EBA-PGE-IBEW LOCAL UNION NO. 125
HEALTH & WELFARE TRUST

SUMMARY PLAN DESCRIPTION

ACTIVE PARTICIPANT PLAN

ELIGIBILITY, ENROLLMENT, COVERAGE AND RELATED INFORMATION

EFFECTIVE DATE: JANUARY 1, 2011

IMPORTANT REMINDER

All questions about the Plan should be directed to the Trust Office. Trustees are not authorized to answer questions concerning eligibility, coverage or benefits.

The contact information for the Trust Office is:

EBA-PGE-IBEW Local No. 125 Health & Welfare Trust
c/o ATPA, 7600 SW Mohawk Street, Tualatin, OR 97062
(503) 454-3829 or (888) 556-7213

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1. INTRODUCTION

1.1 ESTABLISHMENT OF THE PLAN

This Plan described in this Summary Plan Description was established by the Board of Trustees for the purpose of providing the employee welfare benefits to eligible Participants and their Dependents pursuant to a collective bargaining agreement between PGE and IBEW Local Union No. 125.

The Plan is governed by the terms of the EBA-PGE-IBEW Local Union 125 Health and Welfare Trust ("Trust"), and contracts between the Trust and Regence BlueCross BlueShield of Oregon, Vision Service Plan and Oregon Dental Service. Collectively these documents are referred to as the "Plan Document".

1.2 SUMMARY PLAN DESCRIPTION INFORMATION

The Summary Plan Description for your benefits under the Active Participant Plan consists of the following documents:

- This document; and
- The Benefits Booklet for Active Participants issued by Regence BlueCross BlueShield of Oregon, which describes the Plan's medical and prescription drug Benefit Programs and coverages;
- The Member Handbook issued by Oregon Dental Service, which describes the Plan's dental Benefit Program and coverages; and
- The Benefits Booklet issued by Vision Service Plan, which describes the Plan's vision Benefit Program and coverages.

The documents that make-up your Summary Plan Description or "SPD" are important documents, which you should keep in a safe location. Together, the documents inform you of your rights and benefits under the Active Participant Plan.

As the name implies, a SPD is merely a summary of the Plan terms and conditions. Every effort has been made to describe the Plan's benefits and coverages accurately in the SPD. However, the terms of the Plan Document will control if there is an ambiguity and/or difference between the terms of the SPD and the Plan Document.

WHY THIS DOCUMENT IS IMPORTANT

This document provides you the following important information:

- A description of the Plan's eligibility, enrollment and coverage rules, applicable to the Benefit Programs available under the Plan; and
- Information concerning Plan administration and your rights under the Plan.

2. DEFINITIONS

The following capitalized terms shall have the meanings set forth below. Any reference herein to a statute, regulation or other authority shall be a reference to such statute, regulation or other authority as amended and in effect from time to time

2.1 "Benefit Program" refers to the various benefits provided under the Plan. Benefit Programs that provide employee welfare benefits are subject to a Federal law called "ERISA" (see definition below).

2.2 "Claims Administrator" means the person or entity hired by the Plan Administrator (the Board of Trustees) to manage the payment of claims under a Benefit Program. The current Claims Administrators are:

Benefit Program	Claims Administrator
Medical benefits	Regence BlueCross Blue Shield of Oregon
Prescription drug benefits	Regence BlueCross Blue Shield of Oregon
Dental benefits	Oregon Dental Service or "ODS"
Vision benefits	Vision Service Plan or "VSP"

2.3 "Code" means the Internal Revenue Code of 1986, as amended, and the applicable regulations and rulings thereunder.

2.4 "Dependent" means any person eligible for dependent coverage under a Benefit Program. The rules for determining which dependents are eligible for coverage are provided in this document.

2.5 "Eligibility Administrator" means the person or entity hired by the Plan Administrator (the Board of Trustees) to determine which Employees and their Dependents satisfy the Plan's eligibility rules. The current Eligibility Administrator is: ATPA, 7600 SW Mohawk Street, Tualatin, OR 97062.

2.6 "Employee" means each common-law employee of an Employer who is eligible to become a Plan Participant. Except to the extent specifically provided otherwise in the Governing Documents of a Benefit Program, "Employee" shall not include any individual designated by an Employer as an independent contractor; a leased employee within the meaning of Code § 414(n); or a temporary or seasonal employee; even if such designation is found to be in error by a court or administrative agency of competent jurisdiction.

2.7 "Employer" means an entity that adopts the Plan for the benefit of its eligible Employees, and their Dependents. The term "Employer" includes Portland General Electric and any other employer authorized to adopt this Plan by the Board of Trustees.

2.8 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the applicable regulations and rulings thereunder.

2.9 “Family” means an Employee and the Employee’s eligible Dependents.

2.10 “Governing Documents” means, with respect to a Benefit Program and as applicable, the contracts, certificates of coverage, Participant handbook, summary plan description and any other document which governs the terms of the Benefit Program.

2.11 “Health Benefit Program” means a Benefit Program which is a group health plan and which provides benefits for health care (directly or otherwise) to Employees, former Employees, and their Dependents, as provided under the terms of the applicable Health Benefit Program.

2.12 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended, and the applicable regulations and rulings thereunder.

2.13 “Participant” means any individual (including a Dependent) who is enrolled in and participates in a Benefit Program.

2.14 “Plan” means this Plan and the Benefit Programs provided under this Plan.

2.15 “Plan Administrator” means the Board of Trustees. The Plan Administrator is a “named fiduciary” under ERISA. Additional information concerning the Plan Administrator is provided in Article 9 and Section 11.2.

2.16 “Plan Year” means the time period for which the Plan Administrator keeps the Plan’s records. The Plan Year for this Plan is the calendar year. However, a Benefit Program may have a separate 12-month period for determining benefit eligibility, limits, etc.

3. PLAN ELIGIBILITY AND ENROLLMENT RULES

3.1 BARGAINING MEMBERS

Eligibility Requirements. In order to be eligible to participate in the Plan, you must satisfy all of the following requirements:

- You must be covered by the collective bargaining agreement ("CBA") between PGE and IBEW Local Union No. 125;
- You must satisfy the following service requirements:
  - Regular employees: none.
  - Temporary employees: completion of six months of employment.

Eligibility Dates.

- Regular Employees. A regular employee's eligibility date is the first day of the month following the date on which the employee satisfies eligibility requirements above.
- Temporary Employees Hired as Regular. The eligibility date for a temporary employee who is hired as a regular employee during his/her six month eligibility period is the first day of the month after the employee becomes a regular employee, regardless of his/her days or months of employment.

Enrollment Documents. You must complete an Enrollment Form in order to have coverage under the Plan. Enrollment documents are complete when filed and accepted by the Trust Office.

If you are enrolling:	You need to provide:
A spouse:	a complete copy of your marriage certificate
A domestic partner:	a completed Affidavit of Domestic Partnership (a Plan form)
Dependents:	• complete copies of marriage or birth certificates, if applicable; or • an Affidavit of Domestic Partnership and Affidavit of Domestic Partnership: Children, if applicable (both are Plan forms) and birth certificates

Enrollment Rules. You must complete the enrollment documents based on the following rules:

- Completion Within 30 Days. You will have the following coverages if you complete enrollment documents within 30 days after your eligibility date:
  - You are automatically covered effective as of your eligibility date for medical, dental, vision and prescription coverages; and
  - You may elect coverage for your dependents including spouse or eligible domestic partner for medical, dental, vision and prescription coverages effective as of your eligibility date.

- Completion After 30 Days. You will have the following coverages if you fail to complete enrollment documents within 30 days after your eligibility date:
  - You are automatically covered effective as of your eligibility date for medical, dental, vision and prescription coverages; and
  - You cannot elect coverage for your dependents including spouse or eligible domestic partner for medical, dental, vision and prescription coverages until the next Plan open enrollment period.

EXAMPLE:	*The employee's eligibility date is March 1, 2012, but the employee does not complete enrollment documents until April 10, 2012. The employee missed the 30 day enrollment period. The employee is automatically covered as of March 1, 2012. The employee cannot enroll his dependents (and for actives, domestic partners) until the next open enrollment period, effective as of January 1, 2013.*

3.2 NON-BARGAINING MEMBERS

Transfers to Bargaining. A non-bargaining employee who transfers to the bargaining unit is eligible on the first day of the month after the transfer date.

EXAMPLE:	*An employee is hired as a non-bargaining unit employee on May 7 and transfers to the bargaining unit on May 25. The employee's eligibility date is June 1.*

Transfers to Nonbargaining. A bargaining unit employee who transfers to non-bargaining may elect to retain his/her coverage under the Plan each year during open enrollment subject to the following rules:

- The employee must have met the eligibility rules for participation prior to the transfer.
- The employee's right to elect Plan coverage ceases if the employee does not maintain continuous Plan coverage.

EXAMPLE:	*In 2006 an employee becomes eligible to participate in the Plan as a bargaining unit employee. In 2008 the employee transfers to non-bargaining and elects to remain in the Plan. The employee elects coverage under another PGE plan during open enrollment in the fall of 2010, effective January 1, 2011. For all future enrollment periods the employee loses his/her right to elect Plan coverage during open enrollment.*

Enrollment Documents for NonBargaining Members. You must complete an Enrollment Form in order to have coverage under the Plan. Enrollment documents are complete when filed and accepted by the Trust Office.

If you are enrolling:	You need to provide:
A spouse:	a complete copy of your marriage certificate
A domestic partner:	a completed Affidavit of Domestic Partnership (a Plan form)
Dependents:	• complete copies of marriage or birth certificates, if applicable; or • an Affidavit of Domestic Partnership and Affidavit of Domestic Partnership: Children, if applicable (both are Plan forms) and birth certificates

Enrollment Rules. You must complete the enrollment documents based on the following rules:

- Completion Within 30 Days. You will have the following coverages if you complete enrollment documents within 30 days after your eligibility date:
  - You are automatically covered effective as of your eligibility date for medical, dental, vision and prescription coverages; and
  - You may elect coverage for your dependents including spouse or eligible domestic partner for medical, dental, vision and prescription coverages effective as of your eligibility date.
- Completion After 30 Days. You will have the following coverages if you fail to complete enrollment documents within 30 days after your eligibility date:
  - You are automatically covered effective as of your eligibility date for medical, dental, vision and prescription coverages; and
  - You cannot elect coverage for your dependents including spouse or eligible domestic partner for medical, dental, vision and prescription coverages until the next Plan open enrollment period.

3.3 MEMBERS ON LONG TERM DISABILITY

Eligibility. If you are an eligible participant on long term disability, you can continue to participate in the Plan as an Active Participant until:

- You return to work; or
- You are eligible for Medicare by either age or disability. In that case, benefit coverages are provided as follows:

Participant:	medical coverage is provided under the Trust's Medicare Supplement Plan (part of the Retiree Plan) and dental and vision benefits continue under this Plan, the Active Participant Plan.[1]
Dependents:	medical, dental vision benefits continue under this Plan, the Active Participant Plan.
Dependents eligible for Medicare	medical and prescription coverages are provided under the Trust's Medicare Supplement Plan (part of the Retiree Plan) and dental and vision benefits continue under this Plan, the Active Participant Plan.

[1] If you or your dependent is eligible for the Medicare Supplement Plan, you should request a copy of the Medicare Supplement Plan SPD from the Trust Office.

NOTE:	*The Plan assumes a participant (or dependent) who, at any time, becomes eligible for Medicare has applied for and is eligible for Medicare benefits. Therefore, it is important that you contact Social Security office at least 45 days before the month in which you or your dependent are eligible for Medicare so that you can enroll when you are first eligible.*

Enrollment Documents for Members on Long Term Disability. You must contact the Trust Office when you first become eligible for long term disability and provide a copy of your disability award. Enrollment documents are complete when filed and accepted by the Trust Office.

You are required to provide a copy of your or your dependent's Medicare card to the Trust Office when you or your dependent first become eligible for Medicare.

3.4 ACTIVE PLAN PARTICIPANTS PLANNING TO RETIRE

Active Plan Participants who are planning to retire may be eligible to continue medical, prescription and dental benefits under a retiree plan. You should consult the Summary Plan Description for the Retiree Plan for specific eligibility rules.

However, you should keep in mind that for eligibility purposes, the Retiree Plan assumes that if you are eligible for Medicare, that you have applied for Medicare coverage. You should contact the Social Security office at least 45 days before the month in which you plan to retire so you are covered under Medicare on your retirement date.

Participants Who Delay Retirement. This rule also applies to Active Plan Participants who delay retirement and continue to work past their initial Medicare eligibility date. They can continue to receive coverage under the Active Participant Plan until they retiree. However, these participants should make sure that they apply for Medicare before their retirement date so that Medicare coverage is available when they do retire. As noted above the Retiree Plan assumes Medicare coverage is in place at retirement and pays secondary to Medicare. If the retiree does not have Medicare coverage the retiree will be responsible for costs Medicare would have paid.

4. QUALIFIED DEPENDENTS

4.1 ELIGIBLE DEPENDENTS

The only dependents eligible for coverage under the Active Participant Plan are qualified dependents, subject to the eligibility rules provided in Section 4.3 below. A "qualified dependent" for eligibility purposes under the Plan includes:

- Your legal spouse. A spouse must be a husband or wife of opposite sex, as provided in the Defense of Marriage Act (a federal law). A common-law spouse may be treated as a spouse only if the state in which you reside recognizes common-law marriages and you satisfy the state requirements at the time of enrollment.
- Your domestic partner. In order to be eligible a domestic partner must satisfy all the requirements listed on the Plan's Affidavit of Domestic Partnership. The affidavit is available from the Trust Office.
- Your children. A child may be up to age 26. Your "child" or "children" include the following:
    - Biological children of the Employee, the Employee's spouse and/or the Employee's domestic partner.
    - Children adopted by the Employee, the Employee's spouse and/or the Employee's domestic partner.
    - Children placed for adoption with the Employee, the Employee's spouse and/or the Employee's domestic partner.
    - Foster children placed with the Employee, the Employee's spouse and/or the Employee's domestic partner.
    - Children and/or grandchildren for whom the Employee, the Employee's spouse and/or the Employee's domestic partner has legal guardianship (you must file a court order showing legal guardianship with the Trust Office). The child must be related to the Employee, the Employee's spouse and/or the Employee's domestic partner by blood or marriage.
    - Children for whom coverage is required under a Qualified Medical Child Support Order applicable to the Employee. This coverage is subject to the Qualified Medical Child Support Order Rules provided below.
- A Disabled Adult Child. A child who is disabled and who is age 26 and older may be covered provided ALL of the following requirements are met:
    - The child is unmarried and dependent upon the Participant for support.
    - The child is incapable of self-support because of a physical, mental, or developmental disability.
    - The disability occurred before the child's 26th birthday.

4.2 INELIGIBLE DEPENDENTS

Coverage under this Active Participant Plan is not available for the following individuals, who are ineligible dependents:

- Any dependent on active duty in the uniformed services or armed forces of any country.
- A former spouse or the former spouse's dependents after a divorce, even if the divorce decree or settlement agreement requires you to provide coverage under the Active Participant Plan (the former spouse and/or dependents may be entitled to continue coverage under COBRA).

NOTE:	*The Plan provides special coverage rules for certain former spouses over age 55, as described below.*

- A former domestic partner and/or the former domestic partner's dependents after termination of the domestic partnership, even if a court order or settlement agreement requires you to provide coverage under the Active Participant Plan (the former domestic partner and/or dependents may be entitled to continue coverage under COBRA).
- Your parents, even if they are your dependents for federal income tax purposes. This rule also applies to the parents of your spouse and/or domestic partner.
- The spouse and/or domestic partner of a child or grandchild.

4.3 DEPENDENT ELIGIBILITY RULES

1. A child is not eligible for coverage under the Active Participant Plan if the child is eligible for coverage under another group health plan (other than a parent's group health plan), whether or not the child is enrolled.

EXAMPLE:	*For example, a child is not eligible to enroll in the Active Participant Plan if the child, or the child's spouse: (a) is employed and eligible for health insurance coverage provided by an employer; and (b) all or a portion of premium for the coverage is paid either by the employer, the child or the child's spouse.*

2. There may be income tax consequences of enrolling a child who is not your tax dependent. The Patient Protection and Affordability Care Act excludes the value of coverage provided to certain adult children from taxable income. However, state laws may not be amended to conform to this new federal law until 2011 or 2012. You should contact the Trust Office if you have questions concerning income tax issues.

3. You are responsible for notifying the Trust Office in writing, within 30 days, if you enroll and adult child and the adult child subsequently becomes eligible for coverage under another group health plan. Failure to notify the Trust Office of other coverage and/or any false statements or misrepresentation made on an enrollment form is considered fraudulent and may result in retroactive termination of coverage under the Active Participant Plan. In addition, you will be responsible for reimbursement for all amounts paid in connection with the coverage, including claims incurred.

4.4 DEPENDENT ELIGIBILITY DATES

- A new spouse and his/her children become(s) eligible on the date of the marriage, with coverage effective the first day of the next month. However, your new stepchildren must meet the eligibility requirements in order to be enrolled.
- A new domestic partner and his/her children become(s) eligible on the date a domestic partnership is established and an Affidavit of Domestic Partnership is approved by the Trust Office, with coverage effective the first day of the next month.. The Trust Office approves applications after determining that the qualifying conditions in the Affidavit of Domestic Partnership are met and all required documents have been filed.
- A newly acquired child becomes eligible for coverage on date of the birth, adoption, placement for adoption and/or foster care placement.

IMPORTANT REMINDER!

A newly acquired child is covered for the first 31 days following the date of eligibility. To continue coverage the child beyond the first 31 days, you have to submit an Enrollment Form to the Trust Office after the child is born, adopted, or placed for adoption or foster care.

4.5 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) RULES

- The Plan will cover dependents deemed to be alternative recipients under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law. QMCSOs are typically issued as part of a divorce or as part of a state child support order proceeding. QMCSOs require health plan coverage for an alternative recipient.
- An alternative recipient is a child who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to you. The child's coverage under the Active Participant Plan will be effective as of the date specified in the QMCSO, and that the child is eligible for enrollment in the Active Participant Plan.
- You may obtain a copy of the procedures governing qualified medical child support order determinations from the Trust Office, without charge. See also Section 9.2.

4.6 ENROLLMENT DOCUMENTS FOR DEPENDENTS

- Open Enrollment. You can always add an eligible dependent during open enrollment each year. Open enrollment is generally held in the fall with coverage available as of January 1st of the next year. You must file an application on behalf of all dependents to be enrolled, including all documents required by the Trust Office such as birth certificates, marriage certificates and/or domestic partnership forms.

- Special Enrollment. You can enroll an eligible dependent at any time during the plan year if the following requirements are met:
    - You are already enrolled.
    - You are adding coverage for a new dependent, such as a newborn child, new spouse or new domestic partner.
    - You complete an Enrollment Form provided by the Trust Office and include copies of marriage or birth certificates, if applicable, or an Affidavit of Domestic Partnership and Affidavit of Domestic Partnership: Children, if applicable. Enrollment documents are complete when filed and accepted by the Trust Office.
    - You complete the enrollment process **within 30 days** of your dependent's eligibility date. If you fail to satisfy this requirement your dependent is not eligible for coverage until the first day of the next plan year.

NOTE:	*Coverage under Special Enrollment is effective the first of the month following the date of the qualifying event, or from the date of birth for a newborn, or the date of placement for adoption.*

- Loss of Coverage Enrollment. You can enroll an eligible dependent who is child who is under age 26 any time during the plan year if the dependent loses medical coverage under another group or individual health benefit plan.

  In order to enroll an eligible dependent under Loss of Coverage Enrollment the following requirements must be met:

  - You are already enrolled.
  - You complete an Enrollment Form provided by the Trust Office and include copies of marriage or birth certificates, if applicable, or an Affidavit of Domestic Partnership and Affidavit of Domestic Partnership: Children, if applicable, and a Certificate of Creditable Coverage. Enrollment documents are complete when filed and accepted by the Trust Office.
  - You complete the enrollment process **within 30 days** of your dependent's eligibility date. If you fail to satisfy this requirement your dependent is not eligible for coverage until the first day of the next plan year. However, you have **60 days** to complete the enrollment process if your dependent's eligibility is attributable to:
    - involuntarily loss of coverage under Medicaid or Children's Health Insurance Program (CHIP); or
    - your eligible dependent becoming eligible for premium assistance under Medicaid or CHIP coverage.

NOTE:	*Coverage under Loss of Coverage Enrollment is effective as of the first day of the month following the date other coverage is lost.*

5. PLAN COVERAGE RULES

5.1 NOTIFICATION REQUIREMENTS: DEPENDENTS NO LONGER ELIGIBLE

You must notify the Trust Office **within 30 days** if your enrolled dependent no longer meets the Plan eligibility requirements. Coverage will end for the dependent on the last day of the month in which the dependent loses eligibility.

EXAMPLE:	*Your divorce is finalized on March 2. Your spouse's and enrolled stepchildren's coverage ends on March 31.*

NOTE:	*The Plan has a special eligibility rule for spouses who are age 55 or older at the time of the divorce. Please see Article 7, below.*

5.2 NOTIFICATION REQUIREMENTS: DEPENDENT ELIGIBLE FOR MEDICARE

You must notify the Trust Office **within 30 days** if your enrolled dependent becomes eligible for Medicare. As long as you remain eligible under the Active Participant Plan this plan will be the dependent's primary plan for medical and prescription coverages and Medicare will be secondary.

5.3 WHEN COVERAGE ENDS

Coverage under this Active Participant Plan for you and your dependents may end under the following situations.

- Plan Termination. Your coverage ends on the date the Active Participant Plan terminates. No Participant has a vested right to benefits under the Plan.
- Loss of Eligibility. Coverage ends on the last day of the month in which you or your dependent no longer meets the Plan's eligibility requirements.
- Terminated by Participant. A Participant may end coverage for any of the Participant's dependents by giving the Trust Office written notice of the termination. Coverage ends on the last day of the month in which the Participant gives the termination notice.
- Death. Coverage for your enrolled dependents ordinarily ends on the last day of the month in which your death occurs. However, surviving

spouses and/or dependent children may be able to continue coverage under special Plan rules, provided below.

- Divorce. Coverage ends for your enrolled spouse and your stepchildren on the last day of the month when a divorce or annulment is final, or in the case where the decree is appealed, the date the divorce or annulment would have been final but for the appeal.

NOTE:	*The Plan provides special coverage rules for certain former spouses over age 55, as described below.*

- Termination of Domestic Partnership. Coverage ends on the last day of the month for a domestic partner and the domestic partner's children if your domestic partnership is terminated. A domestic partnership is considered terminated if the partnership no longer meets any of the qualifying conditions under the Affidavit of Domestic Partnership.

NOTE:	*The Plan treats a domestic partner, and the domestic partner's dependents, as "Qualified Beneficiaries" for COBRA purposes (effective August 30, 2011). This means that a domestic partner and/or the domestic partner's dependents may have an independent election right to continue coverage under COBRA rules.*

5.4 PGE LEAVES OF ABSENCE

You may continue coverage under this Plan for you and your dependents while on leave pursuant to the following schedule:

Leaves:	employee medical; family medical, parental or sick child leaves; leave for victims of certain crimes; leave to attend criminal proceedings; military caregiver and military qualifying exigency leaves
Coverage:	available for member and covered dependents during leave
Contributions:	If sufficient PGE pay to cover benefits, employer contributions continue during leave and employee before-tax payroll deductions continue.
	If no PGE pay or insufficient PGE pay to cover benefits, employer contributions stop during leave and employee is responsible for paying premiums with after-tax dollars.

Leave:	military leave
Coverage:	available for member and covered dependents during leave
Contributions:	If sufficient PGE pay to cover benefits, employer contributions continue during leave and employee before-tax payroll deductions continue.
	If no PGE pay or insufficient PGE pay to cover benefits, employer contributions continue during leave and employee is responsible for paying employee contributions with after-tax dollars.
Leave:	personal leaves
Coverage:	available for member and covered dependents during leave
Contributions:	If sufficient PGE pay to cover benefits, employer contributions continue during leave and employee before-tax payroll deductions continue.
	If no PGE pay or insufficient PGE pay to cover benefits, employer contributions ends three months after the end of the month in which unpaid leave begins. Employee is responsible for paying premiums with after-tax dollars.

5.5 RESCISSION OF COVERAGE

Coverage under this Plan for you and your dependents is conditioned upon the complete and accurate provision of information, including but not limited to the filing of enrollment forms and supporting documents. The Plan Administrator has the right to rescind coverage if the Plan Administrator determines any person, including but not limited to the applicant or a person acting on for or on behalf of an applicant, has committed fraud or made an intentional misrepresentation of material fact to secure coverage. In that case, the Plan Administrator may discontinue coverage retroactively.

You will be notified in advance before your coverage is rescinded. You will then have an opportunity to appeal the decision as an adverse benefit determination.

If coverage is rescinded, claims payments made will be retained as liquidated damages and the Plan Administrator reserves the right to recover from you and/or your enrolled dependent the benefits paid under the Active Participant Plan.

6. COVERAGE RULES FOR SURVIVING SPOUSES AND DEPENDENT CHILDREN

6.1 SURVIVING SPOUSE ELIGIBILITY

A surviving spouse may continue ***medical, prescription and dental benefits*** under a retiree plan (see 6.2 below) after the Participant's death under the following rules:

- The deceased Participant must have been eligible for medical benefits under the Active Participant Plan prior to death (i.e., not on COBRA coverage).
- The surviving spouse must have had medical coverage under the Active Participant Plan or the Medicare Supplement Plan prior to the Participant's death (i.e., not COBRA coverage).
- The surviving spouse is not eligible for coverage under the Plan if the surviving spouse has, or becomes eligible for, medical coverage under another plan (excluding Medicare).

6.2 SURVIVING SPOUSE COVERAGE

The surviving spouse is entitled to the following coverage:

- Medicare Eligible. If the surviving spouse is eligible for Medicare at the time of the Participant's death, the surviving spouse continues coverage under the Medicare Supplement Plan (part of the Retiree Plan).
- Not Medicare Eligible. If the surviving spouse is not eligible for Medicare at the time of the Participant's death, the surviving spouse continues coverage under the Early Retiree Plan (part of the Retiree Plan). Once the surviving spouse is eligible for Medicare (by age or disability), the surviving spouse's coverage switches to the Medicare Supplement Plan (part of the Retiree Plan).

EXAMPLE:	*A surviving spouse covered under the Active Participant Plan at the time of the Participant's death may elect coverage under the Early Retiree Plan after the Participant's death.*

NOTE:	*Surviving spouses who satisfy the above coverage rules prior to January 1, 2012, may retain coverage under the Active Participant Plan through December 31, 2011.*

6.3 SURVIVING SPOUSE: TERMINATION OF COVERAGE

The surviving spouse's right to coverage ceases in ANY of the following situations:

- The surviving spouse does not maintain continuous coverage under the Early Retiree Plan (part of the Retiree Plan) and/or the Medicare Supplement Plan (part of the Retiree Plan).
- The surviving spouse remarries.
- The surviving spouse has, or becomes eligible for, medical coverage under another plan (excluding Medicare).

6.4 SURVIVING SPOUSE: DEPENDENT CHILDREN ELIGIBILITY AND COVERAGE

An eligible surviving spouse that elects to continue coverage under the Plan may also cover the deceased Participant's dependent child or children. The same eligibility and termination of coverage rules that apply to surviving spouses also apply to dependent child or children.

NOTE:	*Domestic partners and their dependents are not eligible for surviving spouse coverage.*

6.5 ENROLLMENT DOCUMENTS FOR SURVIVING SPOUSES

A surviving spouse must complete an Enrollment Form ***within 30 days of the Participant's death*** in order to maintain coverage under the Plan for the surviving spouse and the Participant's surviving dependents. The premium for the first two months of coverage must be included with the Enrollment Form. The surviving spouse must provide a certified copy of the death certificate and birth certificates, if applicable. Enrollment documents are complete when filed and accepted by the Trust Office.

7. DIVORCED SPOUSES AGE 55 AND OLDER

7.1 DIVORCED SPOUSE ELIGIBILITY

A divorced spouse of a Participant in the Active Participant Plan may continue ***medical, vision, prescription and dental benefits*** under the Plan after divorce under the following rules:

- The divorced spouse must have been eligible for medical benefits under the Active Participant Plan at the time of the divorce (i.e., not on COBRA coverage); and
- The divorced spouse must be age 55 or older and not eligible for Medicare.

7.2 DIVORCED SPOUSE COVERAGE

Coverage is provided under the Plan the divorced spouse was covered under at the time of the divorce at the applicable COBRA rates.

7.3 DIVORCED SPOUSE TERMINATION OF COVERAGE

The divorced spouse's right to coverage ceases in ANY of the following situations:

- The divorced spouse remarries; or
- The divorced spouse becomes eligible for other medical coverage, including Medicare (by age or disability) or another medical plan; or
- The divorced spouse fails to maintain continuous Plan coverage.

NOTE:	*A divorced spouse may not cover dependent children. Domestic partners and their dependents are not eligible for coverage under the divorced spouse coverage rules.*

7.4 ENROLLMENT DOCUMENTS FOR DIVORCED SPOUSES

A divorced spouse must complete an Enrollment Form ***within 30 days of the divorce*** in order to maintain coverage under the Plan. The premium for the first two months of coverage must be included with the Enrollment Form. The divorced spouse must provide a court certified copy of the divorce decree (available from the court clerk's office). Enrollment documents are complete when filed and accepted by the Trust Office.

8. CONTINUATION OF COVERAGE

8.1 COBRA

The Plan shall be operated in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), and the regulations thereunder, as set out in the governing documents for each Health Benefit Program.

8.2 Family and Medical Leave Act

A Participant who is on an approved leave of absence under the FMLA shall be entitled to continue participation in the Plan during the leave, to the extent required by and in accordance with the FMLA and applicable regulations and as set out in the governing documents for each Health Benefit Program.

8.3 USERRA

The Plan shall be operated in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act and the regulations thereunder. The Plan shall be interpreted to comply with USERRA and related regulations. USERRA provisions may vary slightly among the various Benefit Programs. To the extent consistent with applicable law, the specific USERRA provisions in any Health Benefit Program shall govern over the terms of this Section 5.

Unless otherwise specifically provided in the applicable Governing Documents:

(1) a Participant must notify his/her Employer of the Participant's intention to elect USERRA continuation of coverage prior to the expiration of the COBRA election period provided under the Health Benefit Program; and

(2) any period of USERRA continuation of coverage shall run concurrently with COBRA continuation coverage.

9. PLAN ADMINISTRATION

9.1 NON-DISCRIMINATION

The Board of Trustees reserves the right to adjust, terminate or otherwise modify the terms and operation of the Plan and/or any Benefit Program to the extent necessary to avoid, reduce or eliminate prohibited discrimination under any provision of ERISA, the Internal Revenue Code or other applicable law or regulation that prohibits discrimination in eligibility, benefits or other feature of a Benefit Program.

9.2 QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This section applies to Health Benefit Programs that are subject to ERISA § 609(a). In that case, the Health Benefit Program shall provide benefits in accordance with the terms of a qualified medical child support order that meets the requirements of ERISA § 609(a). The Board of Trustees has the authority and discretion to establish reasonable written procedures to determine whether a medical child support order is a qualified medical child support order. A Participant may request a copy of the procedures, at no charge.

9.3 SUBROGATION AND RECOVERY

If a Participant incurs covered expenses or receives benefits under a Benefit Program with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan retains all rights of subrogation, recovery and reimbursement as set out more specifically in the Governing Documents for each Benefit Program. ***The Plan's subrogation rights shall apply even if the Participant has not been made whole.***

9.4 ADMINISTRATION OF PLAN AND BENEFIT PROGRAMS

The Board of Trustees, acting as the Plan Administrator, is responsible for the general administration of the Plan and all Benefit Programs. The Plan Administrator shall have full authority and discretion to interpret the terms of the Plan and/or any Benefit Program. The Plan Administrator shall have, without limitation, the following discretionary authority, duties and powers:

- To make and enforce rules and regulations the Plan Administrator deems as necessary or proper for the efficient administration of the Plan and/or Benefit Program, including the establishment of any claims procedures that may be required by applicable provisions of law;
- To interpret the provisions of the Plan, make findings of fact, and correct errors in, supply omissions from, and resolve inconsistencies or ambiguities in the language of the Plan, and to decide all claims and appeals arising under the Plan;
- To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

- To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and
- To allocate and delegate the Plan Administrator's fiduciary and administrative responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing. Without limitation, the Plan Administrator may designate other organizations or persons to carry out the following:
    - pursuant to an administrative services or claims administration agreement, the responsibility for administering and managing a Benefit Program or Programs, including the processing and payment of claims under the Program and the recordkeeping related thereto;
    - the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any government agency or to be prepared and disclosed to Participants or other persons entitled to disclosure under the Benefit Programs; and
    - the responsibility to review claims or claim denials under the Benefit Programs, including discretionary authority to act as claims fiduciary to determine adverse claims determinations within the meaning of Department of Labor Regulations.

9.5 PLAN ADMINISTRATOR'S DECISIONS

Any interpretation of the provisions of the Plan and the Benefit Programs and any decisions on any matter within the discretion of the Plan Administrator made by the Plan Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Plan Administrator shall not be liable in any manner for any determination of fact made in good faith.

10. VOLUNTARY APPEALS TO THE BOARD OF TRUSTEES

The Board of Trustees allows Participants who have exhausted their appeal rights provided by Regence, ODS or VSP to voluntarily appeal the denial of all or a portion of their claim to the Board of Trustees.

10.1 VOLUNTARY APPEAL

An appeal to the Board of Trustees is strictly voluntary. A Participant is not required to appeal to the Board in order to have exhausted the Plan's appeal process. This means that a Participant may pursue his/her rights under ERISA without appealing to the Board, including filing a lawsuit.

If you submit the claim to Board of Trustees, the Board agrees that:

- the voluntary appeal will not have any effect on your rights to any other Plan benefit;
- any statute of limitations is tolled during this voluntary review process;
- no fees or costs are imposed on you as part of this voluntary appeal process; and
- the Board of Trustees waives any right to assert that you did not exhaust your administrative remedies if you elect not to appeal to the Board of Trustees.

10.2 APPEAL FILING

All appeals of the Board of Trustees should be sent to the Trust Office at the following address:

EBA-PGE-IBEW Local No. 125 Health & Welfare Trust
c/o ATPA, 7600 SW Mohawk Street, Tualatin, OR 97062

Phone: (503) 454-3829 or (888) 556-7213

10.3 APPEAL RULES

You or your representative may review and copy pertinent documents and may submit issues and comments in writing as part of your appeal. You should contact the Trust Office to determine what documents are available.

In addition, the Board of Trustees reserves the right to adopt administrative policies governing appeals to the Board. A copy of the current policies will be provided to a participant upon receive of a notice of appeal. The Board's administrative policies govern whether you and/or your representative may attend an appeal hearing with the Board of Trustees.

10.4 APPEAL OF URGENT CARE

You may appeal an adverse urgent care claim to the within 180 days of an adverse decision. You may request an expedited review. If you do not make the request your claim will be given a non-expedited review.

- An expedited review may be submitted orally or in writing. All necessary information, including the benefit determination, will be transmitted between you and the Plan by telephone, facsimile or other expedited method.
- The decision on review will be made as soon as possible but no later than 72 hours after receipt of the request for an expedited review.
- A non-expedited review will be decided within 60 days of your request for review.
- If special circumstances are required, the Claims Review Committee and/or Board of Trustees may delay a decision provided you are given notice.

10.5 APPEALS OF ONGOING CARE

You may appeal an Ongoing Care claim within 180 days of an adverse decision. A decision will be made within 60 days of your request for review.

- If special circumstances require, the Claims Review Committee and/or Board of Trustees may delay a decision provided you are given notice.
- The Board of Trustees will notify you in writing as soon as possible of its decision but not later than 5 days after the decision.

10.6 CLAIMS REVIEW COMMITTEE

The Board of Trustees may appoint a Claims Review Committee to first review the appeal. The Claims Review Committee may consist of one or more current Trustees and/or Plan service providers. You will be notified if your appeal has been assigned to the Claims Review Committee.

You may appeal to the Board of Trustees the decision of the Claims Review Committee.

- The appeal must be written and made within 180 days after the receipt of the decision of the Claims Review Committee.
- The Board of Trustees will decide the appeal within 60 days of your request for review.
- If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that you are given notice.

- The notice will be given prior to commencement of the extension; will state the special circumstances which require the extension; and will state the expected date of the decision.
- The Board of Trustees will notify you in writing as soon as possible of its decision but not later than 5 days after the decision.

10.7 INDEPENDENT REVIEW

The Claims Review Committee and/or Board of Trustees may elect to obtain an independent evaluation of a claim. This review is primarily for procedures that may be experimental, investigational or medically necessary, but may also be used for other claims. The independent evaluation will be made by an Independent Review Organization that has not been previously involved with the claim. The independent evaluation will be paid by the Plan. The Claims Review Committee and/or Board of Trustees may accept or reject the opinion of the Independent Review Organization.

11. PLAN INFORMATION

11.1 PLAN SPONSOR

The Plan Sponsor is the Board of Trustees of the EBA-PGE-IBEW Local Union No. 125 Health & Welfare Trust. A copy of the collective bargaining agreement between PBE and IBEW Local Union No. 125 may be obtained upon written request to the Plan Administrator and is available for examination at the Trust Office.

The Board of Trustees are split equally between "labor" and "management" Trustees. The current Trustees are:

Trustees Representing the Union	Trustees Representing PGE
Mike Pyatt, Co-Chair c/o PGE 209 Warner-Milne Rd. Oregon City, OR 97045	Valerie Giles, Co-Chair c/o PGE 1WTC0502 121 SW Salmon Street Portland OR 97204
Jim Sweet c/o PGE 209 Warner-Milne Rd. Oregon City, OR 97045	Joyce Bell c/o PGE 1WTC0602 121 SW Salmon Street Portland OR 97204
Donald Eri, Jr. c/o PGE 1705 NE Burnside Gresham, OR 97030	Jim Cox c/o PGE 1WTC0604 121 SW Salmon Street Portland OR 97204

11.2 PLAN ADMINISTRATOR AND TRUSTEE

The Board of Trustees serves as both the Trustee responsible for Plan assets and as the Plan Administrator. However, in order to conduct the day to day administration of the Plan the Board of Trustees has contracted with a third party administrator to act as Eligibility Administrator. The contact information for the third party administrator and the Plan's Administrative office is:

EBA-PGE-IBEW Local No. 125 Health & Welfare Trust
c/o ATPA, 7600 SW Mohawk Street
Tualatin, OR 97062
(503) 454-3829 or (888) 556-7213

11.3 PLAN IDENTIFICATION NUMBERS

The federal employer identification number of the Plan sponsor listed above is: 93-1204757.

The three digit plan identification number is: 001.

11.4 PLAN TYPE

This Plan is considered a "welfare benefit plan" under federal law because the Plan provides group health benefits.

11.5 PLAN FUNDING

The Plan is "self-funded". Benefits under the Plan are funded by contributions by PGE and from Participants. Contribution amounts are determined under the collective bargaining agreement. The Plan Administrator determines the benefits available under the Plan and premiums.

Contributions to the Plan are held by the Board of Trustees in a Trust for the purpose of paying for benefits and the cost of administering the Plan.

11.6 SERVICE OF PROCESS

Service of process may be made upon the Plan Administrator, at the address provided above for the Plan's administrative office.

11.7 FISCAL YEAR

The Plan's financial records are maintained on calendar year.

12. PARTICPANT RIGHTS UNDER ERISA

12.1 ERISA RIGHTS

Plan Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan Participants shall be entitled to the rights provided below.

12.2. RECEIVE INFORMATION ABOUT THE PLAN AND BENEFITS

Plan Participants may:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreement, copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- 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 summary annual report.

12.3 PORTABILITY

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if Participants have creditable coverage under another plan. Participants should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when Participants lose coverage under the Plan, when Participants become entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage or if the Participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, Participants may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the Participant's enrollment date of the coverage.

12.4 CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health coverage for participants, including covered spouses or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Participants have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

12.5 PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including the Participant's Employer, union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or exercising your right under ERISA.

12.6 ENFORCE YOUR RIGHTS

If a Participant's claim for a benefit under the Plan is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps Participants can take to enforce the above rights. For instance, if a Participant requests materials from the Plan and does not receive them within 30 days, the Participant may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until he or she receives the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. In addition, if a Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the claim is frivolous.

12.7 ASSISTANCE WITH PARTICIPANT'S QUESTIONS

If a Participant has any questions about the Plan, he or she should contact the Plan Administrator. If a Participant has any questions about this statement or about his or her rights under ERISA, or, if the Participant needs assistance obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the U. S. Department of Labor, Employee Benefits Security Administration listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. Participants may also obtain certain publication about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

13. REQUIRED LEGAL NOTICES

13.1 WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). F or individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

13.2 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 to 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 that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

13.3 SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) mandates Special Enrollment rights when you and/or your eligible dependents decline health coverage during the initial enrollment period.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Under the special enrollment provisions of HIPAA, an employee will be eligible, in certain situations, to enroll in an employee medical plan during the year, even if the employee previously declined coverage. This right extends to the employee and all eligible family members.

- The employee will be eligible to enroll himself (and eligible dependents) if, during the year the employee or dependents have lost coverage under another health plan because:
  - Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility;
  - Employer contributions to the plan stopped;
  - The plan was terminated;
  - COBRA coverage ended;
  - The lifetime maximum for medical benefits was exceeded under the existing medical coverage option.
- If the employee gains a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, the employee may enroll that dependent, as well as himself and any other eligible dependents, in the plan – again, even if the employee previously declined medical coverage. Coverage will be retroactive to the date of the birth or adoption for children enrolled during the year under these provisions.

- Effective April 1, 2009, the employee will be eligible to enroll himself and eligible dependents if either of two events occur:
  - The employee or dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because of loss of eligibility.
  - The employee or dependent qualifies for state assistance in paying employer group medical plan premiums.

  Regardless of other enrollment deadlines, the employee will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the employer medical plan.

Please note that special enrollment rights allow the employee to either:

- Enroll in current medical coverage; or
- Enroll in any medical plan benefit option for which the employee and dependents are eligible.

To request HIPAA special enrollment rights or obtain more information, contact the Trust Office at 503-454-3829 or 1-888-556-7123.

13.4 GRANDFATHERED STATUS

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator as follows:

EBA-PGE-IBEW Local No. 125 Health & Welfare Trust
c/o ATPA
7600 SW Mohawk Street
Tualatin, OR 97062
(503) 454-3829 or (888) 556-7213

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.