

# ***Table of Contents***

## ***Updated May 1, 2008***

<b>TRUSTEES' LETTER .....</b>	<b>1</b>	<b>Protected Health Information .....</b>	<b>18</b>
<b>MEDICARE SUPPLEMENT/ MEDICARE ADVANTAGE BENEFITS ...</b>	<b>3</b>	<i>Privacy Practices of the Harrison Trust and Retired Trust Plan.....</i>	<i>18</i>
Retiree Eligibility: Requirements and Rules....	3	<i>Policy of the Plan Regarding Your Health Information.....</i>	<i>18</i>
Termination of Coverage for the Retiree .....	4	<i>How the Plan May Use and Disclose Protected Health Information About You.....</i>	<i>19</i>
Termination of Coverage for Dependents .....	4	<i>Authorization to Use or Disclose Protected Health Information .....</i>	<i>23</i>
Enrollment Procedures .....	5	<i>Minimum Necessary Disclosure of Protected Health Information .....</i>	<i>23</i>
Medicare Benefits and Costs .....	5	<i>Potential Impact of State Laws.....</i>	<i>23</i>
Dental Benefits.....	6	<i>Your Rights with Respect to Your Protected Health Information .....</i>	<i>23</i>
<b>ADMINISTRATION OF THE PLAN .....</b>	<b>7</b>	<i>Duties of the Plan.....</i>	<i>25</i>
Claims for Medical and Prescription Drug Benefits .....	7	<i>Complaints .....</i>	<i>25</i>
<i>Claims Appeal Procedure.....</i>	<i>7</i>	<i>Contact Person .....</i>	<i>25</i>
<b>COBRA — CONTINUATION OF COVERAGE.....</b>	<b>10</b>	<i>Disclosure of Protected Health Information to the Board of Trustees .....</i>	<i>25</i>
Introduction .....	10	<b>SUMMARY PLAN DESCRIPTION .....</b>	<b>29</b>
What Is COBRA Continuation Coverage .....	10	Name of Plan .....	29
Notices and Elections of COBRA Continuation Coverage .....	11	Effective Date.....	29
Benefits Available Under COBRA Continuation Coverage .....	13	Plan Sponsor .....	29
How Long COBRA Continuation Coverage Lasts .....	13	Employer And Plan Identification Numbers.....	29
How Much COBRA Continuation Coverage Costs.....	14	Type Of Plan .....	29
When and How Must Payment for COBRA Continuation Coverage be Made .....	14	Trust Office.....	29
Termination of COBRA Continuation Coverage Before the End of the Maximum Period .....	15	Agent For Legal Service .....	30
Transfer Rights.....	16	Board Of Trustees.....	30
More Information About Individuals Who May Be Qualified Beneficiaries.....	17	Description Of Collective Bargaining Agreements .....	30
For More Information About COBRA Continuation Coverage .....	17	Plan Benefits.....	31
Keep the Trust Office Informed of Address Changes .....	17	Benefits, Eligibility And Termination Of Eligibility .....	31
The Trust Office .....	17	Source Of Contributions.....	31
Qualified Medical Child Support Orders.....	18	Organizations Providing Benefits, Funding Media and Type of Administration.....	31
Certificate Of Creditable Coverage From The Harrison Trust.....	18	<i>Medicare Supplements/Medicare Advantage Plans .....</i>	<i>32</i>
		<i>Dental Plan.....</i>	<i>32</i>
		Plan Year.....	32
		Plan Termination .....	33
		Liability of Participating Employers, Unions and the Board of Trustees .....	33
		ERISA Statement of Rights.....	33
		<i>Prudent Actions by Plan Fiduciaries.....</i>	<i>34</i>
		<i>Enforce Your Rights .....</i>	<i>34</i>
		<i>Assistance with Your Questions .....</i>	<i>35</i>
		<b>DEFINITION OF TERMS .....</b>	<b>36</b>

# ***Trustees' Letter***

It is the pleasure of the Board of Trustees to present this new Plan Document and Benefit Booklet that takes effect August 15, 2007. This Plan Document and Benefit Booklet replace and supersede all previous Plan Documents and Benefit Booklets that concern the Medicare Supplement/Medicare Advantage Plans, which provide medical and prescription drug benefits, and the Willamette Dental Plan, which provides dental benefits.

This Benefit Booklet summarizes the Medicare Supplement/Medicare Advantage Plans' and Willamette Dental Plan's requirements relating to:

1. Eligibility to enroll in one of the Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan offered by the Harrison Trust;
2. The circumstances that may result in termination of eligibility to participate;
3. A summary of the benefit options available and the procedure to obtain benefits;
4. Appeal rights; and
5. Your rights under the Employee Retirement Income Security Act of 1974.

This Benefit Booklet describes eligibility for Medicare Supplement/Medicare Advantage Plans and the Willamette Dental Plan. If you are not yet eligible for Medicare, ask the Trust Office for the Retired Trust Plan Benefit Booklet for non-Medicare eligible Retirees and their dependents.

**The benefits provided by the Harrison Trust including the Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan are provided on a month-to-month basis and are not vested.** The Board of Trustees expressly reserves the right, in its sole discretion, to terminate, amend, or change, at any time, the Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan described in this Benefit Booklet. The Board of Trustees also reserves the right, in its sole discretion, to change the eligibility rules, change the benefits, eliminate a benefit provider, reduce the benefits, require self-payments, or increase self-payments. Under no circumstances will benefits ever become non-forfeitable.

The Board of Trustees has the complete and exclusive discretionary power to construe and interpret the provisions of this Benefit Booklet, including, but not limited to eligibility for benefits, subject to the claims appeal procedure set forth in the Summary Plan Description. 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 or to act as agent for the Board of Trustees. Only the Board of Trustees is authorized to interpret this Benefit Book. The Board of Trustees has authorized the Trust Office to respond informally to written inquiries from Retirees and dependents. As a convenience to Retirees and dependents, the Trust Office will provide oral answers on an informal basis. However, the written and oral answers are not binding upon the Board of Trustees.

The first letters of some words are capitalized. These words are defined in this Benefit Booklet. See page 36 for the definition of certain words.

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  
Phone in Portland: 1-503-224-0048, ext. 1679  
Outside Portland, toll free: 1-800-547-4457, 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*

# ***Medicare Supplement/ Medicare Advantage Benefits***

You, your spouse and dependents who have attained the age of 65 or who are otherwise eligible for Medicare must enroll in both Parts A and B of Medicare as a prerequisite to enrolling in one of the Medicare Supplement/Medicare Advantage Plans offered by the Harrison Trust.

Currently, the Medicare Supplement/ Medicare Advantage Plans offered are:

<b>Provider</b>	<b>Medicare Supplement/Advantage Plan</b>
<b>United Healthcare (PacifiCare)</b>	Secure Horizons
<b>Providence Health Plan</b>	<ul style="list-style-type: none"> <li>• Providence Medicare Extra; or</li> <li>• Providence Medicare Supplement Plan F</li> </ul>
<b>Kaiser Foundation Health Plan of the Northwest</b>	Medicare Senior Advantage
<b>Clear Choice Health Plan</b>	Medicare Traditional Advantage Plan
<b>Regence BlueCross BlueShield of Oregon</b>	<ul style="list-style-type: none"> <li>• Oregon Companion Plan F;</li> <li>• Washington Companion Plan F;</li> <li>• MedAdvantage;</li> <li>• First Choice 65; or</li> <li>• Preferred Choice 65</li> </ul>
<b>Regence Blue Shield of Washington</b>	MedAdvantage+ Rx Enhanced Plan

You must reside in the service area of the provider to enroll in one of its plans. Upon request, the Trust Office will make a copy of these plans available to you for review.

Prescription benefits are provided through the Medicare Supplement/Advantage Plan you choose.

## **Retiree Eligibility: Requirements and Rules**

To be eligible for a Medicare Supplement/Medicare Advantage Plan, you must meet the following eligibility requirements:

1. **Age.** You must be age 65 or older, or otherwise be eligible for Medicare.
2. **Enrollment.** You must be enrolled in both Parts A and B of Medicare.

3. **Retirement.** You must have met the eligibility requirements for Retired Plan A, Retired Plan B, Retired Plan C, or the Early Retiree Plan described in the Retired Trust Plan Benefit Booklet for non-Medicare eligible Retirees and their dependents. Contact the Trust Office (whose address and telephone number are listed on page 2) for a copy of the Benefit Booklet for non-Medicare eligible Retirees and their dependents.

## **Termination of Coverage for the Retiree**

A Retiree's coverage under a Medicare Supplement/Medicare Advantage Plan and Willamette Dental Plan will end on the last day of the month in which any of the following events occur:

1. You fail to make a self-payment within the time limits established by the Board of Trustees;
2. The Board of Trustees change the eligibility rules and you cease to be in a class of persons eligible for benefits provided by the Plan;
3. The Board of Trustees terminates the Plan or portion of the Plan;
4. You fail to remain continuously enrolled in Parts A and B of Medicare;
5. You become covered under the Active Employee Plan through active employment;
6. You pass away; or
7. You work in "Restricted Non-Covered Employment" in the "Electrical Industry." See the Definition of Terms section of this Benefit Booklet starting on page 36 for the definition of "Restricted Non-Covered Employment" and "Electrical Industry."

## **Termination of Coverage for Dependents**

A Retiree's Dependent's coverage under a Medicare Supplement/Medicare Advantage Plan and Willamette Dental Plan will end on the last day of the month in which any of the following events occur:

1. The spouse or child ceases to meet the definition of a Dependent (page 36);
2. The spouse or child fails to remain continuously enrolled in Parts A and B of Medicare;
3. The Retiree's coverage under the Plan ends for any reason other than death;
4. The Retiree's spouse or child fails to make a timely self-payment within the time limits established by the Board of Trustees;
5. The Board of Trustees change the eligibility rules and the Retiree's spouse or child ceases to be in a class of persons eligible for benefits provided by the Plan;
6. The Board of Trustees terminates the Plan or a portion of the Plan; or
7. The Retiree's spouse or child dies.

In the event coverage under a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan ends for a Retiree because of death, the Retiree's Dependents can continue on a Medicare Supplement/Medicare Advantage Plan and Willamette Dental Plan.

Coverage under a Medicare Supplement/Medicare Advantage Plan must be continuous for the Retiree and Dependents. If you enroll in a Medicare Supplement/Medicare Advantage Plan and subsequently allow enrollment to lapse for a reason other than to return to active employment, you will not be allowed to reenroll in a Medicare Supplement/Medicare Advantage Plan.

## **Enrollment Procedures**

Approximately 90 days before reaching age 65 or otherwise becoming eligible for Medicare, you should contact the Trust Office and select a Medicare Supplement/Medicare Advantage Plan offered by the Retired Trust Plan in which you wish to enroll.

You will need to file an application with the Trust Office so your eligibility status can be determined.

Once you have enrolled in a Medicare Supplement/Medicare Advantage Plan, you may change your selection during the open enrollment period held annually by the Board of Trustees during the month of November for new coverage effective January 1.

## **Medicare Benefits and Costs**

If you qualify for coverage under Retired Plan A (retired with 60 months of employer-paid coverage in the last 180 months), Retired Plan B (disabled with Social Security), or the Early Retiree Plan, and you select one of the Medicare Supplement/Medicare Advantage Plans offered by the Retired Trust Plan, the Harrison Trust currently pays a portion of your Medicare Supplement/Medicare Advantage premium. Your accumulated reserve can be used to offset your required payments until your reserve balance is exhausted.

If you qualify for coverage under Retired Plan A, Retired Plan B or the Early Retiree Plan, and do not reside within the service area of one of the Medicare Supplement/Medicare Advantage Plans detailed on page 3, offered by the Retired Trust Plan, the Harrison Trust will reimburse you for a portion of your out-of-pocket cost for an individual Medicare Supplement/Medicare Advantage policy. Payment will be made on a quarterly basis. To receive reimbursement, you must provide documentation to the Trust Office that you or your Dependent have purchased a Medicare Supplement/Medicare Advantage policy and proof of your out-of-pocket costs.

If you qualify for coverage under Retired Plan C (retired with 24 months of employer-paid coverage in the last 60 months), you must pay the full cost of the Medicare Supplement/Medicare Advantage Plan. Your accumulated reserve can be used to offset your required payments until your reserve balance is exhausted.

If you have any questions, please feel free to contact the Trust Office: In Portland: 1-503-224-0048, ext. 1679 Outside Portland Toll Free: 1-800-547-4457, ext. 1679.

## **Dental Benefits**

The Board of Trustees has made a dental plan available for Retirees and Dependents enrolled in one of the Medicare Supplement/Medicare Advantage Plans. The dental benefits are provided pursuant to a contract between the Harrison Trust and Willamette Dental.

The main features of the Willamette Dental Plan are:

1. Anyone enrolled in a Medicare Supplement/Medicare Advantage Plan through the Harrison Trust can select the Willamette Dental Plan. For example, if a husband and wife are enrolled in one of the Medicare Supplement/Medicare Advantage Plans, the husband and wife can both select the Willamette Dental Plan, only one person can select the Willamette Dental Plan, or both persons can decline dental coverage.
2. The Retiree or Dependent must pay the monthly fee for the Willamette Dental Plan. For 2008, the fee is \$23.46 per person per month. The fee may increase in 2009.
3. If the Retiree and/or Dependent does not enroll in the Willamette Dental Plan within 31 days after initial enrollment in one of the Medicare Supplement/Medicare Advantage Plans, the Retiree and/or Dependent must wait to enroll until the next open enrollment period agreed to between Willamette Dental and the Board of Trustees.
4. If coverage through the Willamette Dental Plan is selected, coverage must be continuous. If the Retiree or Dependent elects the Willamette Dental Plan and later stops paying the monthly fee, he/she cannot re-enroll in the Willamette Dental Plan at a later date.
5. Contact the Trust Office if you are interested in the Willamette Dental Plan and would like to receive a Willamette Dental benefit booklet describing covered and non-covered dental procedures, deductibles, co-payments and annual dental maximum payments.

# ***Administration of the Plan***

The administrative details of the Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan are handled by the Trust Office:

A&I Benefit Plan Administrators, Inc.  
1220 SW Morrison Street  
Suite 300  
Portland, OR 97205  
1-503-224-0048  
Outside Portland 1-800-547-4457

If you have any questions regarding the Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan, please contact the Trust Office.

## **Claims for Medical and Prescription Drug Benefits**

Claims for medical and prescription drug services should be directed to your Medicare Supplement/Medicare Advantage provider. Claims concerning dental services should be directed to Willamette Dental.

### ***Claims Appeal Procedure***

Claims concerning a benefit from one of the Medical Supplement/Medicare Advantage Plans offered by the Retired Trust Plan or the Willamette Dental Plan should be filed with that organization in accordance with its benefit appeal procedures.

Claims concerning eligibility for the Medicare Supplement/Medicare Advantage Plans or the Willamette Dental Plan should be filed with the Trust Office. You should contact the Trust Office for forms and instructions for making a claim.

The claims appeal procedure is set forth below.

#### **1. Appeal of an Eligibility Determination.**

- a. The Trust Office is responsible for reviewing claims concerning eligibility for benefit coverage. If your eligibility claim is denied, in whole or in part, the Retiree or Dependent will receive a written explanation from the Trust Office.
- b. If you disagree with the initial adverse eligibility determination, you or your authorized representative may file a written appeal within 180 days after receiving the adverse 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

- c. Upon written request, you will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to your appeal. Whether a document, record or other information is relevant is determined in accordance with 29 CFR §2560.503-1(m)(8).
- d. 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.
- e. If you or your authorized representative request to appear at a hearing before the Board of Trustees at the time your appeal is filed, you will be notified of the time, date and place of a hearing by regular mail at the return address shown on the appeal.
- f. You may be represented at the hearing before the Board of Trustees by an attorney or other authorized representative at your cost and expense.

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

- a. 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 filed less than 30 days prior to the meeting. If this is the case, the Board of Trustees will review the appeal not later than the date of the subsequent Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees requires an extension of time to review the appeal, you will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.
- b. The decision of the Board of Trustees will be in writing and sent within five days after the decision is reached.
- c. If the Board of Trustees denies the 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.
- d. You are required to use the procedures set forth above before bringing a civil lawsuit under ERISA.
- e. The Board of Trustees has the full and exclusive authority to administer the Plan, interpret the Benefit Booklet and resolve all questions arising in the administration, interpretation and application of the Plan including eligibility for 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 appeals so long as the rules and procedures are consistent with ERISA;

- iii. The right to construe and interpret this Benefit Booklet; and
- iv. The exercise of the aforementioned powers and authorities by the Board of Trustees will be given the fullest deference allowed by law.

# ***COBRA – Continuation of Coverage***

## **Introduction**

This section of the Benefit Booklet contains important information about rights you may have to COBRA continuation coverage, which is a temporary extension of medical and prescription drug coverage, or medical, prescription drug and dental 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 by a Medicare Supplement/Medicare Advantage Plan offered by the Board of Trustees when you lose your Medicare Supplement/Medicare Advantage Plan coverage and/or Willamette Dental Plan coverage due to a qualifying event. 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.

The Harrison Trust offers no greater COBRA rights than what the COBRA statutes, administrative rules and law requires, and this section of the Benefit Booklet should be construed accordingly.

## **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, Retirees, and/or Dependents may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

***If you are a Retiree***, you will become a qualified beneficiary if you will lose your coverage under a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees 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 of a Retiree***, you will become a qualified beneficiary if you will lose your coverage under a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees because any of the following qualifying events happens:

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

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

***If you are a dependent child of a Retiree***, you will become a qualified beneficiary if you will lose your coverage under a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees because any of the following qualifying events happens:

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

**Special Second Election Period.** Certain Retirees who may be 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 60 days or less (but only if the election is made within six months after Plan coverage is lost). **If you are a Retiree and qualify for federal trade adjustment assistance or alternative trade adjustment assistance, contact the Trust Office, whose name, address and telephone number is on page 2 of the Benefit Booklet, after qualifying for the federal trade adjustment 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**

**Important:** For the following qualifying events (divorce or legal separation of the Retiree and spouse or a dependent child who no longer qualifies as a dependent child), the Retiree, spouse or dependent child must notify the Trust Office ***in writing*** within 60 days after the divorce, legal separation, 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 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 Retiree 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 or 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 Trust Office receives timely written notice that one of the three qualifying events (divorce, legal separation 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 or dependent child will also be notified of the right to elect COBRA continuation coverage automatically (without any action required by you, your spouse or dependent child) when coverage is lost because the Retiree's employment ended, hours were reduced, death or enrollment in Medicare (Part A, Part B or both).

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 applied 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 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 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 coverage if you get COBRA coverage for the maximum time available to you.

## **Benefits Available Under COBRA Continuation Coverage**

A qualified beneficiary has the right to elect COBRA continuation coverage for medical and prescription drug coverage only, or for medical, prescription drug and dental coverage. COBRA continuation coverage is identical to the medical, prescription drug and dental coverage available to similarly situated Retirees and Dependents. If the medical, prescription drug or dental 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 causing the loss of coverage is the death of the Retiree, the Retiree becoming entitled to Medicare benefits (Part A, Part B or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event causing the loss of coverage is the Retiree's termination of employment or reduction of the Retiree's hours of employment, and the Retiree became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Retiree lasts until 36 months after the date of Medicare entitlement. For example, if a Retiree 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 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 Retiree's termination of employment or reduction of the Retiree'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 COBRA continuation coverage.** If the Retiree or a Dependent covered by a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees is determined by the Social Security Administration to be disabled and you notify the Trust Office in a timely fashion, the Retiree and Dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 61st 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 12. In addition, your notice must include the name of the qualified beneficiary who becomes disabled, 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 60-day 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 a Dependent experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Dependent 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 a Dependent receiving COBRA continuation coverage if the Retiree dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated or if the dependent child no longer qualifies as a dependent child but only if the event would have caused the Dependent to lose coverage under a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees had the first qualifying event not occurred. In all these cases, the Dependent must make sure that the Trust Office is notified *in writing* of the second qualifying event within 60 days of the second qualifying event. The Dependent must follow the procedures specified in the box, entitled "Notice Procedures" on page 12. The written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce, the notice must include a copy of the divorce decree. 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 may 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 Retiree 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](http://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 a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees 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 will continue 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. 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 a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees 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 a qualified beneficiary 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, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both). COBRA continuation coverage will end only for the qualified beneficiary who becomes entitled to Medicare benefits;

3. After electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan (but only after any exclusions of that other plan for a preexisting condition for a qualified beneficiary has been exhausted or satisfied). COBRA continuation coverage will end only for the qualified beneficiary who becomes covered under another group health plan;
4. The Harrison Trust no longer provides Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan to any of its eligible participants; or
5. During a disability extension period (explained on page 13), the Retiree or Dependent is determined by the Social Security Administration to be no longer disabled. In this circumstance, COBRA continuation coverage will terminate for the Retiree and Dependents 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 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled; or (ii) the end of the coverage period that applies without regard to the disability extension.

The qualified beneficiary must notify the Trust Office **in writing** within 30 days if, after electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both), becomes covered under other group health plan coverage, or you, your spouse or dependent child is determined by the Social Security Administration to no longer be disabled. Follow the "Notice Procedures" on page 12 of the Benefit Booklet.

## **Transfer Rights**

If you are covered by a Medicare Supplement/Medicare Advantage Plan that covers a limited geographic area and relocate to another area, you may be entitled to elect coverage available to other Retirees in that area. If you find yourself in this situation, call or write the Trust Office. Under no circumstance would such a transfer prolong your maximum COBRA continuation coverage.

## **More Information About Individuals Who May Be Qualified Beneficiaries**

**Children born to or placed for adoption with the Retiree during COBRA period.** A child born to, adopted by or placed for adoption with a Retiree during a period of COBRA continuation coverage may be considered to be a qualified beneficiary provided the Retiree has elected COBRA continuation coverage for himself or herself. The child's COBRA continuation coverage, if any, begins when the child is born and it lasts as long as COBRA continuation coverage lasts for other family members of the Retiree. To be enrolled in a Medicare Supplement/Medicare Advantage Plan or the Willamette Dental Plan offered by the Board of Trustees, the child must satisfy the otherwise applicable eligibility requirements (for example, disability).

**Alternate recipients under Qualified Medical Child Support Orders.** A child of a Retiree who is receiving benefits from a Medicare Supplement/Medicare Advantage Plan or Willamette Dental Plan offered by the Board of Trustees pursuant to a Qualified Medical Child Support Order is entitled to the same rights under COBRA as a dependent child of the Retiree, regardless of whether that child would otherwise be considered a dependent.

## **For More Information About COBRA Continuation Coverage**

Questions concerning the Medicare Supplement/Medicare Advantage Plans or Willamette Dental Plan offered by the Board of Trustees or your COBRA continuation coverage rights should be addressed to the Trust Office identified below. For more information about your rights under the Employee Retirement Income Security Act, 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](http://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. The name, address and telephone number of the Trust Office is:

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

## **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.

## **Certificate Of Creditable Coverage From 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 Retired Trust Plan. 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, if applicable; and
3. If you request a certificate, within 24 months following cessation of coverage under the Retired Trust Plan.

## **Protected Health Information**

### ***Privacy Practices of the Harrison Trust and Retired Trust Plan***

This section of the Benefit Booklet describes how Protected Health Information about you may be used and disclosed and how you can get access to your Protected Health Information. This section is applicable to the Harrison Trust and the Plan. If you have medical and prescription drug coverage or dental coverage through an insured plan such as a Medicare Supplement/Medicare Advantage Plan offered by the Board of Trustees or Willamette Dental, that plan has its own privacy practices to protect your Protected Health Information.

### ***Policy of the Plan Regarding Your Health Information***

The Plan understands that Protected Health Information about you is personal. The Plan is committed to safeguarding Protected Health Information about you. This section will tell you about the ways in which the Plan may use and disclose Protected Health Information about you. This section also describes the Plan's obligations and your rights regarding the use and disclosure of Protected Health Information. Your physician or health care provider may have different policies or notices regarding their use and disclosure of your Protected Health Information created in the physician's office or clinic.

The Plan is required by law to:

1. Make sure that Protected Health Information that identifies you is kept private;
2. Give you notice of the Plan's legal duties and privacy policies regarding your Protected Health Information; and
3. Follow the terms of this section of the Benefit Booklet until modified.

## ***How the Plan May Use and Disclose Protected Health Information About You***

This section describes different ways the Plan may use and disclose your Protected 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 Protected Health Information will fall within one of these categories.

1. **To Make or Obtain Payment.** The Plan may use and disclose Protected Health Information about you to determine eligibility for benefits, to facilitate payment for the treatment and service you receive from health care 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. The Plan may also share Protected Health Information with a utilization review or precertification service provider. Likewise, the Plan may share Protected 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 Protected Health Information to facilitate treatment or services by providers, including coordination or management of health carrier related services. For example, the Plan may disclose Protected Health Information about you with physicians who are treating you.
3. **To Coordinate Health Care Operations.** The Plan may use and disclose your Protected Health Information to facilitate the administration of the Plan. These uses and disclosures are necessary to run the Plan. 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 health care 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 Protected Health Information about you when required to do so by federal, state or local law. For example, the Plan may disclose Protected Health Information when required by a court order in a lawsuit such as a malpractice case.
  5. **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose Protected Health Information about you when necessary to prevent a serious threat to your health and safety, the health and safety of the public or another person. Any disclosure, however, will only be made to someone able to help prevent the threat. For example, the Plan may disclose Protected Health Information about you in a proceeding regarding the licensure of a physician.
  6. **Military and Veterans.** If you are a member of the armed forces, the Plan may release Protected Health Information about you as required by military command authorities. The Plan may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.
  7. **For Treatment Alternatives.** The Plan may use and disclose your Protected Health Information to 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 Protected 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 Protected Health Information to another health plan maintained by the Harrison Trust or to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Plan. In addition, the Plan may provide summary Protected 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 Protected Health Information known to a family member or close personal friend. Disclosure of your Protected Health Information will be determined based on how involved the person is in your health care or payment of your health 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 Protected Health Information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your Protected Health Information, the Plan, through the Trust Office, may use its professional judgment to determine whether the disclosure is in your best interest. If you do not want your Protected Health Information disclosed to a family member or close personal friend as outlined in this paragraph, you must notify the Plan as described in the Right to Request Restrictions on page 23.

11. **Personal Representative.** The Plan will disclose your Protected 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 Protected 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 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 Protected Health Information, but only after agreeing, in writing, to appropriate safeguards concerning your Protected Health Information.
13. **Other Covered Entities.** The Plan may use or disclose your Protected Health Information to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose your Protected Health Information to a provider when needed by the provider to render treatment to you or the Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.
14. **To Conduct Health Oversight Activities.** The Plan may disclose your Protected Health Information to a health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws. However, the Plan may not disclose your Protected 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 Protected 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 Protected 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 Protected 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 Protected 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 Protected 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 Protected 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 Protected 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 Protected Health Information; and (b) approved the research.
20. **Inmates.** If you are an inmate of a correctional institution, the Plan may disclose your Protected Health Information to the correctional institution or to a law enforcement official for: (a) the institution to provide health care to you; (b) your health and safety and the health and safety of others; or (c) the safety and security of the correctional institution.
21. **Coroners, Medical Examiners, Funeral Directors and Organ Donation.** The Plan may disclose your Protected Health Information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan may also disclose, as authorized by law, information to funeral directors so they may carry out their duties. Further, the Plan may disclose your Protected Health Information to organizations that handle organ, eye or tissue donation and transplantation.
22. **Workers' Compensation.** The Plan may release your Protected 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 US Department of Health and Human Services.** The Plan is required to disclose your Protected 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 Protected Health Information***

Other than as stated above, the Plan will not disclose your Protected Health Information without your written authorization. If you authorize the Plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time.

## ***Minimum Necessary Disclosure of Protected Health Information***

The amount of your Protected Health Information the Plan will use or disclose will be limited to the “minimum necessary” as defined in the HIPAA Privacy Rule.

## ***Potential Impact of State Laws***

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protection. 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 your Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

## ***Your Rights with Respect to Your Protected Health Information***

You have the following rights regarding your Protected Health Information that the Plan maintains:

1. **Right to Request Restrictions.** You have the right to request restrictions or limitations on the Protected Health Information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the Plan’s disclosure of your Protected 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 to the Client Service Representative for the Harrison Trust in writing at the address on page 25. 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 Protected 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 to the Client Service Representative for the Harrison Trust in writing at the address on page 25. 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 Protected Health Information. A request to inspect and copy records containing your Protected Health Information must be made to the Client Service Representative for the Harrison Trust in writing at the address on page 25. If you request a copy of your Protected 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 Protected 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 Protected Health Information is maintained by the Plan.

A request for an amendment of your Protected Health Information records must be made to the Client Service Representative for the Harrison Trust in writing at the address on page 25. 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 Protected Health Information records were not created by the Plan, if the Protected Health Information you are requesting to amend is not part of the Plan's records, if the Protected Health Information you wish to amend falls within an exception to the Protected Health Information you are permitted to amend, or if the Plan determines that records containing your Protected 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 Protected 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 Protected 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 to the Client Service Representative for the Harrison Trust in writing at the address on page 25. 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 on page 25.

## ***Duties of the Plan***

The Plan is required by law to maintain the privacy of your Protected Health Information as set forth in this section of the Benefit Booklet 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 of the Benefit Booklet and to make the new provisions effective for all your Protected Health Information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the section of the Benefit Booklet and will provide a copy of the revised section of the Benefit Booklet 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 to the Client Service Representative for the Harrison Trust in writing at the address in the next paragraph. The Plan encourages you to express any concerns you may have regarding the privacy of your Protected 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  
c/o 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

**If you have any questions regarding this section of the Benefit Booklet, 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, the 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 on page 26.

2. **Board of Trustees' Obligations Regarding Protected Health Information.** The Board of Trustees will:
- a. Neither use nor disclose your Protected Health Information except as permitted by the Benefit Booklet for the Plan as amended from time to time or required by law.
  - b. Ensure that any subcontractor or agent to whom the Board of Trustees provides your Protected Health Information received from the Harrison Trust and/or Plan agrees to the restrictions and conditions in the Benefit Booklet for the Plan, including this section, with respect to your Protected Health Information.
  - c. 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. Report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed by the Benefit Booklet for the Plan promptly upon learning of such inconsistent use or disclosure.
  - e. Make your Protected Health Information available to you in accordance with 45 C.F.R. § 164.524.
  - f. 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. 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. Make the Harrison Trust's and Plan's internal practices, books and records relating to the use and disclosure of your Protected Health Information available to the US Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-164.
  - i. 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. 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 Protected Health Information that are not subject to these restrictions) on behalf of the Harrison Trust and/or Plan concerning you, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic 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 Harrison Trust's or Plan's written request.

4. **Adequate Separation Between the Board of Trustees, the Harrison Trust and the Plan.**

The Board of Trustees represents that adequate separation exists between the Harrison Trust and the Plan and the Board of Trustees so that Protected Health Information will be used only for plan administration purposes.

The following persons and organizations that have a contractual arrangement with the Harrison Trust or Board of Trustees may receive your Protected Health Information relating to payment, health care operations or other matters pertaining to the Plan:

- a. Employees of the Trust Office; and
- b. Business associates of the Harrison Trust and Plan and business associates' employees, officers, directors, agents and subcontractors provided the business associate has signed a business associate agreement.

The persons and organizations identified above will have access to your Protected Health Information only to perform plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of their contracts, for any use or disclosure of your Protected Health Information that violates the business associate agreement.

The Board of Trustees will ensure that the provisions of this Section 4 are supported by reasonable and appropriate security measures to the extent that the persons or organizations identified above have access to your electronic 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 26.

# ***Summary Plan Description***

This summary is a general explanation of certain terms of the Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan and other legal instruments, and is not intended to modify or change them in any manner. The rights and duties of all persons connected with the Plan are set forth in those instruments, which may be inspected at the Trust Office.

## **Name of Plan**

This Plan is known as the Harrison Electrical Workers Trust Fund – Medicare Supplement/Medicare Advantage Plans and Willamette Dental Plan, also referred to as the Plan or the Retired Trust Plan.

## **Effective Date**

August 15, 2007

## **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  
1-503-224-0048  
Outside Portland: 1-800-547-4457

## **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 Group 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 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  
503-224-0048 ext. 1679  
Outside Portland 1-800-547-4457 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)  
Oregon-Columbia Chapter NECA  
601 NE Everett  
Portland, OR 97232

Randy Wagner (Second Alternate)  
5805 SW Hood Avenue  
Portland, OR 97239

### **LABOR ORGANIZATION TRUSTEE**

Clif 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 Harrison Trust for the purpose of enabling employees working under the collective bargaining agreements and in some instances Retirees to participate in the benefits provided by the Harrison Trust. 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 copy of the collective bargaining agreements may be obtained upon written request to the Trust Office and is available for examination by Retirees and Dependents at the office of the Trust Office, or employer's place of business or union office upon advance request.

A complete list of employers and employee organizations sponsoring the Harrison Trust may be obtained upon written request to the Trust Office and is available for examination by Retirees and Dependents at the Trust Office, an employer's place of business or union office upon advance request. The Trust Office can also advise you whether a particular employer or labor union is a sponsor of the Harrison Trust and, if so, its address.

## **Plan Benefits**

This Plan provides Medicare Supplement/Medicare Advantage Plans and a dental plan through Willamette Dental for Retirees and Dependents who are eligible for Medicare and enrolled in Medicare Parts A and B.

## **Benefits, Eligibility And Termination Of Eligibility**

This Benefit Booklet describes benefits, eligibility and termination of eligibility requirements. 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 office.

## **Source Of Contributions**

This Plan is partially funded through employer contributions, the amount of which is specified in the collective bargaining agreements or determined by the Board of Trustees. Also, self-payments are required in some instances. The amount of self-payments is fixed from time to time by the Board of Trustees. The contributions and investment income are held in trust.

## **Organizations Providing Benefits, Funding Media and Type of Administration**

The names and addresses 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.

## ***Medicare Supplements/Medicare Advantage Plans***

Retirees and Dependents eligible for Medicare and enrolled in Medicare Parts A and B have the option of selecting one of the following Medicare Supplement/Medicare Advantage Plans. These plans are insured and provided under contracts between the Harrison Trust and the insurance company or HMO. The insurance company or HMO is responsible for paying claims and administering the Medicare Supplement/Medicare Advantage Plans.

Secure Horizons  
5 Centerpointe Drive, Suite 600  
Lake Oswego, OR 97035

Providence Medicare Extra  
PO Box 4327  
Portland, OR 97208

Providence Medicare Supplement Plan F  
PO Box 4327  
Portland, OR 97208

Clear Choice Health Plan  
2650 NE Courtney Dr  
Bend, OR 97701

Kaiser Foundation Health Plan  
500 NE Multnomah Street, Suite 100  
Portland, OR 97232

Regence BlueCross BlueShield Oregon  
Companion Plan F  
PO Box 1271  
Portland, OR 97207

Regence BlueCross BlueShield Preferred  
Choice 65  
PO Box 1271  
Portland, OR 97207

Regence BlueCross BlueShield First Choice 65  
PO Box 1271  
Portland, OR 97207

Med Advantage  
PO Box 1271  
Portland, OR 97207

Regence BlueCross BlueShield Washington  
Companion Plan F  
PO Box 1271  
Portland, OR 97207

## ***Dental Plan***

Retirees and Dependents enrolled in a Medicare Supplement/Medicare Advantage Plan have the option of selecting dental coverage provided pursuant to a contract between the Harrison Trust and Willamette Dental Insurance, Inc. Willamette Dental Insurance, Inc. is responsible for administering the dental contract and paying claims.

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 the Harrison Trust terminate for any reason, all moneys and assets remaining, 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 by regulation by the Secretary of Labor. You would be notified in writing if the Board of Trustees terminates the Retired Trust Plan or the Harrison Trust.

**The benefits provided by the Retired Trust Plan are provided on a month-to-month basis and are not vested. The Board of Trustees expressly reserves the right, in its sole discretion, to terminate, amend or change, at any time, the Retired Trust Plan. The Board of Trustees also reserves the right, in its sole discretion, to change the eligibility rules, change the benefits, eliminate a benefit provider, reduce the benefits, require self-payments or increase self-payments. Under no circumstances will any benefits ever become nonforfeitable.**

## **Liability of Participating Employers, Unions and the Board of Trustees**

No participating employer has any liability, directly or indirectly, to provide the benefits established by the Retired Trust 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 there are insufficient 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 the following rights:

1. Examine, without charge, at the Trust Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefit Administrator).
2. Obtain, upon written request to the Trust Office, 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 financial 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 the Benefit Booklet starting on page 10 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 you become entitled to elect COBRA Continuation Coverage, 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.

### ***Prudent Actions by Plan Fiduciaries***

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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.

### ***Enforce Your Rights***

If your claim for a welfare benefit is denied or ignored in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual reports 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 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), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling the Employee Benefits Security Administration's toll-free number 866-444-3272 or writing to the following address:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272. You may also find assistance for your questions and a list of Employee Benefits Security Administration field offices at: [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/).

# ***Definition of Terms***

**Benefit Booklet** - This booklet and any amendments, additions, or deletions hereto or subsequently made hereto.

**Board of Trustees** - The individuals who govern the Harrison Electrical Workers Trust Fund and their successors.

**Dependent** - Means:

1. A Retiree's spouse (if not legally separated from the Retiree) and enrolled in Parts A and B of Medicare. Same sex spouses and same-sex or opposite-sex partners are not covered.
2.
  - a. A Retiree's unmarried child enrolled in Parts A and B of Medicare (including a stepchild, legally adopted child or child placed in a Retiree's home pending adoption) from live birth until the end of the month the child attains age 19;
  - b. A Retiree's unmarried child enrolled in Parts A and B of Medicare (including a stepchild, legally adopted child or child placed in a Retiree'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 Retiree for the majority of his or her support; and
    - (iii) Covered by this Plan just prior to the day he/she attained age 19.
  - c. A Retiree's unmarried child enrolled in Parts A and B of Medicare (including a stepchild, legally adopted child or child placed in a Retiree's home pending adoption) who is enrolled in an accredited school as a full-time student and has not attained age 25.
3. A Retiree's unmarried grandchild, niece or nephew enrolled in Parts A and B of Medicare in the custody of the Retiree and, for whom the Retiree is providing the majority of his or her support will be considered a Dependent if the Retiree has been named as legal guardian by a court of competent jurisdiction until the end of the month the grandchild, niece or nephew attains age 19. Coverage for the grandchild, niece or nephew can continue beyond age 19 provided the grandchild, niece or nephew is enrolled in parts A and B of Medicare and meets the criteria in paragraph 2(b) or 2(c) above.

**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.

**Medicare** - Medical benefits provided by Title XVIII of the Federal Social Security Act.

**Plan Administrator** - The Board of Trustees of the Harrison Trust.

**Plan or Retired Trust Plan** - The health and welfare benefits described in this Benefit Booklet and any amendments, additions or deletions hereto or subsequently made hereto.

**Protected Health Information** - Individually identifiable Protected 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.

**Restricted Non-Covered Employment** - Means work as an employee, independent contractor, owner, consultant or in any other capacity in the Electrical Industry that does not meet one or more 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 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 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 plan where one of the sponsors of the health and welfare 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 that is involved in contract negotiations with an employer that meets one of the criteria in paragraphs 1 through 4 above.
6. Work for an employer in a related building trade pursuant to a referral or authority of an organization affiliated with the International Brotherhood of Electrical Workers;
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, but the individual has received approval from the Board of Trustees to engage in the work without jeopardizing his Harrison coverage.

**Retiree** - An individual who has completed an application for one of the Medicare Supplement/ Medicare Advantage Plans or Willamette Dental Plan offered by the Board of Trustees and meets the eligibility requirements described in this Benefit Booklet.

**Trust or Harrison Trust** - The Harrison Electrical Workers Trust Fund.

**Trust Office** - A&I Benefit Plan Administrators, Inc., whose address is 1220 SW Morrison Street, Suite 300, Portland, OR 97205 and whose telephone numbers are 503-224-0048 and 800-547-4457.

**Administered By:**

*A&I Benefit Plan Administrators, Inc.  
1220 SW Morrison Street, Suite 300  
Portland, OR 97205  
In Portland: 1-503-224-0048, Ext. 1679  
Outside Portland Toll Free: 1-800-547-4457, Ext. 1679*

**Employee Benefit Specialists**

*Joseph H. Herrle & Associates, Inc.  
James B. Nibley Insurance, Inc.*

**Legal Counsel**

*Brownstein, Rask, Sweeney, Kerr, Grim, DeSylvia & Hay LLP*

**Auditor**

*Bjorklund & Montplaisir*

**Investment Manager**

*Ferguson, Wellman Capital Management, Inc.*

