*. The Plan contracts with business associates who perform various services for the Plan. For example, the Trust Office handles many functions in connection with the operation of the Plan. To perform these functions, or provide the services, the Plan's business associates may receive, create, maintain, transmit, use or disclose Your Protected Health Information, but only after agreeing, in writing, to implement appropriate safeguards concerning Your Protected Health Information. For example, the Plan may disclose Your Protected Health Information to a business associate to process Your medical claims for payment or to provide utilization management or pharmacy benefit management services but only after the business associate enters into a business associate contract with the Harrison Trust.

12. *Other Covered Entities*. The Plan may use or disclose Your Protected Health Information to assist Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose Your Protected Health Information to a Provider when needed by the Provider to render treatment to You or the Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.

13. *To Conduct Health Oversight Activities*. The Plan may disclose Your Protected Health Information to a health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. These

activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

14. *Legal Proceedings*. If You are involved in a lawsuit or a dispute, the Plan may disclose Your Protected Health Information in response to a court or administrative order. The Plan may also disclose Your Protected Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the legal dispute, but only if efforts have been made to tell You about the request or to obtain a court or administrative order protecting the information requested.

15. *Law Enforcement*. The Plan may disclose Your Protected Health Information to law enforcement officials if asked to do so. Some of the reasons for such a disclosure include, but are not limited to:

    a. It is required by law or some other legal process;

    b. Locate or identify a suspect, fugitive, material witness or missing person;

    c. A death believed to be the result of criminal conduct; or

    d. It is necessary to provide evidence of a crime that occurred.

16. *National Security and Intelligence*. The Plan may disclose Your Protected Health Information to authorized federal officials to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.

17. *Research*. The Plan may disclose Your Protected Health Information to researchers when:

    a. The individual identifiers have been removed; or

    b. When the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approved the research.

18. *Inmates*. If You are an inmate in a correctional institution, the Plan may disclose Your Protected Health Information to the correctional institution or to a law enforcement official for:

    a. The institution to provide health care to You;

    b. Your health and safety and the health and safety of others; or

    c. The safety and security of the correctional institution.

19. *Coroners, Medical Examiners, and Funeral Directors.* The Plan may disclose Your Protected Health Information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan may disclose information to funeral directors so they may carry out their duties.

20. *Organ and Tissue Donation.* If You are an organ or tissue donor, the Plan may disclose Protected Health Information after Your death to organizations that handle organ, eye or tissue donation and transplantation or to an organ or tissue donation bank.

21. *Workers' Compensation*. The Plan may disclose Your Protected Health Information for workers' compensation or similar programs but only as authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs that provide benefits for work-related Injuries or Illnesses.

22. *Disclosures to the Secretary of the U.S. Department of Health and Human Services*. The Plan is required to disclose Your Protected Health Information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

23. *Public Health Risks*. The Plan may disclose Your Protected Health Information for public health activities. These activities generally include the following:

    a. To prevent or control disease, Injury or disability;

    b. To report births and deaths;

    c. To report child abuse or neglect;

    d. To report reactions to medications or problems with products;

    e. To notify people of recalls of products they may be using;

    f. To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and

    g. To notify the appropriate governmental authority if the Plan believe that a person has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if You agree, or when required or authorized by law.

24. *Disclosures to the Centers for Medicaid and Medicare Services.* The Plan may disclose Your Protected Health Information, as permitted by federal regulations, to the Centers for Medicaid and Medicare Services, in order to comply with mandatory Medicare coordination of benefit requirements. The Plan may share required data, including health information, with the Centers for Medicaid and Medicare Services and state Medicaid agencies.

25. *Disclosures to You*. At Your request, the Plan is required to disclose the portion of Your Protected Health Information that contains medical records, billing records and other records used to make decisions regarding Your health care benefits. The Plan is also required, when requested, to provide You with an accounting of most disclosures of Your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations and if the Protected Health Information was not disclosed pursuant to Your authorization.

Authorization to Use or Disclose Your Protected Health Information

Other uses or disclosures of Your Protected Health Information not described above will only be made with Your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose Your psychiatric notes; will not use or disclose Your Protected Health Information for marketing purposes; and the Plan will not sell Your Protected Health Information, unless You give the Plan written authorization. You may revoke written authorization at any time so long as the revocation is in writing. Once the Plan receives Your written revocation, it will only be effective for further uses and disclosures. It will not be effective for any Protected Health Information that may have been used or disclosed in reliance upon the written authorization prior to receiving Your written revocation.

Minimum Necessary Disclosure of Protected Health Information

The amount of Protected Health Information the Plan will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

Potential Impact of State Laws

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example, the Plan will follow more stringent state privacy laws that relate to use and disclosure of Protected Health Information concerning HIV or AIDS, mental health, substance abuse, chemical dependency, genetic testing, reproduction rights, and so on.

Your Rights with Respect to Your Protected Health Information

You have the following rights regarding Your Protected Health Information that the Plan maintains:

1. *Right to Request Restrictions*. You have the right to request restrictions or limitations on the Protected Health Information the Plan uses or discloses about You for treatment, payment or health care operations. You also have the right to request a limit on Your Protected Health Information that the Plan discloses to someone involved in Your care or the payment for Your care such as a family member or friend. For example, You could ask that the Plan not use or disclose information about a surgery You had.

   Except as provided in the next paragraph, the Plan is not required to agree to Your request. However, if the Plan does agree to the request, it will honor the restriction until You revoke it or the Plan notifies You.

   The Plan will comply with any restriction request if: except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for the purpose of carrying out treatment); and the Protected Health Information pertains solely to a health care item or service for which the Provider involved has been paid in full by You or someone else.

To request restrictions, You must make Your request in writing to the HIPAA Client Service Representative for the Harrison Trust at the address on page 138. In Your written request, You must tell the Plan:

a. What Protected Health Information You want to limit;

b. Whether You want to limit the Plan's use, disclosure or both; and

c. To whom You want the limits to apply, for example, non-disclosure to Your spouse.

2. *Right to Request Confidential Communications*. You have the right to request that the Plan communicate with You about health matters in a certain way or in a certain location. For example, You may ask that the Plan communicate with You only at a certain post office box, telephone number or by email.

   To request confidential communications, You must make Your request in writing to the HIPAA Client Service Representative for the Harrison Trust at the address on page 138. The Plan will not ask You the reason for the request. Your written request must specify how or where You wish to receive confidential communications. The Plan will accommodate all reasonable requests.

3. *Right to Inspect and Copy Your Protected Health Information*. You have the right to inspect and copy Your Protected Health Information that may be used to make decisions about Your Plan benefits. If the Protected Health Information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the Protected Health Information can be readily produced in that form and format. If the Protected Health Information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If the Plan cannot agree on an electronic form and format, it will provide You with a paper copy. A request to inspect and copy records containing Your Protected Health Information must be made in writing to the HIPAA Client Service Representative for the Harrison Trust at the address on page 138. If You request a copy of Your Protected Health Information, the Plan may charge a reasonable fee for copying, mailing, or other supplies associated with the request.

4. *Right to Amend Your Protected Health Information*. If You believe that Your Protected Health Information maintained by the Plan is inaccurate or incomplete, You may request that the Plan amend Your Protected Health Information. The request may be made as long as the Protected Health Information is maintained by the Plan.

   A request for an amendment of Protected Health Information records must be made in writing to the HIPAA Client Service Representative for the Harrison Trust at the address on page 138 and must provide a reason for the request.

   The Plan may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny Your request if You ask the Plan to amend Protected Health Information that: is not part of the Protected Health Information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the Protected Health Information is no longer available to make the amendment; is not part of

the Protected Health Information that You would be permitted to inspect and copy; or is already accurate and complete. If the Plan denies Your request, You have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed Protected Health Information will include Your statement.

5. *Right to an Accounting of Disclosures*. You have the right to request an accounting of certain disclosures of Your Protected Health Information that were made contrary to the Notice of Privacy Practices and/or the HIPAA Privacy Rule. The accounting will not include: disclosures for purposes of treatment, payment or health care operations; disclosures made to You; disclosures made pursuant to Your authorization; disclosures made to friends or family members in Your presence or because of an emergency; disclosures for national security purposes; and disclosures incidental to otherwise permissible disclosures.

   The request for an accounting must be made in writing to the HIPAA Client Service Representative for the Harrison Trust at the address on page 138. The accounting request should specify the time period You are requesting the accounting. Accounting requests may not be made for periods of time going back more than six years from the date of the request. Your request should state the form You want the list of disclosures (for example, paper or electronic). The Plan will provide the first accounting You request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform You of the fee in advance.

6. *Right to be Notified of a Breach*. You have the right to be notified in the event that the Plan, or a business associate, discovers a breach of Your unsecured Protected Health Information.

7. *Right to a Paper Copy of the Plan's Privacy Notice*. You have a right to a paper copy of the Plan's Privacy Practices. You may ask the Plan to give You a copy of this notice at any time. To receive a paper copy, please contact the HIPAA Client Service Representative for the Harrison Trust at the address on page 138.

Complaints

If You believe that Your privacy rights have been violated, You may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, You should notify the HIPAA Client Service Representative for the Harrison Trust, in writing, at the address on page 138. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.

HIPAA Client Service Representative

The Plan has designated the Harrison Trust's Client Service Representative to answer all questions and respond to all issues regarding this notice and Your privacy rights. You may contact this person at:

Harrison Electrical Workers Trust Fund
Attention: HIPAA Client Service Representative
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239
(503) 224-0048, ext. 1679
(800) 547-4457, ext. 1679

If You have any questions regarding this notice, please contact the Harrison Trust's HIPAA Client Service Representative.

Disclosure of Protected Health Information to the Board of Trustees

The Harrison Trust and the Plan may disclose Your Protected Health Information to the Board of Trustees subject to the terms and conditions set forth below:

1. *Disclosure of Protected Health Information to the Board of Trustees.* Unless otherwise permitted by law, the Harrison Trust, Plan and any health insurance issuer or business associate providing services to the Harrison Trust and/or Plan will only disclose Your Protected Health Information to the Board of Trustees to the extent necessary to permit the Board of Trustees to carry out Plan administrative functions consistent with the applicable provisions of HIPAA and its regulations. Any disclosure to or use by the Board of Trustees of Your Protected Health Information will be subject to and consistent with the provisions of sections 2 and 3 below.

2. *Board of Trustees' Obligations Regarding Protected Health Information.* The Board of Trustees will:

    a. **Prohibit Unauthorized Use or Disclosure of Health Information.** Neither use nor disclose Your Protected Health Information except as permitted by the Plan Document and Benefit Booklet for the Plan as amended from time to time or required by law.

    b. **Subcontractors and Agents.** Ensure that any third party or agent to whom the Board of Trustees provides Your Protected Health Information received from the Harrison Trust and/or Plan agrees to the restrictions and conditions in the Plan Document and Benefit Booklet for the Plan, including this section, with respect to Your Protected Health Information.

    c. **Permitted Purposes.** Neither use nor disclose Your Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.

d. **Reporting.** Report to the Plan any use or disclosure of Your Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan Document and Benefit Booklet for the Plan promptly upon learning of such inconsistent use or disclosure.

e. **Access to Your Health Information.** Make Your Protected Health Information available to You in accordance with 45 C.F.R. § 164.524.

f. **Amendment of Health Information.** Make Your Protected Health Information available for amendment and, upon request, amend Your Protected Health Information in accordance with 45 C.F.R. § 164.526.

g. **Accounting of Health Information Disclosures.** Track disclosures of Your Protected Health Information so that an accounting of disclosures can be made to You in accordance with 45 C.F.R. § 164.528.

h. **Disclosure to Governmental Agencies.** Make the Harrison Trust's and Plan's internal practices, books and records relating to the use and disclosure of Your Protected Health Information available to the US Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-164.

i. **Return or Destruction of Health Information.** When Your Protected Health Information is no longer needed for the purpose for which use or disclosure was made, each Trustee must, if feasible, return to the Plan, or destroy, all Protected Health Information that he received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Trustee agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j. **Minimum Necessary Requests.** The Board of Trustees will use its best efforts to request only the minimum necessary type and amount of Your Protected Health Information to carry out the functions for which the information is requested.

3. *Board of Trustees' Obligations Regarding Electronic Health Information.* The Board of Trustees agrees that if it creates, receives, maintains or transmits any electronic health information (other than enrollment/disenrollment information and summary health information that are not subject to these restrictions) on behalf of the Harrison Trust and/or Plan concerning You, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic health information.

The Board of Trustees will ensure that any third party or agents to whom it provides such electronic health information agree to implement reasonable and appropriate security measures to protect this information.

The Board of Trustees will report to the Plan any security incident, as defined in 45 C.F.R. § 164.304, that results in unauthorized access, use, disclosure, modification or destruction of the Harrison Trust's or Plan's electronic health information of which it becomes aware within a

reasonable period of time. The Board of Trustees will also report to the Harrison Trust and Plan any other security incident on an aggregate basis every year, or more frequently based upon the Harrison Trust's or Plan's written request.

4. *Adequate Separation between the Board of Trustees, the Harrison Trust and the Plan.* The Board of Trustees represents that adequate separation exists between the Harrison Trust and the Plan and the Board of Trustees so that Protected Health Information will be used only for Plan administration purposes.

   The following persons or organizations that have a contractual arrangement with the Harrison Trust or Board of Trustees may receive Your Protected Health Information relating to payment, health care operations or other matters pertaining to the Plan:

   a. Employees of the Trust Office; and

   b. Business associates of the Harrison Trust and Plan and business associates' employees, officers, directors, agents and subcontractors provided the business associate has signed a business associate agreement.

   The persons and organizations identified above will have access to Your Protected Health Information only to perform Plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of their contracts, for any use or disclosure of Your Protected Health Information that violates the business associate agreement.

   The Board of Trustees will ensure that the provisions of this section 4 are supported by reasonable and appropriate security measures to the extent that the persons or organizations identified above have access to Your electronic health information.

5. *Reports of Non-Compliance.* Anyone who suspects an improper use or disclosure of Protected Health Information may report the occurrence to the Plan's representative at the following address and telephone number:

   Client Service Representative
   Harrison Electrical Workers Trust Fund
   5331 S Macadam Avenue
   Suite 258, PMB #116
   Portland, OR 97239
   In Portland: (503) 224-0048, ext. 1679
   Outside Portland: (800) 547-4457, ext. 1679

6. *Making Requests.* Requests to inspect and copy, to correct or amend and for an accounting of Your Protected Health Information should be made in writing to:

Client Service Representative
Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

7. *Certificate by the Board of Trustees.* The Harrison Trust, the Plan, any health insurance issuer and HMO will disclose Protected Health Information to the Board of Trustees only upon the receipt of a certificate from the Board of Trustees that the Plan Document has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the Board of Trustees agrees to the conditions of disclosure set forth in section 2 on page 138.

HEALTH AND WELFARE PLAN FOR EARLY RETIREES AND THEIR DEPENDENTS

The Board of Trustees offers a separate health and welfare plan (Early Retiree Plan) that provides medical, prescription drug, dental and vision benefits to eligible early retirees between ages sixty (60) and sixty-five (65) and their Dependents provided certain eligibility criteria are met.

In order to be eligible for the Early Retiree Plan, an early retiree must satisfy all the requirements of Test I, Test II or Test III.

Test I

1. You must be between the ages of sixty (60) and sixty-five (65).

2. You must be retired and not receiving any compensation or working in any capacity in the Electrical Industry or an Organization Affiliated with the Electrical Industry.

3. If You worked under the terms of a collective bargaining agreement, You must have applied for and be qualified to receive a pension from a Pension Plan sponsored by a Local Union affiliated with the I.B.E.W.

4. You must have had fifteen (15) or more years of verifiable employment in the Electrical Industry and/or Organization Affiliated with the Electrical Industry anywhere in the United States.

5. Within the one-hundred eighty (180) Months immediately preceding Your application for the Early Retiree Plan, You must have had one-hundred twenty (120) or more Months of health and welfare coverage provided through the Harrison Trust. The one-hundred twenty (120) Month requirement can be met through employer contributions, self-payments and COBRA payments.

6. Your Months of Harrison Trust coverage needed to qualify for the Early Retiree Plan in paragraph 5 will be forfeited on the day You work in Restricted Non-Covered Employment in the Electrical Industry.

7. You must meet one of the following criteria concerning work for employers who contribute to the Early Retiree Plan:

    a. **Employees who work under the Local 48 Commercial Wireman's Agreement.** Between January 1, 1992 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

    b. **Employees who work under the Local 280 Commercial Wireman's Agreement.** Between January 1, 1999 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early

Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

c. **Employees who work under the Local 659 Commercial Wireman's Agreement.** Between July 1, 1992 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

d. **Employees who work under the Local 932 Commercial Wireman's Agreement.** Between January 1, 1994 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

e. **Employees who worked under the Local 970 Commercial Wireman's Agreement.** Between January 1, 1996 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

f. **Employees who work under the Local 48 Residential Wireman's Agreement.** Between January 1, 1993 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

g. **Employees who work under the Local 932 Residential Wireman's Agreement.** Between January 1, 2000 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

h. **Employees who work under the Local 48 or Local 970 Sound and Communication Agreement.** Between January 1, 2001 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been

worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

i. **Employees who work under the Local 932 Sound and Communication Agreement.** Between January 1, 2002 and the date You apply for the Early Retiree Plan, 70% or more of the hours reported to the Harrison Trust on Your behalf must have been worked under collective bargaining agreements that required employer contributions to the Early Retiree Plan. Reciprocity dollars remitted to the Harrison Trust will count toward the 70% requirement if sufficient money was reciprocated to the Harrison Trust to fund the employer contribution to the Early Retiree Plan.

j. If You worked for I.B.E.W. Local 48, 280, 659, 932 or 970, the Local Union made contributions on Your behalf to the Harrison Trust.

k. If You worked for an Organization Affiliated with the Electrical Industry in the geographic area covered by I.B.E.W. Local 48, 280, 659, 932 or 970, the Organization Affiliated with the Electrical Industry made contributions on Your behalf to the Harrison Trust.

l. If You worked under a Category II Agreement, Your employer made contributions on Your behalf to the Harrison Trust.

8. Within sixty (60) Months immediately preceding Your application for the Early Retiree Plan, You must have had thirty (30) or more Months of health and welfare coverage provided through the Harrison Trust. The thirty (30) Month requirement can be met through employer contributions and self-payments.

Test II

1. You meet the criteria in paragraphs 1, 2, 3, 6 and 7 detailed in Test I above.

2. You have twenty-five (25) or more years of verifiable employment in the Electrical Industry and/or an Organization Affiliated with the Electrical Industry within the geographic area covered by I.B.E.W. Locals 48, 280, 659 and 932.

3. Within three-hundred (300) Months (25 years) immediately preceding Your application for the Early Retiree Plan, You must have had one-hundred eighty (180) or more Months (15 years) of health and welfare coverage provided through the Harrison Trust. The one-hundred eighty (180) Month requirement can be met through employer contributions, self-payments and COBRA payments.

4. Within the one-hundred twenty (120) Months immediately preceding Your application for the Early Retiree Plan, You must have had sixty (60) or more Months of health and welfare coverage provided through the Harrison Trust. The sixty (60) Month requirement can be met through employer contributions and self-payments.

The Months of Harrison Trust coverage in paragraphs 3 and 4 needed to qualify for the Early Retiree Plan will be forfeited on the day You work in Restricted Non-Covered Employment in the Electrical Industry.

If You have questions regarding the eligibility criteria concerning the Early Retiree Plan, contact the Trust Office.

Test III

1. You meet the criteria in paragraphs 1, 2, 3, 6 and 7 detailed in Test I above.

2. You have forty (40) or more years of verifiable employment in the Electrical Industry and/or for an Organization Affiliated with the Electrical Industry within the geographic area covered by I.B.E.W. locals 48, 280, 659 and 932.

3. Within the forty (40) years immediately preceding Your enrollment in the Early Retiree Plan, You must have had one hundred eighty (180) or more Months of health and welfare coverage provided through the Harrison Trust. The one hundred eighty (180) Month requirement can be met through Employer Contributions, self-payments, COBRA payments, and/or reciprocity dollars remitted to the Harrison Trust.

4. Within sixty (60) Months immediately preceding Your enrollment in the Early Retiree Plan, You must have had thirty (30) or more Months of health and welfare coverage provided through the Harrison Trust. The thirty (30) Month requirement can be met through Employer Contributions, self-payments, COBRA payments, and/or reciprocity dollars remitted to the Harrison Trust.

   OR

   Within one hundred twenty (120) Months immediately preceding Your enrollment in the Early Retiree Plan, You must have had sixty (60) or more Months of health and welfare coverage provided through the Harrison Trust. The sixty (60) Month requirement can be met through Employer Contributions, self-payments, COBRA payments, and/or reciprocity dollars remitted to the Harrison Trust.

AMENDMENT AND TERMINATION

Plan Amendments and Restatements

The Benefit Booklet may be amended or restated from time to time by the Board of Trustees in accordance with the voting procedures in the Trust Agreement for the Harrison Trust. None of the provisions in the Benefit Booklet are vested.

Plan Termination

The Board of Trustees may terminate the Plan in accordance with the terms and the voting procedures in the Trust Agreement for the Harrison Trust.

SUMMARY PLAN DESCRIPTION

This summary is a general explanation of certain terms of the Plan and other legal instruments, and is not intended to modify or change them in any manner. The rights and duties of all persons connected with the Plan are set forth in those instruments, which may be inspected at the Trust Office.

Name of Plan

Harrison Electrical Workers Trust Fund - Active Employee Plan.

Effective Date

September 1, 2016

Plan Sponsor

Board of Trustees of the Harrison Electrical Workers Trust Fund
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239
In Portland: (503) 224-0048, ext. 1679
Outside Portland: (800) 547-4457, ext. 1679

Employer and Plan Identification Numbers

Employer Identification Number: 93-6023048
Plan Identification Number: 501

Type of Plan

This Plan is a health and welfare benefit plan.

Trust Office

This Plan is administered by the Board of Trustees of the Harrison Electrical Workers Trust Fund, with the assistance of BeneSys, Inc., a contract administration organization whose address and telephone number are:

BeneSys, Inc.
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239
In Portland: (503) 224-0048 ext. 1679
Outside Portland: (800) 464-0292 ext. 1679

Agent for Legal Service

Lee Centrone
BeneSys, Inc.
5331 S Macadam Avenue, Suite 220
Portland, OR 97239

Service of legal process may also be made upon a member of the Board of Trustees or the Trust Office.

Board of Trustees

EMPLOYER TRUSTEES	LABOR ORGANIZATION TRUSTEES
Timothy Gauthier Oregon-Columbia Chapter NECA 601 NE Everett Portland, OR 97232	Garth Bachman I.B.E.W. Local No. 48 15937 NE Airport Way Portland OR 97230
Todd Mustard (First Alternate) Oregon-Columbia Chapter NECA 601 NE Everett Portland, OR 97232	Diana Winther (First Alternate) I.B.E.W. Local No. 48 15937 NE Airport Way Portland OR 97230
Patrick Maloney (Second Alternate) Tice Electric Company 5405 North Lagoon Avenue Portland OR 97217	Trillium Ward (Second Alternate) I.B.E.W. Local 48 15937 NE Airport Way Portland, OR 97230

Description of Collective Bargaining Agreements

This Plan is maintained pursuant to the terms of collective bargaining agreements between the Oregon-Columbia Chapter and Oregon-Pacific Cascade Chapter of the National Electrical Contractors Association and International Brotherhood of Electrical Workers, Local Nos. 48, 280, 659, and 932 and other employers signatory to collective bargaining agreements with I.B.E.W. local unions who have been accepted by the Board of Trustees as participating employers. The collective bargaining agreements provide that employers will make the required contributions to the Harrison Electrical Workers Trust Fund for the purpose of enabling Employees working under the collective bargaining agreements to receive the benefits provided by the Harrison Electrical Workers Trust Fund. The contribution rate is specified in the collective bargaining agreements. Copies of the collective bargaining agreements can be obtained from the Oregon-Columbia Chapter and the Oregon-Pacific Cascade Chapter of the National Electrical Contractors Association and I.B.E.W. Local Nos. 48, 280, 659, and 932.

A complete list of employers contributing to the Harrison Electrical Workers Trust Fund may be obtained upon written request to the Board of Trustees and is available for examination during regular office hours at the Trust Office.

Plan Benefits

This Plan provides time loss benefits, accidental death and dismemberment benefits and life insurance benefits for Employees only, and medical, prescription, dental, and vision benefits for Employees and Dependents.

Your coverage will depend on the Plan You select.

Benefits, Eligibility and Termination of Eligibility

This Plan Document and Benefit Booklet describes benefits, eligibility and termination of eligibility requirements under the Active Employee Plan. If at any time You are unable to locate Your Benefit Booklet, an additional copy may be obtained from the Trust Office:

BeneSys, Inc.
5331 S Macadam Avenue
Suite 258, PMB #116
Portland, OR 97239

Source of Contributions

This Plan is funded through employer contributions, the amount of which is specified in the collective bargaining agreements or, in the case of Category II Agreements, the amount that is specified by the Board of Trustees. Also, self-payments by Employees and Dependents are permitted as outlined on page 4. The amount of self-payments is fixed from time to time by the Board of Trustees.

Organizations Providing Benefits, Funding Media and Type of Administration

The names and addresses of all of the organizations providing benefits and their roles (i.e., whether they are responsible for the administration of the Plan and whether the benefit is payable under an insurance policy) are set forth below.

Medical, Dental, And Time Loss Benefits Under the Active Employee Plan

Claims arising from the Active Employee Plan for medical and dental benefits for Employees and Dependents and the time loss benefits for Employees are paid directly from Harrison Trust assets.

Preferred Provider Organizations

The Harrison Trust has entered into contracts with Preferred Provider organizations that can be used by Employees and Dependents enrolled in the Active Employee Plan for Medical Benefits. The Harrison Trust is responsible for paying claims submitted by Providers, clinics and Hospitals. The Preferred Provider

organizations are responsible for the administration of contracts with Providers, clinics and Hospitals. The Preferred Provider organizations are:

Providence Preferred PPO Network
3601 SW Murray Blvd., Suite 100
Beaverton, OR 97006
(800) 793-9338

Multiplan Preferred Provider Network
115 Fifth Avenue
New York NY 10003
(800) 546-3887

Case Management, Utilization Review, Disease Management and Nurse Help Line

The Harrison Trust has entered into a contract with a company that provides case management, utilization review, disease management and nurse help line services for Employees and Dependents enrolled in the Active Employee Plan for Medical Coverage. The Harrison Trust pays the company a fee for the services it provides. The company providing these services is:

Innovative Care Management, Inc.
P.O. Box 22386
Portland, OR 97269
(503) 654-9447
(800) 862-3338

Health Maintenance Organizations/Alternate Health Plans

Employees and Dependents have the option of selecting medical and prescription drug coverage from a health maintenance organizations (Kaiser Permanente) or a health insurance plan (Providence Health Plan). The medical and prescription drug benefits are insured and provided under contracts between the Harrison Trust and Providence Health Plan and the Kaiser Permanente Foundation Health Plan. Providence Health Plan and the Kaiser Permanente Foundation Health Plan are responsible for administering their plans and paying the claims.

Kaiser Permanente Foundation Health Plan
500 NE Multnomah Street, Suite 100
Portland, OR 97232
(503) 813-2000; or
(800) 813-2000

Providence Health Plan
P.O. Box 139
Portland, OR 97207
(503) 574-7500; or
(800) 578-0481

Prescription Drug Program

The Active Employee Plan's prescription drug program for Employees and Dependents is provided by Providence Health Plan. The Harrison Trust is responsible for paying the prescription drug claims. A fee is paid to Providence Health Plan for administering the prescription drug program.

Providence Health Plan
P.O. Box 3125
Portland, OR 97208-3125
(877) 216-3644

Mail Order Prescription Drug Program

The mail order prescription drug program for Employees and Dependents is arranged by Providence Health Plan. The Harrison Trust is responsible for paying the mail order prescription drug claims. A fee is paid to Providence Health Plan for administering the program. The mail order pharmacies are:

Postal Prescription Services
P.O. Box 2718
Portland, OR 97208
(800) 552-6694

Walgreens Mail Service
P.O. Box 29061
Phoenix, AZ 85038
(800) 635-3070

Specialty Pharmacy Program

The Specialty Pharmacy Program for Employees and Dependents is arranged by Providence Health Plan. The Harrison Trust is responsible for paying the specialty pharmacy drug claims. A fee is paid to Providence Health Plan for administering the program. The specialty pharmacy is:

Credena Health
6348 NE Halsey Street, Suite A
Portland, OR 97213
(503) 962-1700

Vision Plan

Vision benefits are provided for Employees and Dependents enrolled in the Active Employee Plan and Providence Health Plan by Vision Service Plan. The Harrison Trust is responsible for paying the claims. A fee is paid to Vision Service Plan for administering the vision program.

Vision Service Plan
PO Box 997100
Sacramento, CA 95899
(800) 877-7195

Life and Accidental Death and Dismemberment Insurance

The life and accidental death and dismemberment insurance benefits for Employees are provided by Standard Insurance Company. The benefits are provided and insured under group contracts between the

Harrison Trust and Standard Insurance Company. Standard Insurance Company is responsible for administering the programs and paying the claims.

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204
(800) 628-8600

Employee Assistance Program

Employees and Dependents have access to an employee assistance program provided by Cascade Centers, Inc. A fee is paid by the Harrison Trust to Cascade Centers, Inc. for administering the Employee Assistance Program.

Cascade Centers, Inc.
7180 SW Fir Loop, Suite 1A
Portland, OR 97223
(800) 433-2320

Dental Plans

Employees and Dependents have the option of selecting dental coverage from the Active Employee Plan which pays claims out of Harrison Trust assets, from Kaiser Permanente or Willamette Dental. The dental benefits provided by Kaiser Permanente and Willamette Dental are insured and provided under contracts between the Harrison Trust and Kaiser Permanente and Willamette Dental. Kaiser Permanente and Willamette Dental are responsible for administering their dental programs and paying the claims.

Kaiser Permanente Foundation Health Plan
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Willamette Dental Management Corporation dba
Willamette Dental
6950 NE Campus Way
Hillsboro, OR 97124
(503) 644-6444; or
(800) 460-7644

Plan Year

The Plan Year begins each January 1 and ends the following December 31.

Plan Termination

Should this Plan terminate for any reason, all money and assets remaining in the Plan, after the payment of expenses, will be used for the continuance of the benefits provided by the then existing benefit Plans,

until such money and assets have been exhausted, unless some other disposition is required in regulations adopted by the U.S. Department of Labor.

Liability of Third Parties and the Board of Trustees

No employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation to make contributions required by its collective bargaining agreement or Category II Agreement. Likewise, there will be no liability, directly or indirectly, upon the Board of Trustees, individually or collectively, or upon the chapters of the National Electrical Contractors Association or I.B.E.W. local unions to provide the benefits established by this Plan if assets are not available to make such benefit payments.

ERISA Statement of Rights

As a participant in Harrison Electrical Workers Trust Fund, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

1. Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing operation of the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. A reasonable charge may be made for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this annual financial report.

4. Continue health care coverage for Yourself and Your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this Benefit Booklet starting on page 20 for the rules governing Your COBRA Continuation Coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within thirty (30) days, You may file suit in a federal court. In such

a case, the court may require the Plan administrator to provide the materials and pay You up to $110 per day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If You have a claim for benefits that is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack of a decision concerning the qualified status of a medical child support order, You may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Trust Office. If You have any questions about this statement, about Your rights under ERISA, or about Your rights under the Health Insurance Portability and Accountability Act of 1996 or if You need assistance in obtaining documents from the Plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory. Alternatively, You may obtain assistance by calling the Employee Benefits Security Administration's toll-free number 866-444-3272 or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington D.C. 20210

You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272. You may also find assistance for Your questions and a list of Employee Benefits Security Administration field offices at: www.dol.gov/ebsa.

DEFINITION OF TERMS

Accidental Bodily Injury – An Injury caused by an external force or element such as a blow or fall that requires immediate medical attention.

Active Employee Plan or Plan – The health and welfare benefits described in this Benefit Booklet and any amendments, additions or deletions subsequently made.

AD&D Insurance – Accidental death and dismemberment insurance provided under a group policy.

Approved Hospice – A private or public hospice agency or organization approved by Medicare or accredited by the Joint Commission for the Accreditation of Hospitals and/or Accreditation for Hospice Organizations.

Benefit Booklet – This booklet and any amendments, additions or deletions subsequently made.

Benefit Period – Claims incurred for services rendered January through December of a calendar year. A Benefit Period is established and begins when You have incurred, during a calendar year, Covered Charges that exceed the Deductible. All Covered Charges incurred during a Benefit Period are used in computing benefit payments. A Benefit Period terminates on the last day of the calendar year in which it was established.

Birthing Center – A freestanding facility meeting the following criteria:

1. Complies with applicable licensing requirements and maintains adequate levels of insurance;

2. Provides prenatal care, delivery and immediate postpartum care and has at least two beds or birthing rooms;

3. Is directed by at least one Doctor who is a specialist in obstetrics and gynecology;

4. Has a Doctor or certified nurse/midwife present at all births and during the immediate postpartum period;

5. Extends staff privileges to Doctors who practice obstetrics and gynecology in an area Hospital;

6. Provides full time skilled nursing services in the delivery and recovery rooms;

7. Accepts only patients with low risk pregnancies;

8. Has a written agreement with a Hospital in the area for immediate transfer of a patient or a child;

9. Provides a quality assurance program, including reviews by Doctors who do not own or direct the facility; and

10. Is equipped and has a trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor or a child is born with an abnormality that impairs function or threatens life.

Board of Trustees – The individuals who govern the Harrison Electrical Workers Trust Fund and their successors.

Category II Agreement – A written agreement between the Board of Trustees or the Harrison Trust and a Contributing Employer, the I.B.E.W. or I.B.E.W. local union that allows the entity to provide health and welfare benefits to its Employees who are not covered by a collective bargaining agreement.

Chemical Dependency – A physical and/or psychological addictive relationship that an individual has with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. Chemical Dependency does not include an addiction to, or dependency on tobacco, tobacco products or foods.

Claimant – An individual asserting a claim for life insurance or AD&D Insurance benefits.

Contributing Employer – An employer who is obligated to make health and welfare contributions to the Harrison Trust on behalf of Employees covered by a collective bargaining agreement or Category II Agreement.

Cosmetic Surgery – The surgical alteration of tissue for the improvement of Your appearance or self-esteem rather than improvement or restoration of bodily function.

Covered Charges – Charges covered under the Active Employee Plan and provided when You are covered by the Plan.

Custodial Care – Services that:

1. Do not require the technical skill of a licensed nurse at all times;

2. Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and

3. Are not likely to improve Your medical condition.

Deductible – A set amount of Covered Charges for Medical Benefits and/or Dental Benefits that must be paid by You each calendar year.

Denturist – A person certified under the laws of the state to engage in the practice of denture technology.

Dependent – Means:

1. An Employee's spouse if not legally separated or divorced. The Board of Trustees may require the Employee and spouse to submit a marriage certificate to establish their relationship. The

coverage for the spouse ends on the last day of the Month in which the divorce or legal separation occurs unless COBRA coverage is elected.

2. An Employee's Domestic Partner. Coverage for the Domestic Partner and the Domestic Partner's children who qualify as Dependents ends on the last day of the Month in which dissolution of the domestic partnership occurs unless COBRA coverage is elected.

3. An Employee's biological child (including a child of a Domestic Partner, a stepchild, a legally adopted child, or a child placed in an Employee's home pending adoption) from live birth until the end of the Month the child attains age 26.

4. A child for whom the Employee is required to provide health and welfare coverage under a Qualified Medical Child Support Order.

5. An Employee's unmarried child (including a child of a Domestic Partner, a stepchild, legally adopted child or child placed in an Employee's home pending adoption) who has attained age 26 if the child is:

    a. Mentally or physically unable to earn a living and proof of incapacity is furnished to the Board of Trustees within thirty–one (31) days of the date coverage would have ended due to age;

    b. Single and actually dependent on the Employee for the majority of his or her support; and

    c. Covered by this Plan just prior to the date the child attained age 26.

6. An Employee's unmarried grandchild, niece, nephew or sibling in the custody of the Employee and for whom the Employee is providing the majority of his or her support if the Employee has been named as legal guardian by a court of competent jurisdiction and properly enrolls the child until the end of the Month the grandchild, niece, nephew or sibling attains age 19. Coverage for the grandchild, niece, nephew or sibling can continue beyond age 19 if the grandchild, niece, nephew or sibling meets the criteria in paragraph 5 above or is enrolled in an accredited school as a full–time student and has not attained age 25.

7. In the event that a married couple or Domestic Partners are both covered by the Plan as Employees;

    a. Each will be considered a Dependent of the other; and

    b. Each Dependent child of such married couple or Domestic Partners will be considered a Dependent of both individuals. However, no more than 100% of Covered Charges will be paid.

Doctor or Physician – An individual licensed and holding a degree as a Medical Doctor or Doctor of Osteopathy.

Domestic Partner – The Employee and another individual who meet the following criteria:

1. They are residing together and sharing the common necessities of life;

2. Neither of them is married or registered as the Domestic Partner with any other person in any jurisdiction;

3. Neither of them has been married or had another Domestic Partner at any time during the previous six (6) Months. This does not apply if Your prior spouse or Domestic Partner is deceased.

4. They are at least eighteen (18) years of age;

5. They are not related by blood kinship closer than would bar marriage in the state where they reside;

6. They are mentally competent to consent to contract; and

7. They are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for each other's common welfare, including but not limited to food, shelter and other necessary living expenses.

The Board of Trustees may require the Employee and Domestic Partner to submit affidavits, information and documents to establish their Domestic Partner relationship. In the event the Employee and Domestic Partner reside in a city, county or other governmental unit that has a Domestic Partner registry, the Board of Trustees may require the Employee and Domestic Partner submit evidence that they are registered on a governmental body's Domestic Partner registry.

Health and welfare coverage can start the first of the Month after (i) the Board of Trustees or their designee has accepted the Domestic Partner relationship; (ii) all enrollment forms are completed and returned to the Trust Office; and (iii) if applicable, the Employee has made a payment to the Trust Office to cover the federal and, if applicable, state income taxes for the value of the employer paid health and welfare coverage provided to the Domestic Partner and, if applicable, his/her children.

The Domestic Partnership will cease to exist on the first day of the Month after the date that all the aforementioned criteria for Domestic Partner status are not met.

Durable Medical Equipment – Equipment that is:

1. Able to withstand repeated use;

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful to a person except for the treatment of an Illness or Injury.

Electrical Industry – Work of any nature for an employer who performs the type of work that falls within the craft jurisdiction of an I.B.E.W. local union.

Emergency Medical Condition – A medical condition with acute symptoms of sufficient severity (including severe pain) so that a prudent layperson that possesses an average knowledge of health and medicine, could reasonably expect the condition, in the absence of immediate medical attention, could result in (i) placing the health of the individual or unborn child in serious jeopardy; (ii) seriously impair the individual's bodily functions; or (iii) cause serious dysfunction to an individual's organ or body part.

Employee – A person who is working for a Contributing Employer or on the out–of–work list of an I.B.E.W. local union.

Health Care Facility – A facility licensed by the state or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Health Care Provider or **Provider** – means:

1. A licensed Medical Doctor (MD)

2. A licensed Doctor of Osteopathy (DO)

3. A Chiropractic Physician (DC) (under certain limited conditions)

4. A Naturopathic Physician (ND) who is licensed by the state in which care is rendered (if that state's laws license Naturopathic Physicians) and who practices within the scope of his or her license

5. A Doctor of Medical Dentistry (DMD)

6. A Doctor of Dental Surgery (DDS)

7. A Denturist (under certain limited conditions)

8. An Optometrist (OD)

9. A Doctor of Podiatric Medicine (DPM)

10. A Licensed Clinical Psychologist (PhD)

11. A Clinical Social Worker who:

    a. Has a master's or doctoral degree in social work;

    b. Has at least two years of clinical social work practice;

    c. Is certified by the Academy of Certified Social Workers (ACSW); and

    d. In states requiring license, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered (LCSW or RCSW).

12. A Mental Health Practitioner who is a member of the Plan's Preferred Provider organization network at the time the service is provided.

13. A Master of Science or Arts

14. A Certified Competent Clinician Audiology

15. A Nurse Midwife, who:

    a. Is a Certified Nurse Practitioner;

    b. Is certified by the American College of Nurse Midwives;

    c. Is under the supervision of a qualified Doctor or Hospital; and

    d. Is licensed as a Nurse Midwife by the state in which care is rendered (if that state's laws license Midwives).

16. A Physical Therapist who is licensed as a Physical Therapist by the state in which care is rendered (if that state's laws license Physical Therapists), for rehabilitative services rendered upon the written referral of a Doctor.

17. A Speech Therapist who:

    a. Has a master's degree in speech pathology;

    b. Has completed an internship; and

    c. Is licensed as a Speech Therapist by the state in which services are performed (if that state's laws license Speech Therapists).

18. A Physician's Assistant who is certified by the National Commission on Certification of Physician's Assistants; or is a certified graduate of an approved training course which is accredited by the American Medical Association's Committee on Allied Health Education; and works for a clinic or for a Doctor who is an MD or DO. This does not apply if applicable law does not allow it.

19. A Nurse Practitioner (Certified).

20. An Occupational Therapist who is licensed as an Occupational Therapist by the state in which care is rendered (if that state's laws license Occupational Therapists), for rehabilitation services rendered upon the written referral of a Doctor.

Hospice Treatment Plan – A written plan of care established and periodically reviewed by a Doctor. The Doctor must certify that You are Terminally Ill and the Hospice Treatment Plan must describe the services and supplies for Medically Necessary or Palliative Care to be provided by an Approved Hospice.

Hospital – A facility that:

1. Is licensed (if required) as a Hospital;

2. Is open at all times;

3. Is operated mainly to diagnose and treat Illnesses or Injuries on an inpatient basis;

4. Has a staff of one or more Doctors on call at all times;

5. Has 24–hour nursing services by registered nurses;

6. Is not mainly a Skilled Nursing Facility, clinic, nursing home, rest home, convalescence home or like place; and

7. Has organized facilities for major surgery.

Hospital does not include an institution that is primarily a rest home, nursing home, Skilled Nursing Facility, convalescent home or home for the aged.

I.B.E.W. – International Brotherhood of Electrical Workers.

Illness – A disorder or disease of the body or mind, including Pregnancy. All Illnesses due to the same cause, or to a related cause, will be deemed one Illness. The donation of an organ or tissue by You for transplanting into another person is considered an Illness.

Injury – An Injury to Your body, including but not limited to an Accidental Bodily Injury.

Medical Coverage or Medical Benefits – Benefits in this Plan other than weekly time loss benefits, life insurance benefits, AD&D Insurance, vision benefits and dental benefits.

Medical Necessity – The services and supplies required for diagnosis or treatment of an Illness, Injury, Mental Illness or Chemical Dependency and that, in the judgment of the Board of Trustees, are:

1. Necessary to the care or treatment of Illness, Injury, Mental Illness or Chemical Dependency;

2. Appropriate with regard to standards of good medical practice;

3. Not primarily for the convenience of You or a Provider of services or supplies;

4. Cannot be left out without adversely affecting Your condition; and

5. The least costly of the alternative supplies or level of service that can be safely provided to You. This means, for example, that care rendered in a Hospital inpatient setting or by a nurse in Your home is not Medically Necessary if it could be provided in a less expensive setting, such as Skilled Nursing Facility without harm to You.

The fact that a Provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary. Any final review will be based on professional medical opinion.

The requirement for Medical Necessity shall not apply to any service or supply that is covered by the Plan as preventive services.

Medicare – Medical benefits provided by Title XVIII of the Federal Social Security Act.

Mental Illness – Conditions and diseases listed in the most recent edition of the Internal Classification of Diseases (ICD) as psychoses, neurotic disorders or personality diseases; other non–psychotic mental disorders listed in the ICD as determined by the Board of Trustees. Mental Illness does not include the treatment of Chemical Dependency.

Month – A period starting at 12:01 a.m. on any day in a calendar Month and ending at 12:01 a.m. on that same numbered day in the next calendar Month. If that next calendar Month does not have a same numbered day, the Month will end at 11:59 p.m. of the last day of that next calendar Month. (Examples: 12:01 a.m. of May fourteen (14) up to 12:01 a.m. of June 14; and 12:01 a.m. of May thirty-one (31) through 11:59 p.m. of June 30.)

One Continuous Period of Disability – A period of time during which You are Totally Disabled. Successive periods of Total Disability due to the same or related causes will be considered One Continuous Period of Total Disability. When You have successive periods of Total Disability that are due to the same or related causes and which are not separated by two or more continuous weeks after being released for active employment by Your Doctor this is One Continuous Period of Disability.

Open Enrollment Period – The period in which Employees, Dependents and Domestic Partners can enroll or disenroll and the period in which medical and dental coverage can be changed as authorized by the Board of Trustees.

Organization Affiliated with the Electrical Industry – A business or organization that provides support services to the Electrical Industry in Oregon or Southwest Washington. These organizations include, but are not limited to a training trust such as the NECA–I.B.E.W. Electrical Training Trust, a Local Union affiliated with the I.B.E.W. or a chapter of the National Electrical Contractors Association.

Outpatient Service – A program or service providing treatment by appointment. It must be licensed and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs.

Palliative Care – Care primarily for the relief and control of distressing symptoms, not a cure.

Plan Document – The health and welfare benefits described in this Benefit Booklet and any amendments, additions or deletions subsequently made.

Pregnancy – Childbirth or related medical conditions, including complications of Pregnancy.

Preferred Provider – Any Provider, Hospital, medical clinic or facility which belongs to a Preferred Provider organization network recognized by the Trust as a Preferred Provider.

Primary Care Physician – A Physician who is responsible for monitoring a person's overall medical care and referring the individual to more specialized Physicians for additional care. Primary Care Physicians practice in the following specialties: group practice, family practice, internal medicine, pediatrics and obstetrics/gynecology.

Protected Health Information – Individually identifiable health information that is not subject to specific exclusions. The definition of Protected Health Information in 45 C.F.R. § 164.501 is adopted for use in the Benefit Booklet.

Reasonable and Customary Charges – The usual charges made by the Provider rendering or furnishing the services, treatments or materials, but in no event charges in excess of the general level of charges made by other Providers rendering or furnishing such services, treatments or materials to persons of similar income or net worth within the area in which You normally reside for Illnesses or Injuries comparable in severity and nature to the Illness or Injury being treated. As to any particular service, treatment or material, the term "area" means a county or such representative cross section of persons, groups or other entities rendering or furnishing such services, treatment or material to persons of similar income or net worth.

Reserve Account - A separate bookkeeping record maintained by the Trust Office that credits the monetary contributions that a Contributing Employer pays to the Harrison Trust on behalf of an Employee performing work under a collective bargaining agreement.

Residential Facility, Day or Partial Hospitalization Program – A program or facility licensed and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs to provide an organized full–time or part–day program of treatment but not licensed to admit persons requiring 24–hour nursing care.

Respite Care - Care of a hospice patient for a period of time to relieve persons residing with and caring for the patient from their duties.

Restricted Non-Covered Employment - Work as an employee or otherwise (for example, independent contractor, owner or consultant) in the Electrical Industry that does not meet one of the following criteria:

1. Work for an employer that has a contractual obligation to contribute to the Harrison Trust pursuant to a collective bargaining agreement or a Category II Agreement;

2. Work for an employer that contributes to a health and welfare trust or plan sponsored by an organization affiliated with the I.B.E.W. that has an agreement or arrangement that transfers health and welfare contributions or eligibility credits on behalf of employees to the Harrison Trust;

3. Work for an employer that has a collective bargaining agreement that requires health and welfare contributions to a health and welfare trust or plan where one of the sponsors of the health and welfare trust or plan is an organization affiliated with the I.B.E.W.;

4. Work for an employer pursuant to a collective bargaining agreement negotiated with an organization affiliated with the I.B.E.W.;

5. Work for an employer in a related building trade pursuant to a referral or authority from an organization affiliated with the I.B.E.W.;

6. Work for an employer that is involved in contract negotiations that meets one of the criteria in paragraphs 1 through 5 above;

7. Work for an employer as a SALT organizer authorized by an organization affiliated with the I.B.E.W.; or

8. Work for an employer that does not meet one of the criteria in paragraphs 1 through 7 above so long as the individual has received approval from the Board of Trustees to engage in the work without jeopardizing prior Harrison Trust service and/or his/her Reserve Account.

Room and Board Charges - Charges made by a Hospital or Skilled Nursing Facility for the room, meals and routine nursing services for a person confined as a bed patient. Room and board is limited to the Hospital's prevailing charge for a semiprivate room.

Skilled Nursing Facility - A facility certified as a Skilled Nursing Facility by the Secretary of Health and Human Services pursuant to Medicare.

Special Charges - Those charges made by the Hospital for other than room and board. Special Charges include, but are not limited to, charges made by a Doctor for professional services in connection with radiology and pathology. Anesthesiology is included unless otherwise provided under the surgical benefits.

Terminally Ill - The condition has reached a point where recovery can no longer be expected and You are facing imminent death.

TMJ/Temporomandibular Joint Syndrome - Pain or other symptoms affecting the head, jaw, and face that are believed to result when the temporomandibular joints (jaw joints) and the muscles and ligaments that control and support them do not work together correctly. Also referred to as Myofascial Pain Disorder.

Totally Disabled or **Total Disability** - Except for the life insurance benefit, if an Employee is claiming benefits under this Plan, Total Disability is defined as Your inability to work in Your normal job because of an Illness or Accidental Bodily Injury and You are under the care of a Doctor.

Trust Agreement - The Harrison Electrical Workers Trust Fund Restated Trust Agreement effective November 1, 2002, and any amendments and restatements subsequently made.

Trust Office - BeneSys, Inc., whose address is 5331 S Macadam Avenue, Suite 258, PMB #116, Portland, OR 97239.

Trust Agreement – The Harrison Electrical Workers Trust Fund Restated Trust Agreement effective November 1, 2002, and any amendments and restatements subsequently made.

Trust or Harrison Trust - The Harrison Electrical Workers Trust Fund.

You or **Your** - The Employee and/or Dependent.

When necessary to the meaning of any term or provision of this Benefit Booklet, and except when otherwise indicated by the context, either the masculine or the neuter pronoun will be deemed to include the masculine, feminine and the neuter and the singular will be deemed to include the plural, however, only one benefit will apply in any one case.

IMPORTANT PLAN CONTACTS

PLANS/PROGRAMS	PHONE NUMBER	ADDRESS/WEB/EMAIL
Trust Office Questions about eligibility for coverage, premiums, reserve account and for booklets	**In Portland** (503) 224-0048 Ext. 1679 **Outside Portland** (800) 547-4457 Ext. 1679	BeneSys, Inc. 5331 S Macadam Avenue Suite 258, PMB #116 Portland, OR 97239 www.harrisonbenefits.com
Active Employee Plan Questions about medical and dental benefits, claims payments, claim forms, Mail Order Prescription Forms, and other Plan benefits	**In Portland** (503) 224-0048 Ext. 1679 **Outside Portland** (800) 547-4457 Ext. 1679	BeneSys, Inc. 5331 S Macadam Avenue Suite 258, PMB #116 Portland, OR 97239 www.harrisonbenefits.com
PPO Networks		
Providence Preferred Network	(800) 793-9338	http://phppd.providence.org/ (select "PPO")
Multiplan Preferred Provider Network	(800) 464-0292	www.multiplan.com/search
Active Employee Plan Hospital Precertification and Disease Management	**In Portland** (503) 654-9447 **Outside Portland** (800) 862-3338	Innovative Care Management www.innovativecare.com
Active Employee Plan Retail Pharmacy	(877) 216-3644	Providence Health Plan http://providencehealthplan.org/Harrison
Active Employee Plan Mail Order Pharmacies	(800) 552-6694 (800) 635-3070	Postal Prescription Services www.ppsrx.com Walgreens Mail Service www.walgreens.com/mailservice
Active Employee Plan Specialty Pharmacy	(503) 962-1700	Credena Health www.providence.org/credena-health
Nurse Helpline Answer Your health care questions	(800) 971-2680	

PLANS/PROGRAMS	PHONE NUMBER	ADDRESS/WEB/EMAIL
Providence Health Plan Questions about Providence Health Plan benefits, claims and ID cards	**In Portland** (503) 574-7500 **Outside Portland** (800) 878-4445	www.providence.org/health_plans
Providence Health Plan RN Medical Advice Line	**In Portland** (503) 574-6520 **Outside Portland** (800) 700-0481	
Kaiser Permanente Questions about Kaiser benefits, claims and ID cards (refer to group #2454-0004)	**In Portland** (503) 813-2000 **Outside Portland** (800) 813-2000	www.kp.org
Hearing Aids Willoughby Hearing Aid Center (to schedule a test or fitting)	(800) 547-1949	
Willamette Dental Questions about dental benefits	**In Portland** (503) 644-6444 **Outside Portland** (800) 460-7644	www.willamettedental.com
Vision Plan Vision Service Plan Questions about vision benefits, claims and to find a VSP Provider	(800) 877-7195 TDD/Hearing Impaired (800) 735-2922	www.vsp.com
Employee Assistance Program Cascade Centers, Inc. (call to speak to a counselor or make an appointment)	**In Portland** (503) 639-3009 **Outside Portland** (800) 433-2320	www.cascadecenters.com