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Trustees' Letter

The Board of Trustees is pleased to issue this new Benefit Booklet. This Benefit Booklet serves as the Plan Document for the Harrison Electrical Workers Trust Fund Active Employee Plan.

This Benefit Booklet has been prepared to provide you with a summary of the structure, benefits and other information concerning the Harrison Electrical Workers Trust Fund Active Employee Plan. Starting on page 119 is the Summary Plan Description, which is required by the Employee Retirement Income Security Act.

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

1. Eligibility to participate in the Active Employee Plan;
2. The circumstances that may result in termination of eligibility to participate;
3. Conditions pertaining to eligibility to receive benefits from the Active Employee Plan;
4. The benefits provided by the Active Employee Plan;
5. Appeal rights if your claim for a benefit is denied; and
6. Your rights under the Employee Retirement Income Security Act of 1974.

The benefits provided by the Active Employee Plan are not vested. Although the Board of Trustees intends to continue to provide health and welfare benefits for you and your family, unforeseen circumstances or circumstances beyond the control of the Board of Trustees may make it inadvisable to continue the Active Employee Plan in its present form. The Board of Trustees reserves the right to amend, change or terminate the Active Employee Plan, including the right to change the eligibility rules, change or reduce benefits and require or increase self payments.

The Board of Trustees has made three medical plans available to you and your dependents. You and your dependents can have medical benefits provided by Providence Health Plan, Kaiser Permanente, or the Active Employee Plan described in this Benefit Booklet. Effective January 1, 2006, the Board of Trustees has also made three dental plans available to you and your dependents. You and your dependents can have dental benefits provide by Kaiser Permanente, Willamette Dental, or by the Active Employee Plan described in this Benefit Booklet.

Regardless of the medical and dental plans you choose, you and your dependents are eligible for the employee assistance benefits described in this Benefit Booklet. You are also eligible for time loss benefits, life insurance benefits, accidental death and dismemberment benefits and Employee Assistance Program described in this Benefit Booklet. You and your dependents will be provided with the vision benefits described in this Benefit Booklet, unless you have elected Kaiser Permanente for your medical benefits, in which case Kaiser Permanente provides vision benefits.

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

For your convenience there is a *Definition of Terms* section located in the back of this Benefit Booklet. If you would like further information or assistance, please call or write the Trust Office:

Harrison Electrical Workers Trust Fund
1220 SW Morrison Street, Suite 300
Portland, Oregon 97205
In Portland: 503-224-0048 ext. 1679
Outside Portland: 800-547-4457 ext. 1679

HARRISON ELECTRICAL WORKERS TRUST FUND

Timothy Gauthier
Management Trustee

Clif Davis
Union Trustee

Gary Price
First Alternate Management Trustee

Tim Foster
First Alternate Union Trustee

Randy Wagner
Second Alternate Management Trustee

Eric Hayes
Second Alternate Union Trustee

Eligibility

Category I Employees

Regular Eligibility

A Category I employee works under a collective bargaining agreement between an employer and certain local unions of the IBEW. Employers who have a collective bargaining agreement with certain local unions of the IBEW will pay the hourly contribution rate stipulated in the collective bargaining agreement to the Harrison Trust for each hour of service an employee worked. All hours, for the purpose of calculating contributions, will be treated as straight-time hours.

All employer contributions for work you have performed are credited (in dollars) to your reserve account. This is a continuing process. You may call the Trust Office to determine the dollars in your reserve account.

To become eligible and to maintain coverage, you must accumulate a sufficient balance (in dollars) in your reserve account in any qualifying month to meet the required charge for coverage in the corresponding coverage month, as shown below.

Sufficient Balance in the Qualifying Month of...	Provides Coverage for the Corresponding Month of...
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February
January	March
February	April
March	May
April	June

Special Eligibility

An employer and a local union of the IBEW or a non-IBEW local union approved by the Board of Trustees may request permission from the Board of Trustees to negotiate in a collective bargaining agreement a flat monthly contribution rate in lieu of a contribution rate based on hours of service. The Board of Trustees will allow a flat contribution rate only for non-construction bargaining units where employees work a steady number of hours each month and there is little employee turnover. The Board of Trustees will determine the flat monthly rate. The Board of Trustees has sole discretion to determine whether a bargaining unit is eligible for the flat monthly contribution rate.

Category II Non-Bargaining Employees

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

1. The employer must have a Collective Bargaining Agreement with International Brotherhood of Electrical Workers Local Nos. 48, 280, 659, 932, or 970 (the Harrison Unions) that requires the employer to make a contribution to the Harrison Trust for Category I (bargaining unit) employees;

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

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

4. All employer reports are subject to audit to verify compliance with the terms of the Category II Agreement;

5. New employees, during their first full or partial month of employment, can be excluded;

6. A part-time employee who works 20 hours or less per week can be excluded;

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

8. In addition to the exclusions in paragraphs 5 through 7, an employer can exclude a limited number of non-bargaining unit employees from coverage pursuant to a schedule obtainable from the Trust Office;

9. A health and welfare contribution is not allowed for a non-bargaining unit employee who is not employed on the last day of the month; and

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

If the Employer intends to exclude employees from coverage under paragraph number 8 above, the Employer must send a written notice, including the employee's name(s), to the Trust Office. Once an employee is excluded from coverage under paragraph number 8 above, the Employer will not be allowed to provide coverage for the employee and dependents under the Category II Agreement for 18 months. Furthermore, the excluded employee must sign a form provided by the Trust Office acknowledging that the employee and dependents will not have health and welfare coverage through the Harrison Trust for a minimum of 18 months.

The monthly contribution amount for employees covered by a Category II Agreement will be determined by the Board of Trustees. The monthly contribution must be paid in advance each month and be accompanied by the proper form provided by the Trust Office.

Contact the Trust Office for a copy of the Category II Agreement, which spells out the rules in more detail.

Partial Self-Payments

If you are a Category I employee, you will be allowed to maintain coverage by making timely self-payments in the amount equal to the required monthly deduction less the existing dollar credit in your reserve account. This is called a partial self-payment. You must meet the requirements of rules 1, 2, 3, or 4 as outlined below, to make a partial self-payment.

To make a partial self-payment there must be no lapse in coverage and you must have had coverage in the month immediately proceeding the month for which you want to make a partial self-payment. The prior month's coverage must not have been provided through COBRA self-payment. If you do not make a partial self-payment to continue coverage, you will not be eligible to make future self-payments until your reserve account has enough employer contributions to pay for a month's coverage, except as set forth under the *Continuation of Coverage* rules starting on page 14. You must make the required self-payment by the 10th day of the month for which you are self-paying the premium.

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

To be eligible to make a partial self-payment, use your reserve account to obtain benefits or obtain a disability waiver of health and welfare premiums, you must meet one of the following:

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

2. Available for immediate dispatch to a Contributing Employer by being registered on the appropriate local union's out-of-work list; and you are not working in Restricted Non-Covered Employment in the Electrical Industry. See the Definition of Terms section of the Benefit Booklet for the definitions of "Restricted Non-Covered Employment" and "Electrical Industry." IF YOU ARE WORKING IN RESTRICTED NON-COVERED EMPLOYMENT, YOU MUST NOTIFY THE TRUST OFFICE. IF YOU FAIL TO NOTIFY THE TRUST OFFICE AND CONTINUE TO RECEIVE HEALTH AND WELFARE COVERAGE, THE HARRISON TRUST WILL HOLD YOU RESPONSIBLE FOR ANY HEALTH INSURANCE PREMIUMS PAID AND

HEALTH AND WELFARE CLAIMS PAID FOR THE MONTH(S) YOU WERE INELIGIBLE TO USE YOUR RESERVE ACCOUNT. INFORMATION FOR NOTIFYING THE TRUST OFFICE IS:

Harrison Electrical Workers Trust Fund
1220 SW Morrison Street Suite 300
Portland OR 97205

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

4. Eligible to receive, currently receiving or have received an IBEW pension, not working in the Electrical Industry, or disabled.

If you fail to qualify under one or more of the above paragraphs for 12 consecutive months, at the end of the 12th month, your reserve account will be canceled and the funds will be transferred to the general fund of the Harrison Trust.

If You Are Out of Work

As long as you maintain a reserve and comply with paragraphs 1, 2, 3, or 4, your benefits will be continued.

If you fail to meet the requirements, but then return to work and accumulate the required amount, your benefits will be automatically reinstated as of the first day of the coverage month corresponding to the qualifying month as previously described.

If You Lose Time Because of Sickness or Injury

If you become totally disabled, due to an occupational or non-occupational accident or disease, you have health and welfare coverage on the date of disability and your disability continues for at least one calendar month, you may apply to the Board of Trustees to have the amount charged for coverage waived during your disability. Your reserve account will be frozen and the waiver begins on the first day of the month you become disabled and qualify for the Disability Waiver of Health and Welfare Premiums.

The initial waiver will apply only for three months. After that time, you may apply for an additional three months, provided you are still disabled. This waiver is only allowed for six months in a lifetime. In order to be considered for a waiver, you must obtain a statement from your attending physician giving the nature of your disability, the date your disability started, and the date you expect to return to work. This information must be provided to the Board of Trustees on the application form that is available from the Trust Office.

If You Move from One Contributing Employer to Another

Your benefits under this Plan will continue, provided you have maintained the necessary reserve as of the first of each month. If you transfer from one Contributing Employer to another, your reserve account will be maintained, and you will not lose any benefits. You should make sure your new Employer is contributing to the Harrison Trust for you.

The Maximum Accumulation in Your Reserve Account

The maximum amount you are allowed to accumulate in your reserve account is set by the Board of Trustees. You should check with the Trust Office for the maximum amount. In the event you accumulate a full reserve account at the end of three consecutive months in a calendar quarter, the Harrison Trust will deposit $100.00 into an individual account for you. For example, if you have accumulated a full reserve account at the end of the months of January, February, and March, the Harrison Trust will deposit $100.00 to your individual account at the end of that quarter (first quarter).

To check on your reserve each month, contact the Trust Office:

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

In Portland: 503-224-0048, ext. 1679
Outside Portland: 800-547-4457, ext. 1679

Employee Contributions to an Individual Account

If you are a Category I employee or you have a frozen reserve account and now participate as a Category II employee, you have the option of making after-tax contributions to the Harrison Trust in order to pay for future health and welfare coverage after your reserve account has been depleted. In order to make the after-tax contribution, you must meet one of the criteria to make a partial self-payment or utilize the reserve account as described on page 5 of this Booklet. A separate account will be established in your name. This account will *not* draw interest. The maximum contribution to this account is equal to the cost of six months of health and welfare coverage. If you wish to take advantage of this option, please contact the Trust Office for a form that must accompany your payment.

Once a payment is made to the individual account, it cannot be withdrawn for any reason other than to purchase health and welfare coverage for you and your dependents after employer contributions to your reserve account have been depleted. In the event you die, your dependents can use the money in the account to continue eligibility for health and welfare coverage.

If you want additional information concerning contributions to an individual account, please call or write the Trust Office.

Domestic Partner Coverage, Rules and Procedures

Effective January 1, 2007, the Harrison Trust and its insured plans (Kaiser Permanente and Providence) are offering health and welfare coverage to an employee's domestic partner and the domestic partner's dependent children subject to the rules and policies set forth below, in other sections of this Benefit Booklet and in the Kaiser Permanente and Providence booklets.

The definition of "domestic partner" is set forth in the definitional section of the Benefit Booklet.

An employee may enroll a domestic partner and the domestic partner's children for health and welfare coverage during the following time periods:

1. Within 30 days after the employee becomes eligible for employe-paid health and welfare coverage;

2. Within 30 days after the domestic partnership relationship is first established;

3. Within 30 days after the domestic partner has a new child (enrollment for the child only if the domestic partner is already enrolled for coverage); and

4. During the annual open enrollment period established by the Board of Trustees.

Contact the Trust Office for enrollment forms.

If an employee enrolls a domestic partner for health and welfare coverage and allows the health and welfare coverage for the domestic partner to lapse while health and welfare coverage is maintained for the employee, the employee will not be allowed to re-enroll his/her domestic partner for health and welfare coverage until the next annual open enrollment period.

If an employee enrolls a domestic partner and the domestic partner's children for health and welfare coverage and allows the health and welfare coverage for the domestic partner's dependent children to lapse while health and welfare coverage is maintained for the employee, the employee will not be allowed to re-enroll the domestic partner's dependent children for health and welfare coverage until the next annual open enrollment period.

Federal law requires that the value of employer paid health and welfare coverage provided to a domestic partner and the domestic partner's dependent children be treated as taxable income to the employee unless the employee certifies that the domestic partner and/or the domestic partner's dependent children are claimed as "dependents" of the employee for federal income tax purposes under 26 U.S.C. § 1.52 of the Internal Revenue Code. An employee who elects to provide health and welfare coverage to a domestic partner and the domestic partner's dependent children as a result of employer paid health and welfare coverage, absent a certification satisfactory to the Board of Trustees that states the domestic partner and/or the domestic partner's dependent children qualify for and are claimed as dependents of the employee for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code, the employee will be required to pay the federal and, if applicable, state income taxes associated with the value of employer paid health and welfare coverage to the domestic partner and the domestic partner's dependent children. The Board of Trustees will determine the value of the monthly health and welfare coverage to the domestic partner and, if applicable, the domestic partner's dependent children. Contact the Trust Office for the current information. The employee will receive a W-2 form from the Harrison Trust at the end of each calendar year in an amount equal to the value of the employer paid health and welfare coverage provided to the domestic partner and, if applicable, the domestic partner's dependent children.

The federal taxes that must be paid by an employee who elects to provide health and welfare coverage to a domestic partner and, if applicable, the domestic partner's dependent children as a result of employer paid health and welfare coverage are:

- 28% - Withholding tax.
- 15.3% - FICA tax.

A payment to the Harrison Trust to cover the federal taxes attributable to the value of employer paid health and welfare coverage provided to the domestic partner and, if applicable, the domestic partner's dependent children must be paid by the 20th day of the month preceding the coverage month. If the employee fails to make a timely payment, health and welfare coverage for the domestic partner and, if applicable, the domestic partner's dependent children will end and the employee will not be allowed to re-enroll the domestic partner and, if applicable, the domestic partner's dependent children until the next annual open enrollment period.

If an employee elects to provide health and welfare coverage for a domestic partner and, if applicable, the domestic partner's dependent children, and certifies that the domestic partner and/or dependent children qualify for and are claimed as "dependents" of the employee for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code, the employee will not receive a W-2 form from the Harrison Trust for the value of the employer paid health and welfare coverage provided and will not be subject to the pre-payment of federal taxes detailed in the preceding paragraph. However, in order to avoid receipt of a W-2 form and the pre-payment of federal taxes detailed in the preceding paragraph, the employee must sign a certificate regarding "dependent" status of the domestic partner and, if applicable, the domestic partner's children. Contact the Trust Office for the certification. The certification must be signed prior to the first month in which health and welfare coverage is provided to the domestic partner and, if applicable, the domestic partner's dependent children and before January 1 of each subsequent year.

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

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

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

If either the employee or domestic partner has made a false statement or representation regarding their status as domestic partners in the enrollment form or fails to notify the Trust Office in writing within 30 days after they no longer qualify as domestic partners and the Harrison Trust suffers any loss as a result thereof, the Harrison Trust or the Board of Trustees may bring a civil action against either or both the employee and the domestic partner to recover any losses incurred by the Harrison Trust including reasonable attorney's fees and court costs. The Board of Trustees may also offset prospective benefits payable to either the employee, domestic partner or either of their dependent children in order to recover the Harrison Trust's loss. The Board of Trustees may also withdraw money from the employee's reserve account in order to recover the Harrison Trust's loss.

Family and Medical Leave

If you are a Category I or Category II employee and leave work temporarily for Family and Medical Leave, the Trust will pay up to three months of health and welfare coverage for you (or up to six months of health and welfare coverage for you if the Family and Medical Leave is to care for a "covered servicemember") if you meet certain criteria. If you qualify, you receive the same coverage you had before taking Family and Medical Leave.

Prerequisites for Coverage Under Family and Medical Leave

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

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

3. You must have worked for one or more Contributing Employers at least 1,250 hours during the 12 months before the Family and Medical Leave;

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

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

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

    c. Your own "serious health condition";

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

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

5. A "serious health condition" is an illness, injury or impairment involving:

    a. Inpatient treatment;

    b. Absence from work or school for three or more days with continuing treatment by a health care provider;

    c. Continuing treatment by a health care provider for a condition that is incurable or serious enough to result in three or more days of incapacity; or

    d. Prenatal care.

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

7. You may use the Family and Medical Leave benefit once per 12 consecutive months.

The Family and Medical Leave Benefit for Qualified Employees

If you qualify for this benefit as a Category I employee, the Trust will credit your made on your behalf but for the Family and Medical Leave. The Harrison Trust will credit your Reserve Account with a maximum of three health months of health and welfare contributions. If you lose Harrison Trust-paid coverage, you are responsible for payment of health and welfare coverage by COBRA payment.

If you qualify for this benefit as a Category II employee, your Employer will pay the health and welfare premium for the month you last worked before taking the Family and Medical Leave. The Harrison Trust then pays up to three months of health and welfare premiums. After three months of Harrison Trust paid coverage, health and welfare premiums must be paid by your Employer or by COBRA payment.

Application Process

If you think you qualify for Family and Medical Leave and want to use this benefit, call the Trust Office to obtain an application form. You will need to complete the application form and return the completed application to the Trust Office. You will be notified whether you qualify for this benefit.

Harrison Trust-paid health and welfare coverage will stop before the third month if you return to work or otherwise terminate your Family and Medical Leave.

Plan Options

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

If you meet the eligibility requirements for coverage under the Active Employee Plan, you may choose to enroll yourself and your dependents for medical, dental, vision and employee assistance benefits. Only employees are eligible for accidental death and dismemberment, life insurance and time loss benefits.

You may change your medical and/or dental coverage choice during the annual open enrollment. For example, you can switch from Providence Health Plan or Kaiser Permanente to the Active Employee Plan or from the Active Employee Plan to Providence Health Plan or Kaiser Permanente. You can also switch from the Active Employee dental plan to either the Kaiser Permanente Dental Plan or the Willamette Dental Plan or vice versa. The annual open enrollment period is determined and announced by the Board of Trustees. If you select Providence Health Plan, Kaiser Permanente Medical or Dental Plan or the Willamette Dental Plan during the annual open enrollment period, you must complete an enrollment form and return it to the Trust Office.

If you do not live within the Providence Health Plan, Kaiser Permanente or Willamette Dental service area, you may not select Providence Health Plan, Kaiser Permanente or Willamette Dental coverage. If you choose or are considering Providence Health Plan, Kaiser Permanente or the Willamette Dental Plan, you should refer to the benefit book offered by Providence Health Plan, Kaiser Permanente or Willamette Dental for the schedule of benefits, exclusions for preexisting conditions and the claim appeal procedure. Contact the Trust Office for a Benefit Booklet.

Active Employee Plan

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

1. Medical;
2. Prescription drugs;
3. Dental;
4. Vision;
5. Employee assistance;

6. Accidental death and dismemberment;

7. Life insurance; and

8. Time loss.

Providence Health Plan

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

Kaiser Permanente

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

COBRA — Continuation of Coverage

This section is applicable to all employees and their dependents regardless of whether you are enrolled in the Active Employee Plan, Providence Health Plan or Kaiser Permanente Foundation Health Plan.

Introduction

This section of the Benefit Booklet contains important information about your right to COBRA continuation coverage, which is a temporary extension of medical and prescription drug coverage or medical, prescription drug, dental and vision coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your dependents who are covered under this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) when you would otherwise lose your group health and welfare coverage. This section explains COBRA continuation coverage, when it may become available to you and your dependents, and what you need to do to preserve your right to COBRA continuation coverage.

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) because any of the following qualifying events happens:

1. Your spouse or domestic partner dies;
2. Your spouse's or domestic partner's hours of employment are reduced;
3. Your spouse's or domestic partner's employment ends for any reason;
4. Your spouse or domestic partner becomes enrolled in Medicare (Part A, Part B, or both); or

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

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

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated or the domestic partnership ends; or
6. The child is no longer eligible for coverage because he or she no longer qualifies as a "dependent child."

Special Second Election Period. Certain employees and former employees who are eligible for federal trade adjustment assistance or alternative trade adjustment assistance are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of sixty (60) days or less (but only if the election is made within six (6) months after Plan coverage is lost). **If you are an employee or former employee and you qualify for federal trade adjustment assistance or alternative trade adjustment assistance, contact the Trust Office, whose name, address and telephone number is on page 22 of this Benefit Booklet, after qualifying for federal trade assistance or alternative trade adjustment assistance or you will lose any right that you may have to elect COBRA during a special second election period**. Contact the Trust Office for more information about this special second election period.

Notices and Elections of COBRA Continuation Coverage

Under this Plan, but not an insured plan (Providence Health Plan or Kaiser Permanente), your spouse's or domestic partner's coverage ends the day that a divorce or legal separation or dissolution of a domestic partnership relationship occurs (coverage is lost for the spouse only or, in the case of a domestic partnership, the domestic partner and his/her children). Under this Plan and an insured Plan (Providence Health Plan or Kaiser Permanente), a dependent child's coverage ends on the last day of the month in which the dependent child no longer qualifies as a dependent.

Important: For the following qualifying events (divorce or *legal* separation of the employee and spouse, dissolution of a domestic partnership, or a dependent child who no longer qualifies as a dependent child), you, the spouse, domestic partner or dependent child must notify the Trust Office ***in writing*** within 60 days after the divorce, legal separation, dissolution of the domestic partnership or child losing dependent status using the procedures specified in the box below. If these procedures are not followed and the notice is not provided in writing to the Trust Office during the 60-day notice period, any spouse, domestic partner or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT COBRA – CONTINUATION COVERAGE.

Notice Procedures

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

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

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

If the Trust Office receives timely written notice that one of the four qualifying events (divorce, legal separation, dissolution of a domestic partnership or child losing dependent status) has happened, the Trust Office will notify the family member of the right to elect COBRA continuation coverage. You, your spouse, domestic partner or dependent child will also be notified of the right to elect COBRA continuation coverage automatically (without any action required by you, your spouse, domestic partner or dependent child) when coverage is lost because your employment ends, hours are reduced, you die or become enrolled in Medicare (Part A, Part B or both).

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

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions apply to you by other group health plans if you have more than a 63-day gap in health coverage and election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA coverage for the maximum time available to you.

Benefits Available Under COBRA Continuation Coverage

You, your spouse, domestic partner and each dependent child has the right to elect COBRA continuation coverage for medical and prescription drug coverage only, or for medical, prescription drug, dental and vision coverage. Any other benefits provided to you or your family by this Plan such as time loss benefits, life insurance and accidental death and dismemberment benefits are not available by electing COBRA continuation coverage. COBRA continuation coverage is identical to the medical, prescription drug, dental and vision coverage available to similarly situated employees and dependents. If the medical, prescription drug, dental and vision coverage is modified, COBRA continuation coverage will be modified in the same way. All family members must select the same coverage.

How Long COBRA Continuation Coverage Lasts

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

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

When the qualifying event is the employee's termination of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if an employee becomes entitled to Medicare eight months before the date on which his coverage terminates because of a reduction in hours, COBRA continuation coverage for his spouse or domestic partner and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the employee's termination of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If you or a dependent covered under this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) is determined by the Social Security Administration to be disabled and you notify the Trust Office in a

timely fashion, you and your dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of COBRA continuation coverage. You must make sure that the Trust Office is notified ***in writing*** of the Social Security Administration's disability determination within 60 days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must follow the procedures specified in the box, entitled "Notice Procedures" on page 16. In addition, your notice must include the name of the disabled person, the date that the qualified beneficiary became disabled and the date that the Social Security Administration made its determination. Your notice must also include a copy of the Social Security Administration's disability determination. If these procedures are not followed or if the notice is not provided in writing to the Trust Office within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Trust Office of that fact in writing within 30 days after the Social Security Administration's determination.

Extension of 18-month period of COBRA continuation coverage due to a second qualifying event. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Notice of the second qualifying event must be given in a timely manner to the Trust Office. This extension may be available to the spouse, domestic partner and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced, legally separated, the domestic partnership dissolves or if the dependent child no longer qualifies as a dependent child but only if the event would have caused the spouse, domestic partner or dependent child to lose coverage under this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) had the first qualifying event not occurred. In all these cases, the spouse, domestic partner or dependent child must make sure that the Trust Office is notified ***in writing*** of the second qualifying event within 60 days of the second qualifying event. The spouse, domestic partner or dependent child must follow the procedures specified in the box, entitled "Notice Procedures" on page 16. Your written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. If the second qualifying event is the dissolution of a domestic partnership, your notice must state the date the domestic partnership dissolved. If these procedures are not followed or if the notice is not provided in writing to the Trust Office within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

How Much COBRA Continuation Coverage Costs

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

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new

tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

When and How Must Payment for COBRA Continuation Coverage Be Made

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

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

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

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

Monthly payments for COBRA continuation coverage. After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. These monthly payments are due by the first day of the month. If you make a monthly payment on or before the first day of the month, your coverage under the Plan will continue for that coverage period without any break. **The Trust Office will not send periodic notices of payments due for these coverage periods**.

Monthly payments for COBRA continuation coverage should be sent to:

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

Grace periods for monthly payments. Although monthly payments are due by the first day of the month, you will be given a grace period of 30 days to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month but before the end of the grace period, your coverage under this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage) is reinstated.

If you fail to make a monthly payment by the end of the grace period, you will lose all rights to COBRA continuation coverage.

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

COBRA continuation coverage for you, your spouse or domestic partner and dependent children will automatically end (even before the end of the maximum coverage period) if:

1. The premium is not paid by the end of the grace period;
2. After electing COBRA continuation coverage, you, your spouse, domestic partner or dependent child becomes enrolled in Medicare benefits (under Part A, Part B or both);
3. After electing COBRA continuation coverage, you, your spouse or domestic partner or dependent child becomes covered under another group health plan (but only after any exclusions of that other plan for a preexisting condition for you, your spouse or domestic partner or dependent child has been exhausted or satisfied);
4. The Harrison Trust no longer provides group health coverage for any of its participants;
5. Your last employer stops contributing to the Harrison Trust and makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the employer's employees formerly covered under the Harrison Trust. In this situation, the group health plan maintained by the employer (or the other multiemployer plan) from that date forward has the obligation to make COBRA continuation coverage available to any person who was receiving coverage under the Harrison Trust on the day before the cessation of contributions by the employer and who is, or whose qualifying event occurred in connection with, an employee whose last employment prior to the qualifying event was with the employer; or
6. During a disability extension period (explained on page 17), you, your spouse or domestic partner or dependent child is determined by the Social Security Administration to be no longer disabled. In this circumstance, COBRA continuation coverage will be terminated for you, your spouse or domestic partner and your dependent children who are receiving extended COBRA continuation coverage under the disability extension as of the later of (i) the first day of the month that is more than thirty (30) days after the final determination by the Social Security Administration that you, your spouse or domestic partner or dependent child is no longer disabled; or (ii) the end of the coverage period that applies without regard to the disability extension.

You, your spouse or domestic partner and/or dependent child must notify the Trust Office ***in writing*** within thirty (30) days if, after electing COBRA continuation coverage, you, your spouse or domestic partner or your dependent child becomes entitled to Medicare (Part A, Part B or both), becomes covered under other group health plan coverage, or you, your spouse or domestic partner or dependent child is determined by the Social Security Administration to no longer be disabled. Follow the "Notice Procedures" on page 16 of this Benefit Booklet.

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

When you elect COBRA continuation coverage, coverage for your spouse and your dependent children will continue automatically unless your spouse (your domestic partner if he/she had coverage immediately before the qualifying event) independently declines COBRA continuation coverage. If you choose not to elect COBRA continuation coverage, your spouse, domestic partner (if he/she had coverage immediately before the qualifying event) and dependent children may still elect COBRA continuation coverage. Of course, in all circumstances, anyone electing COBRA continuation coverage must pay the required premium.

Transfer Rights

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

More Information About Individuals Who May Be Qualified as Beneficiaries

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

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

For More Information About COBRA Continuation Coverage

Questions concerning this Plan or an insured plan (Providence Health Plan or Kaiser Permanente) or your COBRA continuation coverage rights should be addressed to the Trust Office identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act and other laws affecting group health plans, contact the nearest Regional or District office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the website.

Keep the Trust Office Informed of Address Changes

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

The Trust Office

The Trust Office manages COBRA continuation coverage on a day-to-day basis. The name, address and telephone number of the Trust Office are:

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

Oregon Portability Health Insurance Plans

This section of the Benefit Booklet applies only if you reside in Oregon and your health insurance benefits are provided by Providence Health Plan or Kaiser Permanente.

Oregon law requires some types of insurance companies and HMO's that previously offered you and your dependents group health insurance benefits to provide a choice of two health insurance plans when group health insurance coverage ends. These individual plans do not contain preexisting condition provisions, exclusions or waiting periods. These individual plans can be used in lieu of COBRA, during COBRA or after your COBRA coverage has expired. The health insurance plans are called "portability health benefit plans" and are intended to improve the availability and affordability of health benefit plans when individuals leave group coverage.

Eligibility Requirements for Portability Health Benefit Plans. To enroll in one of the portability plans, you, your spouse or dependent child must:

1. Have ended coverage or lost eligibility under the Providence Health Plan or Kaiser Permanente.
2. Have been continuously enrolled with Providence Health Plan or Kaiser Permanente, or Providence Health Plan or Kaiser Permanente and one or more other Oregon group health plans (including any continuation coverage under COBRA) for at least 180 days prior to the loss of eligibility under the Providence Health Plan and/or Kaiser Permanente.
3. Be a resident of Oregon.
4. Not be eligible for Medicare.

How to Apply for a Portability Health Benefit Plan. In order to exercise the right to enroll in one of the portability health benefit plans, you, your spouse or dependent child must:

1. Submit a written application to Providence Health Plan or Kaiser Permanente.
2. Apply for individual coverage within 60 days after you lose your group health insurance coverage or after your COBRA coverage expires.
3. Be responsible for paying the cost of the individual insurance coverage.

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

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

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

Medical Benefits

New Employees

New employees (those who have not been eligible for coverage through the Harrison Trust in any of the previous 12 consecutive months) and their dependents are subject to a preexisting conditions limitation, and should contact the Trust Office to verify benefits and coverage. See page 132 for a definition of a preexisting condition and page 61 (paragraph 5) for a summary of the preexisting condition limitations.

Medical Benefits

Deductible: Employee and Dependents	$250 per calendar year	An annual deductible of $250.00 per person or a maximum of $750.00 per family will be charged for covered charges occurring during a calendar year.
Deductible: Family	$750 per calendar year	
Non-Preferred Provider Percentage	70% of reasonable and customary covered charges	
Preferred Provider	80% of negotiated charges	
Special Benefit Percentage - Limited Preferred Network	If there are fewer than two Preferred Provider primary care physicians within a 30 mile radius of your primary residence, medical benefits will be paid at 80% of reasonable and customary covered charges.	

The medical benefits portion of this Benefit Booklet provides that all covered charges (other than for dental, orthodontia, vision and chemical dependency), after satisfying the deductible, will be payable at 70% of the reasonable and customary covered charges for a nonpreferred provider and 80% of the negotiated charges for a preferred provider. Your out-of-pocket maximum, excluding the deductible, is $2,000.00, or $6,000.00 per family during a calendar year. After the out-of-pocket maximum has been met, all covered charges (other than those for dental, orthodontia, vision and chemical dependency) will be paid at 100% of the reasonable and customary charges, or 100% of the negotiated rate for a preferred provider, for the remainder of the calendar year up to the lifetime maximum benefit.

Any covered charges incurred during the last three months of the calendar year and applied to the deductible will apply toward the deductible in the next calendar year.

If a single accident causes injuries to two or more members of a family unit, a single deductible will apply to the family for covered charges incurred during that calendar year and resulting from such injuries. In no event will a lesser amount be paid than would be payable if this single deductible did not apply.

Chemical dependency charges are not included in the out-of-pocket expense maximum. There is a separate maximum and specific allowances for the treatment of chemical dependency. See pages 45 through 47.

Maximum Benefit

The $2 million maximum benefit is a lifetime aggregate for all covered charges paid. However, if you have received payment for all or part of the maximum benefit, you will have up to $2,500.00 of your maximum automatically reinstated each January 1.

Benefit Period

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

A benefit period ends on the earliest of the following:

1. The last day of the calendar year in which it was established; or
2. The day coverage provided under this Plan ends; or
3. The day the maximum benefit is paid.

Determination of Benefits

Benefits to be paid will be determined by multiplying the benefit percentage *by* the amount of reasonable and customary covered charges in a benefit period that exceed the deductible. For example:

Hospital Visit You are Charged	**Covered Charges**	**Deductible (You Pay)**	**Plan Pays 80% Preferred Provider 70% Non-Preferred Provider**	**You Pay**
$500.00	$500.00	$250.00	$250.00 x 80% = $200.00 $250.00 x 70% = $175.00	$50.00 $75.00

Covered Charges

1. Semi-private room and board and routine nursing for confinement in a hospital.
2. Semi-private room and board and routine nursing for confinement in a skilled nursing facility (not to exceed the average semi-private hospital room rate). Services must commence within 14 days after discharge of three or more days in an acute care hospital.
3. Intensive Nursing Care for each day of confinement in a hospital as follows:
    a. For those hospitals which make a separate charge for Intensive Nursing Care, the hospital's specific charge for Intensive Nursing Care is covered;
    b. For those hospitals that make a combined charge for Room and Board and Intensive Nursing Care, the part of the combined charge that is in excess of the hospital's prevailing semi-private Room and Board rate will be the covered charge for Intensive Nursing Care.

4. Medical services and supplies furnished by the hospital.

5. Anesthetics and their administration.

6. Medical treatment given by or at the direction of a physician, if such treatment is within the scope of the provider.

7. Services of a RN for private duty nursing services in a hospital.

8. Services of a LPN for private duty nursing services in a hospital.

9. Services of a licensed physiotherapist.

10. Charges by a doctor or speech therapist for rehabilitative speech therapy that is necessary because of an illness (other than a functional nervous disorder), or is necessary because of surgery on account of an illness. Charges by a doctor or speech therapist for speech therapy that is necessary as the result of Down Syndrome. If the speech therapy is necessary because of a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

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

12. X-ray and radiation therapy.

13. Charges for the repair of sound, natural teeth (including their replacement) required as a result of, and performed within 24 months of, an accidental bodily injury that occurs while the person is covered under the Plan.

14. Transportation within the United States and Canada to and/or from a hospital or care center will be a covered charge if medically necessary and recommended by your attending physician.

15. Medical supplies as follows:

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

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

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

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

    e. Purchase or rental of hospital-type equipment for kidney dialysis for your personal and exclusive use. The total purchase price considered will be on a monthly prorata basis during the first 24 months of ownership, but only so long as dialysis treatment continues to be medically necessary. Also covered are all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also reasonable and necessary expenses for the training of a person to operate and maintain the equipment for your sole benefit. No benefits are paid on or after the day you are entitled to benefits under Medicare.

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

g. Purchase of durable medical equipment (hospital-type medical equipment), if approved, will be prorated over 12 months beginning with date of purchase.

h. Medically necessary prosthesis.

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

16. Smoking Cessation: The Plan covers prescription stop-smoking aids the same as any other prescription drug. Coverage is provided only if the item requires a prescription from your doctor, and it must be dispensed by a licensed pharmacist or doctor.

17. Maternity Expenses (employees and spouses only): Employees and spouses are covered for maternity expenses on the same basis as for any other illness, whether or not the pregnancy commences while you are covered under this Plan. Coverage must be in effect at the time of delivery. Benefits are not available for maternity related expenses for your pregnant child, even if the child is covered under the Plan.

18. Immunizations.

19. Well Baby Care: This benefit is not subject to the deductible. This benefit provides for well baby visits during the first three years of your child's life. In addition, medically necessary immunizations are covered for your child.

20. Birthing Center: Covers charges made for services and supplies furnished by a birthing center for prenatal care, delivery of a child or children and postpartum care rendered within 24 hours after delivery.

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

22. Childbirth: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require a provider obtain authorization from the Plan or the issuer for prescribing length of stay not in excess of 48 hours (or 96 hours).

23. Breast Reconstruction: If following a mastectomy you elect breast reconstruction in connection with such mastectomy, the following charges will be covered:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce symmetric appearance;

c. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedsmas, in a manner determined in consultation between you and your attending physician;

d. This benefit is subject to the annual deductible and copayments.

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

25. Bariatric surgical procedures including gastric-bypass and laproscopic procedures but only if surgery is preapproved in writing by a medical review agency selected by the Board of Trustees using its most stringent medical necessity review criteria. The medical review agency currently used by the Board of Trustees is Qualis Health in Seattle, Washington.

26. A colonoscopy, once every 10 years if you are over age 50. A colonoscopy will be allowed before age 50, or more often than once every 10 years if you are age 50 or over, if the colonoscopy is medically necessary.

27. Viagra and like medication is limited to three pills per week.

28. Yearly limitation on Chiropractic and Naturopathic services: 26 visits per calendar year maximum for Chiropractic services and 26 visits per calendar year maximum for Naturopathic services. The number of visits for which you will receive benefit payment will be reduced if these services are used to meet part or all of your calendar year deductible.

29. Acupuncture services provided by an MD, DO, or Licensed Acupuncturist. Benefits are limited to 26 visits per calendar year. Services are payable at 70% of reasonable and customary charges (80% if preferred provider), payment not to exceed $50.00 per visit.

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

31. Services of a licensed medical doctor, licensed doctor of osteopathy, or an occupational therapist for rehabilitation services provided to restore fully developed skills that were lost or impaired due to an injury, illness or sickness.

Hearing Aid Benefit

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

1. The hearing aid device must be ordered by a physician, certified audiologist or licensed hearing aid dealer.

2. Charges for a hearing aid device ordered by a physician, certified audiologist or licensed hearing aid dealer will be eligible for coverage through the Plan's hearing aid benefit. Covered charges for a hearing aid device are not subject to the deductible and the first $400.00 will be payable at 100% by the Trust. After the first $400.00, the Trust will pay 50% of the covered charges for a hearing aid device up to an additional payment of $3,000.00. The maximum benefit is $3,400.00. For example:

Hearing Aid Device You Are Charged	**Covered Charges**	**Deductible (You Pay)**	**Plan Pays 100% First $400.00 50% up to $1,500.00**	**You Pay**
$500.00	$500.00	$0.00	$400.00 x 100% = $400.00 $100.00 x 50% = $50.00	$50.00

3. This benefit renews every 36 months.

4. Benefits will not be paid for batteries and for ancillary equipment that is not obtained upon purchase of the Hearing Aid Device, and for any charge for repairs, servicing or alteration of a Hearing Aid Device.

Home Maker Services

This benefit is available when you are physically unable to perform daily household tasks and no other household member is able to perform these tasks. The out-of-pocket cost for home maker services will be reimbursed by the Trust at 80% of the reasonable and customary charge, to a maximum of $100.00 per week. A week commences the first day charges for home maker services are incurred. Lifetime maximum benefit for these services is $5,000.00. For example:

Home Maker Services You are Charged	Covered Charges	Deductible (You Pay)	Plan Pays 80% up to Lifetime Maximum of $5,000.00	You Pay
$100.00 for one week	$100.00	$250.00	$100.00 x 80% = $80.00	$20.00

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

1. You must formally apply to the Trust Office and demonstrate both cause and need.
2. Services cannot be rendered by a family member.

Inpatient Custodial Care

Inpatient care that is custodial in nature is reimbursed at 100% to a maximum of $100.00 per day for the first 20 days of confinement and $78.50 per day for an additional 80 days. The lifetime maximum benefit for these services is $8,280.00. For example:

Inpatient Custodial Care You are Charged	**Covered Charges**	**Deductible (You Pay)**	**Plan Pays 80% up to Lifetime Maximum of $5,000.00**	**You Pay**
$100.00 per day for 20 days $100.00 per day for 5 days	$100 per day for 20 days $78.50 per day for 5 days	$0.00	$100.00 x 20 days = $2,000.00 $78.50 x 5 days = $392.50	$107.50

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

1. You must formally apply to the Trust Office and demonstrate both cause and need.
2. This benefit is not payable if the provider is eligible under the skilled nursing provision of the Plan.
3. The service must be provided by a state licensed inpatient care facility.

Hospice Benefit

This benefit is available when you have been diagnosed with a terminal illness or disease. The lifetime maximum hospice benefit is $5,000.00.

The hospice benefit covers the services and supplies listed below when they are included in the hospice treatment plan and provided and billed by an approved hospice.

The Trust will pay up to $5,000.00 toward the:

1. Reasonable and customary charges for hospice inpatient services and supplies at an approved hospice; and
2. Reasonable and customary charges for respite care provided when you require continuous attention. The services and reasonable charges of a non-professional provider may be covered by respite care if approved by the Trust Office or Board of Trustees in advance.

Hospice Exclusions

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

1. Services provided for others, including bereavement counseling for family members;
2. Pastoral and spiritual counseling;
3. Services performed by family members or volunteer workers; and
4. Homemaker or housekeeping services, except as allowed by the *Home Health Care* and *Home Maker Services* portions of the Benefit Booklet.

Home Health Care

Home health care benefits provide payment of 70% (80% for Preferred Providers) of eligible home health care charges for a single visit. These benefits are payable up to a maximum of 100 visits during a calendar year.

Covered Charges

Charges are covered for illness or accidental bodily injury:

1. That does not arise out of or in the course of any employment, or
2. For which you are not entitled to benefits under any workers' compensation law.

The charges must meet the following requirements:

1. The charges must be medically necessary for your treatment, you are totally disabled and, in the opinion of your physician, would otherwise be confined as a registered bed patient in a hospital or skilled nursing facility provided:
    a. You are under the direct care of a physician;
    b. The plan of treatment covering home health care is established in writing by your physician prior to commencement of such treatment;
    c. The plan of treatment covering home health care is reviewed and updated in writing by your physician at least once every month; and
    d. You are examined by your physician once every 60 days.
2. The charges that are provided by a home health agency that meet the following requirements:
    a. It is primarily engaged in and is federally certified as a home health agency and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services (as listed in this section);
    b. Its professional service policies are established by a professional group association with such agency or organization, including at least one physician and at least one registered nurse, to govern the services provided;
    c. It provides for full-time supervision of home health care service by a physician or by a registered nurse;
    d. It maintains a complete medical record for each patient; and
    e. Has an administrator.
3. Charges must be incurred for one or more of the following, unless such charges are covered charges under the *Medical Benefits* portion of this Benefit Booklet:
    a. Part-time or intermittent nursing care by a licensed practical nurse;

b. Service by a registered nurse;

c. Skilled Nursing Care (including but not limited to):

   i. Giving of injections, including IVs;

   ii. Changing and irrigating urinary catheters;

   iii. Drawing blood for testing;

   iv. Taking of blood pressure;

   v. Giving insulin shots;

   vi. Use of oxygen and breathing machines;

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

   viii. Bandaging surgical incisions.

d. Speech language therapy for lost communication skills (loss due to an accident or illness while covered under this Plan) including but not limited to:

   i. Teaching communication skills;

   ii. Alternate means of expression; and

   iii. Help with choking or swallowing problems.

e. Physical therapy (including but not limited to):

   i. Planning an exercise program;

   ii. Teaching balance and coordination skills; and

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

Home Health Care Exclusions

1. Charges for services for which you are not, in the absence of this coverage, legally required to pay;
2. Charges for services performed by your immediate family or any person residing with you;
3. Charges for general housekeeping services (except as specified under *Home Maker Services Benefit);* and
4. Charges for services for custodial care (except as specified under *Inpatient Custodial Care Benefit)*.

Replacement of Organs or Tissue

The following procedures are payable on the same basis as any other illness:

1. Cornea transplants;
2. Artery or vein transplants;
3. Kidney transplants;
4. Joint replacements;
5. Heart valve replacements;
6. Implantable prosthetic lenses in connection with cataracts;
7. Prosthetic by-pass or replacement vessels;
8. Bone marrow transplants;
9. Heart transplants;
10. Heart and lung transplants; and
11. Liver transplants.

Wellness

Staying healthy can be your biggest benefit. We can all take steps to work toward better health. When you are in shape, you feel better, look better, enjoy life more fully and are likely to live longer.

Here are a few reminders that could lead to a better quality life-style:

1. Proper nutrition: Eat three balanced meals each day. Be sure to eat breakfast. Try to eliminate junk food, excessive fat, sugar and salt.
2. Watch your weight: Obesity can lead to many serious health problems.
3. Exercise at least three times a week: Exercise relieves tension, improves appearance, increases coordination and endurance and improves respiration and circulation.
4. Avoid smoking and drugs: Smoking is a leading cause of cancer, heart disease, high blood pressure and respiratory ailments.
5. Use alcohol in moderation: The recommended maximum amounts are two drinks per day for men and one drink per day for women.
6. Get enough sleep: Seven or eight hours of sleep each night is recommended.
7. Keep immunizations up to date.
8. Practice safety precautions on the road and at home: Buckle up for safety and keep the phone number handy for the local poison control center.
9. Have regular preventive exams to monitor your health.

These health care reminders are brought to you by the Board of Trustees as part of its ongoing commitment to improving your health.

Covered Preventive Care

These benefits are payable under the guidelines set forth in the Medical Plan and Dental Plan described in this Benefit Booklet.

1. Annual pap and pelvic examination;
2. Annual breast examination;
3. Annual mammogram;
4. Annual prostate examination;
5. Well-baby exams for the first three years;
6. Immunizations; and
7. Dental exams and fluoride treatment allowed twice per calendar year.

Wellness Program

This benefit is also available to employees and their spouses covered under this Plan as well as Kaiser Permanente and the Providence Health Plan.

The Harrison Trust offers you and your spouse a comprehensive wellness program with services provided by Oregon Wellness Clinic, Providence Medford Center for Occupational Medicine and the Bay Clinic in Coos Bay. This program is intended for preventive care and early detection of disease, not treatment. For sickness or injury, see your regular doctor.

Through this program you are provided with a thorough medical evaluation and follow ups designed to assist you in preventing disease and staying healthy.

The wellness program consists of a complete physical exam, preventive and assessment testing, and one-on-one counseling to help you:

1. Reduce heart attack risk;
2. Reduce stress;
3. Reduce cholesterol and blood pressure;
4. Learn to exercise;
5. Learn to eat right;
6. Control your weight;
7. Prevent certain cancers;
8. Stop smoking; and
9. Improve your overall fitness and health.

All physical exams are conducted by physicians and include:

1. Complete medical history;
2. Complete multi-chem blood count with cholesterol and urinalysis;
3. Visual acuity;
4. Pelvic exams, pap smears, and mammograms for women;
5. Prostate cancer screen for men;
6. Determination of percent body fat and ideal body weight;
7. Treadmill stress test with EKG, or resting EKG if indicated; and
8. Extensive written report and follow-up session for risk factor management.

Additional tests may include:

1. Lung function test;
2. Hearing test;

3. Screen for colorectal cancer;
4. Chest x-ray;
5. HIV test (additional cost);
6. Tetanus booster;
7. Thyroid test (for those taking thyroid medication); and
8. Colonoscopy once every 10 years if you are over age 50. A colonoscopy will be allowed before age 50 or more often than once every 10 years if you are age 50 or older and if the colonoscopy is medically necessary.

Diagnostic testing is not covered through this program. Please contact the Trust Office if you have any questions.

Costs and Appointments

The cost for this program is $50.00 per exam. The entire copayment is waived if the employee or spouse is over age 40 and has not previously received a Wellness exam. Contact the Trust Office for a location near you.

Eligibility

You must be eligible for coverage under the Trust at the time of testing. **If you are enrolled in this Plan, Kaiser Permanente or Providence Health Plan, you are eligible for the wellness program.**

You and your spouse will be eligible for exams based on age and risk factors, such as:

1. Diabetes;
2. Tobacco use;
3. Overweight;
4. Poor exercise habits;
5. High blood pressure;
6. High cholesterol; and
7. Family history of heart disease/stroke.

WELLNESS EXAM FREQUENCY		
Age	**Number of Risk Factors**	**Frequency**
20-40	0-1	Every 3 years
20-40	2-3	Every 2 years
20-40	4 or more	Every year
41-49	0-2	Every 2 years
41-49	2 or more	Every year
50+		Every year

For more information or to schedule an appointment, call:

- Oregon Wellness Clinic in Portland at 503-241-9593 or toll free 800-977-5633;
- Providence Medford Center for Occupational Medicine at 541-732-5554;
- Bay Clinic in Coos Bay at 541-269-0333 ext. 251.

Nurse Help Line

The Harrison Trust provides the Nurse Help Line benefit to help you obtain reliable, personal advice about your health information so you can make good health care decisions.

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

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

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

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

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

Nurse Help Line
Call: 800-971-2680

Preferred Provider Organization

As part of the Harrison Trust's voluntary Preferred Provider Organization ("PPO") program, you can qualify for substantial savings on a wide variety of health care services offered by the Harrison Trust's two PPO Networks. When you choose a provider who is member of the, PPO Network to provide care for covered charges, benefits paid by the Harrison Trust are usually higher and you pay less out of pocket. This is because providers of the PPO Network have contracted to provide services at negotiated rates. In addition, bills from providers who are members of the PPO Network are paid at 80% of the negotiated rate after the deductible has been satisfied rather than 70% of the reasonable and customary charge after the deductible has been met for a non-PPO provider. There is one exception. If there are fewer than two primary care physicians who are members of the PPO Network within a 30 mile radius of your primary residence, covered charges (except hospital charges) will be paid at 80% of the reasonable and customary charge after the deductible has been met rather than 70% of the reasonable and customary charge after the deductible has been met.

Retaining Your Freedom of Choice

The PPO Network is voluntary and presents no limitations to you. You are free to choose any health care provider you wish, even if that provider, physician, hospital or clinic is not a member of the PPO Network.

The Trust Has Made Two PPO Networks Available

There are two PPO Networks available to you. The Providence Preferred PPO Network is available in Oregon and SW Washington (Clark, Cowlitz, Klickitat, Skamania and Wahkikum Counties). The MultiPlan PPO Network is available in all other parts of the country.

The Providence Preferred PPO Network

Anytime you need to see a provider, physician or need to be admitted to a hospital or clinic in Oregon or Southwest Washington (Clark, Cowlitz, Klickitat, Skamania and Wahkikum Counties), consult the Providence Preferred PPO Network Directory for a list of providers, physicians, hospitals and clinics that are members of the Providence Preferred PPO Network. You can review the list of PPO providers, physicians, hospitals, and clinics by telephoning Providence at 800-793-9338 or using the Providence website. If you use the Providence website, follow the following directions:

1. Go to www.providence.org/Health_Plans/Members/directories.htm
2. Select "Provider Directories"

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

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

The MultiPlan Network

Any time you need to see a provider, physician or need to be admitted to a hospital or clinic outside Oregon and Southwest Washington (Clark, Cowlitz, Klickitat, Skamania and Wahkikum Counties), consult MultiPlan for a list of providers, physicians, hospitals and clinics that are members of the MultiPlan PPO Network. You can review the list of PPO providers, physicians, hospitals and clinics at www.multiplan.com or by telephoning 800-546-3887. The MultiPlan PPO Network is nationwide. Therefore, if you have a dependent living elsewhere (for example, a student attending college or a child from a previous marriage), he or she may seek medical care from one of the MultiPlan PPO providers, physicians, hospitals and clinics located outside Oregon and Southwest Washington. When you are traveling outside Oregon and Southwest Washington, you may seek medical care from one of the MultiPlan PPO providers, physicians, hospitals and clinics located throughout the United States.

How to Get the Most out of the PPO Network

The following are a few helpful hints when using the Providence Preferred and MultiPlan PPO Networks:

1. When you seek medical services, identify yourself as a member of the Providence Preferred or MultiPlan PPO Network and present your identification card.

2. If your physician is not a member of the PPO Network, you can still save money by asking your physician to refer you to a PPO Network hospital, clinic, or specialist whenever necessary.

3. Keep track of and review your provider’s billing statements.

Additional Provider Discounts

The Harrison Trust has an arrangement with organizations that attempt to obtain discounts for your medical bills even if the provider is not a member of the PPO Network. You and the Harrison Trust both share in the savings. For example, assume you have met your deductible for the year and went to see a non-PPO provider who charged $100.00. Under normal circumstances, you would pay 30% of the bill ($30.00) and the Harrison Trust would pay 70% of the bill ($70.00). On occasion, the Harrison Trust may be able to obtain a discount from the non-PPO provider who would, for example, agree to accept $80.00 in full payment of the charge. Under this scenario, you would pay 30% of the bill ($24.00) and the Harrison Trust would pay 70% of the bill ($56.00).

Preadmission Review Procedures

Preadmission Review Procedures is a program that reviews the necessity and quality of inpatient stays for hospitalization, chemical dependency and mental illness. This program is provided by Innovative Care Management, Inc.

Authorization given by Innovative Care Management, Inc., for an inpatient stay for hospitalization, chemical dependency or mental illness is only for the purpose of reviewing whether the stay is necessary for the care and treatment of an illness or injury. It does not guarantee that all charges are covered by the Plan. All charges submitted for payment are subject to all terms and conditions of the Plan, regardless if preadmission authorization is received from Innovative Care Management, Inc.

Your physician and you have, in all cases, the final decision regarding hospitalization and medical treatment.

Contacting Innovative Care Management for Preadmission Review

For all inpatient hospital stays, except childbirth, and all inpatient stays for the treatment of chemical dependency and mental illness, you, a family member, your physician or hospital should contact Innovative Care Management, Inc., prior to admission. The telephone numbers for Innovative Care Management, Inc., are 800-862-3338 and 503-654-9447 in the Portland area. The information you will need to provide to Innovative Care Management, Inc., is:

1. Trust Name: Harrison Electrical Workers Trust Fund;
2. Employee's name and Social Security Number;
3. Name, date of birth and address of person being admitted;
4. Family contact and telephone numbers;
5. Admitting physician's name and telephone number;
6. Hospital name, address and telephone number;
7. Date of admission; and
8. Diagnosis, surgery or procedure to be performed.

Preadmission Certification Program

Innovative Care Management, Inc., provides a preadmission evaluation for each inpatient hospitalization, except childbirth, and all inpatient stays for the treatment of chemical dependency and mental illness.

1. **Non-Emergency Hospitalizations and Inpatient Stays for the Treatment of Chemical Dependency and/or Mental Illness:** Before admission to a hospital as an inpatient for any reason except childbirth and before an inpatient stay for the treatment of chemical dependency and/or mental illness, you, a family member, your physician or hospital should

call Innovative Care Management, Inc., at least 10 days prior to the scheduled hospitalization or inpatient stay for the treatment of chemical dependency and/or mental illness to determine whether the hospital stay is medically necessary.

2. **Urgent Hospitalization and Inpatient Stay for the Treatment of Chemical Dependency and/or Mental Illness.** An urgent hospitalization or inpatient stay for the treatment of chemical dependency and/or mental illness occurs when the condition is not life threatening but requires an admission of less than 10 days notice. In this situation, you, a family member, your physician or hospital should notify Innovative Care Management, Inc., prior to the scheduled hospitalization or inpatient stay for the treatment of chemical dependency and/or mental illness. If you, a family member, your physician or hospital do not have time to call Innovative Care Management, Inc., before admission, you, a family member, your physician or hospital should call Innovative Care Management, Inc., within 48 hours of the admission or surgery in order to receive maximum benefits.

3. **Emergency Hospitalization and Inpatient Stay for the Treatment of Chemical Dependency and/or Mental Illness.** An emergency hospital admission or inpatient stay for the treatment of chemical dependency and/or mental illness occurs as the result of an unforeseen condition requiring immediate medical attention and does not require preadmission certification. However, Innovative Care Management, Inc., should be called by you, a family member, your physician or hospital within 48 hours of the admission or surgery. For weekend admissions or surgeries, notification should occur within 72 hours of the admission or surgery. For holiday admissions, notification should occur on the first business day following the admission.

Concurrent Review

After admission to a hospital or inpatient stay for the treatment of chemical dependency and/or mental illness, Innovative Care Management, Inc., will continue to evaluate your progress through concurrent review that monitors the length of stay. If Innovative Care Management, Inc., disagrees with the length of stay recommended by your physician, or determines the continued confinement is no longer necessary, you and your physician will be consulted. You and your physician have, in all cases, the final decision regarding hospital confinement and medical treatment.

Hospital Discharge Planning

During your hospital stay or inpatient stay for treatment of chemical dependency and/or mental illness, Innovative Care Management, Inc., will monitor your progress. Timely discharge planning will help you return home at the earliest date.

Case Management Services

The Trust offers case management service through Innovative Case Management, Inc. When you need intensive, chronic or expensive care, Innovative Case Management, Inc. health care professionals guide you through the complex health care system maze.

Innovative Case Management, Inc. nurses work with you, your family and your doctor to help you find appropriate providers, and determine the right care and equipment for your specific needs. They:

- Support you and your physician in your plan of care and help you avoid delays or complications.
- Provide support and education if you or a family member is living with diabetes, heart disease or respiratory disease.
- Help you evaluate clinical, economic and humanistic outcomes.
- Encourage you to take an active role in your health care.

Using case management is voluntary. If you call for pre-certification or you have a number of claims that indicate you'll need extensive or chronic care, the Plan will refer you to Innovative Case Management, Inc. If Innovative Case Management, Inc. agrees that you could benefit from case management, an Innovative Case Management, Inc. representative will contact you and ask you if you want the assistance of an Innovative Case Management, Inc. health care professional.

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

Disease Management Program

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

The purposes of the disease management program include:

- Early detection and management of the diseases identified above;
- Encourage the patient to take an active role in the management of his/her medical condition;
- Provide education to the patient about his/her medical condition; and
- Encourage the patient to follow through with his/her treatment plan.

The Disease Management Program is voluntary. If you have been diagnosed with one of the diseases identified above, you may receive a brochure from Innovative Care Management, Inc. concerning your specific disease and a telephone call from an employee of Innovative Care Management, Inc. concerning how the Disease Management Program can benefit you.

Chemical Dependency Benefits

New Employees

New employees (those who have not been eligible for coverage through the Harrison Trust in any of the previous 12 consecutive months) and their dependents are subject to a preexisting conditions limitation, and should contact the Trust Office to verify benefits and coverage. See page 132 for a definition of a preexisting condition and page 61 (paragraph 5) for a summary of the preexisting condition limitations.

Confidential Help Line – Here Is How It Works

Drug and alcohol abuse affects all of us, but now there is help coping with drug and alcohol problems for you and your family. A confidential service offered by the Harrison Trust, in conjunction with Providence Health System EAP, will evaluate the problem and help you make the right choice for treatment.

If you need help, you should call Providence Health System EAP at one of these toll-free numbers: In Oregon, 800-255-5255; in Portland, 503-215-3561. Providence Health System EAP will evaluate your situation, then direct you to an eligible facility if you need treatment. This health care facility will be licensed by the state or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

How Much the Active Employee Plan Pays

The type of treatment you receive for chemical dependency is called a setting. Each setting costs a certain amount, depending on the kind of treatment administered. The total amount payable for all settings within a 24-month period is $20,000.00. The 24-month period starts on the day of your first setting, and ends on the last day of the 24th month after your first setting. The $20,000.00 limit applies to any combination of inpatient, residential, day or partial hospitalization, and outpatient care. **(Kaiser Permanente and Providence Health Plan participants will be paid benefits in accordance with the Kaiser Permanente or Providence Health Plan schedule of benefits.)**

Your treatment may include settings at a residential facility, day or partial hospitalization programs that provide full-time or part-day treatment. Or you may receive treatment by appointment through an outpatient service. All of these facilities and programs must be licensed and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs.

All of your covered charges will be reimbursed at 70% (80% for a Preferred Provider), subject to your annual deductible. None of the covered charges apply to your out-of-pocket maximum.

If you need a physical exam as part of your chemical dependency treatment program, you should contact the Trust Office. The Trust Office will give you information about a physical exam through the Wellness Program or this Plan.

Your benefits will renew, in full, on the first day of the 25th month of coverage after your first use of a treatment program. If you enroll in a chemical dependency program but do not complete it, and have reached the 24-month maximum benefit amount, you will have to apply directly to the Board of Trustees to reenroll in another treatment program.

Eligible Providers

Treatment must be provided by:

I . A licensed doctor (MD or DO);

2. A naturopathic physician who is licensed in the state in which care is rendered (if that state's laws license naturopathic physicians) and who practices within the scope of his or her license;

3. A psychiatrist (PhD) or other person licensed as a psychiatrist by the state in which he or she practices;

4. A Clinical Social Worker;

5. A counselor with a Master of Social Work degree; or

6. A Licensed Nurse Practitioner.

Eligible Facilities

Treatment must be provided by:

1. Facilities, programs and providers that are licensed by the state and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs;

2. Programs that are accredited for the particular level of care by the Joint Commission on Accreditation of Healthcare Organizations or the Commission of Accreditation of Rehabilitation Facilities;

3. Inpatient programs provided by a licensed health care facility;

4. Licensed facilities or residential programs for overnight stays or 40-hour weekly programs; or

5. Programs where the staff is directly supervised, or where the treatment plans are approved, by licensed medical or osteopathic physicians, psychologists, nurse practitioners or clinical social workers and that meet the standards of the Office of Alcohol and Drug Abuse or the Mental Health Division.

What Is Not Covered

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

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

Important Points to Remember

1. You must be covered under the Active Employee Plan to be eligible for chemical dependency benefits.
2. Your $20,000.00 Chemical Dependency Benefit is for all treatment that you receive and for which you are charged during a 24-month period.
3. Your benefits will renew in full on the first day of the 25th month of coverage following your first treatment program.
4. If you are covered by Kaiser Permanente or Providence Health Plan, your benefits will be paid in accordance with those plans.
5. All expenses are reimbursed at 70% (80% for a Preferred Provider) of the covered charges and are subject to the annual deductible. None of the covered charges apply to your out-of-pocket maximum.
6. If your treatment program requires you take a medical exam, contact the Trust Office.
7. You must receive treatment from authorized providers.

Mental Illness Benefits

New Employees

New employees (those who have not been eligible for coverage through the Harrison Trust in any of the previous 12 consecutive months) and their dependents are subject to a preexisting conditions limitation, and should contact the Trust Office to verify benefits and coverage. See page 132 for a definition of a preexisting condition and page 61 (paragraph 5) for a summary of the preexisting condition limitations.

Eligible Providers

Treatment must be provided by:

1. A licensed physician (MD or DO);
2. A naturopathic physician who is licensed in the state in which care is rendered (if that state's laws license naturopathic physicians) and who practices within the scope of his or her license;
3. A psychiatrist (PhD) or other person licensed as a psychiatrist by the state in which he or she practices;
4. A clinical social worker;
5. A counselor with a Master of Social Work degree; or
6. A licensed nurse practitioner.

Eligible Facilities

Treatment must be provided by:

1. Facilities, programs and providers listed by the state and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs;
2. Programs that are accredited for the particular level of care by the Joint Commission on Accreditation of Hospitals or the Commission of Accreditation of Rehabilitation Facilities;
3. Inpatient programs provided by a licensed health care facility;
4. Licensed facilities or residential programs for overnight stay or 40-hour weekly programs; or
5. Programs where the staff is directly supervised, or where the treatment plans are approved by licensed medical or osteopathic physicians, psychologists, nurse practitioners or clinical social workers, and that meet the standards of the Office of Alcohol and Drug Abuse or the Mental Health Division.

Employee Assistance Program

This benefit is also available to employees and dependents enrolled in Kaiser Permanente and Providence Health Plan.

The employee assistance program is designed to provide confidential counseling for you and your dependents who need assistance with personal problems at no cost to you. The employee assistance program can provide help and counseling with issues such as:

1. Family stress, including relationship concerns and conflicts;
2. Life crises brought on by the death of someone close to you, divorce or other major life events;
3. Personal pressures, stress, depression;
4. Alcohol and drug concerns;
5. Financial and legal concerns; and
6. Parenting and elder care issues.

The employee assistance program provides up to three counseling sessions per issue with a professional counselor at no cost to you. If you are referred to (or elect) services or treatment by other resources or providers, you will be responsible for the cost. However, the cost may be covered by your health plan or will be of low or no cost to you.

Anything you discuss with the employee assistance program counselor remains strictly confidential, except as required to be disclosed by law. Any questions regarding confidentiality should be discussed with your counselor.

How to Use the Program

Portland Area Employees and Dependents:

1. Call 503-215-3561 and identify yourself as an employee or dependent of the Harrison Trust.
2. Make an appointment with a counselor or ask that a counselor call you.
3. Meet confidentially with a counselor. The counselor will assist in evaluating the problem, provide short-term counseling and, if needed, offer referrals for professional help beyond the scope of the employee assistance program. You will be responsible for any fees charged by the professional to which the employee assistance program refers you.

If you live outside the Portland-Metropolitan Area:

1. Call 800-255-5255 and identify yourself as an employee or dependent of the Harrison Trust.
2. You will speak with an assessment counselor by phone to describe your concerns. You will receive the name of a counselor in your area.
3. Make an appointment with a counselor or ask that a counselor call you.

4. You will meet confidentially with the counselor. The counselor will assist in evaluating the problem, provide short-term counseling, and, if needed, offer referrals for professional help beyond the scope of the employee assistance program. You will be responsible for any fees charged by the professional to which the employee assistance program refers you.

Prescription Drug Program

You are eligible to use this prescription drug program if you are enrolled in the Active Employee Plan. If you are enrolled in the Kaiser Permanente Plan, prescription drug benefits are provided by Kaiser Permanente. If you are enrolled in the Providence Health Plan, prescription drug benefits are provided by the Providence Health Plan. For more information about the Kaiser Permanente Plan and the Providence Health Plan, please contact the Trust Office.

Prescription drug benefits are provided in cooperation with RESTAT, LLC. Information concerning prescription drug benefits, including a list of RESTAT retail pharmacies, can be obtained by calling RESTAT at 800-248-1062. Additional information concerning prescription drug benefits can also be obtained at the RESTAT website www.restat.com.

Covered Prescription Drugs

The Prescription Drug Program covers drugs that require a written prescription from a doctor; that must be dispensed by a licensed pharmacist or doctor; and are not subject to any limitations or exclusions in the Benefit Booklet. The Prescription Drug Program covers contraceptive prescription medication and certain devices. Surgically implantable contraceptive devices, intrauterine devices (IUDs), Depo-Provera and other non-self administered contraceptives are not covered by the Prescription Drug Program but may be covered under the Medical Benefits section of the Plan.

Prescription Drug Options

There are four options for obtaining Your prescription drugs:

1. RESTAT retail pharmacy network (30-day supply)
2. Out-of-network retail pharmacy (30-day supply)
3. Many pharmacies in the RESTAT retail pharmacy network disperse a 90-day supply of maintenance prescription drugs at the mail order price (90-day supply)
4. CVS/Caremark mail order pharmacy for maintenance prescription drugs (90-day supply)

Each option is discussed below.

RESTAT Retail Pharmacy Network

You can purchase up to a 30-day supply of a prescription drug from a pharmacy in the RESTAT retail pharmacy network by paying the copayment. There are more than 62,000 pharmacies in the RESTAT retail pharmacy network, including most national chains such as Safeway, Fred Meyer, Walgreens, Hi-School Pharmacy, Bi-Mart, Costco, Target and many others (but not Wal-Mart and Sam's Club). You may call RESTAT at 800-248-1062 or go on the web at www.restat.com for a list of pharmacies in the RESTAT Retail Pharmacy Network in your area.

You will receive a health benefit card, which will include your prescription drug information. When obtaining a prescription drug from a pharmacy in the RESTAT Retail Pharmacy Network, do the following:

1. Present your health benefit card at the pharmacy; and

2. Pay the copayment amount.

Out-of-Network Retail Pharmacies

You do not have to obtain prescription drugs from a pharmacy in the RESTAT Retail Pharmacy Network. To obtain a prescription drug from a pharmacy outside the RESTAT Retail Pharmacy Network, you must pay for the prescription at the time of purchase. Obtain a pharmacy receipt that lists the drug name, quantity dispensed and date of service. Contact the Trust Office for a reimbursement claim form or get a reimbursement claim form on the web at www.harrison.aibpa.com. Mail the pharmacy receipt together with your name, address, Social Security Number and the reimbursement claim form to:

RESTAT, LLC
ATTN: Patient Reimbursement
PO Box 758
West Bend, WI 53095-0758

90 Day Supply of Prescription Drugs at RESTAT Retail Pharmacies

You can purchase up to a 90-day supply of many prescription drugs at many RESTAT retail pharmacies. Medications taken on a long term basis (called maintenance medication), can be dispensed for 90 days. There will be a lower out-of-pocket cost if you obtain your maintenance medication through a RESTAT retail pharmacy authorized to dispense a 90-day supply of maintenance medication. You may call RESTAT at 800-248-1062 or go online at www.restat.com for a list of RESTAT pharmacies that dispense a 90-day supply of maintenance medication at the mail order price. **For medications taken on a long-term basis (called maintenance medication), it is mandatory that you purchase the medication from a RESTAT retail pharmacy that will fill a 90-day supply of maintenance medication or from the CVS/Caremark mail order pharmacy**.

90 Day Supply of Prescription Drugs from the CVS/Caremark Mail Order Pharmacy

You can purchase a 90-day supply of many prescription drugs from CVS/Caremark mail order pharmacy. Medications taken on a long-term basis (called maintenance medication) can be dispensed for 90 days. There will be a lower out-of-pocket cost if you obtain your maintenance medication through CVS/Caremark mail order pharmacy. **For medications taken on a long-term basis (called maintenance medication), it is mandatory that you purchase the medication from the CVS/Caremark mail order pharmacy or a RESTAT retail pharmacy that will fill a 90-day supply of maintenance medication.**

How to Order by Mail

1. Have your doctor write a prescription for a 90-day supply of a maintenance medication.

2. Complete and send the Order Form to CVS/Caremark with:

    a. New or refill prescription and copayment.

3. Mail your order to:

   CVS/Caremark
   PO Box 94467
   Palatine, IL 60094-4467

Refills by Phone

Must be paid with a credit card only.

1. Call the touch-tone automated phone number:

   English – 800-552-8159
   Español – 800-659-6404

2. Available 24 hours per day/7 days a week

3. Have the prescription number and credit card ready when you call

Refills by Internet

1. Log on to www.caremark.com

2. Available 24 hours per day/7 days a week

Prescription Delivery

Please allow two weeks for delivery from the date you mail your order. Most prescriptions will be delivered by US Postal Service. A re-order form/envelope, an invoice/receipt, renewal/refill cards will accompany each order.

In case of emergency, prescriptions can be shipped overnight for an additional fee. For maintenance drugs you need to start taking right away, ask your doctor for two prescriptions: one for a 30-day supply to be filled at a RESTAT pharmacy and one for the mail order pharmacy.

Payment

1. Make checks or money orders payable to: CVS/Caremark

2. Credit cards accepted: Visa, MasterCard, American Express, Discover

3. Do not send cash.

Summary of Benefits

RESTAT RETAIL PHARMACY NETWORK			
Copayment for Generic Prescription Drugs	**Copayment for Brand Names Prescription Drugs**	**Copayment for a Brand Name if Generic is Available**	**Prescription Drug Supply Maximum**
$10.00	$30.00 or 20% of drug cost – whichever is greater – up to a $50.00 maximum	50% of the cost of the brand name drug, unless prescription is written “dispense as written”	Up to a 30-day supply

OUT-OF-NETWORK PHARMACIES			
Copayment Minimum	**Reimbursement Percentage**	**Reimbursement Percentage for a Brand Name if a Generic is Available**	**Prescription Drug Supply Maximum**
$30.00	70% of the cost had the prescription been filled at a RESTAT Retail Network Pharmacy	50% of the cost had the prescription been filled at a RESTAT Retail Network Pharmacy unless prescription is written “dispense as written”	Up to a 30-day supply

Reimbursement will be 70% of the cost of the prescription drug had it been obtained from a RESTAT Retail Network Pharmacy. However, if a brand name prescription drug is requested and a generic is available, you will be reimbursed at 50% of the cost of the brand name drug had it been obtained from a RESTAT Retail Network Pharmacy. If your doctor writes the prescription “dispense as written,” reimbursement will be at 70% of the cost of the brand name drug had it been obtained from a RESTAT Retail Network Pharmacy. Your copayment for all prescriptions will be subject to a minimum copayment of $30.00.

MAIL ORDER AND 90-DAY RETAIL PRESCRIPTIONS			
Copayment for Generic Prescription Drugs	**Copayment for Brand Name Prescription Drugs**	**Copayment when Generic Available but Brand Name Selected**	**Drug Supply Maximum**
$10.00	$60.00 or 20% of the drug cost - whichever is greater - up to a $100.00 maximum	50% of the cost of the brand name drug, unless prescription is written “dispense as written”	Up to a 90-day supply

Specialty Pharmacy Program for Certain Prescription Drugs

Certain prescription drugs used for treating complex health conditions MUST be obtained from the Caremark Therapeutic Services Specialty Pharmacy. Specialty prescription drugs often require special storage and handling requirements, may be injectable or infused and are used to treat complex health conditions including:

- Ankylosing Spondylitis
- Growth hormone deficiency
- Hepatitis B
- Juvenile Rheumatoid Arthritis
- Multiple Sclerosis
- Osteoporosis
- Asthma
- Deep vein thrombosis
- Solid organ transplants
- Hepatitis C
- HIV/AIDS
- Infertility
- Psoriasis
- Psoriatic Arthritis
- Respiratory Syncytial Virus
- Cystic Fibrosis
- Prostate cancer
- Oncology related conditions

Many specialty drugs are not available in a retail pharmacy. The Harrison Trust requires participants to use the Caremark Therapeutic Services Specialty Pharmacy to provide prescription drugs for treating complex health conditions. The specialty medication is shipped to your doctor's office or to your home, depending on where the medication is administered.

In order to determine whether a prescription drug must be obtained by the Caremark Therapeutic Services Specialty Pharmacy and to obtain a prescription drug that must be obtained from the Caremark Therapeutic Services Specialty Pharmacy, call RESTAT at 877-526-9906. A RESTAT clinical staff specialist will coordinate the approval process with the Caremark Therapeutic Service Specialty Pharmacy. The RESTAT clinical staff specialist will begin the process by verifying eligibility and coverage of the requested medication. When calling RESTAT, identify yourself as a Harrison Electrical Trust participant. The RESTAT clinical staff specialist will contact your doctor to verify your prescription and ensure that you will receive your next prescription exactly when you need it.

Specialty drugs have the same copayments as a 30-day supply of a prescription drug from the RESTAT Retail Pharmacy Network.

Mandatory Generic Substitution

Many prescription drugs are available as a trademark or "brand" name drug and a chemical or "generic" name drug. By law, brand and generic drugs must meet the same standards for safety and effectiveness. Obtaining generic drugs, whenever possible, can provide you with savings directly (by paying a lower copayment) and indirectly (because the Plan saves money — which ultimately benefits you).

When you have a prescription filled, you will receive a generic substitute whenever possible, unless your doctor will not allow a generic substitute or you specify otherwise on the order form.

Three Step Therapy Program for Certain Prescription Drugs (Prior Authorization Required)

A number of brand name prescription drugs have generic or over-the-counter equivalents that can be obtained without a prescription. Therefore, certain brand name prescription drugs are not covered unless the following step therapy criteria are met.

Step therapy establishes a hierarchy for 11 classes of prescription drugs. Within each class, prescription drugs are divided into three categories or steps as follows:

- Category A: prescription drugs are generic and approved for everyone.
- Category B: prescription drugs are approved only after the Category A drug is proved ineffective and your doctor has provided RESTAT with clinical notes to support that conclusion.
- Category C: prescription drugs are approved only after Category A and B drugs are proved ineffective and your doctor has provided RESTAT with clinical notes to support that conclusion.

Step therapy requires you to use a Category A prescription drug before being authorized to use a more expensive version of the same drug in Category B or C. You must follow the proper steps to have prescription drugs in Categories B and C covered.

In order to obtain a Category B or Category C prescription drug, your doctor must provide RESTAT with clinical notes indicating the Category A prescription drug is not effective and also provide a prior authorization request. Steps you and your doctor should follow to have a Category B or Category C prescription drug approved after a Category A prescription drug is proved ineffective are:

- Your doctor should go to RESTAT's website to download a prior authorization request form at the following address: www.restat.com.
- The prior authorization forms can be found in the Provider section under "Physician Community."
- Your doctor can also download a copy of RESTAT's step therapy brochure in the Clients section under Forms.
- If you or your doctor have questions regarding the step therapy process, please contact RESTAT's customer service line at 800-248-1062.

There are 11 drug classes subject to step therapy as follows:

Advair/Symbicort (asthma)
Antihypertensive (high blood pressure)
Bisphosphonates (osteoporosis)
Hypnotics (sleep agents)
Proton pump inhibitor (GI/ulcer)
Singular (allergic rhinitis)
Antidepressants
Anti-virals (anti-herpes)
Cox-1 sparing NSAIDs (anti-inflammatory)
Intranasal Steroids (allergy)
Statins (high cholesterol)

Any prescription drug that you are taking on February 1, 2010 will be "grandfathered," meaning it will not need to go through the step therapy authorization process. However, the step therapy authorization process will apply to any new prescription drug in the 11 drug classes above effective February 1, 2010.

Two Step Therapy Program for Antihistamines and Antihistamines Plus Decongestant (Prior Authorization Required)

Step therapy establishes a hierarchy for antihistamines and antihistamines plus decongestant. Category A prescription drugs are approved for everyone. Category B prescription drugs are authorized only after the Category A prescription drug is proved ineffective and your doctor has provided RESTAT with clinical notes to support that conclusion. Step therapy requires you to use a Category A prescription drug before being authorized to use a more expensive version of the same drug in Category B. You must follow the proper steps to have prescription drugs in Category B covered. The drug categories are:

Antihistamines

Category A	Fexofenadine
Category B	Clarinex (all forms), Xyzal and Allegra (all forms)

Antihistamines Plus Decongestant

Category A	Fexofenadine plus pseudoephedrine (12 hours)
Category B	Clarinex-D (12 and 24 hours) and Allegra-D (24 hours)

In order to obtain a Category B prescription drug, your pharmacy records must reflect that you tried a Category A prescription drug or your doctor must provide RESTAT with clinical notes indicating the Category A prescription drug is not effective. Steps you and your doctor should follow to have a Category B prescription drug approved after a Category A prescription drug is proved ineffective are:

- Your doctor should go to RESTAT's website to download a prior authorization request form at the following address: www.restat.com.
- The prior authorization form can be filled in the Provider section under "Physician Community."
- Your doctor can download a copy of RESTAT's Step Therapy brochure in the Clients section under Forms.
- If you or your doctor have questions regarding the Step Therapy process, please contact RESTAT's customer service line at 800-248-1062.

Any antihistamine or antihistamine plus decongestant that you are taking on February 1, 2010 will be "grandfathered" meaning it will not need to go through a Step Therapy authorization process. However, the Step Therapy authorization process will apply to any new prescription antihistamine or antihistamine plus decongestant effective February 1, 2010.

Special Rule for Sudafed and Like Kind Prescription Drugs

In states where Sudafed and any like kind drug requires a prescription, for example Oregon, there is a 100% copayment. This means that the participant must pay 100% of the cost of Sudafed and any like kind prescription drug.

Quantity Limitation Program

There may be instances where the pharmacy will dispense less than a 30-day or 90-day supply of a prescription drug. The Quantity Limitation Program manages the quantity of a prescription drug you can receive at a particular time. The quantity of a prescription drug may be limited to less than a 30-day or 90-day supply based upon current medical findings, manufacturer-labeling information, and/or Food and Drug Administration guidelines. The Quantity Limitation Program targets prescription drugs that are not used on a daily basis but on a per episode basis. Examples include medications for nausea and vomiting, migraine headaches, erectile dysfunction and acute pain. Prescriptions may be limited to a specific number of doses per month or per fill, or by number of days' supply you can receive at one time.

Medical Benefit Charges That are Not Covered

1. Charges that are, after professional medical review, deemed not medically necessary to the care or treatment of an injury or illness. Any final review will be based on professional medical opinion.
2. Charges that would not have been made if no plan existed.
3. Charges that you are not legally obliged to pay.
4. Charges that are in excess of the reasonable and customary charges for services and material.
5. Charges for treatment by a provider that is not within the scope of his or her license.
6. Charges for which benefits are not provided in this Plan.
7. Charges for dental services or supplies for treatment of the teeth, gums or alveolar processes. Except the Plan will pay for:
    a. Hospital charges if you are a bed patient; or
    b. Any dental charges covered under the *Medical Benefits* portion of this Plan.
8. Charges for eye glass lenses or contact lenses and the fitting of them. Except the Plan will pay for charges covered under the *Medical Benefits* portion of the Plan following cataract surgery.
9. Charges for confinement in a Skilled Nursing Facility, unless such confinement:
    a. Starts within 14 days after you have been confined for at least three days in a hospital for which room and board charges were paid;
    b. Is for treatment of the illness causing the hospital confinement;
    c. Is one during which a doctor visits at least once every 30 days; and
    d. Is not routine custodial-type care.
10. Charges for any treatment for cosmetic purposes or for cosmetic surgery. Except that, the Plan will pay for reconstructive treatment or surgery of one of the following:
    a. Solely due to an accidental bodily injury if the injury occurred while covered by the Plan;
    b. Solely due to surgical removal of all or a part of the breast tissue as the result of an illness; or
    c. Solely due to a birth defect if covered by the Plan on the date of birth.
11. Charges for services of a person who usually lives in the same household as you, or who is a member of your immediate family.

12. Charges for services or supplies furnished by an agency of the United States Government or foreign government agency, unless excluding them is prohibited by law.

13. TMJ – Temporomandibular Joint Syndrome: Charges for necessary care and treatment of temporomandibular joint syndrome and associated myofacial pain are limited to a maximum benefit payment of $3,000.00 Lifetime Outpatient Care and $10,000.00 Lifetime for Surgeons' charges for surgical care. Hospital charges associated with surgical care are payable as any other illness.

14. Payment for corrective shoes or arch supports.

15. In-hospital medical or surgical care for conditions that do not generally require hospitalization.

16. Services and supplies for weight loss or obesity except for surgical procedures that are allowed under the section *Covered Charges*, paragraph 25, page 28.

17. Non-medical self-help or training, such as programs for weight control, and general fitness or exercise programs.

18. Pregnancy-related expenses that are not a covered medical expense under this Plan.

19. Drugs and medicines that can be obtained without a doctor's prescription.

20. Counseling or treatment in the absence of illness, including individual or family counseling or treatment for marital, behavioral, family, occupational, religious or educational problems or treatment of "normal" transitional response to stress. There may, however, be limited coverage under the employee assistance program described on page 49.

21. Services related to sex change procedures and complications.

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

23. Family Planning: Services and supplies for artificial insemination, in-vitro fertilization or surgery to reverse elective sterilization are not covered.

24. Radial Keratotomy and lasik surgery is not covered.

25. Charges for services or purchases before covered by the Plan: The charges for services or purchases will be deemed to have been incurred on the date the services were performed or the date the purchases occurred.

26. All charges not specifically listed as covered charges are not covered.

Exclusions, Limitations and Non-Covered Charges

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

No benefits are provided for:

1. Any accidental bodily injury that arises out of or in the course of any employment for wage or profit or with an employer for which you could receive benefits under any workers' compensation law or occupational disease law, or you receive any settlement from a workers' compensation carrier.

2. Any illness for which you could receive benefits under any workers' compensation law or occupational disease law, or you receive any settlement from a workers' compensation carrier.

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

4. Charges incurred or disability claimed while you are not under the direct care of a physician.

5. Preexisting Condition Limitation for New Employees or Dependents. A new employee is one who has not been eligible for coverage through the Harrison Trust in any of the previous 12 consecutive months.

   The Plan will pay only a limited amount of up to $4,000.00 toward covered charges, services or supplies for a new employee or a new employee's dependents for a preexisting condition during the first six months you and your dependents are covered by the Plan.

   A preexisting condition is a condition that was diagnosed or treated or for which medication was prescribed or taken in the three months before the effective date of coverage.

   The six-month waiting period for full coverage of a preexisting condition can be reduced or eliminated if you had previous health and welfare coverage before becoming covered by this Plan. To eliminate or reduce the six-month waiting period, provide the Trust Office with a written certificate of prior health and welfare coverage. This certificate can be obtained from your previous employer or health insurance company. The six-month waiting period for preexisting conditions will be reduced by one month for each month of prior health and welfare coverage you had under the prior plan as long as there is not a gap of more than 63 days between when your coverage under the prior health and welfare plan ended and when the coverage under this Plan began.

6. Charges for any care incurred prior to the effective date of your coverage under this Plan.

7. Experimental or Investigational Services. Treatment, procedures, equipment, drugs, devices or supplies (hereinafter called "services") that are, in the Board of Trustees' judgment, experimental or investigational. Services are considered experimental or investigational if:

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

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

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

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

9. Mental retardation, learning disabilities.

10. Emergency Care or Urgent Care Facilities: if you receive treatment from a hospital emergency room for a non-life threatening illness or injury when an urgent care facility was available to treat the illness or injury, you must pay the first $150.00 for the emergency room visit. This $150.00 payment is in addition to any deductible that must be met under the Active Employee Plan.

Dental Benefits

New Employees

If you are a new employee who has not been eligible for coverage through the Harrison Trust in any of the previous 36 consecutive months, you and your dependents will be eligible for dental benefits after six months of coverage under the Harrison Trust.

If you have not had coverage under the Harrison Trust in any of the previous 36 consecutive months, the six months of coverage under the Harrison Trust before dental benefits became effective will be waived for you and your dependents if you had previous dental coverage under a prior health and welfare plan so long as there is not a gap of more than 63 days between the date your dental coverage under the prior health and welfare plan ended and the date coverage under the Harrison Trust begins.

Dental Benefit Options

When you become eligible for dental benefits, the Harrison Trust makes three options available to you and your dependents. The options are:

1. The Active Employee Plan's dental benefits described in this Benefit Booklet.
2. Kaiser Permanente dental benefits. You do not have to be enrolled in the Kaiser Permanente medical and prescription drug plan to select Kaiser Permanente dental benefits. The Kaiser Permanente dental benefits are described in a separate benefit booklet that is available by contacting the Trust Office.
3. Willamette Dental. The Willamette Dental benefits are described in a separate benefit booklet that is available by contacting the Trust Office.

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

Comprehensive Dental Benefits

Dental Maximum per Person per Calendar Year	$1,500.00. You can make a written request to the Trust Office that up to $500.00 of the following calendar year's dental maximum be used to pay covered dental charges in the current year. You cannot use this procedure for two consecutive calendar years. You cannot use or borrow another family member's dental maximum.
Dental Benefits at 80%	Covered charges for orthodontic benefits up to the lifetime maximum. Covered dental charges for routine exams and for routine prophylaxis (cleaning and scaling of teeth by a dentist or dental hygienist) but no more than twice during a calendar year.
Dental Benefits at 70%	Covered dental charges other than those payable at 80% and 50%.
Dental Benefits at 50%	Covered dental charges for dentures, gold fillings, crowns, inlays, onlays and bridgework.
Orthodontic Lifetime Per Person	$2,000.00
Deductible	$25.00 per person per calendar year. The maximum deductible a family must pay per calendar year is $75.00. All dental charges including orthodontic benefits, routine exams and routine prophylaxis are subject to the deductible.

If contemplating dental work in excess of $300.00, you are urged to submit to the Trust Office, in advance, a copy of the treatment plan, commonly called predetermination of benefits. The dentist performs the examination, including X-rays, then lists on the predetermination form the procedures and charges necessary to complete the treatment. The completed form, together with the X-rays, are then sent to the Trust Office where the amount payable under the Plan will be computed and you will be informed of the amount that will be paid by the Plan.

If you do not request predetermination of benefits, the Trust Office will calculate benefits on the basis of the amount of benefits that would have been paid had you requested predetermination.

Predetermination is encouraged, particularly if the course of treatment is expected to involve total dental charges in excess of $300.00.

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

The charge for a dental procedure is considered to have been incurred on the day of performance of the procedure. If a procedure is not completed in one day, the day that the procedure is completed is deemed to be the incurred day for any charges in connection with such procedure.

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

Covered Dental Charges

The following dental charges (if reasonable and customary) are covered:

1. Charges for any accidental injury:

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

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

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

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

4. Charges that do not exceed the reasonable and customary charges for the procedures performed or materials furnished.

5. Fluoride treatments are allowed twice per calendar year.

6. Sealants for dependents under the age of 19. This benefit applies only to the following numbered teeth on the dental claim form: 1 through 5, 12 through 16, 17 through 21 and 28 through 32. This benefit renews every calendar year and the maximum annual payment is $100.00.

Dental Charges Not Covered

The following dental procedures are not covered:

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

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

3. Charges for dental procedures you have incurred for the repair of sound natural teeth (including their replacement) required as a result of, and within 24 months of, an accidental bodily injury can be considered for benefit payment under medical expense benefits.

4. Charges for services or materials for cosmetic purposes, except for cosmetic dental procedures, incurred within 24 months of an accident suffered while covered by this Plan for dental expense benefits.

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

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

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

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

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

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

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

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

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

10. Charges for dental appointments that are not kept.

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

12. Charges for the replacement of a prosthesis within five years after it was first placed, except for:

    a. A crown which is needed for restoration only;

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

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

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

TMJ — Temporomandibular Joint Syndrome. Charges for necessary care and treatment of temporomandibular joint syndrome and associated myofacial pain are covered under the Active Employee Plan but are limited. See the section *Exclusions, Limitations and Non-Covered Charges* on page 61.

Certified Denturists

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

1. The denturist has successfully completed a course in advanced oral pathology as prescribed by the Health Division and has received a certificate of completion; or
2. You have received a statement, dated within 30 days prior to the date of treatment, signed by a dentist, or a physician, that your oral cavity is substantially free from disease.

The following definitions apply:

1. “Denture” means any removable full upper or lower prosthetic dental appliance to be worn in the human mouth.
2. “Denturist” means a person certified under the statutes of the state to engage in the practice of denture technology.

Vision Care Benefits

This Plan is your vision plan if you are enrolled in the Active Employee Plan or Providence Health Plan. If you are enrolled in Kaiser Permanente, your vision benefits are provided by Kaiser Permanente.

New Employees

If you are a new employee who has not been eligible for coverage through the Harrison Trust in any of the previous 36 consecutive months, you and your dependents will be eligible for vision benefits after six months of coverage under the Harrison Trust.

If you have not had coverage under the Harrison Trust in any of the previous 36 consecutive months, the six months of coverage under the Harrison Trust before vision benefits become effective will be waived for you and your dependents if you had previous dental or vision coverage under a prior health and welfare plan so long as there is not a gap of more than 63 days between the date your dental or vision coverage under the prior health and welfare plan ended and the date coverage under the Harrison Trust begins.

If your employer requires safety eye wear on the job, the six month waiting period for the safety eye wear benefit will be waived for the employee only.

If you are a reciprocity employee, contact your employer for instructions concerning safety eye wear.

Vision Benefits

You and your dependents are eligible for an eye exam and lenses every 12 months and frames every 24 months. Contacts are allowed every 12 months. Twelve months after you obtain your contact lenses, you are eligible for the frame and lenses benefit.

How to Use the Vision Plan

The vision benefits are provided through a contract with Vision Service Plan (VSP). The most important things to remember are:

1. To find a VSP network doctor close to your home or work, call VSP at 800-877-7195, or visit their website at www.vsp.com.
2. To receive the maximum benefit, select a VSP network doctor and make an appointment. Identify yourself as a VSP member. Your doctor and VSP will handle the rest.
3. Your VSP network doctor will charge you a $15.00 copayment for the exam.
4. If your VSP network doctor prescribes glasses, your lenses are covered in full. You may choose from a wide selection of frames covered up to $130.00, plus 20% off any out-of-pocket costs. Your copayment to the VSP eyewear dispenser will be $25.00.

If you select cosmetic items including but not limited to, oversize lenses, tinted, coated or blended lenses, or select a frame that is outside the cost range of VSP's allowance, you will need to pay for these in addition to the $25.00 copayment. **You will be advised by the VSP doctor of the out-of-pocket expense before you place your order.**

5. You do not have to use a VSP network doctor. You may use the qualified vision care provider of your choice. Remember, you may use a VSP network doctor to dispense your glasses even if your exam was performed by a non-VSP provider. Likewise, you may obtain an eye exam from a VSP network doctor and have your lenses and frames dispensed from a non-VSP provider.

   Selecting a VSP network doctor assures direct payment to the doctor and is a guarantee of quality and cost control.

6. Extra discounts and savings. When visiting a VSP network doctor, you'll receive:

   a. 20% off an additional pair of glasses and sunglasses;

   b. Up to 20% savings on lens extras such as scratch resistance and anti-reflective coatings and progressives;

   c. Exclusive pricing on annual supplies of contacts; and

   d. 15% discount off the cost of contact lens exam (fitting and evaluation).

7. If you use a non-VSP provider:

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

   b. Mail the itemized receipt to:

      VSP
      PO Box 997195
      Sacramento, CA 95899-7195

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

      i. Employee's name;

      ii. Address;

      iii. Social Security Number;

      iv. Patient's name;

      v. Date of birth; and

      vi. Relationship to the employee.

      VSP will reimburse you according to the non-VSP provider reimbursement schedule.

   c. You must submit a copy of the provider's itemized billing statement to VSP within six months of the date of service.

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

VSP Member Copayments

When you choose a VSP network doctor for your vision care services and eyewear, you pay these low copayments:

Exam	$15.00
Glasses or Contacts (lenses, frames, contacts)	$25.00

Non-VSP Provider Reimbursement Schedule

It is important to remember that your copayment still applies to non-VSP provider services. If you obtain examination services from a non-VSP provider, your VSP reimbursement will be:

Vision Exam	up to $42.00

If you get your glasses from a non-VSP provider, your VSP reimbursement will be:

Single Vision Lenses	Up to $42.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Frames	Up to $45.00
Tinted Lenses (Employee Only)	Up to $5.00
Contacts	Up to $105.00

Vision Care Benefits - What Is Covered and What Is Not Covered

Services Covered

Vision exam: Includes a refraction test to determine the need for glasses, analysis for binocularity, and testing of the overall health of the eyes and related optic structures. This benefit is available once every 12 months from the last date of service.

Eyewear Covered

1. **Frames and lenses**: benefits for lenses are covered in full and available once every 12 months from the last date of service. Benefits for frames are covered up to $130.00 and available once every 24 months from the last date of service. Before you select your frames or lenses, check with your VSP network doctor to find out which frames and lenses are fully covered under this Plan.

2. **Contacts**: when you choose contacts instead of glasses, your $130.00 in-network or $105.00 out-of-network allowance applies to the cost of your contact lens exam (evaluation and fitting) and contacts. The exam is in addition to your exam to ensure proper fit of contacts. This benefit is available once every 12 months from the last date of service. Twelve months from the last date of service you are eligible for the frame and lenses benefit in paragraph 1 above.

Services and Materials NOT Covered

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

1. Orthopedics or vision training and any associated supplemental testing;
2. Plano lenses (less than $\pm$ 0.50 diopter power);
3. Two pair of glasses in lieu of bifocals;
4. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
5. Medical or surgical treatment of the eyes;
6. Corrective vision treatment of an experimental nature;
7. Costs for services and/or materials above the Plan allowances; and
8. Services and/or materials not indicated in the *Vision Care Benefits* section of the Benefit Booklet.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of VSP's optometic consultants, it is necessary for the visual welfare of the Covered Person.

Limitations of Benefits (Patient Options)

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

1. Optional cosmetic processes;
2. Anti-reflective coatings;
3. Color coatings;
4. Mirror coatings;
5. Scratch coatings;
6. Blended lenses;
7. Cosmetic lenses;
8. Laminated lenses;
9. Oversize lenses;
10. Progressive multi focal lenses;

11. Photo chromatic lenses;
12. Tinted lenses except pink #1 and pink #2;
13. UV (ultraviolet) protective lenses;
14. Certain limitations on low vision care;
15. A frame that costs more than the Plan allowance; and
16. Contact lenses (except as noted elsewhere in the *Vision Care Benefits* section of this Benefit Booklet).

Special Conditions

If you need an eye exam or new eyeglasses before your 12- or 24-month period is completed because of a medical condition, you should have your doctor submit an authorization and a request for payment to VSP. After review and upon the Board of Trustee's approval, VSP may authorize services under the Plan.

Use of a Non-VSP Provider Ophthalmologist

In the event you have a vision exam performed by a non-VSP provider ophthalmologist, the Trust will pay 80% of the reasonable and customary charges for the exam. This benefit is available once every 12 months from the last date of service, and applies only to a non-VSP provider ophthalmologist. This benefit DOES NOT apply to a non-VSP provider optometrist.

Mail a copy of the ophthalmologist's itemized billing to:

Harrison Electrical Workers Trust
c/o A & I Benefit Plan Administrators
1220 SW Morrison Street, Suite 300
Portland, OR 97205-2222

Include the following information:

1. Employee's name;
2. Address;
3. Social Security Number;
4. Patient's name;
5. Date of birth; and
6. Relationship to employee.

Optomap Retinal Examination

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

The Optomap Retinal Examination is not covered by VSP. Therefore, if your eye care professional recommends an Optomap Retinal Examination, the Trust will pay for the cost of the examination up to $25. This benefit is available once every twelve months measured from the date of the last Optomap Retinal Examination. There is no deductible to pay.

In order to obtain reimbursement (up to $25) for the Optomap Retinal Examination, do the following:

Mail a copy of your eye care professional's billing for the Optomap Retinal Examination to:

Harrison Electrical Workers Trust Fund
c/o A&I Benefit Plan Administrators, Inc.
1220 SW Morrison Street, Suite 300
Portland, OR 97205-2222

Include the following information with the billing:

1. Employee's Name;
2. Address;
3. Social Security Number;
4. Patient's Name;
5. Patient's Date of Birth; and
6. Patient's Relationship to Employee.

Safety Eyewear Benefit

For Active Employees Only

Since many employers now require safety eye wear on the job, the Trust now offers you the opportunity to get prescription safety glasses at no cost.

Through your VSP network doctor, you will receive prescription lenses and a frame certified as safe for a work environment by meeting the test requirements of the American National Standards Institute and OSHA. All you do is make a $15.00 copayment that will be reimbursed by your employer if the job you are working on requires safety glasses.

What are Safety Glasses?

Safety glasses feature a frame constructed so that, if impacted from the front, the lens will not come out the back of the frame. Safety lenses are three millimeters thick at the thinnest point. The lens must be impact-tested and monogrammed by the fabricating laboratory indicating that it is a safety lens. Contacts do not meet the test requirements and therefore are not included in this safety eyewear benefit.

Here's How to Receive Your Safety Glasses

1. *Before* you make an appointment for vision care services, call VSP at 800-877-7195 or visit VSP's website at www.vsp.com to find a VSP network doctor and VSP eyewear dispenser close to your home or work.
2. Make an appointment and identify yourself as a VSP member and indicate to the VSP doctor you are requesting safety glasses. Your doctor and VSP will handle the rest.
3. You pay a $15.00 copayment to that doctor. You will receive a receipt from the doctor for the copayment of your safety glasses.
4. Present the copayment receipt to your employer and you will be reimbursed for the copayment. **You will be reimbursed only if the job you are working on requires safety glasses**.

Things to Remember About Your Safety Eyewear Benefit

1. This benefit applies to safety glasses only. For regular eye exam, lenses and frames, go through the regular VSP program.
2. If you are a Kaiser Permanente participant, contact the Trust Office for specific instructions.

Safety Eyewear - What Is Covered and What Is Not Covered

Eyewear Covered

1. Basic safety frames and basic safety lenses (single vision, bifocal, lined and unlined trifocal) are covered in full by this benefit.
2. You are eligible to receive safety lenses every 12 months and a safety frame every 24 months from the last date of service.

Services Covered

1. Safety glasses must be obtained from a VSP network doctor. Eye exams are covered under your regular VSP program.
2. The Plan usually requires a six-month waiting period for new employees before VSP benefits apply. However, if your employer requires safety glasses on the job, the six-month waiting period will be waived for this safety glasses benefit only.

Eyewear Not Covered

1. Eyewear obtained from a non-VSP provider will not be reimbursed.
2. Optional items (including, but not limited to, blended or oversize lenses, tinted or photochromatic lenses, coated or laminated lenses, no-line multifocal lenses, polycarbonate lenses, and a frame that exceeds the basic plan allowance) are not covered by this benefit.
3. Cosmetic eyewear or dress wear lenses are not covered by this benefit.
4. Plano lenses.

Services Not Covered

1. Services obtained from a non-VSP provider will not be reimbursed.

2. Dependents are not covered by this benefit.

3. If you are not covered under the Harrison Electrical Workers Trust Fund, this benefit does not apply. There is no reciprocity available. If you have traveled from another area and your employer requires safety glasses on the job, please contact your employer for instructions.

Claim Appeal Procedure for all Vision Care Benefits

If your claim for vision benefits is denied in whole or in part by VSP, you may appeal the denial. Appeals must be sent to VSP within 60 days of the denial and include your name, Social Security number, date of birth and any comments or arguments concerning the appeal. In connection with the appeal, you may review any pertinent, nonprivileged document in the possession of VSP. You will receive the resolution of your appeal in writing. Send your appeal to:

VSP
PO Box 997100
Sacramento, CA 95899

Life Insurance

For Employees Only

Life insurance benefits are available to employees only. Dependents are not eligible for life insurance benefits. Retired employees and those making payments under COBRA are not eligible for life insurance benefits. Life insurance is provided through a contract with Standard Insurance Company.

Amount of Insurance

The Plan provides $10,000.00 of life insurance coverage.

Reductions in Insurance

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

Age	Benefit
65 through 69	$6,500.00
70 through 74	$5,000.00
75 or more	$3,500.00

Life Insurance Effective Date

Your life insurance becomes effective on the date you qualify for group health and welfare benefits.

When Life Insurance Ends

Your life insurance automatically ends on the earliest of:

1. The date the last period ends for which a required premium is made on your behalf to Standard Insurance Company by the Harrison Trust;
2. The date the group policy terminates; or
3. The date you cease to be eligible for the Active Employee Plan due to the lack of employer, or a combination of employer and employee, contributions for the health and welfare benefits. A self-payment under COBRA to continue health and welfare benefits **WILL NOT** serve to extend your life insurance benefits.

Waiver of Premium

Life insurance will continue without premium payment while you are totally disabled if:

1. You become totally disabled while insured under the group policy prior to age 60;
2. You remain totally disabled for at least 180 days;
3. Satisfactory proof of total disability is furnished to Standard Insurance Company; and
4. Such proof is submitted to Standard Insurance Company no later than 18 months after you become "totally disabled."

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

Premium payment must continue to be made during the first 180 days of total disability. If you qualify for the Waiver of Premium Benefit, those premiums will be refunded to the Trust.

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

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

1. The date the you are no longer totally disabled;
2. 90 days after the date Standard Insurance Company mails a request for additional proof of total disability, if satisfactory proof is not given;
3. The date you fail to attend an examination or cooperate with the examiner;
4. The effective date of an individual life insurance policy, if you have converted under Right to Convert; or
5. The date you attain age 65.

Accelerated Benefit

1. ***Qualifying for an Accelerated Benefit***

   If you qualify for a Waiver of Premium Benefit and you have a Qualifying Medical Condition you have the option of accelerating the life insurance benefit payment. Standard Insurance Company will pay an accelerated benefit, after receiving satisfactory proof of loss. Qualifying Medical Condition means that you are terminally ill with a life expectancy of less than 12 months.

2. ***Application for Accelerated Benefit***

   You must have at least $10,000.00 of insurance in effect to be eligible.

You must apply for an Accelerated Benefit. To apply you must give Standard Insurance Company satisfactory proof of loss on their forms. Proof of loss must include a statement from a physician that you have a Qualifying Medical Condition.

Standard Insurance Company may have you examined at their expense in connection with your claim for an Accelerated Benefit. Any examination will be conducted by one or more physicians of their choice.

3. ***Amount of Accelerated Benefit***

You may receive an Accelerated Benefit of up to 75% of your life insurance. The minimum Accelerated Benefit is $5,000.00.

If the amount of your insurance is scheduled to reduce within 24 months following the date you apply for the Accelerated Benefit, your Accelerated Benefit will be based on the reduced amount.

If your insurance is scheduled to end within 24 months following the date you apply for the Accelerated Benefit, you will not be eligible for the Accelerated Benefit.

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

4. ***Effect on Insurance and Other Benefits***

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

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

b. The amount of the Accelerated Benefit; *minus*

c. An interest charge calculated as follows:

A *times* B *times* C *divided* by 365 = interest charge.

A = The amount of the Accelerated Benefit.

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

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

i. The date you die, and

ii. The date you have a right to convert.

5. ***Exclusions***

No Accelerated Benefit Will be Paid if:

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

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

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

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

e. You have previously received an Accelerated Benefit under the Group Policy.

Right to Convert

1. ***Right to Convert***

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

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

b. You apply in writing and pay Standard Insurance Company the first premium during the conversion period, which is the 31 days after your life insurance ends.

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

2. ***Limits On Right to Convert***

If your insurance ends or is reduced because of termination or amendment of the Group Policy, the following will apply:

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

b. The maximum amount you have a right to convert is the amount of your insurance immediately prior to your termination of coverage under the group plan, *minus* any other group life insurance for which you become eligible during the 31 days after termination of this Group Policy.

3. ***The Individual Policy***

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

a. A term insurance policy;

b. A universal life policy;

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

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

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

4. ***Death During the Conversion Period***

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

Filing Life Insurance Claims

1. ***Filing a Claim***

Claims should be filed on Standard Insurance Company forms. You may obtain a claim form by calling A&I Benefit Plan Administrators, whose address and phone number are listed on page 136 of this Benefit Booklet.

2. ***Time Limits for Filing Proof of Loss***

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

Proof of Loss for Waiver of Premium must be provided within 18 months after the date of total disability. Further Proof of Loss will be required at reasonable intervals, but not more often than once a year after you have been continuously totally disabled for two years.

If Proof of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while you or your beneficiary lacks legal capacity.

3. ***Proof of Loss***

Proof of loss means written proof that a loss occurred:

a. For which the Group Policy provides benefits;

b. That is not subject to any exclusions; and

c. That meets all other conditions for benefits.

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

4. ***Investigation of Claim***

Standard Insurance Company may have you examined at their expense at reasonable intervals. Any such examination will be conducted by specialists of their choice.

Standard Insurance Company may have an autopsy performed at their expense, except where prohibited by law.

5. ***Time of Payment***

Benefits will be paid within 60 days after Proof of Loss is satisfied.

6. ***Notice of Decision on Claim***

Standard Insurance Company (Standard) will evaluate a claim for benefits promptly after Standard receives it. With respect to all claims except Waiver of Premium claims, within 90 days after Standard receives the claim, it will send the claimant:

a. A written decision about the claim; or

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

With respect to Waiver of Premium claims, within 45 days after Standard receives the claim, it will send the claimant:

a. A written decision about the claim; or

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

Before the end of this extension, Standard will send the claimant:

a. A written decision about the claim; or

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

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

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

a. The reasons for the extension;

b. When Standard expects to decide the claim;

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

d. The unresolved issues preventing a decision; and

e. Any additional information Standard needs to resolve these issues.

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

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

a. The reasons for Standard's decision;

b. Reference to the parts of the Insurance Policy on which the decision is based;

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

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

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

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

7. ***Review Procedure***

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

a. Within 180 days after receiving notice of denial of a claim for Waiver of Premium;

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

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

Standard will review the claim promptly after it receives the request for review. With respect to all claims except Waiver of Premium claims, within 60 days after Standard receives the request for review, it will send the claimant:

a. A written decision on review; or

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

With respect to Waiver of Premium claims, within 45 days after Standard receives the request for review, it will send the claimant:

a. A written decision on review; or

b. A written notice that Standard is extending the review period for 45 days.

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

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

a. The reasons for the extension;

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

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

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

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

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

a. The reasons for Standard's decision;

b. Reference to the parts of the Insurance Policy on which the decision is based;

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

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

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

The Insurance Policy does not provide voluntary alternative dispute resolution options. However, you may contact the local office of the United States Department of Labor or your state insurance commissioner for assistance.

Benefit Payment and Beneficiary Provisions

1. ***Payment of Benefits***

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

2. ***Naming a Beneficiary***

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

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

a. Must be dated and signed by you;

b. Must be delivered to the Trust Office, A&I Benefit Plan Administrators, Inc., during your lifetime;

c. Must relate to the insurance provided under the Group Policy; and

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

You may obtain a beneficiary designation form by calling the Trust Office, A&I Benefit Plan Administrators, Inc. The Trust Office's address and telephone number are listed in the *Administration of the Plan* section of this Benefit Booklet.

3. ***Simultaneous Death Provision***

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

4. ***No Surviving Beneficiary***

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

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

b. Your children;

c. Your parents;

d. Your brothers and sisters; and

e. Your estate.

5. ***Methods of Payment***

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

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

6. ***Definition***

For purposes of life insurance benefits, spouse means:

a. A person to whom you are legally married; or

b. Your domestic partner. Your domestic partner means an individual recognized as such under applicable law.

Allocation of Authority

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

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

1. The right to resolve all matters when review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it; and
3. The right to determine:
    a. Your eligibility for insurance;
    b. Your entitlement to benefits;
    c. The amount of benefits payable; and
    d. The sufficiency and the amount of information we may reasonably require to determine a, b, or c, above.

Subject to the review procedures of the Group Policy, any decision Standard Insurance Company makes in the exercise of its authority is conclusive and binding.

Time Limits on Legal Actions

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

1. The date Standard Insurance Company receives proof of loss; and
2. The time within which proof of loss is required to be given.

Assignment

The rights and benefits under the group policy cannot be assigned.

Address and Telephone Number

The address and telephone number of Standard Insurance Company are:

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1093
503-321-7000

Accidental Death & Dismemberment Insurance

For Employees Only

Accidental Death & Dismemberment (AD&D) insurance benefits are available to employees only. **Accidental Death & Dismemberment insurance benefits are not available to retired employees, employees making payments under COBRA or dependents of active or retired employees.**

Introduction

Accidental Death & Dismemberment insurance (AD&D) provides benefits for dismemberment or death resulting from accidental bodily injuries. The AD&D insurance benefit is summarized below.

1. ***When Benefits are Payable***

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

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

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

   a. Is caused solely and directly by an accident;

   b. Occurs independently of all other causes; and

   c. Occurs within 365 days after the accident.

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

3. ***Amount Payable***

   The amount payable is equal to a percentage of your AD&D insurance in effect on the date of the accident. Your AD&D insurance is $10,000.00. The amount payable is as follows:

Loss	Amount
Life	$10,000.00
One hand, one foot, or sight of one eye	$5,000.00
Two or more of the above losses	$10,000.00

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

4. ***Seat Belt Benefit***

The amount of the seat belt benefit is $10,000.00.

Standard Insurance Company will pay a seat belt benefit if:

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

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

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

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

5. ***AD&D Insurance Exclusions***

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

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

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

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

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

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

f. Heart attack or stroke;

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

6. ***When AD&D Insurance Becomes Effective***

Your AD&D insurance becomes effective on the date you qualify for group health and welfare benefits.

7. ***When AD&D Insurance Ends***

Your AD&D insurance automatically ends on the earliest of:

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

b. The date the Group Policy terminates; or

c. The date you cease to be eligible for the Active Employee Plan as a result of employer or a combination of employer and employee contributions for the health and welfare benefits. A self-payment under COBRA to continue health and welfare benefits will not extend your AD&D insurance benefit.

Filing Accidental Death & Dismemberment Claims

1. ***Filing a Claim for Benefits***

   Claims should be filed on Standard Insurance Company claim forms. You may obtain a claim form by calling A&I Benefit Plan Administrators, Inc., whose address and telephone number are listed on page 136 of this Benefit Booklet.

2. ***Time Limit for Filing Proof of Loss***

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

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

3. ***Proof of Loss***

   Proof of loss means written proof that a loss occurred:

   a. For which the Group Policy provides benefits;

   b. That is not subject to any exclusions; and

   c. That meets all other conditions for benefits.

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

4. ***Investigation of Claim***

   Standard Insurance Company may have you examined at their expense at reasonable intervals. Any such examination will be conducted by specialists of their choice.

   Standard Insurance Company may have an autopsy performed at their expense, except where prohibited by law.

5. ***Time of Payment***

   Benefits will be paid within 60 days after Proof of Loss is satisfied.

6. ***Notice of Decision on Claim***

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

   a. A written decision about the claim; or

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

Before the end of this extension, Standard will send the claimant:

a. A written decision about the claim; or

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

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

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

a. The reasons for the extension;

b. When Standard expects to decide the claim;

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

d. The unresolved issues preventing a decision; and

e. Any additional information Standard needs to resolve these issues.

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

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

a. The reasons for Standard's decision;

b. Reference to the parts of the Insurance Policy on which the decision is based;

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

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

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

7. ***Review Procedure***

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

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

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

a. A written decision on review; or

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

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

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

a. The reasons for the extension;

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

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

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

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

a. The reasons for Standard's decision;

b. Reference to the parts of the insurance Policy on which the decision is based;

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

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

The Insurance Policy does not provide voluntary alternative dispute resolution options. However, you may contact the local office of the United States Department of Labor or your state insurance commissioner for assistance.

Assignment

The rights and benefits under the Group Policy cannot be assigned.

Benefit Payment and Beneficiary Provisions

1. ***Payment of Benefits***

   Benefits payable because of your death will be paid to your beneficiary. Beneficiary means the person you name to receive your benefits. Dismemberment benefits will be paid to you if you are living. Any dismemberment benefits which are unpaid at your death will be paid to your beneficiary.

2. ***Naming a Beneficiary***

   The beneficiary(ies) you name for life insurance will be your beneficiary for AD&D benefits. You may name one or more beneficiaries. Two or more surviving beneficiaries will share equally, unless you specify otherwise. You may name or change beneficiaries at any time without the consent of a beneficiary.

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

   a. Must be dated and signed by you;

   b. Must be delivered to the Trust Office, A&I Benefit Plan Administrators, Inc., during your lifetime;

   c. Must relate to the insurance provided under the Group Policy; and

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

   You may obtain a beneficiary designation form by calling the Trust Office, A&I Benefit Plan Administrators, Inc. The Trust Office's address and telephone number are listed in the *Administration of the Plan* section of this Benefit Booklet.

3. ***Simultaneous Death Provision***

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

4. ***No Surviving Beneficiary***

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

   a. Your spouse;

   b. Your children;

   c. Your parents;

   d. Your brothers and sisters; and

   e. Your estate.

5. ***Methods of Payment***

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

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

6. ***Definition***

   For purposes of AD&D insurance benefits, spouse means:

   a. A person to whom you are legally married; or

   b. Your domestic partner. Your domestic partner means an individual recognized as such under applicable law.

Allocation of Authority

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

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

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it; and
3. The right to determine:
   a. Your eligibility for insurance;
   b. Your entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine, a, b or c, above.

Subject to the review procedures of the Group Policy, any decision Standard Insurance Company makes in the exercise of its authority is conclusive and binding.

Time Limits on Legal Actions

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

1. The date Standard Insurance Company receives proof of loss; and
2. The time within which proof of loss is required to be given.

Address and Telephone Number

The address and telephone number of Standard Insurance Company are:

Standard Insurance Company
900 SW 5th Avenue
Portland, OR 97204-1093
503-321-7000

Time Loss

For Employees Only

New Employees

If you are a new employee and have not been eligible for coverage through the Harrison Trust in any of the previous 36 consecutive months, you will be eligible for Time Loss benefits as the result of a non-occupational illness or injury occurring after six months of coverage under the Harrison Trust.

If you have not had coverage under the Harrison Trust in any of the previous 36 consecutive months, the six months of coverage under the Harrison Trust before Time Loss benefits become effective will be waived if you had previous dental or time loss coverage under a prior health and welfare plan so long as there is not a gap of more than 63 days between the date your dental or time loss coverage under the prior health and welfare plan ended and the date coverage under the Harrison Trust begins.

Employees making self-payments under COBRA are not eligible for this benefit. Dependents are not eligible for this benefit.

Time Loss Benefits

Time Loss benefits are available only in the event of non-occupational illness or injury.

Weekly Benefit - $250.00
(Up to 52 weeks)

Overall Maximum Payment—52 Weeks

This benefit is designed to partially replace your income while disabled. Payment will commence on the first day of an accident and the eighth day of illness due to a non-occupational disability. Payment will also commence on the first day of an illness in the event of hospitalization. You must be covered by the Plan on the day the disability commences. The disability must be certified by a Physician or Surgeon. You need not be confined to your home, but you must be wholly and continuously disabled and prevented from performing each and every function pertaining to your employment and you must be under the care of a Physician or Surgeon. If you return to full-time work for a continuous period of at least two weeks, any subsequent disability will be deemed to be a new disability regardless of its cause.

Your time loss payments are subject to federal income tax and, if applicable, state income tax. The Trust Office will mail W-2 forms for time loss payments made during the year to employees by January 31st of the following year.

Filing Time Loss Claims

Please contact the Trust Office for the appropriate forms and payment schedule for these benefits.

Prior to the payment of benefits, the Board of Trustees reserves the right to have an independent medical exam performed.

Administration of the Plan

The day-to-day administrative details of the Harrison Trust are handled by the Trust Office:

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

If you have any questions regarding the Active Employee Plan, please contact A&I Benefit Plan Administrators, Inc.

Claims (Other Than Life and Accidental Death & Dismemberment Insurance)

Claim forms must be completed in all instances in order to receive benefits. Claim forms may be obtained by calling or writing A&I Benefit Plan Administrators, Inc. After completing the claim form, mail or bring it, together with the itemized billing from the provider, to the Trust Office for processing. If you require any assistance, the Trust Office will gladly help you.

Claims Will Be Paid in the Following Manner

1. Upon presentation to the Trust Office of the completed claim form and itemized bill for a covered charge, a check will be made payable to you by the Trust Office on behalf of the Harrison Trust.

2. In the event you assign payment of a claim to the hospital or provider in writing, the check will be made payable to the hospital or provider.

3. Vision claims are processed and paid by an independent provider at:

   Vision Service Plan
   PO Box 997100
   Sacramento, CA 95899-7100
   800-877-7195
   TDD/Hearing Impaired 800-735-2922

4. If you are using the Caremark mail prescription drug program, you must submit orders directly to Caremark. Forms are available from the Trust Office. Mail your order form to:

   CVS/Caremark
   PO Box 94467
   Palatine, IL 60094-4467

5. For Providence Health Plan enrollees, present your ID card to your provider at the time of service and make sure your provider bills Providence Health Plan directly.

6. For Kaiser Permanente enrollees, present your ID card at your Kaiser Permanente facility for services and prescription drugs.

Claim Filing Requirements

1. ***Time Requirements***

    a. Written notice of a claim must be given to the Trust Office as soon as reasonably possible.

    b. Proof - 90 days

        i. Proof of claim for hospital confinement must be given to the Trust Office within 90 days after release from the hospital.

        ii. Proof of claim for any other service, supply or treatment must be given to the Trust Office within 90 days after the service or treatment.

        iii. If proof of any claim is not given within 90 days, the claim will not be denied or reduced if the proof of the claim was given as soon as reasonably possible. However, no claim will be paid if submitted to the Trust Office more than one year after date of service or treatment.

        iv. "Proof" means proof satisfactory to the Board of Trustees.

2. ***Examination***

    a. The Board of Trustees, at the expense of the Harrison Trust, has the right to have you examined by a provider, as often as it may require, whenever your illness or injury is the basis of a claim.

    b. The Board of Trustees has the right to require an autopsy, if not prohibited by law. A disputed illness is a basis for this requirement.

Payment of Claims

All medical and dental claim payments will be made to the employee unless the claim has been assigned or unless the Trust Office or Board of Trustees determines that the employee is not legally able to complete a binding receipt or payment should be made to another person or entity.

If the Trust Office or Board of Trustees determines that the employee is not legally able to receive such payment, the Board of Trustees may, at its option, pay the provider, your estate or a relative. Any payment made under this option will completely discharge the Board of Trustees from further obligation for such payment.

The Board of Trustees reserves the right to allocate the deductible amount to any covered charges and to apportion the benefits to you and to any assignees. Such actions will be binding on you and on your assignees.

Return of Overpayment

If the Board of Trustees or Trust Office mistakenly pays a claim for you for which you are not entitled or, if the Board of Trustees or Trust Office makes a payment to a person or provider of services who is not entitled to the payment, or you do not make a required subrogation or reimbursement

payment, the Board of Trustees has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Board of Trustees' right to recover includes the right to deduct the amount paid by mistake or not paid via subrogation or reimbursement from future covered charges of you or any family member even if the mistaken payment was not made on that family member's behalf or from your dollar bank reserve account. The Board of Trustees' right to recover when money is not repaid via subrogation or reimbursement includes the right to withdraw money from your dollar bank reserve account or the dollar bank reserve account of the employee until the Trust's right to reimbursement has been satisfied.

Claims Appeal Procedure

If you have a claim concerning the denial of a time loss benefit, refer to the next section of the Benefit Booklet entitled *Claims Appeal Procedure for Time Loss Claims*.

If you have a claim concerning Providence Health Plan and/or Kaiser Permanente, Vision Service Plan or Standard Insurance Company, the claim should be filed with that organization in accordance with its claims appeal procedures.

If you have a claim that involves eligibility for coverage (such as insufficient money in your reserve account or a late self-payment), you may file an appeal pursuant to paragraph 3 on page 98.

If you have a claim for benefits that involves the Active Employee Plan (such as a medical, prescription drug or dental benefit), the procedures outlined below apply.

1. ***Denial of a Claim by the Trust Office***

    a. The Trust Office, A&I Benefit Plan Administrators, Inc. is responsible for reviewing claims concerning eligibility and the Active Employee Plan. If your claim for a benefit under the Active Employee Plan is denied, in whole or in part, you or your dependent will receive a written explanation from the Trust Office or the Harrison Trust's designee. The time in which a denial letter must be provided is based on the type of claim you have submitted.

        i. **Concurrent Claim**. A concurrent claim is a claim that is reconsidered after initial approval of an ongoing course of treatment and results in a reduction or termination of benefits before the end of the approved course of treatment. An example would be an inpatient hospital stay originally approved for five days that is subsequently shortened to three days. In the event of reconsideration, you must be notified so that you can appeal the decision and obtain a decision on appeal before the benefit is reduced or terminated.

        ii. **Post Service Claim**. A post-service claim is a claim for payment after the care or treatment has already been provided, for example, the extent to which a provider's bill will be paid. The Trust Office will provide notice of the benefit determination (whether approved or adverse) within a reasonable period of time but no 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 Trust 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 Trust 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.

In the event of an adverse benefit determination, you may appeal to the Board of Trustees, who will act on the appeal within the time limits set forth in Section 4 (on page 99).

2. ***Content of Initial Adverse Benefit Determination Notice***

a. If your claim is denied, the adverse benefit determination will be in writing and will provide:

i. The specific reason for the adverse benefit determination;

ii. Reference to the specific Plan provision on which the adverse benefit determination is based;

iii. A description of any additional material or information necessary to perfect the claim and an explanation why such material or information is necessary;

iv. A description of the Plan's review procedure, the time limits applicable to such procedures, and your right to bring a civil lawsuit for the benefit after an adverse determination by the Board of Trustees;

v. If the adverse benefit determination is based upon an internal rule, guideline, protocol or similar criterion, you will be notified of your right to receive the document free of charge upon request; and

vi. If the adverse benefit determination is based upon a decision involving medical necessity or because the service was experimental or investigational, you will be notified of your right to receive a statement of the scientific or clinical judgement for the decision free of charge upon request.

3. ***Appeal of an Adverse Benefit Determination and Eligibility Determination***

a. If you disagree with the initial adverse benefit or eligibility determination, you or your authorized representative may file a written appeal within 180 days after receiving the adverse benefit or eligibility determination. The written appeal must be filed 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 is 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 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 authorized representative of your choosing at your own cost and expense.

4. ***Decision by the Board of Trustees***

a. Upon receipt of a timely appeal, the Board of Trustees will review the claim de novo (meaning without deference to the initial decision). The Board of Trustees will review all relevant information regardless of whether the information was previously submitted. If the appeal involves issues of medical judgment such as whether a particular treatment, drug or other item is experimental, investigational or medically necessary, the Board of Trustees will consult a health care professional who has appropriate training and experience in the field of medicine. If the Board of Trustees consults a health care professional, he/she will be identified regardless of whether the Board of Trustees relies on his/her opinion. If the Board of Trustees consults a health care professional, he/she will be different than the health care professional previously consulted and will not be a subordinate of the health care professional previously consulted.

b. A decision will be made by the Board of Trustees at its 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 no later than the date of the subsequent Board of Trustee's 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 benefit appeal, the adverse benefit determination will include the following:

i. The specific reason for the adverse benefit determination;

ii. Reference to the specific Plan provision on which the decision is based;

iii. A statement that, upon written request, you will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to your claim. Whether a document, record or information is relevant is determined in accordance with 29 CFR §2560.503-1(m)(8);

iv. A statement of your right to bring a civil lawsuit for the benefit under ERISA;

v. A statement that any internal rule, guideline, protocol or similar criteria used as a basis for the adverse benefit determination will be available free of charge upon written request; and

vi. A statement that if the adverse benefit determination was based on medical necessity, experimental treatment or other similar exclusions or limitations, the

scientific or clinical judgement used in the decision will be provided free of charge upon request.

e. If the Board of Trustees deny your eligibility appeal, the decision will include the following:

   i. The specific reason for the decision;

   ii. Reference to the specific Plan provision on which the decision is based; and

   iii. A statement of your right to bring a civil lawsuit under ERISA.

f. You are required to use the procedures set forth above before bringing a civil lawsuit for the benefit under ERISA.

g. The Board of Trustees has the full and exclusive authority to administer the Active Employee Plan, interpret the Active Employee Plan, determine eligibility questions, determine eligibility for benefits, and resolve all questions arising in the administration, interpretation and application of the Active Employee Plan. The Board of Trustees' authority includes, but is not limited to:

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

   ii. The right to establish and enforce rules and procedures for the administration of claims so long as the rules and procedures are consistent with ERISA;

   iii. The right to construe and interpret the Active Employee Plan and determines eligibility for benefits; and

   iv. The exercise of the aforementioned powers and authorities by the Board of Trustees will be given the fullest deference allowed by law.

Claims Appeal Procedure for Time Loss Claims

This Claims Appeal Procedure is applicable for the denial, reduction or termination of a time loss benefit.

1. ***Denial of a Time Loss Benefit by the Trust Office***

   a. The Trust Office, A&I Benefit Plan Administrators, Inc., is responsible for reviewing an application for time loss benefits subject to the following time frames:

      i. If a claim for time loss benefits is to be denied by the Trust Office, you will be notified in writing. The written notice of denial will normally be provided to you within 45 days after receipt of a completed application for time loss benefits. If the Trust Office determines an extension of time is necessary to complete review of the time loss claim because of matters beyond its control, the 45-day period may be extended for up to 30 days provided the Trust Office notifies you of the extension of time for processing the time loss claim during the initial 45-day period. If, prior to the end of the first 30 day extension, the Trust Office determines that a further extension of time is necessary to complete review of the time loss 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 Trust Office notifies you of the extension of time for processing the time loss claim before the end of the first 30 day extension period. If an extension of time is required by the Trust Office, you will be notified in writing and the notice will specify the reason(s) for the extension, the unresolved issue(s), if any, preventing a decision, additional information, if any, needed to resolve the issue(s) and the date a decision is expected.

2. ***Content of the Denial Notice from the Trust Office***

a. If the Trust Office denies your claim for time loss benefits, the denial notice will be in writing and will provide:

i. The specific reason or reasons for the decision. If the decision is based on an internal rule, guideline, protocol or other similar criteria, the internal rule, guideline, protocol or similar criteria will be described or provided to you free of charge upon request;

ii. Reference to the specific Plan provision 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; and

iv. A description of the Plan's review procedures, your right to relevant documents, records and information and the time limits applicable to such procedures.

3. ***Appeal Procedure to the Board of Trustees***

a. Where a claim for time loss benefits has been denied or partially denied, you may appeal the denial to the Board of Trustees.

b. Upon written request, you will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to your claim for time loss benefits. Whether a document, record or other information is relevant to a claim will be determined in accordance with ERISA regulation 29 CFR §2560.503-1(m)(8).

c. You or your representative have 180 days following receipt of the denial notice from the Trust Office to file an appeal with the Board of Trustees. The appeal must be in writing and mailed or delivered as follows:

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

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

e. If you request to appear at the hearing before the Board of Trustees at the time your appeal is filed, you will be notified of the time, date and place of the hearing by regular mail at the return address shown on your request for review.

f. You may be represented at the hearing before the Board of Trustees by an attorney or other representative of your choosing at your own 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 decision of the Trust Office). The Board of Trustees will review all relevant information regardless of whether the information was submitted to the Trust Office. If the appeal involves issues of medical judgement, the Board of Trustees will consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement. If the Board of Trustees consult a medical or vocational expert, he will be identified regardless of whether the Board of Trustees rely on his opinion.

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 such meeting. If this is the case, the Board of Trustees will review the appeal not later than the date of the next Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees require an extension of time to review the appeal, you will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

c. The decision of the Board of Trustees will be in writing and sent within five days after the decision is reached.

d. If the Board of Trustees deny your appeal for time loss benefits, the decision will include the following:

i. The specific reason or reasons for the decision. 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;

ii. Reference to the specific Plan provision on which the denial is based;

iii. Upon written request, you will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to your claim for time loss benefits. Whether a document, record or other information is relevant to a claim will be determined in accordance with 29 CFR §2560.503-1(m)(8);

iv. Your right to bring a lawsuit for time loss benefits under §502(a) of ERISA; and

v. A statement of voluntary alternative dispute resolution options, if any, which may be available to you.

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

f. The Board of Trustees has the full and exclusive authority to administer time loss claims, interpret the Active Employee Plan as it relates to time loss benefits, determine eligibility for time loss benefits and resolve all questions arising in the administration, interpretation and application of the Active Employee Plan that concerns time loss benefits. The Board of Trustees' authority includes, but is not limited to:

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

ii. The right to establish and enforce rules and procedures for the administration of time loss benefits and any claim concerning time loss benefits so long as the rules and procedures are consistent with ERISA;

iii. The right to construe and interpret the Active Employee Plan as it relates to time loss benefits and determines eligibility for benefits; and

iv. The exercise of the aforementioned powers and authorities by the Board of Trustees will be given the fullest deference allowed by law.

Coordination of Benefits (COB) for Medical Benefits

When a husband and wife both work, each may have family health and welfare coverage provided at his or her place of employment. If each spouse has health and welfare coverage for the other and for their children, questions may arise as to which health and welfare plan should pay what amount in the event an illness or injury occurs. Coordination of benefits is a method for determining which health and welfare plan has primary responsibility to pay for benefits in a given situation and which health and welfare plan has secondary responsibility.

Definitions

For purposes of this section, the following terms are defined:

Plan – means any of the following coverages which provide benefit payments or services to an employee or dependent for medical coverage:

1. Group or blanket insurance (except student accident insurance);
2. Group BlueCross and/or BlueShield and other pre-payment coverage on a group basis, including HMOs;
3. Coverage under a labor-management trusted plan, a union welfare plan, an employer organization plan or an employee benefit plan;
4. Coverage under governmental plans, other than Medicaid, and any other coverage required or provided by law;
5. Group or individual "no fault" coverage; and
6. Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceed $100 per day.

Claimant – means the person for whom the claim for medical benefits is made.

Claim Period – means part or all of a calendar year during which the employee or dependent is covered by this Plan.

Covered Charge – means the usual and customary charge for any medically necessary medical care service or supply that is covered at least in part by any of the Plans involved during a Claim Period. Where a Plan provides medical benefits in the form of services or supplies rather than cash payments, the reasonable cash value of the service or supply during a Claim Period will also be considered a Covered Charge. The difference in cost of a private hospital room and a semi-private hospital room is not considered a Covered Charge unless the employee's or dependent's stay in a private hospital room is considered medically necessary by at least one of the Plans involved.

Coordination of Benefits

If an employee or dependent is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pays.

1. The Primary Plan (which is the plan that pays benefits first) pays all the benefits that would be payable under its terms in the absence of this provision.
2. The Secondary Plan (which is the plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the Primary Plan will not exceed the greater of:
    a. 100% of the Covered Charges; or
    b. The amount of Covered Charges it would have paid had it been the Primary Plan.

If this Plan is the Secondary Plan, its financial obligation under this COB provision may be limited. If this Plan's payment obligation (as the Secondary Plan) for Covered Charges for an illness, injury or sickness would exceed $10,000.00, then it shall never pay more than the amount of money paid by the Primary Plan for the same illness, injury or sickness.

Order of Benefit Determination Rules

If the Coordination of Benefits provision applies, the order of benefit determination rules set forth below control and determine which plan is primary and which plan(s) is secondary.

When another Plan does not have a COB provision, that Plan must determine benefits first.

When another Plan does have a COB provision, the first of the following rules which apply determine which Plan is the Primary Plan:

1. If a Plan covers the Claimant as an employee, member or non-dependent, then that plan is the Primary Plan;
2. If the Claimant is a dependent child whose parents are not divorced or separated, then the Plan of the parent whose birthday is earlier in the calendar year will pay first except:
    a. If both parents' birthdays are on the same day, rule (4) below will apply.

b. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a COB rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.

3. If the Claimant is a dependent child whose parents are divorced or separated, the following rules will apply:

   a. A Plan which covers a child as a dependent of the parent who by court decree must provide health coverage will be the Primary Plan; and

   b. When there is no court decree that requires a parent to provide health coverage to a dependent child, the following rules will apply:

      i. When a parent who has custody of a child has not remarried, that parent's Plan will be the Primary Plan; and

      ii. When a parent who has custody of a child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second and by the Plan of the parent without custody third.

4. If none of the above rules apply, the Plan that has covered the Claimant for the longest period of time will be the Primary Plan except when:

   a. One Plan covers the Claimant as a laid-off or retired employee (or a dependent of such employee); and

   b. The other Plan includes this COB rule for laid-off or retired employees (or is issued by a state that requires this COB rule by law)

   then the Plan that covers the Claimant as other than a laid-off or retired employee (or dependent of such an employee) will pay first.

Right to Receive and Release Necessary Information

In order to receive benefits, the Claimant must give the Plan any information that is needed to coordinate benefits. The Plan may release to or collect from any other person or organization any needed information about the Claimant.

Facility of Payment

Any payment made by another Plan may include an amount that should have been paid by this Plan. If so, this Plan may pay that amount to the Plan that made the payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this Plan is more than should have been paid under this COB section, this Plan may recover the excess from one or more of:

1. Any person or organization to whom payment was made;

2. Any insurance company, service plan or other organization that should have made payment; or

3. The Claimant.

If you or your dependent have other health and welfare coverage and this Plan is secondary, you will receive faster claims service if you submit the claim to the Primary Plan first and attach a copy of its Explanation of Benefits form and an itemized bill showing the services received to your claims submission to this Plan.

Subrogation and Reimbursement Obligations

There may be situations in which you have a legal right to recover covered charges paid by the Harrison Trust from your insurance company or a third party who may be responsible for your illness or injury (the third party claim). For example, if you are injured in a store or at work, the store owner or a workers' compensation insurance carrier may be responsible for the covered charges arising out of the injury. If you have such a third party claim, the following rules will apply:

The Harrison Trust will not pay for covered charges for any illness or injury for which your insurance company or a third party may be responsible, except as provided below. If you have a claim against your insurance company or a third party who is or may be responsible for any illness or injury for which the Harrison Trust has paid for covered charges or if you have any other recovery of any kind relating to an illness or injury caused by a third party, the Harrison Trust will be subrogated to all rights, claims, interests, rights of action, judgments and recoveries you have to the extent of the covered charges the Harrison Trust has paid to you, or on your behalf, relating to the third party claim, regardless of the source of such rights, claims, interests, rights of action, judgments or recoveries. In such cases, the Harrison Trust will pay for covered charges subject to the following terms and conditions:

1. You warrant and represent that no recovery or settlement of any kind has been obtained from or made with any person or entity relating to the third party claim except as disclosed to the Harrison Trust.

2. If you obtain any recovery, regardless of the source and regardless of the characterization of the recovery, including personal insurance policies of you or a family member, relating to any third party claim, you will first reimburse the Harrison Trust, or cause the Harrison Trust to be reimbursed, to the extent of such recovery for all covered charges provided to you, or on your behalf, relating to the third party claim immediately upon collection of such recovery, whether by action of law, settlement or otherwise and with no more than a 25% reduction of covered charges for attorney fees if you have employed an attorney who assisted in the recovery even if you have not been made whole. The Harrison Trust will be paid first from any recovery. Until payment is made to the Harrison Trust, you must preserve and protect funds sufficient to satisfy the Harrison Trust by holding such funds in an escrow or trust account. If you or your attorney fail to honor the Harrison Trust's right to reimbursement, you will be liable for all covered charges related to the third party claim as well as all costs of enforcement and collection, including attorneys' fees through and including any appeals. The Board of Trustees may, at its election, offset future covered charges otherwise payable from the Harrison Trust to or on behalf of you or a family member until such time as the Harrison Trust's right to reimbursement has been satisfied by way of such offset or otherwise. The Board of Trustees

may also, at its election, take money from your reserve account or the reserve account of the employee until the Harrison Trust's right to reimbursement has been satisfied. The rights of the Board of Trustees are cumulative.

3. You agree to assign, transfer and subrogate to the Harrison Trust all rights, claims, interests, rights of action, judgments and recoveries that you may have, to the extent of the amount of covered charges paid by the Harrison Trust relating to any third party claim, regardless of the source of such rights, claims, interests, rights of action, judgments and recoveries, including personal insurance policies of you or a family member, and the Harrison Trust will have a security interest in and lien on any settlement or recovery obtained by you to the extent of the amount of covered charges paid by the Harrison Trust.

4. The Board of Trustees may, at its election, undertake legal action against any third party or your personal insurance company or the insurance company of a family member to pursue and/or enforce the rights under paragraphs 1, 2, and 3, above, and you authorize the Board of Trustees to sue, compromise or settle in your name; provided that the Board of Trustees has no duty to undertake such legal action, and provided further that if the Board of Trustees does undertake such legal action, the Board of Trustees may, at its election, and in accordance with applicable law, pursue such legal action in the name of the Board of Trustees or the Harrison Trust and only to the extent of covered charges provided, plus costs of recovery, including attorneys' fees through and including any appeal. In addition, if the Board of Trustees does undertake such legal action, the Harrison Trust will be entitled to retain from any recovery, the amount of covered charges provided, plus costs of recovery, including attorneys' fees through and including any appeals, and you will be entitled to the remainder of the recovery, if any. You agree to execute and deliver any instrument and papers, and provide all assistance necessary to enable the Board of Trustees to undertake and pursue such legal action.

5. You shall do nothing to prejudice the Board of Trustees' rights under paragraphs 1, 2, 3, and 4, on the previous page, and the Board of Trustees may, at its election, suspend payment of or deny all covered charges for which a third party is or may be responsible that are otherwise payable from the Harrison Trust with respect to any injury or illness sustained by you if you, or the parent or guardian, or your attorney fail to perform any and all acts required under this section or there is a reasonable basis to believe you and/or your attorney will not honor the Harrison Trust's subrogation and reimbursement rights.

6. If the Harrison Trust provides covered charges for any injury or illness, for which your insurance company or a third party is or may be responsible, the Board of Trustees will have all the foregoing rights regardless of whether you agree thereto in writing. As a prerequisite to providing covered charges to you, the Board of Trustees may require you or the parent or guardian and your attorney to sign a written subrogation and/or reimbursement agreement.

7. The Board of Trustees has the authority to compromise subrogation/reimbursement claims on a case-by-case basis depending on the facts and circumstances of each case.

Qualified Medical Child Support Orders

The Board of Trustees will recognize and be bound by Qualified Medical Child Support Orders. You may contact the Trust Office to obtain, without charge, the procedure the Board of Trustees will follow when a Medical Child Support Order is received.

Military Service

If you or a dependent join the Armed Forces of the United States or are called to active duty for more than 30 days, health and welfare coverage for you or your dependent will end on the date you or your dependent enters full-time active duty.

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

1. Your reserve account will be preserved for a maximum of five years. However, you may use your reserve account to provide coverage for your Dependents.
2. There will be COBRA-type continuation coverage rights for a maximum of 24 months from the date military leave began. See the *COBRA* section on page 14 or contact the Trust Office for more information.
3. When your military leave is expected to last 31 days or less, your employer may be required to pay the health and welfare coverage for this limited period of time. You must notify your employer of the expected military leave and must return to employment within the time frames established by the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994.
4. When your military service ends, any eligibility waiting period cannot be applied to you and your dependents unless the waiting periods were established after you left for military service and the new waiting periods apply to all employees. Likewise, when returning from military service, you cannot be required to satisfy any preexisting condition exclusion unless the preexisting condition exclusion applies to all employees. This rule does not apply to service related injuries or illnesses.

If you have questions concerning your rights under the Uniformed Services Employment and Reemployment Rights Act of 1994, contact your employer or the Trust Office.

Reciprocal Agreements

The Harrison Trust is a party to the Electrical Industry Health and Welfare Reciprocal Agreement. If you would like to have health and welfare contributions sent from the Harrison Trust to your home fund or from the health fund where you are working to the Harrison Trust, contact the Trust Office for instructions. You will be required to register in the Electronic Reciprocity Transfer System (ERTS) before health and welfare contributions can be transferred under the Electrical Industry Heath and Welfare Reciprocal Agreement.

Certificate of Creditable Coverage Under the Harrison Trust

In accordance with the Health Insurance Portability and Accountability Act of 1996, the Trust Office will provide you with a written certificate concerning the length of health and welfare coverage under the Harrison Trust. This certificate will be provided to you at the following times:

1. When you cease to be covered under the Plan.
2. (Again) when you cease to be covered under COBRA.

3. If you request a certificate, within 24 months following cessation of coverage.

Protected Health Information

Privacy Practices of the Harrison Trust and Active Employee Plan

This section of the Benefit Booklet describes how protected health information (hereafter health information) about you may be used and disclosed and how you can get access to this health information. This section is applicable to the Harrison Trust and the Active Employee Plan. If you have medical and prescription drug coverage or dental coverage through an insured plan such as Providence Health Plan, Kaiser Permanente or Willamette Dental, that plan has its own Privacy Practices to protect your health information.

Policy of the Plan Regarding Your Health Information

The Plan understands that health information about you is personal. The Plan is committed to protecting health information about you. This section will tell you about the ways in which the Plan may use and disclose health information about you. This section also describes the Plan's obligations and your rights regarding the use and disclosure of health information. Your physician or provider may have different policies or notices regarding their use and disclosure of your health information created in the physician's office or clinic.

The Plan is required by law to:

1. Make sure that health information that identifies you is kept private;
2. Give you notice of the Plan's legal duties and privacy policies regarding your health information; and
3. Follow the terms of this section until modified.

How the Plan May Use and Disclose Health Information About You

The following categories describe different ways the Plan may use and disclose your health information. For each category of use or disclosure, the Benefit Booklet will explain what is meant and will provide examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose your health information will fall within one of these categories.

1. **To Make or Obtain Payment**. The Plan may use and disclose health information about you to determine eligibility for benefits, to facilitate payment for the treatment and service you receive from providers, to determine benefit responsibility under the Plan or to coordinate health plan coverage. For example, the Plan may tell your health care 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 health information with a stop loss insurance carrier or a utilization review or precertification service provider. Likewise, the Plan may share health information with another entity to assist with the adjudication of health claims or with another health plan to coordinate benefit payments.

2. **To Facilitate Treatment**. The Plan may use and disclose your health information to facilitate treatment or services by providers, including coordination or management of health carrier related services. For example, the Plan may disclose health information about you with physicians who are treating you.

3. **To Coordinate Health Care Operations**. The Plan may use and disclose your health information to facilitate the administration of the Plan. These uses and disclosures are necessary to run the Plan. For example, 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;

    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 health information about you when required to do so by federal, state or local law. For example, the Plan may disclose health information when required by a court order in a lawsuit such as a malpractice case.

5. **To Avert a Serious Threat to Health or Safety**. The Plan may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or of another person. Any disclosure, however, will only be made to someone able to help prevent the threat. For example, the Plan may disclose health information about you in a proceeding regarding the licensure of a physician.

6. **Military and Veterans**. If you are a member of the armed forces, the Plan may release health information about you as required by military command authorities. The Plan may also release health information about foreign military personnel to the appropriate foreign military authority.

7. **For Treatment Alternatives**. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

8. **For Distribution of Health-Related Benefits and Services**. The Plan may use and disclose your health information to provide information on health-related benefits and services that may be of interest to you.

9. **For Disclosure to the Board of Trustees**. The Plan may disclose your health information to another health plan maintained by the Harrison Trust or to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Plan. In addition, the Plan may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan may also disclose to the Board of Trustees information whether you are participating in the Plan.

10. **A Family Member or Close Personal Friend Involved in Your Health Care.** The Plan may make your health information known to a family member or close personal friend. Disclosure of your health information will be determined based on how involved the person is in your health care or payment of your health care claims. For example, the Plan will normally provide information to a family member confirming eligibility for health coverage or if a claim was paid but not the specific treatment or diagnosis provided or the reason the provider was consulted. The Plan may release health information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your health information, the Plan, through its Trust Office, may use its professional judgment to determine whether the disclosure is in your best interest. If you do not want your health information disclosed to a family member or close personal friend as outlined in this section, you must notify the Plan as described in the Right to Request Restrictions on page 113.

11. **Personal Representative**. The Plan will disclose your health information to an individual who has been designated as your personal representative and has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification, such as a 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. The Plan determines, in its professional judgment, that it is not in your best interest to treat the person as your personal representative.

12. **Business Associates**. Business associates perform various functions and services on behalf of the Plan. For example, the Trust Office, A&I Benefit Plan Administrators, Inc., will be handling many of the 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, use or disclose your health information, but only after agreeing, in writing, to appropriate safeguards concerning your health information.

13, **Other Covered Entities**. The Plan may use or disclose your 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 health information to a provider when needed by the provider to render treatment to you or the Plan may disclose health information to another covered entity to conduct health care operations in the area of quality assurance.

14. **To Conduct Health Oversight Activities**. The Plan may disclose your 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. However, the Plan may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

15. **Legal Proceedings**. The Plan may disclose your health information: (a) in the course of any judicial or administrative proceeding; (b) in response to an order of a court or an administrative tribunal (to the extent such disclosure is expressly authorized); and (c) in response to a subpoena, discovery request or other lawful process once the Plan has met the administrative requirements of the Health Insurance Portability and Accountability Act of 1996 (hereinafter the "HIPAA Privacy Rule"). For example, the Plan may disclose your health information in response to a subpoena for such information, but only after the Plan meets certain conditions required by the HIPAA Privacy Rule.

16. **Law Enforcement**. Under certain conditions, the Plan may disclose your health information to law enforcement officials. 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) it is necessary to locate or identify a suspect, fugitive, material witness or missing person; or (c) it is necessary to provide evidence of a crime that occurred.

17. **National Security and Intelligence**. In certain circumstances, federal regulations require the Plan to disclose your health information to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.

18. **Abuse or Neglect**. The Plan may disclose your health information to a governmental entity that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity authorized to receive such information your health information if the Plan believes that you have been a victim of abuse, neglect or domestic violence.

19. **Research**. The Plan may disclose your health information to researchers when an institutional review board or privacy board has: (a) reviewed the research proposal and established protocols to ensure the privacy of your health information; and (b) approved the research.

20. **Inmates**. If you are an inmate of a correctional institution, the Plan may disclose your 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.

21. **Coroners, Medical Examiners, Funeral Directors and Organ Donation**. The Plan may disclose 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 also disclose, as authorized by law, information to funeral directors so they may carry out their duties. Further, the Plan may disclose health information to organizations that handle organ, eye or tissue donation and transplantation.

22. **Workers' Compensation**. The Plan may release your health information to the extent necessary to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

23. **Disclosures to the Secretary of the U.S. Department of Health and Human Services**. The Plan is required to disclose your health information to the Secretary of the US Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your health information without your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

Minimum Necessary Disclosure of Health Information

The amount of 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, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of 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 Health Information

You have the following rights regarding your health information that the Plan maintains:

1. **Right to Request Restrictions**. You have the right to request restrictions or limitations on the health information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in your care or the payment for your care. However, the Plan is not required to agree to your request. If the Plan does agree to the restriction, the Plan will comply with the restriction unless the information is needed to provide emergency medical treatment.

   To request restrictions, you must make your request in writing to the Client Service Representative for the Harrison Trust in writing at the address on page 118. In your written request, you must tell the Plan:

   a. What 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 Receive Confidential Communications**. You have the right to request that the Plan communicate with you about health matters in a manner other than by mail or at an alternative location if you feel the disclosure of your health information could endanger you. For example, you may ask that the Plan communicate with you only at a certain post office box, telephone number or by e-mail.

   To request confidential communications, you must make your request in writing to the Client Service Representative for the Harrison Trust at the address on page 118. The Plan will not ask you the reason for the request. The Plan will attempt to honor all reasonable requests. Your written request must specify how or where you wish to receive confidential communications.

3. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Client Service Representative for the Harrison Trust at the address on page 118. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling and postage.

4. **Right to Amend Your Health Information**. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend its records. The request may be made as long as the health information is maintained by the Plan.

   A request for an amendment of health information records must be made in writing to the Client Service Representative for the Harrison Trust at the address on page 118. The Plan may deny the request if it does not include a reason to support the amendment. The request may also be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to amend, or if the Plan determines that records containing your health information are accurate and complete.

5. **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures of your health information when the disclosure was made for any purpose other than treatment, payment, health care operations or when disclosures are not in accordance with this Section of the Benefit Booklet and applicable law. An accounting of disclosures is not required for disclosures made pursuant to a signed authorization by you or your personal representative. Most disclosures of your health information will be for purposes of treatment, payment or health care operations and, therefore, will not be subject to your right to an accounting.

   The request for an accounting must be made in writing to the Client Service Representative for the Harrison Trust at the address on page 118. The accounting request should specify the time period for which you are requesting the accounting but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six years. 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 a Paper Copy of this Notice**. You have the right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To receive a paper copy, please contact the Client Service Representative for the Harrison Trust at the address below.

Duties of the Plan

The Plan is required by law to maintain the privacy of your health information as set forth in this section and to provide to you this information. The Plan is required to abide by the terms of this section, which may be amended from time to time. The Plan reserves the right to change the terms of this section and to make the new provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the section and will provide a copy of the revised section to you within 60 days of the change.

Complaints

You have the right to express complaints to the Plan and to the Secretary of the US Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Client Service Representative for the Harrison Trust at the address in the next paragraph. The Plan encourages you to express any concerns you may have regarding the privacy of your health information. All complaints should be in writing. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Plan has designated the Harrison Trust's Client Service Representative for all issues regarding this section and your privacy rights. You may contact this person at:

Client Service Representative
Harrison Electrical Workers Trust Fund
1220 SW Morrison Street, Suite 300
Portland, OR 97205
In Portland: 503-224-0048
Outside Portland: 800-547-4457

If you have any questions regarding this section, please contact Client Service Representative at the address and telephone number listed above.

Disclosure of Protected Health Information to the Board of Trustees

The Harrison Trust and the Plan may disclose your Protected Health Information to the Board of Trustees subject to the terms and conditions set forth below:

1. **Disclosure of Protected Health Information to the Board of Trustees**. Unless otherwise permitted by law, the Harrison Trust, Plan and any health insurance issuer or business associate providing services to the Harrison Trust and/or Plan will only disclose your Protected Health Information to the Board of Trustees to the extent necessary to permit the Board of Trustees to carry out plan administrative functions consistent with the applicable provisions of

the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations. Any disclosure to or use by the Board of Trustees of your Protected Health Information will be subject to and consistent with the provisions of Sections 2 and 3 below.

2. **Board of Trustees' Obligations Regarding Protected Health Information**. The Board of Trustees will:

   a. **Prohibit Unauthorized Use or Disclosure of Protected Health Information**. Neither use nor disclose your Protected Health Information except as permitted by the Plan Document and Benefit Booklet for the Plan as amended from time to time or required by law.

   b. **Subcontractors and Agents**. Ensure that any subcontractor or agent to whom the Board of Trustees provides your Protected Health Information received from the Trust and/or Plan agrees to the restrictions and conditions in the Plan Document and Benefit Booklet for the Plan, including this section, with respect to your Protected Health Information.

   c. **Permitted Purposes**. Neither use nor disclose your Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.

   d. **Reporting**. Report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan Document and Benefit Booklet for the Plan promptly upon learning of such inconsistent use or disclosure.

   e. **Access to Your Protected Health Information**. Make your Protected Health Information available to the person in accordance with 45 C.F.R. § 164.524.

   f. **Amendment of Protected Health Information**. Make your Protected Health Information available for amendment and, upon request, amend your Protected Health Information in accordance with 45 C.F.R. § 164.526.

   g. **Accounting of Protected Health Information Disclosures**. Track disclosures of your Protected Health Information so that an accounting of disclosures can be made to you in accordance with 45 C.F.R. § 164.528.

   h. **Disclosure to Governmental Agencies**. Make the Trust's and Plan's internal practices, books and records relating to the use and disclosure of your Protected Health Information available to the US Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-164.

   i. **Return or Destruction of Protected Health Information**. When your Protected Health Information is no longer needed for the purpose for which use or disclosure was made, each Trustee must, if feasible, return to the Plan, or destroy, all Protected Health Information that he received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Trustee agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j. **Minimum Necessary Requests**. The Board of Trustees will use its best efforts to request only the minimum necessary type and amount of your Protected Health Information to carry out the functions for which the information is requested.

3. **Board of Trustees' Obligations Regarding Electronic Protected Health Information**. The Board of Trustees agrees that if it creates, receives, maintains or transmits any electronic Protected Health Information (other than enrollment/dis-enrollment information and summary health information that are not subject to these restrictions) on behalf of the Trust and/or Plan concerning you, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information.

   The Board of Trustees will ensure that any subcontractors or agents to whom it provides such electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect this information.

   The Board of Trustees will report to the Plan any security incident, as defined in 45 C.F.R.§ 164.304, that results in unauthorized access, use, disclosure, modification or destruction of the Harrison Trust's or Plan's electronic Protected Health Information of which it becomes aware within a reasonable period of time. The Board of Trustees will also report to the Harrison Trust and Plan any other security incident on an aggregate basis every year, or more frequently based upon the Trust's or Plan's written request.

4. **Adequate Separation Between the Board of Trustees, the Harrison Trust and the Plan**. The Board of Trustees represents that adequate separation exists between the Trust and the Plan and the Board of Trustees so that Protected Health Information will be used only for plan administration purposes.

   The following persons or organizations that have a contractual arrangement with the Harrison Trust or Board of Trustees may receive your Protected Health Information relating to payment, health care operations or other matters pertaining to the Plan:

   a. Employees of A&I Benefit Plan Administrators, Inc.; and

   b. Business associates of the Harrison Trust and Plan and business associates' employees, officers, directors, agents and subcontractors provided the business associate has signed a business associate agreement.

   The persons and organizations identified above will have access to your Protected Health Information only to perform plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of their contracts, for any use or disclosure of your Protected Health Information that violates the business associate agreement.

   The Board of Trustees will ensure that the provisions of this Section 4 are supported by reasonable and appropriate security measures to the extent that the persons or organizations identified above have access to your electronic Protected Health Information.

5. **Reports of Non-Compliance**. Anyone who suspects an improper use or disclosure of his Protected Health Information may report the occurrence to the Plan's representative at the following address and telephone number:

Client Service Representative
Harrison Electrical Workers Trust Fund
1220 SW Morrison Street, Suite 300
Portland, OR 97205
In Portland: 503-224-0048
Outside Portland: 800-547-4457

6. **Making Requests**. Requests to inspect and copy, to correct or amend and for an accounting of your Protected Health Information should be made in writing to:

   Client Service Representative
   Harrison Electrical Workers Trust Fund
   1220 SW Morrison Street, Suite 300
   Portland, OR 97205

7. **Certificate by the Board of Trustees**. The Harrison Trust, Plan, any health insurance issuer and HMO will disclose Protected Health Information to the Board of Trustees only upon the receipt of a certificate by the Board of Trustees that the Plan Document has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the Board of Trustees agrees to the conditions of disclosure set forth in Section 2 (on page 116).

Summary Plan Description

This summary is a general explanation of certain terms of the Plan and other legal instruments, and is not intended to modify or change them in any manner. The rights and duties of all persons connected with the Plan are set forth in those instruments, which may be inspected at the office of the Trust Office.

Name of Plan

This Plan is known as the Harrison Electrical Workers Trust Fund – Active Employee Plan, also referred to as the Plan or Harrison Trust.

Effective Date

August 1, 2006

Plan Sponsor

This Plan is sponsored by:

Board of Trustees of the
Harrison Electrical Workers Trust Fund
1220 SW Morrison Street, Suite 300
Portland, OR 97205
In Portland: 503-224-0048
Outside Portland: 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 – 93-6023048
Plan Identification Number – 501

Type of Plan

This Plan is a Health and Welfare Benefit Plan.

Trust Office

This Plan is administered by the Board of Trustees of the Harrison Electrical Workers Trust Fund, with the assistance of the Trust Office, 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 ext. 1679
Outside Portland: 800-547-4457 ext. 1679

Agent for Legal Service

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

Service of legal process may also be made upon a member of the Board of Trustees or the Trust Office.

Board of Trustees

Employer Trustee

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

Gary Price (First Alternate)
c/o Oregon-Columbia Chapter NECA
601 NE Everett
Portland, OR 97232

Randy Wagner (Second Alternate)
2904 SW 1st Avenue
Portland, OR 97201

Labor Organization Trustee

Cliff Davis
IBEW Local No. 48
15937 NE Airport Way
Portland, OR 97230

Tim Foster (First Alternate)
IBEW Local No. 48
15937 NE Airport Way
Portland, OR 97230

Eric Hayes (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 and Oregon-Pacific Cascade Chapter of the National Electrical Contractors Association and International Brotherhood of Electrical Workers, Local Nos. 48, 280, 659, 932 and 970 and other employers signatory to collective bargaining agreements with IBEW local unions who have been accepted by the Board of Trustees as participating employers. The collective bargaining agreements provide that employers will make the required contributions to the Trust for the purpose of enabling employees working under the collective bargaining agreements

to participate in the benefits provided by the Harrison Electrical Workers Trust Fund. The hourly contribution rate is specified in the collective bargaining agreements. Copies of the collective bargaining agreements can be obtained from the Oregon-Columbia Chapter and the Oregon-Pacific Cascade Chapter of the National Electrical Contractors Association and IBEW Local Nos. 48, 280, 659, 932, and 970.

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 Trust Office.

Plan Benefits

This Plan provides time loss benefits, accidental death and dismemberment benefits and life insurance benefits for employees only, and medical, prescription, dental, and vision benefits for employees and dependents.

Your coverage will depend on the Plan you have selected.

Benefits, Eligibility and Termination of Eligibility

This Benefit Booklet describes benefits, eligibility and termination of eligibility requirements under the Active Employee Plan. If at any time you are unable to locate your Benefit Booklet, an additional copy may be obtained from the Trust Office:

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

or any participating local union offices.

Source of Contributions

This Plan is funded through employer contributions, the amount of which is specified in the collective bargaining agreements or, in the case of Category II Agreements, the amount that is specified by the Board of Trustees. Also, self-payments by employees and dependents are permitted as outlined on pages 5 and 6. The amount of self-payments is fixed from time to time by the Board of Trustees.

Organizations Providing Benefits, Funding Media and Type of Administration

The names and addresses of all of the organizations providing benefits and their roles (i.e., whether they are responsible for the administration of the benefit plan and whether benefits are guaranteed under an insurance policy) are set forth below.

Medical, Dental and Time Loss Benefits Under the Active Employee Plan

Claims arising from the medical and dental plans by employees and dependents and the time loss benefits for employees are paid directly from Harrison Trust assets.

Preferred Provider Organizations

The Harrison Trust has entered into contracts with preferred provider organizations that can be used by employees and dependents enrolled in the Active Employee Plan for Medical Coverage medical plan. The Harrison Trust is responsible for paying claims submitted by providers. The preferred provider organizations are responsible for the administration of contracts with physicians, specialists, hospitals and clinics. The preferred provider organizations currently are:

Providence Preferred PPO Network
3601 SW Murray Blvd., Suite 100
Beaverton, OR 97006
800-793-9338

MultiPlan
115 Fifth Avenue
New York, NY 10003-1004
800-546-3887

Case Management, Utilization Review Organization and Disease Management

The Harrison Trust has entered into a contract with a case management, utilization review and disease management organization that reviews the setting, necessity and quality of health care provided to employees and dependents enrolled in the Active Employee Plan for medical coverage. The Harrison Trust pays the case management, utilization review and disease management organization a fee for the services it provides. The case management, utilization review and disease management organization currently is:

Innovative Care Management, Inc.
10121 SE Sunnyside Road, Suite 208
Clackamas, OR 97015
503-654-9447
800-862-3338

Nurse Help Line

The Harrison Trust has entered into a contract with an organization for nurse-provided information and advice by telephone. The Harrison Trust pays this organization a fee for the services it provides. The current nurse line service provider is:

Innovative Care Management, Inc.
11021 SE Sunnyside Rd., Suite 208
Clackamas, OR 97015
503-654-9447
800-862-3338

Health Maintenance Organizations/Alternate Health Plans

Employees and dependents have the option of selecting medical coverage from a health maintenance organizations (Kaiser Permanente) or an alternate health plan (Providence Health Plan). The medical benefits are insured and provided under contracts between the Harrison Trust and Providence Health Plan and the Kaiser Permanente Foundation Health Plan. Providence Health Plan and the Kaiser Permanente Foundation Health Plan are responsible for administering their own plans and paying the claims.

Kaiser Permanente Foundation Health Plan
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Providence Health Plan
PO Box 139
Portland, OR 97207

Mail Order Prescription Drug Program

The mail order prescription drug program for employees and dependents is provided by CVS/Caremark. The Harrison Trust is responsible for paying the mail order prescription drug claims. A fee is paid to CVS/Caremark for administering the program.

CVS/Caremark
PO Box 94467
Palatine, IL 90094-4467

Prescription Drug Program

The prescription drug program for employees and dependents is provided by RESTAT, LLC. The Harrison Trust is responsible for paying the prescription drug claims. A fee is paid to RESTAT, LLC for administering the prescription drug program.

RESTAT, LLC
11900 West Lake Park Drive
Milwaukee, WI 53224

Vision Plan

Vision benefits are provided for employees and dependents by Vision Service Plan (VSP). The Harrison Trust is responsible for paying the claims. A fee is paid to VSP for administering the vision plan.

VSP
PO Box 997100
Sacramento, CA 95899

Life and Accidental Death and Dismemberment Insurance

The life and accidental death and dismemberment insurance benefits for employees are provided by Standard Insurance Company. The benefits are provided and insured under group contracts between the Harrison Trust and Standard Insurance Company. Standard Insurance Company is responsible for administering the plans and paying the claims.

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204

Employee Assistance Program

Employees and dependents have access to an employee assistance program provided by the Providence Health System. A fee is paid by the Harrison Trust to the Providence Health System for administering the employee assistance program.

Providence Health System EAP
3510 NE 122nd, Suite 211
Portland, OR 97230

Dental Plans

Employees and dependents have the option of selecting dental coverage from the Active Employee Plan which self-insures the dental benefits, from Kaiser Permanente or Willamette Dental. The dental benefits provided by Kaiser Permanente and Willamette Dental are insured and provided under contracts between the Harrison Trust and Kaiser Permanente and Willamette Dental. Kaiser Permanente and Willamette Dental are responsible for administering their own plans and paying the claims.

Kaiser Permanente Foundation Health Plan
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Willamette Dental Management Corporation dba
Willamette Dental
6950 NE Campus Way
Hillsboro, OR 97124

Plan Year

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

Plan Termination

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 then existing benefit Plans, until such moneys and assets have been exhausted, unless some other disposition is required in regulations of the Secretary of Labor.

Liability of Third Parties and the Board of Trustees

No participating Employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation of the participating 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 this Plan or the Trust Agreement will be construed as obligating any participating Employer to make benefit payments or contributions other than the contributions for which the participating 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 chapters of the National Electrical Contractors Association or IBEW local unions to provide the benefits established by this Plan if assets are not available to make such benefit payments.

ERISA Statement of Rights

As a participant in Harrison Electrical Workers Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing 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 US Department of Labor.

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

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

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Benefit Booklet starting on page 14 for the rules governing your COBRA Continuation Coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when your COBRA Continuation Coverage ceases and if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for six months after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have

the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust Office to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trust Office. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Trust Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), US Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling the Employee Benefits Security Administration's toll-free number 866-444-3272 or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272. You may also find assistance to your questions and a list of Employee Benefit Security Administration filed offices at: www.dol.gov/ebsa/.

Definition of Terms

Accidental Bodily Injury – An injury caused by an external force or element such as a blow or fall that requires immediate medical attention.

Active Employee Plan or Plan – The health and welfare benefits described in this Benefit Booklet and any amendments, additions or deletions subsequently made.

AD&D Insurance – Accidental death and dismemberment insurance provided under the group policy by Standard Insurance Company.

Approved Hospice – A private or public hospice agency or organization approved by Medicare or accredited by the Joint Commission on Accreditation of Hospitals.

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

Benefit Period – Claims incurred for services rendered January through December of a calendar year. A benefit period is established, and begins, when you have incurred during a calendar year covered charges that exceed the deductible amount. All covered charges incurred during a benefit period are used in computing benefit payments. A benefit period terminates on the last day of the calendar year in which it was established.

Birthing Center – A freestanding facility meeting the following criteria:

1. Complies with applicable licensing requirements and maintains adequate levels of insurance;
2. Provides prenatal care, delivery and immediate postpartum care and has at least two beds or birthing rooms;
3. Is directed by at least one physician who is a specialist in obstetrics and gynecology;
4. Has a physician or certified nurse/midwife present at all births and during the immediate postpartum period;
5. Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital;
6. Provides full time skilled nursing services in the delivery and recovery rooms;
7. Accepts only patients with low risk pregnancies;
8. Has a written agreement with a hospital in the area for immediate transfer of a patient or a child;
9. Provides a quality assurance program, including reviews by physicians who do not own or direct the facility; and
10. Is equipped and has a trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor or a child is born with an abnormality that impairs function or threatens life.

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

Category II Agreement – A written agreement between the Board of Trustees and a Contributing Employer that allows the Contributing Employer to provide health and welfare benefits to its employees who do not receive benefits pursuant to a collective bargaining agreement.

Chemical Dependency – A physical and/or psychological addictive relationship that an individual has with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis.

Chemical Dependency does not include an addiction to, or dependency on tobacco, tobacco products or foods.

Claimant – An individual asserting a claim for life insurance benefits with Standard Insurance Company.

Contributing Employer – An employer who is obligated to make health and welfare contributions to the Trust on behalf of employees per a collective bargaining agreement or Category II Agreement.

Cosmetic Surgery – The surgical alteration of tissue for the improvement of your appearance rather than improvement or restoration of bodily function.

Covered Charges – Charges covered under this Plan.

Deductible – A set amount of covered charges that must be paid by you.

Dependent – Means:

1. An employee's spouse (if not legally separated from the employee). Coverage for the spouse ends on the last day of the Month in which the divorce or legal separation occurs unless COBRA coverage is elected.

2. An employee's Domestic Partner. Coverage for the Domestic Partner and the Domestic Partner's children who qualify as Dependents ends on the last day of the month in which the domestic partnership relationship ends unless COBRA coverage is elected.

3. a. An employee's unmarried child (including a child of a Domestic Partner, a stepchild, legally adopted child or child placed in an employee's home pending adoption) from live birth until the end of the month the child attains age 19.

   b. An employee's unmarried child (including a child of a Domestic Partner, a stepchild, legally adopted child or child placed in an employee's home pending adoption) who has attained age 19 if the child is:

      (i) 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 have ended due to age;

      (ii) Single and actually dependent on the employee for the majority of his or her support; and

(iii) Covered by this Plan just prior to the date the child attains age 19.

c. An employee's unmarried child (including a stepchild, legally adopted child or child placed in an employee's home pending adoption) who is enrolled in an accredited school as a full-time student and has not attained age 25. The unmarried child that has not attained age 25 may continue as a dependent even though not enrolled in an accredited school as a full-time student if:

(i) The child loses full-time student status because he/she is suffering from a serious illness or injury that makes the leave of absence medically necessary and a doctor provides written verification to the Trust Office that the child's serious illness or injury makes the leave of absence as a full-time student at an accredited school medically necessary; and

(ii) If the criteria in (i) are met, health and welfare coverage will continue for up to one year from the time the leave of absence begins or the date coverage will otherwise terminate under the terms of the Plan if earlier.

4. An employee's unmarried grandchild, niece, nephew or sibling in the custody of the employee and for whom the employee is providing the majority of his or her support will be considered a dependent if the employee has been named as legal guardian by a court of competent jurisdiction, until the end of the month the grandchild, niece, nephew or sibling attains age 19. Coverage for the grandchild, niece, nephew or sibling can continue beyond age 19 if the grandchild, niece, nephew or sibling meets the criteria in paragraph 3(b) or 3(c) above.

5. In the event that a married couple or Domestic Partners are both concurrently covered by the Plan as employees;

a. Each will be considered a dependent of the other; and

b. Each dependent child of such married couple or Domestic Partners will, be considered a dependent of both individuals. However, no more than 100% of covered charges will be paid.

Doctor or Physician – An individual licensed and holding a degree as a Medical Doctor or Doctor of Osteopathy.

Domestic Partner – The employee and another individual who meet the following criteria:

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

2. Neither of them is married or registered as the Domestic Partner with any other person in any jurisdiction;

3. Neither of them has been married or had another Domestic Partner at any time during the previous six months. This does not apply if your prior spouse or Domestic Partner is deceased.

4. Both of them are at least 18 years of age;

5. They are not related by blood kinship closer than would bar marriage in the state where they reside;

6. They are mentally competent to consent to contract; and

7. They are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for each other's common welfare, including but not limited to food, shelter and other necessary living expenses.

The Board of Trustees may require the employee and Domestic Partner to submit affidavits and other information and documents to establish their domestic partner relationship. In the event the employee and Domestic Partner reside in a city, county or other governmental unit that has a domestic partner registry, the Board of Trustees may require that the employee and Domestic Partner submit evidence that they are registered on a governmental body's domestic partner registry.

The Board of Trustees or their designee must confirm a domestic partner relationship exists before health and welfare coverage can be extended to the Domestic Partner and, if applicable, the children of a Domestic Partner. Health and welfare coverage can start the first of the month after (i) the Board of Trustees or their designee have accepted the Domestic Partner relationship; (ii) all enrollment forms are completed and returned to the Trust Office; and (iii) the employee has made a self-payment to the Trust Office to cover the federal and, if applicable, state income taxes on the value of the employer paid health and welfare coverage provided to the Domestic Partner and, if applicable, his/her children.

The domestic partnership will cease to exist on the earliest date that all the aforementioned criteria for Domestic Partner status are not met.

Earnings – Money paid to the employee by his or her employer as base pay. This does not include:

1. Bonus, incentive, commission and other non-base pay; or

2. Professional fees, retainers and directors' fees.

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 International Brotherhood of Electrical Workers.

Employee – A person who is working for a Contributing Employer or on the out-of-work list of an IBEW local union.

Evidence of Good Health – Satisfactory proof, as determined by the Board of Trustees, that a person is acceptable for coverage.

Health Care Facility – A facility licensed by the state or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospice Treatment Plan – A written plan of care established and periodically reviewed by your attending physician. The physician must certify to the Plan that you are terminally ill and the Plan must describe the services and supplies for medically necessary or palliative care to be provided by an approved hospice.

Hospital – A facility that:

1. Is licensed (if required) as a hospital;

2. Is open at all times;

3. Is operated mainly to diagnose and treat illnesses on an inpatient basis;

4. Has a staff of one or more doctors on call at all times;

5. Has 24-hour nursing services by registered nurses;

6. Is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home or like place; and

7. Has organized facilities for major surgery.

Injury – An injury to your body.

Illness – Means:

1. A disorder or disease of the body or mind;

2. An accidental bodily injury; or

3. Pregnancy.

All illnesses due to the same cause, or to a related cause, will be deemed one illness. The donation of an organ or tissue by you for transplanting into another person is considered to be an illness.

Medical Coverage – Benefits in this Plan other than weekly time loss benefits, life insurance benefits, accidental death and dismemberment benefits, vision benefits and dental benefits.

Medical Necessity – Those services and supplies required for diagnosis or treatment of an illness, injury, mental illness or chemical dependency and that, in the judgement of the Board of Trustees, are:

1. Consistent with the symptoms or diagnosis and treatment of your condition;

2. Appropriate with regard to standards of good medical practice;

3. Not primarily for the convenience of you or a provider of services or supplies;

4. Cannot be left out without adversely affecting your condition; and

5. The least costly of the alternative supplies or level of service that can be safely provided to you. This means, for example, that care rendered in a hospital inpatient setting or by a nurse in your home is not medically necessary if it could be provided in a less expensive setting, such as skilled nursing facility without harm to you.

The fact that a provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary.

Medicare – Medical benefits provided by Title XVIII of the Federal Social Security Act.

Mental Illness – Conditions and diseases listed in the most recent edition of the Internal Classification of Diseases (ICD) as psychoses, neurotic disorders or personality diseases; other non-psychotic mental disorders listed in the ICD as determined by the Board of Trustees. Mental illness does not include the treatment of Chemical Dependency.

Month – A period starting at 12:01 a.m. on any day in a given calendar month and ending at 12:01 a.m. on that same numbered day in the next calendar month. If that next calendar month does not have a same numbered day, the month will end at 11:59 p.m. of the last day of that next calendar month. (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; and 12:01 a.m. of May 31 through 11:59 p.m. of June 30.)

Necessary to the Care or Treatment of Illness – Recommended by a provider and commonly recognized in the provider's profession as proper care or treatment of your medical needs. Any final review will be based on professional medical opinion. Also, in the case of hospital or skilled nursing facility confinement, the length of confinement and the services and supplies furnished by the hospital or skilled nursing facility will be considered "medically necessary" only if it is determined by professional medical review that they are related to the care or treatment of illness or injury. The Board of Trustees does not consider hospitalization medically necessary if the care could be adequately and safely provided in other than a hospital or inpatient setting, such as a skilled nursing facility or outpatient clinic.

The treatment, services or supplies must not be:

1. For the scholastic, education or vocational training of the provider;
2. Experimental in nature; or
3. Primarily for the convenience of you or a provider of services or supplies.

One Continuous Period of Disability – A period of time during which you are totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When you have successive periods of total disability that are due to the same or related causes and which are not separated by two or more continuous weeks after being released for active employment by your physician; or
2. When a dependent has successive periods of total disability that are due to the same or related causes and which are not separated by a period of three or more months during which the dependent is free from total disability that stems from those same or similar causes.

Outpatient Service – A program or service providing treatment by appointment. It must be licensed and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs.

Palliative Care – Care primarily for the relief and control of distressing symptoms, not a cure.

Plan Document – The health and welfare benefits described in this Benefit Booklet and any amendments, additions or deletions subsequently made.

Preexisting Condition – A condition that was diagnosed or treated or for which medication was prescribed or taken in the three months before the effective date of coverage under the Active Employee Plan. Pregnancy is not a preexisting condition.

Pregnancy – One's pregnancy, childbirth or related medical conditions, including complications of pregnancy.

Preferred Provider – Any physician, hospital, medical clinic or facility which belongs to the Preferred Provider Organization network recognized by the Trust as a Preferred Provider.

Protected Health Information – Individually identifiable health information that is not subject to specific exclusions. The definition of Protected Health Information in 45 C.F.R. § 164.501 is adopted for use in the Benefit Booklet.

Provider – Means:

1. A licensed Medical Doctor (MD)
2. A licensed Doctor of Osteopathy (DO)
3. A Chiropractic Physician (DC) (under certain limited conditions)
4. A Naturopathic Physician (ND) who is licensed by the state in which care is rendered (if that state's laws license Naturopathic Physicians) and who practices within the scope of his or her license
5. A Doctor of Medical Dentistry (DMD)
6. A Doctor of Dental Surgery (DDS)
7. A Denturist (under certain limited conditions)
8. An Optometrist (OD)
9. A Doctor of Podiatric Medicine (DPM)
10. A Licensed Clinical Psychologist (PhD)
11. A Clinical Social Worker who:
    a. Has a master's or doctoral degree in social work;
    b. Has at least two years of clinical social work practice;
    c. Is certified by the Academy of Certified Social Workers (ACSW); and
    d. In states requiring license, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered (LCSW or RCSW).
12. A Master of Science or Arts
13. A Certified Competent Clinician Audiology
14. A Nurse Midwife, who:
    a. Is a Certified Nurse Practitioner;
    b. Is certified by the American College of Nurse Midwives;
    c. Is under the supervision of a qualified physician or hospital; and
    d. Is licensed as a Nurse Midwife by the state in which care is rendered (if that state's laws license Midwives).

15. A registered Physical Therapist who is licensed as a Physical Therapist by the state in which care is rendered (if that state's laws license Physical Therapists), for rehabilitative services rendered upon the written referral of a physician.

16. A Speech Therapist who:

    a. Has a master's degree in speech pathology;

    b. Has completed an internship; and

    c. Is licensed as a Speech Therapist by the state in which services are performed (if that state's laws license Speech Therapists).

17. A legally qualified Physician's Assistant who is certified by the National Commission on Certification of Physician's Assistants; or is a certified graduate of an approved training course which is accredited by the American Medical Association's Committee on Allied Health Education; and works for a clinic or for a licensed physician who is an MD or DO. This does not apply if applicable law does not allow it.

18. A Nurse Practitioner (Certified)

19. An Occupational Therapist who is licensed as an Occupational Therapist by the state in which care is rendered (if that state's laws license Occupational Therapists), for rehabilitation services rendered upon the written referral of a physician.

Reasonable and Customary (R&C) Charges – The usual charges made by the person, group or other entity rendering or furnishing the services, treatments or materials, but in no event charges in excess of the general level of charges made by others rendering or furnishing such services, treatments or materials to persons of similar income or net worth within the area in which you normally reside for illnesses or injuries comparable in severity and nature to the illness or injury being treated. As to any particular service, treatment or material, the term "area" means a county or such representative cross section of persons, groups or other entities rendering or furnishing such services, treatment or material to persons of similar income or net worth.

Residential Facility, Day or Partial Hospitalization Program – A program or facility licensed and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs to provide an organized full-time or part-day program of treatment but not licensed to admit persons requiring 24-hour nursing care.

Respite Care – Care of a hospice patient for a period of time to relieve persons residing with and caring for the patient from their duties.

Restricted Non-Covered Employment – Work as an Employee or otherwise (for example, independent contractor, owner or consultant) in the Electrical Industry that does not meet one of the following criteria:

1. Work for an employer that has a contractual obligation to contribute to the Harrison Trust pursuant to a collective bargaining agreement or a Category II Agreement.

2. Work for an employer that contributes to a health and welfare trust or plan sponsored by an organization affiliated with the International Brotherhood of Electrical Workers that has an agreement or arrangement that transfers health and welfare contributions or eligibility credits on behalf of Employees to the Harrison Trust;

3. Work for an employer that has a collective bargaining agreement that requires health and welfare contributions to a health and welfare trust or plan where one of the sponsors of the health and welfare trust or plan is an organization affiliated with the International Brotherhood of Electrical Workers;

4. Work for an employer pursuant to a collective bargaining agreement negotiated with an organization affiliated with the International Brotherhood of Electrical Workers;

5. Work for an employer in a related building trade pursuant to a referral or authority from an organization affiliated with the International Brotherhood of Electrical Workers;

6. Work for an employer that is involved in contract negotiations that meets one of the criteria in paragraphs 1 through 5 above;

7. Work for an employer as a SALT organizer authorized by an organization affiliated with the International Brotherhood of Electrical Workers; or

8. Work for an employer that does not meet one of the criteria in paragraphs 1 through 7 above so long as the individual has received approval from the Board of Trustees to engage in the work without jeopardizing prior Harrison Trust service and/or his/her reserve account.

Room and Board Charges – Charges made by a hospital or skilled nursing facility for the room, meals and routine nursing services for a person confined as a bed patient. Room and board is limited to the hospital's prevailing charge for a semiprivate room.

Sickness – Your sickness, illness or disease.

Skilled Nursing Facility – A facility qualified as such under Medicare.

Special Charges – Those charges made by the hospital for other than room and board. Special Charges include, but are not limited to, charges made by a legally qualified physician for professional services in connection with radiology and pathology. Anesthesiology is included unless otherwise provided under the Surgical Benefits.

Terminally Ill – The condition has reached a point where recovery can no longer be expected and you are facing imminent death.

TMJ/Temporomandibular Joint Syndrome – Pain or other symptoms affecting the head, jaw, and face that are believed to result when the temporomandibular joints (jaw joints) and the muscles and ligaments that control and support them do not work together correctly. Also referred to as Myofacial Pain Disorder.

Totally Disabled – The inability to perform the duties essential to your occupation or employment.

Total Disability – You will be deemed to have total disability under the following circumstances:

1. If an employee is claiming benefits under this Plan, total disability is defined as your inability to work in your normal job because of illness or injury;

2. If a dependent is claiming benefits under this Plan, total disability is defined as the inability of the dependent to do the substantial and material duties of a person in similar circumstances who is in good health.

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

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

You or **Your** – The employee and/or dependent.

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 any one case.

Administered By:

A&I Benefit Plan Administrators, Inc.
1220 SW Morrison, Suite 300
Portland, OR 97205
In Portland: 503-224-0048, ext. 1679
Outside Portland: 800-547-4457, ext. 1679 (*toll tree*)

Employee Benefit Specialists

Joseph H. Herrle & Associates, Inc.
James B. Nibley Insurance, Inc.

Legal Counsel

Brownstein, Rask, Sweeney, Kerr, Grim, DeSylvia & Hay, LLP
Stephen H. Buckley

Auditor

Bjorklund & Montplaisir

Investment Manager

Ferguson Wellman Capital Management, Inc.

Important Plan Contacts

Plans/Programs	Phone Number	Address/Web/Email
Trust Office Questions about eligibility for coverage, premiums, reserve account, and for booklets	**In Portland** 503-224-0048 ext. 1679 **Outside Portland** 800-547-4457 ext.1679	A&I Benefit Plan Administrators 1220 SW Morrison Street, Ste 300 Portland, OR 97205
Active Employee Trust Plan Questions about Trust medical and dental benefits, claims payments, claim forms, Mail Order Prescription Forms, and other Trust plan benefits	**In Portland** 503-224-0048 ext. 1618 **Outside Portland** 800-547-4457 ext.1618	www.harrison.aibpa.com
Active Employee Trust Plan PPO Networks - Providence Preferred Network	800-793-9338	www.providence.org/Health_Plans/Members/directories.htm (select “PPO”)
- Multiplan PPO Network	800-546-3887	www.multiplan.com (select “PPO”)
Active Employee Trust Plan Hospital Precertification and Disease Management - Innovative Care Management	**In Portland** 503-654-9447 **Outside Portland** 800-862-3338	www.innovativecare.com
Active Employee Trust Plan Retail Pharmacy RESTAT	800-248-1062	www.restat.com
Active Employee Trust Plan Mail Order Pharmacy CVS/Caremark Mail-Order	**English** 800-552-8159 **Español** 800-659-6404	www.caremark.com
Active Employee Trust Plan Specialty Pharmacy Caremark Therapeutic Services Specialty Pharmacy	877-526-9906	
Nurse Help Line Answers to your health care questions	800-971-2680	

Plans/Programs	Phone Number	Address/Web/Email
Providence Health Plan Questions about Providence Health Plan benefits, claims and ID cards	**In Portland** 503-574-7500 **Outside Portland** 800-878-4445	www.providence.org/health_plans (select “Open Option”)
Providence Health Plan RN Medical Advice Line	**In Portland** 503-574-6520 **Outside Portland** 800-700-0481	
Kaiser Permanente Questions about Kaiser benefits, claims and ID cards (refer to group #2454-0004)	**In Portland** 503-813-2000 **Outside Portland** 800-813-2000	www.kp.org
Hearing Aids Willoughby Hearing Aid Center (to schedule a test or fitting)	800-547-1949	
Willamette Dental Questions about dental benefits	**In Portland** 503-644-6444 **Outside Portland** 800-460-7644	www.willamettedental.com
Vision Plan Vision Service Plan Questions about vision benefits, claims and to find a VSP Provider	800-877-7195 TDD/Hearing Impaired 800-735-2922	www.vsp.com
Employee Assistance Program (EAP) Providence Health System (call to speak to a counselor or make an appointment)	**In Portland** 503-215-3561 **Outside Portland** 800-255-5255	www.providence.org/eap
Wellness Program Portland Area Oregon Wellness Clinic Questions and appointments	**In Portland** 503-241-9593 **Outside Portland** 800-977-5633	dianew@oregonwellness.com
Southern Oregon Providence Medford Center for Occupational Medicine	**Medford** 541-732-5554	www.providence.org/Medford/Services/ (select “Occupational Medicine”)
Southern Oregon Coast Bay Clinic LLP	**Coos Bay** 541-269-0333 ext. 251	