Harrison Electrical Workers Trust Fund

Flexible Benefits Plan

June 1, 2015

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Introduction

The Harrison Electrical Workers Trust Fund Flexible Benefits Plan (the Plan) was designed to provide you and your Dependents with a variety of benefits to meet your individual circumstances. The Plan allows you to take advantage of favorable tax rules for most benefits, which means you may avoid paying federal and state income tax.

This is the Summary Plan Description for the Plan. It has been prepared to provide you with a summary of information concerning the Plan, including:

1. Eligibility to participate in the Plan;
2. Conditions pertaining to receipt of benefits from the Plan;
3. The benefits provided by the Plan;
4. Appeal rights if your claim for benefits is denied; and
5. Your rights under the Employee Retirement Income Security Act of 1974.

This Summary Plan Description is not meant to interpret, extend or change the provisions of the Plan. The provisions of the Plan may only be determined by reading the Plan Document. A copy of the Plan Document is available from the Administrative Office and may be reviewed by you, your Dependents or your legal representatives at any time upon written request. In the event of a discrepancy between this Summary Plan Description and the terms of the Plan Document, the Plan Document will govern.

The Board of Trustees has discretionary authority to construe and interpret all provisions of the Plan Document and this Summary Plan Description, including but not limited to, eligibility to participate, eligibility for benefits, and amount of benefits, if any, to be paid. No individual Trustee, union representative, employer representative or employee of the Administrative Office is authorized to interpret the Plan Document or this Summary Plan Description for the Board of Trustees. The Board of Trustees has authorized employees of the Administrative 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.

The Plan is intended to be a continuing program for you and your Dependents, but the Board of Trustees reserves the right to modify, alter, amend or terminate the Plan, in whole or in part, at any time. This Plan will be construed in accordance with the Internal Revenue Code and Employee Retirement Income Security Act (ERISA) and regulations issued thereunder and, to the extent applicable, the laws of the state of Oregon.

There is a Definition of Terms section located in the back of this Summary Plan Description. Terms and phrases that have initial capital letters are defined terms.

If you would like further information or assistance, please call or write the Administrative Office:

Harrison Electrical Workers Trust Fund
1220 SW Morrison Street, Suite 300
Portland, Oregon 97205
In Portland: (503) 224-0048 Ext. 1681
Toll Free: (800) 547-4457 Ext. 1681
www.harrison.aibpa.com
harrison@aibpa.com

Harrison Electrical Workers Trust Fund

Timothy Gauthier
Management Trustee

Gary Young
Union Trustee

Randy Wagner
First Alternate Management Trustee

Erik Richardson
First Alternate Union Trustee

Alan Keser
Second Alternate Union Trustee

Eligibility and Participation

Eligible Employee

Electricians who work for an employer bound by the Commercial Wiremen's Agreement, the Sound & Communications Agreement, the Panel Shop Agreement and Residential Wiremen's Agreement between IBEW Local 48 and the Oregon-Columbia Chapter, NECA, and qualifying Category II employees will be eligible to participate in the Plan. You are a qualifying Category II employee if you work for a Contributing Employer that has signed a Category II Agreement for this Plan.

An Employee is a person who works for and receives wages from a Contributing Employer and on whose behalf a Contribution to this Plan is required under the terms of a Category II Agreement or collective bargaining agreement. Individuals who are self-employed, partners of a partnership, independent contractors, and individuals holding two percent or greater ownership in a subchapter S corporation are not eligible to receive benefits from this Plan, regardless of whether they are or work for a Contributing Employer.

Participation

You become a Participant in the Plan if you are an eligible Employee who has accumulated $400 or more of Contributions in your Account.

When Participation Begins

Participation starts on the latest of the following:

1. The date you have $400 in Contributions in your Account; or
2. The date the Board of Trustees, or the Administrative Office, has received your election form to participate.

When Participation Ends

Participation ends on the earliest of the following:

1. The last day of the first full calendar year during which you had no activity in your Account and your total Account balance was under $400; or
2. Regardless of your Account balance, you have had no activity in your Account for five years.

No activity in your Account means no employer contributions have been made to your Account, no payment of benefits has been made from your Account, and no coverage under a Harrison Health Plan. When participation in the Plan ends, your Account balance will be forfeited. Please see the Forfeitures section on page 9.

Account Information

Employer Contributions

Electricians

The Commercial Wiremen's Agreement and Residential Wiremen's Agreement between IBEW Local 48 and the Oregon-Columbia Chapter, NECA, currently require employers to contribute $1.20 per hour for all hours worked by bargaining unit employees. The Sound & Communication Agreement and the Panel Shop Agreement between IBEW Local 48 and the Oregon-Columbia Chapter, NECA, currently require employers to contribute $1.00 per hour for all hours worked by bargaining unit employees.

Category II Employees

Employers whose principal collective bargaining agreement requires Contributions to this Plan may elect to have their Category II employees (non-bargaining unit) participate. A Category II Agreement must be entered into for this Plan and approved by the Board of Trustees prior to participation.

Additional Information

1. Employee Contributions are not permitted.
2. All employer Contributions are deposited into the Harrison Electrical Workers Trust Fund.
3. An Employee may not elect to receive cash or other compensation instead of employer Contributions to this Plan.

Allocating Your Contributions

You must initially allocate Contributions between two main accounts: the Premium Reserve Account and the Wage Replacement Account. The two accounts offer different benefit options and tax effects. Once you allocate Contributions to the Premium Reserve Account or the Wage Replacement Account, those Contributions cannot be transferred from one account to the other. Benefits received may be subject to taxation based on the Account you choose, so please pay close attention to the following section.

Premium Reserve Account (Non-Taxable Account)

All Participants may direct Contributions to the Premium Reserve Account. This is the automatic choice for all Participants, except Travelers, if you fail to make an election. If a Traveler fails to make an election, the automatic choice is the Wage Replacement Account.

When benefits are paid from the Premium Reserve Account, under current law, you will not be taxed for these benefits.

Once funds are in the Premium Reserve Account, you have additional benefit options as follows:

1. Premium Payment Plan – Used to self-pay your health and welfare premium to the Harrison Health Plan in certain cases and for the purchase of Group Term Life Insurance;

2. Medical Expense Reimbursement Account – For reimbursement of certain out-of-pocket medical expenses; and

3. Dependent Care Reimbursement Account – For reimbursement of certain Dependent Care Expenses.

Persons other than Travelers, during the Election Periods may elect to have all or a portion of your Premium Reserve Account allocated to the Medical Expense Reimbursement Account or the Dependent Care Reimbursement Account. However, the Administrative Office will allocate funds from your Premium Reserve Account to your Medical Expense Reimbursement Account only if you have Harrison Health Plan coverage on the date the Account is to be reallocated. For example, if the date that the Administrative Office is scheduled to reallocate a portion of your Premium Reserve Account to the Medical Expense Reimbursement Account is July 1 and you do not have Harrison Health Plan coverage on July 1, the money will remain in your Premium Reserve Account. Once funds are deposited in your Medical Expense Reimbursement Account or your Dependent Care Reimbursement Account, the funds must remain in these Accounts and cannot be used for any other benefits.

Persons other than Travelers are able to allocate all or a portion of future monthly Contributions directed to the Premium Reserve Account to the Medical Expense Reimbursement Account on a monthly basis and these Contributions will be available for use on the first day of the month after the date your employer is obligated to pay the Contributions to the Plan so long as you have Harrison Health Plan coverage on the date the Account is to be reallocated. For example, if the employer Contribution is paid on June 15, the money will be transferred to the Medical Expense Reimbursement Account on July 1, provided you have Harrison Health Plan coverage on July 1. The money transferred to the Medical Expense Reimbursement Account will be eligible for reimbursement of Medical Expenses with dates of service on or after July 1.

If you are a Traveler, during the Election Periods you may elect to have all or a portion of your Premium Reserve Account allocated to the Dependent Care Reimbursement Account. Funds allocated to the Dependent Care Reimbursement Account must remain in this Account and cannot be used for any other benefits. Travelers may not allocate funds to the Medical Expense Reimbursement Account.

Because of special tax rules that apply to the Medical Expense Reimbursement Account and Dependent Care Reimbursement Account, once money is allocated to these accounts, the money cannot be used for the Premium Payment Plan or to purchase Group Term Life Insurance.

Wage Replacement Account (Taxable Account)

All Participants may direct Contributions to the Wage Replacement Account. The benefits payable from the Wage Replacement Account are limited for some Employees. All Employees may use Supplemental Short-Term Disability benefits and Supplemental Workers' Compensation benefits, but only Employees who had Contributions made to the Plan because of a collective bargaining agreement may use Supplemental Unemployment benefits and Economic Dislocation benefits. Category II employees are not eligible to use Supplemental Unemployment benefits or Economic Dislocation benefits.

Benefits in the Wage Replacement Account are subject to taxation whenever you become eligible for them (for example, upon disability or a workers' compensation injury), regardless of whether they are paid. Under the Wage Replacement Account, you may receive the following benefits, which are also described in more detail later in this summary:

1. Supplemental Short-Term Disability - to supplement the disability benefit provided by the Harrison Health Plan;

2. Supplemental Workers' Compensation - to supplement time-loss benefits received from workers' compensation;

3. Supplemental Unemployment - to supplement any state unemployment compensation you receive during periods when you are involuntarily unemployed (bargaining unit employees only); and

4. Economic Dislocation - to assist you in relocating to other IBEW Locals to find work (bargaining unit employees only).

Remember, because of the tax rules associated with the Plan, the IRS requires that once you have allocated funds to the Wage Replacement Account, your funds must remain in the Wage Replacement Account. You do not have the option of moving money from the Wage Replacement Account to the Premium Reserve Account.

Elections

Prior to beginning participation in the Plan, you should submit the election form provided by the Administrative Office to allocate your Contributions between the Wage Replacement Account and the Premium Reserve Account. Periodically, you can change this election as well as redirect funds in the Premium Reserve Account into (but not out of) the Medical Expense Reimbursement Account and/or Dependent Care Reimbursement Account. Travelers may only redirect amounts in the Premium Reserve Account into (but not out of) the Dependent Care Reimbursement Account. The Administrative Office may reject your allocation decision if you do not use the required election form.

Election Periods

Newly Eligible Employees

Newly eligible Employees who become eligible other than during an Election Period must submit an election form within thirty (30) days of notification of eligibility. If you fail to submit a timely election form, the automatic choice for your Contributions will be:

1. For Travelers, the Wage Replacement Account;

2. For all Employees except Travelers, the Premium Reserve Account.

All employer Contributions will be allocated to the automatic account described above until you file an election at a subsequent semi-annual Election Period. If funds are allocated to the Premium Reserve Account, you may be able to redirect those funds to the Medical Expense Reimbursement Account and/or Dependent Care Reimbursement Account but not the Wage Replacement Account during subsequent election periods. Your election becomes effective on the first day of the month after the Administrative Office receives the election form.

Semi-Annual Election Period

You may make an election between the Premium Reserve Account and the Wage Replacement Account each February and August for future monthly Contributions. You may also make an election to allocate Premium Reserve Account balances into the Dependent Care Reimbursement Account.

Employees who are not Travelers may make a second election each February and August to transfer future monthly Contributions from the Premium Reserve Account to the Medical Expense Reimbursement Account on a monthly basis. Employees who are not Travelers may also allocate existing Premium Reserve Account balances into the Medical Expense Reimbursement Account. However, you must have Harrison Health Plan coverage on the date funds are scheduled to be reallocated from the Premium Reserve Account to the Medical Expense Reimbursement Account. If you do not have Harrison Health Plan coverage on this date, the money will remain in your Premium Reserve Account.

Election forms will be mailed with your June 30 and December 31 quarterly statements. If you are an Employee and you wish to begin participation or modify existing elections, you must return an election form. The election form will become effective on the first day of the month after the Administrative Office receives the election form.

Making an Election

To participate in the Plan, you should file an election form with the Administrative Office (remember if you don't, and you are a Traveler, your Contributions will go by default to the Wage Replacement Account; and if you are not a Traveler, your Contributions will go by default to the Premium Reserve Account). The election form should specify the

percentage of employer Contributions to be directed to the Premium Reserve Account and the Wage Replacement Account. The Administrative Office may reject any election form that is not in a form provided by or acceptable to the Administrative Office.

Reallocation of Contributions

If you direct all or part of employer Contributions to the Premium Reserve Account and you are not a Traveler, you may allocate these funds into (but not out of) the Medical Expense Reimbursement Account and/or Dependent Care Reimbursement Account during the semi-annual election period. There are two allocation options for the Medical Expense Reimbursement Account. First, you may elect to allocate all or a portion of your future monthly Contributions allocated to the Premium Reserve Account to the Medical Expense Reimbursement Account on a monthly basis. The monthly Contributions will be transferred from the Premium Reserve Account to the Medical Expense Reimbursement Account on the first day of the month after your employer is obligated to contribute to the Plan so long as you have Harrison Health Plan coverage on the first day of the month. For example, if the employer Contribution is paid on June 15, the funds will be transferred to the Medical Expense Reimbursement Account on July 1 so long as you have Harrison Health Plan coverage on July 1. If you do not have Harrison Health Plan coverage on July 1, the money will remain in the Premium Reserve Account. Second, during the semi-annual election period, you may allocate existing funds in the Premium Reserve Account to the Medical Expense Reimbursement Account and/or Dependent Care Reimbursement Account. The Contributions will be transferred on the first day of the month after the Administrative Office receives and processes the election form. However, the funds can be reallocated from the Premium Reserve Account to the Medical Expense Reimbursement Account only if you have Harrison Health Plan coverage on the re-allocation date.

If you are a Traveler and direct all or part of employer Contributions to the Premium Reserve Account, you may allocate these funds into (but not out of) the Dependent Care Reimbursement Account during the semi-annual election period. You may not allocate these funds into the Medical Expense Reimbursement Account.

Amounts allocated to the Wage Replacement Account cannot be reallocated.

Benefits upon Retirement or Death

Premium Reserve Account

If you retire the portion of your Account allocated to the Premium Reserve Account will remain available for your use. You will have access to benefits under the Premium Payment Plan, and you can continue to direct amounts into the Medical Expense Reimbursement Account, the Dependent Care Reimbursement Account and continue to pay for your Group Term Life Insurance.

If you die the portion of your Account allocated to the Premium Reserve Account will remain available for your Dependents after your death. Your Dependents may receive benefits from the Premium Payment Plan and Medical Expense Reimbursement Account, to the extent they qualify for benefits under those Accounts. Money in the Dependent

Care Reimbursement Account will be forfeited. Your Dependent may redirect any portion of the Premium Reserve Account to the Medical Expense Reimbursement Account at any Election Period so long as your Dependent has Harrison Health Plan coverage on the allocation date.

Group Term Life Insurance is not available to your Dependents, although your designated beneficiary will receive the proceeds of any insurance you purchased through the Plan.

Wage Replacement Account

If you retire or die the portion of your Account allocated to the Wage Replacement Account will be forfeited if you die. Wage Replacement benefits are not available after retirement or death.

Forfeitures

If your Account becomes inactive, it will be forfeited. This means that if there are funds left in your Account and unused for a period of time, you will forfeit the balance and the money will be applied toward administrative expenses of the Plan. If forfeited amounts exceed the Plan's administrative expenses for the Plan Year, the excess amount will be allocated in equal shares among remaining Participants' Accounts.

The following situations will cause an Account to be forfeited:

1. You have less than $400 in your Account at the beginning of a calendar year and you have had no Account activity for an entire calendar year; or

2. Regardless of your Account balance, you have had no activity in your Account for five years.

No activity in your Account means no employer Contributions have been made to your Account, no payment of benefits has been made from your Account, and no coverage under a Harrison Health Plan.

Benefit Options

You may allocate your Contributions between the Premium Reserve Account and Wage Replacement Account.

Premium Reserve Options for Everyone but Travelers

During the semi-annual Election Period, you may allocate funds from the Premium Reserve Account to the Medical Expense Reimbursement Account and/or Dependent Care Reimbursement Account. You may also allocate future monthly Contributions from the Premium Reserve Account to the Medical Expense Reimbursement Account. However, for either election to the Medical Expense Reimbursement Account to be effective, you must have Harrison Health Plan coverage on the date the funds will be allocated from the Premium Reserve Account to the Medical Expense Reimbursement Account. If you do not have Harrison Health Plan coverage on the allocation date, the funds will remain in the Premium Reserve Account.

Premium Reserve Account Options for Travelers

During the semi-annual Election Period, you may leave the funds in your Premium Reserve Account or allocate some or all of the funds in your Premium Reserve Account to the Dependent Care Reimbursement Account.

Premium Reserve Account (Non-Taxable Account)

If you are not a Traveler and fail to make an election, your Contributions will be allocated to the Premium Reserve Account. If you are a Traveler and fail to make an election, your Contributions will be allocated to the Wage Replacement Account.

Under current IRS rules, when benefits are paid from any benefit option under the Premium Reserve Account, you will not be taxed for receipt of these benefits.

You must submit a request for payment on the form provided by the Administrative Office. You must also submit any documentation required by the Administrative Office to establish that the request for payment relates to an Eligible Expense. Payment will be made as soon as reasonably possible following approval of the Administrative Office.

Premium Payment Plan

The Premium Payment Plan allows you to use money in your Premium Reserve Account to pay premiums for continuation of Harrison Health Plan coverage. Your Harrison Health Plan premium may be paid from the Premium Payment Plan provided that:

1. You or your Dependent is eligible to make a partial self-payment, COBRA payment, or Retiree self-payment under the terms of the Harrison Health Plan;

2. You or your Dependent have exhausted all funds in your Harrison Health Plan reserve account and individual after-tax premium account; and

3. Your request to the Administrative Office to transfer funds from the Premium Payment Plan to the Harrison Health Plan is made within the time limits established in the Harrison Health Plan to make a partial self-payment, COBRA payment or Retiree self-payment.

For example:

Full Self-payment Amount	Premium Reserve Account Balance	How many months will account balance cover?	Taxable?
$1,100	$2,300	2	No

COBRA Issue

The money in your Premium Reserve Account can be used to make a COBRA payment to the Harrison Health Plan. This payment will not extend self-payment rights beyond the maximum length of time COBRA allows you to make self-payments at group rates, which is generally 18 months. For more information about COBRA rules, see the COBRA Continuation of Coverage section in your Harrison Health Plan benefit booklet.

You must submit a claim form requesting a transfer of funds from your Premium Reserve Account to the Harrison Health Plan to be used for a partial self-payment, a COBRA payment or a Retiree self-payment.

Group Term Life Insurance Plan

The Group Term Life Insurance Plan allows you to purchase an additional amount of life insurance. You can purchase either $25,000 or $40,000 of life insurance. The life insurance benefit is underwritten and benefits are paid by Standard Insurance Company.

You are eligible for Group Term Life Insurance if:

1. You have sufficient funds in your Premium Reserve Account to pay for one year of life insurance coverage; and

2. You provide evidence of insurability sufficient for Standard Insurance Company. This requirement is waived if you apply for the life insurance benefit within 31 days of first becoming eligible for this benefit.

You are not eligible for this benefit if:

1. You do not qualify for this benefit under the terms of the Plan;

2. You are covered by an employer-sponsored group term life insurance plan in addition to the Harrison Health Plan; or

3. You are a "key employee" as that term is defined in Section 416(i) of the Code.

To enroll, you must complete and return the coverage election form to the Administrative Office.

The life insurance benefit is available on a guaranteed issue basis (no health questions) to those applying for coverage within 31 days after first becoming eligible for the Group Term Life Insurance Plan, which is within 31 days of reaching the initial $400 of Contributions in your Account. If applying for coverage any time after the initial 31 days of eligibility, evidence of insurability will have to be provided to Standard Insurance Company. Coverage is not effective until the date your application is approved by Standard Insurance Company.

If you are participating in the Group Term Life Insurance Plan at the $25,000 coverage level, you may increase coverage to the $40,000 level effective March 1 without providing evidence of insurability to Standard Insurance Company, provided you have sufficient funds in your Premium Reserve Account to pay for an additional year of life insurance coverage. You may also decrease your coverage from $40,000 to $25,000 or terminate coverage effective March 1.

If you are participating in the Group Term Life Insurance Plan when you retire, you can continue coverage provided you have sufficient funds in your Premium Reserve Account to pay for an additional year of life insurance coverage.

The Group Term Life Insurance Plan has the following benefit provisions:

1. Death benefits paid due to any cause of death;

2. Waiver of Premium provision if totally disabled prior to age 60. Premium payment waived while disabled until age 65;

3. Accelerated Death Benefit available to terminally ill Participants who are under age 60, with a life expectancy of 12 months or less who qualify for the Accelerated Death Benefit. This allows a Participant to receive up to 75% of the insurance amount while living; and

4. Conversion privilege that allows a Participant whose coverage is ending for reasons other than failure to make/continue required premium payments, to buy an individual policy of life insurance without evidence of insurability. Conversion must be applied for within 31 days of coverage termination under the Group Term Life Insurance Plan. Standard Insurance Company, upon receipt of your request, will provide the type of policy available and premium cost information.

For a complete copy of the group contract between the Harrison Trust and Standard Insurance Company, call or write the Administrative Office and request a copy.

Benefits will be paid to the beneficiary(ies) you have named on the most recent beneficiary designation form that you have on file with the Administrative Office for the Harrison Health Plan. You can update your designation by completing the appropriate form available from the Administrative Office. Please be sure to maintain a current beneficiary

designation on record. If you do not file a beneficiary designation, benefits will be paid according to the Harrison Health Plan default beneficiary hierarchy.

The cost for additional life insurance is based upon your age as of each January 1. The yearly cost of coverage for the year 2015 is as follows:

Age as of January 1	Rate per $25,000 of Coverage	Rate per $40,000 of Coverage
Under Age 30	$30.00	$48.00
30 through 39	$39.00	$62.40
40 through 44	$48.00	$76.80
45 through 49	$75.00	$120.00
50 through 54	$99.00	$158.40
55 through 59	$150.00	$240.00
60 through 64	$177.00	$283.20
65 through 69	$345.00	$552.00
70 through 74	$600.00	$960.00
75 or older	$1,500.00	$2,400.00
Standard Insurance Company requires that at least 15% of eligible Participants purchase group life insurance for this benefit to be offered.		
You will not be eligible for this benefit if you have any other group life insurance provided by your employer.		

Medical Expense Reimbursement Account (Non-Taxable Account)

The Medical Expense Reimbursement Account reimburses you for out of pocket Medical Expenses such as deductibles, copayments and unreimbursed health and welfare expenses. Medical Expenses may be reimbursed if:

1. The expense qualifies under the Plan's definition of a Medical Expense. A Medical Expense is defined as an expense incurred for medical care as defined under Code Section 213(d) and allowed to be reimbursed on a tax free basis under an employer health plan under Code Sections 105 and 106. Such expense is allowed under the Plan to the extent that such expense:

    a. Is not reimbursed or reimbursable by (i) an employer-provided accident or health plan, or (ii) any other group or individual accident or health insurance; and

    b. Has not been claimed as a deduction on your or you Dependent’s federal income tax return.

    See IRS Publication 502 for a list of eligible Medical Expenses.

2. The expense is incurred after the effective date of your election (the first day of the month after the Administrative Office receives and processes the election form) to direct a portion of your Premium Reserve Account to the Medical Expense Reimbursement Account;

3. The reimbursement amount does not exceed the account balance of your Medical Expense Reimbursement Account as of the date the expense is incurred;

For example:

Medical Expense Incurred 6/3/2015	Medical Reimbursement Account Balance as of 6/1/2015	How much will account balance cover?	Taxable?
$150	$100	$100	No
You have 12 months from the date of service to submit a claim for reimbursement of your Medical Expense. For example, if you see your doctor on June 3, 2015 for an office visit and the office visit is applied to your deductible, you must submit this claim for reimbursement of your out-of-pocket expense by June 2, 2016.			
Remember to attach an explanation of benefits, receipts or other proof of payment when submitting your claim form for reimbursement. For more information see Applying for Benefits on page 21.			

4. The expense is incurred by you or a Dependent. An expense is considered incurred on the day the service is provided; and

5. The expense is submitted to the Administrative Office for reimbursement within 12 months after it is incurred.

Procedure to Opt Out and Forfeit your Medical Expense Reimbursement Account Balance

A Participant or Dependent with a Medical Expense Reimbursement Account balance may make a written election, on a form acceptable to the Administrative Office, to opt out of the Medical Expense Reimbursement Account and forfeit the money allocated to the Medical Expense Reimbursement Account at any time. This action shall not preclude a Participant or Dependent from allocating a portion of his/her Premium Reserve Account to the Medical Expense Reimbursement Account in the future if the prerequisites for an allocation to the Medical Expense Reimbursement Account have been met.

Dependent Care Reimbursement Account (Non-Taxable Account)

The Dependent Care Reimbursement Account provides reimbursement from your Dependent Care Reimbursement Account for qualifying Dependent Care Expenses. Highly compensated employees (as defined in Section 414(q) of the Code) are not eligible to use the Dependent Care Reimbursement Account. Dependent Care Expenses, for Participants who are not highly compensated employees, may be reimbursed through the Plan provided that:

1. The expense must be a Dependent Care Expense which is defined as:

   An expense incurred by a Participant for: (a) the care of a "qualifying individual"; (b) that is paid to a "dependent care service provider"; and (c) is an "employment related expense." The expense must not be reimbursed by any other Dependent Care Plan or used by you or a Dependent to obtain credit against federal income taxes.

   A "qualifying individual" means: (a) a Dependent of the Participant who has not attained age 13; or (b) a Dependent of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the year.

   A "dependent care service provider" means a person who provides care and related household services to a qualifying individual but shall not include: (a) a dependent care center (defined in Code Section 21 (b)(2)(D) unless the center complies with all applicable laws and regulations of the applicable state or local government; or (b) a related individual described in Code Section 129(c).

   An "employment related expense" is defined in accordance with Code Section 21 (b)(2).

2. There must be sufficient money in your Dependent Care Reimbursement Account on the date a qualifying Dependent Care Expense is incurred. An expense is incurred on the date the service is provided.

3. The request for reimbursement must include: (a) the amount, date and nature of the expense; (b) the name of the person, organization or entity to whom the expense was paid; (c) the address and taxpayer identification number or social security number of the person, organization or entity performing the services; (c) a statement that the expense (or the portion for which reimbursement is sought) has not been reimbursed and is not reimbursable under any other dependent care plan; and (d) such other information as the Administrative Office may require.

4. The maximum payment that a Participant may receive from the Dependent Care Reimbursement Account for any calendar year is:

   a. In the case of a Participant who is not married at the close of the calendar year, the lesser of the Participant's earned income (as defined in Code Section 129(e)(2)) for the calendar year or $5,000;

   b. In the case of a Participant who is married at the close of the calendar year, the lesser of:

      (i) The Participant's earned income for the calendar year;

      (ii) The earned income of the Participant's spouse for the calendar year;

      (iii) $5,000 if the Participant and spouse file a joint federal income tax return; or

      (iv) $2,500 if the Participant and spouse file separate federal income tax returns. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income for such month of $250 if there is one person that qualifies for Dependent Care Expenses for whom the Participant seeks reimbursement from his Dependent Care Reimbursement Account or $500 if there is more than one person that qualifies for Dependent Care Expenses for whom the Participant seeks reimbursement from his Dependent Care Reimbursement Account.

   Eligible Expenses from Your Dependent Care Reimbursement Account may include expenses for a "qualifying individual" such as:

   a. Care at a daycare center that complies with all appropriate state and local laws and regulations;

   b. Care by a relative so long as that relative is not one of your dependents. For example, you cannot be reimbursed for paying your 16-year-old child to care for your 2-year-old infant.

   c. Care for an elderly or incapacitated "qualifying individual" either in your house or outside your home. The qualifying individual must spend at least 8 hours each day in your home if you are claiming reimbursement for care outside your home.

   d. Care at a day camp to which you send a "qualifying individual" during school vacations so that you and your spouse, if you are married, can go to work or attend school full-time.

5. Expenses not allowed from your Dependent Care Reimbursement Account include:

   a. The cost of food, clothing and education.

   b. The cost of transportation between your house and the place where daycare services are provided.

   c. Expenses for which the federal child care income tax credit is taken.

   d. Overnight camp expenses.

   e. Nursing home expenses if the "qualifying individual" is confined to a nursing home.

Tax Issue

If you are reimbursed for Dependent Care Expenses by the Plan, you cannot take a tax credit for any reimbursed Dependent Care Expenses under Code Section 21. The money you receive from the Plan for reimbursement of qualifying Dependent Care Expenses is not subject to state or federal income taxes.

You have 15 days after the end of the calendar year to submit a claim. All claims for Dependent Care Expenses incurred in 2015 by January 15, 2016.

Remember to attach bills, invoices or other statements from a dependent care service provider showing the amount of expenses, the dates the expenses were incurred, a description of the expenses, the provider's tax identification or social security number, plus any additional documentation requested by the Administrative Office, when submitting your claim form for reimbursement. For more information, see Applying for Benefits on page 21.

Wage Replacement Account (Taxable Account)

Wage replacement benefits paid from your Wage Replacement Account are subject to taxation when they are paid or available to you because you meet the eligibility criteria even if you do not actually apply for benefits. Once you have allocated funds into the Wage Replacement Account, your funds must remain in this Account. You do not have to allocate your funds among the four benefit options under the Wage Replacement Account.

Once you qualify for benefits, payment will be made under the appropriate benefit option, depending on your Wage Replacement Account balance.

Generally, to receive benefits from the Wage Replacement Account, you must submit a request for payment on the forms provided by the Administrative Office. **You have 15 days after the end of the calendar year to submit a completed claim form. For example, you must submit all claims for wage replacement benefits incurred in 2015 by January 15, 2016. Requests submitted after this date will be denied as untimely by the Administrative Office (even if the benefits are required to be considered taxable to you for that year).** You must also submit any documentation

required by the Administrative Office to establish the request for payment of a wage replacement benefit meets the requirements of the Plan.

If you qualify to receive wage replacement benefits but fail to submit a request for benefits, you will still be subject to taxation on the amount that would have been payable had you requested benefits at the time you qualified.

Supplemental Short-Term Disability

This benefit provides income protection by supplementing the Harrison Health Plan's time-loss benefits when you are unable to work in the Electrical Industry due to a non-occupational (not work related) illness or injury. You may receive $300 per week provided that:

1. You are unable to work in the Electrical Industry because of a Disability;

2. Your Disability was not caused by an accident, illness or injury related to your employment;

3. You are eligible to receive time-loss benefits under the Harrison Health Plan; and

4. You have at least $300 in your Wage Replacement Account at the time you qualify for this benefit. If you have less than $300 in your Wage Replacement Account, you will receive your account balance.

Taxes

Supplemental Short-Term Disability benefits are subject to state and federal taxes as wages when you become eligible to receive them, and are also subject to Federal Unemployment, Social Security and Medicare taxes.

Supplemental Unemployment

This benefit provides income protection by supplementing state unemployment compensation benefits when you become unemployed from lack of work in the Electrical Industry. You may receive $300 per week, provided that:

1. You have been unemployed due to lack of work in the Electrical Industry for at least one week;

2. You are receiving state unemployment compensation benefits, have exhausted all unemployment compensation benefits under state law or failed to qualify for unemployment compensation solely because you are receiving a pension from an electrical industry pension plan;

3. You are actively seeking work in the Electrical Industry and have signed the out-of-work list at an IBEW local union; and

4. You have at least $300 in your Wage Replacement Account at the time you qualify for this benefit. If you have less than $300 in your Wage Replacement Account, you will receive your account balance.

This benefit is not available to Category II Employees.

Taxes

Supplemental Unemployment benefits are subject to state and federal taxes when you become eligible to receive them. Supplemental Unemployment benefits are not subject to Federal Unemployment, Social Security and Medicare taxes, provided that receiving Supplemental Unemployment benefits is linked to receiving state unemployment compensation benefits.

Supplemental Workers' Compensation

This benefit provides income protection by supplementing your time-loss benefits when you are unable to work in the Electrical Industry because of a work-related illness or injury. You may receive $300 per week provided that:

1. You are unable to work in the Electrical Industry because of a compensable workers' compensation injury;

2. You are receiving or have received time-loss benefits under a state workers compensation system for each week that benefits are requested; and

3. You have at least $300 in your Wage Replacement Account at the time you qualify for this benefit. If you have less than $300 in your Wage Replacement Account, you will receive your account balance.

Taxes

Supplemental Workers' Compensation benefits are subject to state and federal taxes as wages when you become eligible to receive them, and are also subject to Federal Unemployment, Social Security and Medicare taxes.

Economic Dislocation

This benefit provides money to cover expenses associated with moving and relocating to find work in the Electrical Industry. You may receive your entire Wage Replacement Account balance provided that:

1. You involuntarily lose your job with a Contributing Employer;

2. You have signed IBEW Local 48's out-of-work list and have been informed that no work is currently available;

3. If you are a member of IBEW Local 48, you have received a travel letter from IBEW Local 48. If you are not a member of IBEW Local 48, you or IBEW Local 48 provide verification to the Administrative Office that you intend to travel to another IBEW Local Union to seek employment in the Electrical Industry; and

4. You travel to another IBEW Local Union to seek employment in the Electrical Industry.

If your application for this benefit is approved, 50% of the money in your Wage Replacement Account will be paid at the time you travel to another IBEW Local Union, in order to assist you with moving and travel expenses. Once you relocate and sign an IBEW Local Union's out-of-work list or have gone to work for a contractor signatory to an agreement with another IBEW Local Union, the balance of the money in your Wage Replacement Account will be paid.

Taxes

Economic Dislocation benefits are subject to state and federal taxes as wages when you become eligible to receive them, and are also subject to Federal Unemployment, Social Security and Medicare taxes.

This benefit is not available to Category II Employees.

Applying for Benefits

The Administrative Office will provide a claim form that you must submit to receive benefits. Claim forms may be obtained by calling or writing A & I Benefit Plan Administrators or at the Harrison website: www.harrisonflex.aibpa.com. After completing the claim form, you can either mail it, fax it, email it or bring it to the Administrative Office for processing. Although you are not required to complete a claim form when requesting Supplemental Short-Term Disability benefits, you are still required to submit documentation to substantiate your claim.

Claims not submitted within the following time limits will be denied as untimely by the Administrative Office.

Claim forms for reimbursement of Medical Expenses must be submitted within 12 months from the date of service.

Claim forms for reimbursement of qualified Dependent Care Expenses must be submitted by January 15th or they will be denied. For example, a claim form for Dependent Care Expenses incurred in 2015 must be submitted by January 15, 2016.

Claim forms for wage replacement benefits (Supplemental Workers' Compensation, Supplemental Unemployment and Economic Dislocation) must be submitted by January 15th or they will be denied. For example, a claim form for a wage replacement benefit you qualified to receive in 2015 must be submitted by January 15, 2016.

Additional Documentation

In addition to submitting the claim form for reimbursement, the following benefits also require additional documentation.

Medical Expense Reimbursement

You must provide satisfactory proof (such as an explanation of benefits) to the Administrative Office that you or your Dependent has incurred a Medical Expense such as a deductible, copayment or unreimbursed expense. The documentation must include:

1. The date the Medical Expense was incurred;

2. The family member who incurred the Medical Expense and his or her relationship to you; and

3. A description of the Medical Expense (i.e., co-payment for a prescription drug).

You must certify the deductible, copayment or unreimbursed expense is not subject to payment from any other health and welfare plan or insurance policy.

You must submit your claim within 12 months of the time that the deductible, copayment or unreimbursed Medical Expense was incurred and money must have been in your Medical Expense Reimbursement Account on the date the service was provided.

Dependent Care Reimbursement

You must provide proof to the Administrative Office that you have incurred Dependent Care Expenses. The documentation must include:

1. Proof that the expense has been paid;

2. The name of the Dependent for whom the expense was incurred;

3. A description of the nature of the expense;

4. The amount of requested reimbursement; and

5. The name, address, and taxpayer identification number or social security number of the dependent care service provider who charged you for the Dependent Care Expenses.

The claim form must be accompanied by bills, invoices or other statements from the dependent care service provider, showing the amount of expenses plus any additional documentation the Administrative Office may request.

You must submit your claim no later than January 15th after the calendar year the expense was incurred. Otherwise, your claim will be denied as untimely by the Administrative Office.

Supplemental Short-Term Disability

You do not have to submit a claim form to apply for this benefit. You automatically receive the benefit if you are receiving Harrison Health Plan time-loss benefits and have funds in your Wage Replacement Account. This benefit is available only for individuals receiving Harrison Health Plan time-loss benefits.

Supplemental Unemployment

Within four weeks of the week that you meet the eligibility requirements, you should complete a claim form to receive supplemental unemployment benefits. You have 15 days after the end of the calendar year to submit a completed claim form. For example, if you met the eligibility requirements for supplemental unemployment benefits in 2015, you must submit the completed claim form by January 15, 2016. The claim form requires you to provide proof of the following:

1. Documentation from the state unemployment office demonstrating that you are eligible for, or have exhausted, state unemployment benefits;

   For example:

   Oregon.gov website may provide you with a copy of your unemployment claims history. The claims history will look like this:

Week Ending Date	Date Received	Claim Status		Amt. Paid	Date Processed
04/25/15	04/27/15	Paid	$	549	04/27/15
04/18/15	04/20/15	Paid	$	549	04/20/15
04/11/15	04/13/15	Paid	$	549	04/13/15

2. Documentation that you are registered on an IBEW Local Union's out-of-work list; and

3. A completed IRS Form W-4.

Proof can include documentation from the state unemployment office or a copy of an unemployment compensation check that shows the week(s) covered.

Supplemental Workers' Compensation

Within four weeks of the week that you meet the eligibility requirements, you should complete a claim form to receive supplemental workers' compensation benefits. You have 15 days after the end of the calendar year to submit a completed claim form. For example, if you met the eligibility requirements for supplement workers' compensation benefits in 2015, you must submit the completed claim form by January 15, 2016. The claim form requires you to provide proof of the following:

1. Documentation that you are receiving time loss benefits under a state workers' compensation system; and

2. A completed IRS Form W-4.

Proof can include documentation from the workers' compensation carrier or a copy of your time-loss check that shows the week(s) covered.

Economic Dislocation

Within four weeks of the week that you meet the eligibility requirements, you should complete a claim form to receive economic dislocation benefits. You have 15 days after the end of the calendar year to submit a completed claim form. For example, if you met the eligibility requirements for economic dislocation benefits in 2015, you must submit the completed claim form by January 15, 2016. The claim form requires you to provide proof of the following:

1. Documentation of involuntary termination of employment;

2. Travel letter, or other proof that you are traveling to another IBEW Local Union to seek work; and

3. A completed IRS Form W-4.

To withdraw the second half of your Wage Replacement Account, you must submit a claim form and provide proof that:

1. You have signed an IBEW Local Union's out-of-work list in the new location; or

2. You have obtained work from a contractor signatory to a collective bargaining agreement with another IBEW Local Union in the new location.

Summary

Benefit	Must Submit Claim Form	Time to Submit Claim/Proof	Maximum Amount	Account Claim Paid From	Taxable
Premium Payment Plan	Yes	See page 10	Account balance	Premium Reserve Account	No
Medical Expense Reimbursement Plan	Yes, receipts or an explanation of benefits showing date of service	One year	Account balance	Medical Expense Reimbursement Account	No
Dependent Care Reimbursement Plan	Yes, receipts, date of service, name, address, and Tax ID of person performing service	By January 15th	Account balance	Dependent Care Account	No. If using this benefit, cannot take a tax credit under Section 21 of the Code
Group Life	Enroll with Administrative Office	30 days of reaching $400 minimum	$25,000 or $40,000	Premium Reserve Account	No
Supplemental Short-term Disability ***Available to Harrison Health Plan Participants Only***	No	No claim form necessary	$300 per week	Wage Replacement Account	Yes
Supplemental Workers' Compensation	Yes	By January 15th	$300 per week	Wage Replacement Account	Yes
Supplemental Unemployment ***Not available to Category II employees***	Yes	By January 15th	$300 per week	Wage Replacement Account	Yes. Subject to state and federal income taxes only
Economic Dislocation ***Not available to Category II employees***	Yes	By January 15th	50% of account balance initially, remaining account balance later	Wage Replacement Account	Yes

Administration of the Plan

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 Administrative Office.

Name of Plan

This Plan is known as the Harrison Electrical Workers Trust Fund Flexible Benefits Plan, also referred to as the Plan.

Effective Date

The Plan was established July 1, 1999. This Benefit Booklet and Summary Plan Description is effective June 1, 2015.

Plan Sponsor

This Plan is sponsored by:

Board of Trustees
Harrison Electrical Workers Trust Fund
1220 SW Morrison Street Suite 300
Portland, OR 97205
In Portland: (503) 224-0048
Toll Free: (800) 547-4457

Employer and Plan Identification Numbers

The employer identification number and plan number assigned to the Plan Sponsor by the Internal Revenue Service are:

Employer Identification Number is 93-6023048
The Plan Number is 501.

Type of Plan

This Plan is an employee welfare benefit plan under ERISA. It allows Participants to choose among wage replacement benefits, health premium reimbursement, medical expense reimbursement, dependent care expense reimbursement, and group term life insurance coverage.

Plan Administrator

This Plan is administered by the Board of Trustees of the Harrison Electrical Workers Trust Fund, with the assistance of A & I Benefit Plan Administrators, Inc., a contract administration organization whose address and telephone number are:

A & I Benefit Plan Administrators, Inc.
1220 SW Morrison Street
Suite 300
Portland, OR 97205
In Portland: (503) 224-0048
Toll Free: (800) 547-4457

Authority and Responsibilities of the Board of Trustees

The Board of Trustees is the fiduciary of the Plan within the meaning of ERISA. The Board of Trustees has the discretionary authority to control and manage the operation and administration of the Plan and has all powers necessary to accomplish these purposes. The authority and responsibility of the Board of Trustees includes, but is not limited to:

1. Determining all questions relating to the eligibility of Employees to participate in the Plan;

2. Computing and certifying the amount and kind of benefits payable to Participants and Dependents;

3. Authorizing all disbursements;

4. Maintaining all necessary records for the administration of the Plan other than those an employer has specifically agreed to maintain;

5. Interpreting and construing the provisions of the Plan Document and Benefit Booklet, including remedying and resolving ambiguities, and publishing such rules for the regulation of the Plan as are deemed necessary and not inconsistent with the terms of the Plan Document; and

6. Directing the Administrative Office to make distributions to Participants, former Participants and Dependents in accordance with the provisions of the Plan.

Agent for Legal Service

The person designated as the Plan's agent for service of legal process is:

Lee Centrone
A & I Benefit Plan Administrators, Inc.
1220 SW Morrison Street
Suite 300
Portland, OR 97205

Service of legal process on the Plan may also be made upon a member of the Board of Trustees.

Board of Trustees

Employer Trustee

Timothy Gauthier
Oregon-Columbia Chapter NECA
601 NE Everett
Portland OR 97232

Randy Wagner (First Alternate)
Dynaelectric Company
5711 SW Hood Avenue
Portland, OR 97239

Union Trustee

Gary Young
IBEW Local No. 48
15937 NE Airport Way
Portland OR 97230

Erik Richardson (First Alternate)
IBEW Local No. 48
15937 NE Airport Way
Portland OR 97230

Alan Keser (Second Alternate)
IBEW Local No. 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 of the National Electrical Contractors Association and IBEW Local No. 48 and other employers signatory to collective bargaining agreements with IBEW Local No. 48 and Category II Agreements. The collective bargaining agreements and Category II 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 agreement or Category II Agreement to receive the benefits provided by the Plan. The hourly contribution rate is specified in the collective bargaining agreements and Category II Agreements. Copies of the collective bargaining agreements and Category II Agreements can be obtained from the Oregon-Columbia Chapter of the National Electrical Contractors Association, IBEW Local No. 48 and the Administrative Office.

A complete list of employers contributing to the Plan may be obtained upon written request to the Board of Trustees and is available for examination during regular office hours at the Administrative Office.

Plan Benefits

This Plan provides Supplemental Short-Term Disability, Supplemental Workers' Compensation, Supplemental Unemployment, Economic Dislocation, Premium Payment, Medical Expense Reimbursement, Dependent Care Reimbursement, and Group Term Life Benefits for eligible Participants.

Your coverage will depend on the benefits you have selected.

Payment of Plan Expenses and Additions to Participant Accounts

On a temporary basis, the Board of Trustees will pay the administrative expenses of operating the Plan from investment income generated from Participant Accounts and, if necessary, Harrison Trust reserves.

On a temporary basis, the Plan will credit to the Account of each Participant interest at the rate of 1% per annum. Interest will be credited to the Account of each Participant monthly based on the value of the Account of each Participant on the last day of each month.

Eligibility, Termination of Eligibility and Benefits

The Benefit Booklet describes benefits, eligibility and termination of eligibility requirements under the Plan. If at any time you are unable to locate your Benefit Booklet, a new Benefit Booklet may be obtained from the Administrative Office:

A & I Benefit Plan Administrators, Inc.
1220 SW Morrison Suite 300
Portland OR 97205

Organizations providing Benefits, Funding Media and Type of Administrations

The names and addresses 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.

All Benefits except Life Insurance

All benefits provided by the Plan except the life insurance benefit are paid directly from Harrison Trust assets.

Life Insurance

The life insurance benefit is provided by Standard Insurance Company under a group contract between the Harrison Trust and Standard Insurance Company. Standard Insurance Company is responsible for administering the life insurance benefit and paying claims.

Standard Insurance Company
900 SW 5th Avenue
Portland, OR 97204
Telephone: (800) 628-8600

Source of Contributions

This Plan is funded through employer Contributions, the amount of which is specified in the collective bargaining agreements and Category II Agreements. Employee contributions are not allowed.

Plan Year

This Plan is administered on a calendar year basis. The Plan Year begins each January 1 and ends the following December 31.

Plan Amendment and Plan Termination

The Board of Trustees may, in their sole discretion, amend, change or terminate the Plan and the Plan Document. **None of the Plan provisions or benefits are vested.**

The Board of Trustees reserves the right to terminate the Plan by a written instrument to that effect. Should this Plan terminate for any reason, all monies and assets remaining in the Plan, after the payment of expenses, will be used for the continuance of the benefits provided by the Plan, until such monies 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 Contributing Employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation of the Contributing Employer to make Contributions as required by its collective bargaining agreement or Category II Agreement. In the event the Plan does not have sufficient assets to permit continued payments, nothing contained in the Plan or the Trust Agreement for the Harrison Trust will be construed as obligating any Contributing Employer to make benefit payments or Contributions other than the Contributions for which the Contributing Employer may be obligated by the collective bargaining agreement or Category II Agreement.

Likewise, there will be no liability upon the Board of Trustees, individually or collectively, or upon the Oregon-Columbia Chapter of the National Electrical Contractors Association or IBEW Local No. 48 to provide or pay for the benefits provided by this Plan if assets are not sufficient to make such benefit payments.

Claims Appeal Procedures

All claims or disputes concerning eligibility to participate in the Plan, elections made or not made under the Plan, eligibility to receive benefits from the Plan and the amount of benefits received from the Plan, except for Group Term Life Insurance benefits, must be filed with the Administrative Office. A claim concerning the receipt or denial of benefits from the Group Term Life Insurance Plan must be filed with Standard Insurance Company, 900 SW Fifth Avenue, Portland, OR 97204, (503) 628-8600.

There are two different Claims Appeal Procedures depending on the type of claim. There is a Claims Appeal Procedure for Supplemental Short-Term Disability Benefits and Supplemental Workers' Compensation Benefits. There is a separate Claims Appeal Procedure for all other types of claims or disputes.

Claims Appeal Procedure for Supplemental Short-Term Disability and Supplemental Workers' Compensation Benefits

This Claims Appeal Procedure is applicable for the denial, reduction or termination of supplemental short-term disability and supplemental workers' compensation benefits.

1. Denial, Reduction or Termination of Supplemental Short-Term Disability and Supplemental Workers' Compensation Benefits by the Administrative Office

a. The Administrative Office is responsible for reviewing applications for supplemental short-term disability and supplemental workers' compensation benefits. The Administrative Office will normally provide a notice of benefit determination (whether approved or adverse) within a reasonable period of time but not later than 45 days after receipt of a completed claim. If the Administrative Office determines an extension of time is necessary to complete review of the claim because of matters beyond its control, the 45 day period may be extended for up to 30 days provided the Administrative Office notifies you of the extension of time for review of the claim during the initial 45 day period. If, prior to the end of the first 30 day extension, the Administrative Office determines that a further extension of time is necessary to complete review of the claim because of matters beyond its control, the 30 day extension period may be extended for up to an additional 30 days provided that the Administrative Office notifies you of the extension of time for review of the claim before the end of the first 30 day extension period.

If an extension of time is required by the Administrative Office, you will be notified in writing and the notice shall 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 from the Administrative Office

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 for you to perfect the claim and an explanation why such material or information is necessary;

iv. A description of the Plan's review 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 determination by the Board of Trustees; 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 to the Board of Trustees

a. If you disagree with the initial denial notice, you or your authorized representative must file a written appeal within 180 days after receiving the denial notice. The written appeal must be mailed or delivered as follows:

Harrison Electrical Workers Trust Fund
ATTN: Appeals Board
c/o A & I Benefit Plan Administrators, Inc.
1220 SW Morrison Street, Suite 300
Portland OR 97205

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 claim for benefits. Whether a document, record or other information is relevant to your claim will be determined in accordance with ERISA regulation 29 CFR §2560.503-1 (m)(8).

c. In conjunction with your appeal, you or your representative may submit written comments, documents, records and other information relating to your claim for benefits to the Board of Trustees.

d. 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 appeal.

e. You may be represented at the hearing before the Board of Trustees by an attorney or other representative of your choosing at your cost and expense.

4. Decision by the Board of Trustees

a. Upon receipt of an appeal, the Board of Trustees will review the claim de novo (meaning without deference to the initial decision of the Administrative Office). The Board of Trustees will review all relevant information regardless of whether the information was previously submitted to the Administrative Office. If the appeal involves issues of medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the applicable field of medicine. If the Board of Trustees consults a medical or vocational expert, he will be identified regardless of whether the Board of Trustees relies on his opinion. If the Board of Trustees consults a medical or vocational expert, he will be different than the medical or vocational expert previously consulted and he will not be a subordinate of the medical or vocational expert previously consulted.

b. A decision will be made by the Board of Trustees at its next regularly scheduled meeting following receipt of the appeal unless the appeal is received less than 30 days prior to such meeting. If this is the case, the Board of Trustees will review the appeal not later than the next Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees 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 will be in writing and sent within five days after the decision is reached.

d. If the Board of Trustees denies your appeal, the decision will be in writing and 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 non-privileged 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 CFR §2S60.S03-1 (m)(8);

iv. Your right to bring a lawsuit for the benefit under ERISA; 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.

e. You are required to use the procedures set forth above before bringing a lawsuit for benefits under ERISA.

f. The Board of Trustees has the full and exclusive authority to administer supplemental short-term disability benefits and supplemental workers' compensation benefits, interpret the Plan and Benefit Booklet, interpret the Harrison Health Plan and resolve all questions arising in the administration, interpretation and application of this Plan, the Benefit Booklet and the Harrison Health Plan that concern supplemental short-term disability and supplemental workers compensation benefits. The Board of Trustees' authority includes, but is not limited to:

i. The right to resolve all matters when the Claims Appeal Procedure has been invoked;

ii. The right to establish and enforce rules and procedures for the administration of supplemental short-term disability and supplemental workers' compensation benefits and any claim concerning supplemental short-term disability and supplemental workers' compensation benefits so long as the rules and procedures are consistent with ERISA;

iii. The right to construe and interpret the Plan, the Benefit Booklet and the Harrison Health Plan as they relate to supplemental short-term disability and supplemental workers' compensation benefits; and

iv. The exercise of such power and authority by the Board of Trustees will be given the fullest deference allowed by law.

Claims Appeal Procedure for All Claims Except Life Insurance, Supplemental Short-Term Disability and Supplemental Workers' Compensation Benefits

This Claims Appeal Procedure is applicable to all types of claims except life insurance, Supplemental Short-Term Disability and Supplemental Workers' Compensation claims.

1. Denial, Reduction or Termination of the Claim by the Administrative Office.

a. The Administrative Office is responsible for reviewing all types of claims except life insurance claims. The Administrative Office will normally provide a notice of the benefit determination (whether approved or adverse) within a reasonable period of time but not later than 30 days after receipt of the claim. The time period may be extended up to an additional 15 days for matters beyond the Administrative Office's control, but you will be notified of the extension before the end of the initial 30 day period. The notice will identify circumstances requiring the extension and the date by which the Administrative Office 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 45 days to furnish the information.

2. Content of Denial Notice from the Administrative Office

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 for you to perfect the claim and an explanation why such material or information is necessary;

iv. A description of the Plan's review procedure, 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 determination by the Board of Trustees;

v. If the denial is based upon a decision involving medical necessity or because the service was experimental or investigational, you will be notified of your right to receive a statement of the scientific or clinical judgment for the decision free of charge upon request; and

vi. If the denial is based upon an internal rule, guideline, protocol or other similar criterion, you will be notified of your right to receive the document free of charge upon request.

3. Appeal to the Board of Trustees

a. If you disagree with the initial denial notice, you or your authorized representative must file a written appeal within 180 days after receiving the denial notice. The written appeal must be mailed or delivered as follows:

Harrison Electrical Workers Trust Fund
ATTN: Appeals Board
c/o A & I Benefit Plan Administrators, Inc.
1220 SW Morrison Street, Suite 300
Portland OR 97205

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 to your claim will be determined in accordance with 29 CFR §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 a hearing by regular mail at the return address shown on your appeal.

e. You may be represented at the hearing before the Board of Trustees by an attorney or other representative of your choosing at your cost and expense.

4. Decision by the Board of Trustees

a. Upon receipt of an appeal, the Board of Trustees will review the claim de novo (meaning without deference to the initial decision of the Administrative Office). The Board of Trustees will review all relevant information regardless of whether the information was previously submitted to the Administrative Office. If the appeal involves issues of medical judgment such as whether a particular treatment, drug or other item is experimental, investigational or medically necessary, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the applicable field of medicine. If the Board of Trustees consults a health care professional, he will be identified regardless of whether the Board of Trustees relies on his opinion. If the Board of Trustees consults a health care professional, he 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 at their next regularly scheduled meeting following receipt of the appeal unless the appeal is received less than 30 days prior to the meeting. If this is the case, the Board of Trustees will review the appeal not later than the next Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees 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 will be in writing and sent within five days after the decision is reached.

d. If the Board of Trustees denies your appeal, the decision will be in writing and 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;

   iii. A statement that, 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 claim. Whether a document, record or information is relevant is determined in accordance with 29 CFR §2S60.S03-1 (m)(8);

   iv. If the decision was based on medical necessity, experimental treatment or other similar exclusions or limitations, the scientific or clinical judgment used in the decision will be described or provided free of charge upon request;

   v. Your right to bring a lawsuit for the benefit under ERISA; and

   vi. If the decision is based on an internal rule, guideline, protocol or other similar criteria, the internal rule, guideline, protocol or other similar criteria 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 civil lawsuit for the benefit under ERISA.

f. The Board of Trustees has the full and exclusive authority to control and manage the Plan, to administer and interpret the Plan and Benefit Booklet, interpret the Harrison Health Plan and resolve all questions arising in the administration, interpretation and application of the Plan, the Benefit Booklet, and the Harrison Health Plan. The Board of Trustees' authority includes, but is not limited to:

i. The right to resolve all matters when the Claims Appeal Procedure has been invoked;

ii. The right to establish and enforce rules and procedures for the administration of the Plan and any claim that arises under it so long as the rules and procedures are consistent with ERISA;

iii. The right to construe and interpret the Plan, Benefit Booklet and the Harrison Health Plan; and

iv. The exercise of such power and authority by the Board of Trustees will be given the fullest deference allowed by law.

Unsecured Right to Payment

No Participant has any interest in any specific asset of the Harrison Trust. A Participant has only an unsecured right to receive payments in accordance with the provisions of the Plan. Plan Accounts are a record-keeping device only, and the Board of Trustees will not segregate amounts in the Harrison Trust according to a Participant's Account balance.

Assignment of Benefits

No Participant has the right or power to alienate, anticipate, pledge, encumber or assign any of the benefits or proceeds recorded for the Participant under the terms of this Plan. Furthermore, no Plan benefits or proceeds are subject to seizure by any creditor of the Participant except as allowed by applicable law.

Notice of Privacy Practices of the Trust Fund and Plan

THIS SECTION 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.

Policy regarding Your Protected Health Information

This section 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 section 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 the Plan, from which it is possible to individually identify you and that relates to:

1. Your past, present, or future physical or mental health condition;

2. The provision of health care to you; or

3. 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 Trust Fund's HIPAA Client Service Representative whose address and telephone number are listed on page 49.

The Plan's Responsibilities

The Plan is required by law to:

1. Maintain the privacy of your Protected Health Information;

2. Provide you with certain rights with respect to your Protected Health Information;

3. Give you this information which describes the Plan's legal duties and privacy policies regarding your Protected Health Information; and

4. Follow the terms of this section until modified.

The Board of Trustees reserve the right to change the terms of this section 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 section, 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 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 your providers, to determine benefit responsibility under the Plan, and to coordinate Plan coverage. For example, the Plan may tell your provider 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 also 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 Trust Fund 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 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 Administrative 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 46.

With only limited exceptions, the Plan will send all mail to the Participant. This includes mail related to the Participant'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 Participant, spouse, and other family members and information on the denial of any Plan benefits involving the Participant, 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 Administrative 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 disclosed 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 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 Trust Fund at the address on page 49. 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 Trust Fund at the address on page 49. 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 Trust Fund at the address on page 49. 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 Trust Fund at the address on page 49 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 Trust Fund at the address on page 49. The accounting request should specify the time period for which 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 Trust Fund at the address on page 49.

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 Trust Fund, in writing, at the address on page 49. 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 Trust Fund'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
ATTN: HIPAA Client Service Representative
1200 SW Morrison Street, Suite 300
Portland, OR 97205
In Portland: (503) 224-0048
Toll Free: (800) 547-4457

If you have any questions regarding this notice, please contact the Trust Fund's HIPAA Client Service Representative.

Statement of ERISA Rights

As a participant in the Harrison Electrical Workers Trust Fund Flexible Benefits Plan, 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 the following rights:

1. Examine, without charge, at the Administrative Office and at other specified locations, such as worksites and union halls, all documents governing 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrative Office may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

4. Continue health care coverage for you or a Dependent if there is a loss of coverage as a result of a qualifying event. You or your Dependent may have to pay for such coverage. Review the benefit booklet for the Harrison Health Plan for the rules governing 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 dependents. 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 a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor.

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. 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 Administrative Office. If you have any questions about this Statement, or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Sponsor, 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 1-866-444-3272 or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington DC 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 1-866-444-3272. You may also find answers to your questions and a list of Employee Benefits Security Administration field offices at: www.dol.gov/ebsa.

Definition of Terms

Account – The separate bookkeeping record or records maintained by the Administrative Office in the name of a Participant in accordance with this Plan.

Administrative Office – A & I Benefit Plan Administrators Inc., whose address is 1220 SW Morrison, Suite 300, Portland, OR 97205, or its successor.

Benefit Booklet – This booklet and any amendments, additions or deletions subsequently made.

Board of Trustees – The individuals who govern the Harrison Electrical Workers Trust Fund and this Plan and their successors.

Category II Agreement – A written agreement between the Board of Trustees or the Harrison Trust and a Contributing Employer that requires the Contributing Employer to make Contributions to the Harrison Trust on behalf of Employees who do not work under a collective bargaining agreement.

Code – The Internal Revenue Code of 1986, as amended.

Contributing Employer – An employer who is obligated to make Contributions to the Harrison Trust on behalf of Employees covered by a collective bargaining agreement or Category II Agreement that will be used to maintain an Account for the Employee in accordance with the terms of the Plan.

Contributions – The payments a Contributing Employer is required to make to the Harrison Trust, under the terms of a Category II Agreement or collective bargaining agreement, so its covered Employees may be eligible for one or more of the benefits offered by the Plan.

Dependent – Means:

1. A Participant's spouse (if not legally separated or divorced).

2. A Participant's child (son, daughter, stepchild, legally adopted child, or a child placed in the Participant's home pending adoption) until the end of the month the child attains age 26.

3. A Participant's Domestic Partner and/or the Domestic Partner's child (until the end of the domestic partnership or the month the child attains age 26) provided the individual is claimed as a "dependent" for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code.

4. A Participant's unmarried child 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 31 days of the date coverage would end due to age;

b. Single and dependent on the Participant for the majority of his or her support; and

c. The Participant claims the child as a "dependent" for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code.

5. A Participant's unmarried grandchild, niece, nephew, or sibling until the end of the month the child attains age 19 (or 25 if enrolled in an accredited school as a full-time student) if:

a. The Participant has been named as legal guardian by a court of competent jurisdiction;

b. The child is in the custody of the Participant;

c. The Participant provides the majority of the child's support; and

d. The Participant claims the child as a "dependent" for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code.

Dependent Care Expense – An expense incurred by a Participant for: (a) the care of a "qualifying individual"; (b) that is paid to a "dependent care provider service"; and (c) is an "employment related expenses." The expense must not be reimbursed by another other dependent care plan or used by you or your spouse to obtain credit against federal income taxes.

A "qualifying individual" means: (a) a Dependent of the Participant who has not attained age 13; or (b) a Dependent of the Participant who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the year.

A "dependent care service provider" means a person who provides care and related household services to a qualifying individual but shall not include: (a) a dependent care center (defined in 26 U.S.C. § 21 (b)(2)(D) of the Internal Revenue Code) unless the center complies with all applicable laws and regulations of the applicable state or local government; or (b) a related individual described in 26 U.S.C. § 129(c) of the Internal Revenue Code.

An "employment related expense" is defined in accordance with 26 U.S.C. § 21 (b) (2) of the Internal Revenue Code.

In the event of an inconsistency between the definition of Dependent Care Expense in the Benefit Booklet and the applicable provisions of the Code and its administrative regulations, the provisions of the Code and its administrative regulations will control.

Disability – A Participant is unable to work in his/her normal job because of an illness or accidental bodily injury and is under the care of a doctor.

Domestic Partner – The Participant and another individual who meets the following criteria:

1. They are residing together and sharing the common necessities of life;

2. Neither of them is married or registered as a 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 months. This does not apply if your prior spouse or Domestic Partner is deceased;

4. They are at least age 18;

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;

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; and

8. The Participant claims the Domestic Partner as a "dependent" for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code.

Election Period – The period designated by the Board of Trustees for a Participant to elect how Contributions will be allocated between the Wage Replacement Account and the Premium Reserve Account, and the period designated by the Board of Trustees for a Participant to allocate amounts in the Premium Reserve Account to the Dependent Care Reimbursement Plan and Medical Expense Reimbursement Plan.

Electrical Industry – Work of any nature for an employer who performs the type of work that falls within the craft jurisdiction of a local union affiliated with the IBEW.

Eligible Expense – An expense incurred during a coverage period that is eligible for payment or reimbursement pursuant to the terms of the Plan, and that is not reimbursed to a Participant outside the Plan.

Employee – A common law employee of a Contributing Employer who receives wages as defined in 26 U.S.C. § 3401(a) of the Internal Revenue Code from a Contributing Employer. The term Employee does not include self-employed individuals defined in 26 U.S.C. § 401(c) of the Internal Revenue Code, partners of a partnership, independent contractors, or individuals holding a two percent or greater ownership in a corporation defined in 26 U.S.C. § 1361 of the Internal Revenue Code.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Harrison Health Plan – The health and welfare plans the Board of Trustees have implemented or will implement for employees, early retirees, retirees and their dependents. The health and welfare plans currently offered by the Board of Trustees are known as the Active Employee Plan and the Retired Trust Plan.

IBEW – The International Brotherhood of Electrical Workers.

Medical Expense – An expense incurred for medical care as defined in 26 U.S.C. § 213(d) of the Internal Revenue Code and allowed to be reimbursed on a tax free basis under an employer health plan under 26 U.S.C. §§ 105 and 106 of the Internal Revenue Code, but only to the extent such expenses are not reimbursed or reimbursable by (i) an employer-provided accident or health plan or (ii) any other group or individual accident or health insurance. In addition, such an expense may only be claimed under this Plan to the extent the expense is not claimed as a deduction on the Participant's or Dependent's federal income tax return.

NECA – The National Electrical Contractors Association.

Participant – An Employee who commences participation in accordance with eligibility and participation provisions of the Plan.

Plan or Plan Document – The Harrison Electrical Workers Trust Fund Flexible Benefits Plan, as amended from time to time.

Plan Sponsor – The Board of Trustees.

Plan Year – The period January 1 through December 31.

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. §160.103 is adopted for use in the Plan.

Retirement or Retired or Retiree – An individual has voluntarily ceased working in the Electrical Industry and is eligible for Harrison Health Plan retiree health plan benefits on account of age and eligibility.

Traveler – A Participant who has elected to have his/her Harrison Trust health contribution, but not his/her Contribution to the Plan, transferred to a health and welfare trust fund other than the Harrison Trust pursuant to the I.B.E.W./NECA Electronic Reciprocity Transfer System or similar reciprocity arrangement.

Trust Fund or Harrison Trust – The Harrison Electrical Workers Trust Fund.

Union – Local 48 of the International Brotherhood of Electrical Workers.

Gender and Number – When necessary to the meaning hereof, 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 anyone case.

Administered By:

A & I Benefit Plan Administrators, Inc.
1220 SW Morrison Street, Suite 300
Portland OR 97205
In Portland: (503) 224-0048, Ext. 1681
Toll Free: (800) 547-4457, Ext. 1681
www.harrison.aibpa.com
harrison@aibpa.com