LiUNA! OREGON & SOUTHERN IDAHO DISTRICT COUNCIL OF LABORERS
Feel the Power

UNION CONTRACTOR GROUP
AGC Oregon-Columbia Chapter

Oregon Laborers-Employers
Health and Welfare Plan

Active Hourly Laborers and Associates II and A
in Oregon and Idaho

Summary Plan Description

July 2020

IMPORTANT MESSAGE TO PARTICIPANTS AND BENEFICIARIES

We are pleased to present you with this updated booklet describing the benefits available to you and your family under the Oregon Laborers-Employers Health and Welfare Plan for Active Hourly Laborers and Associates II and A. This booklet reflects the benefit plan in effect as of July 1, 2020.

This booklet will help you understand what services are covered and the specific steps you need to follow to receive the highest level of coverage. We encourage you to become familiar with your benefits and the valuable protection they provide. Please keep this booklet for future reference, so you will understand how to make your Plan work best for you and your family.

Please do not hesitate to call the Trust Fund Office (William C. Earhart Company) if you have questions about your eligibility or accident and sickness benefits. They can be reached at:

William C. Earhart Company, Inc.	
P.O. Box 4148	(503) 460-5245
12029 N.E. Glenn Widing Drive	(877) 396-5845
Portland, OR 97208	www.wcearhart.com

Regence Blue Cross Blue Shield of Oregon (BCBSO) will continue to pay medical, hearing, dental, and vision claims for the Trust. They can be reached at:

Regence BlueCross BlueShield of Oregon	(888) 367-2116
P.O. Box 1106	
Lewiston, ID 83501	

Sincerely,

Board of Trustees

All benefits described in this booklet are self-funded by the Trust with the following exceptions:

- Kaiser Permanente insures the Kaiser Foundation Health Plan of the Northwest EPO (exclusive provider organization).
- Willamette Dental Insurance, Inc. insures the alternative prepaid dental plan.
- Life and AD&D (accidental death and dismemberment) benefits are insured by LifeMap Assurance Company.

Your eligibility to participate in the Plan and the amount, nature, and duration of your benefits under the Plan, are determined by the Plan document, this summary plan description, and the policies and interpretations of the Board with respect to the Plan. The Board has complete and exclusive discretionary authority to establish, amend, modify, or terminate the Plan, or any benefits thereunder, including required rates of participant or beneficiary contributions, and has complete and exclusive discretionary authority in the administration of the Plan, including the authority to delegate Plan administrative or fiduciary functions.

The Board has complete and exclusive discretionary authority to interpret, construe, and apply terms and conditions of the Plan, the Trust agreement, this booklet, and all policies, procedures, actions, and resolutions adopted to administer or operate the Plan or the Trust. The Board or its delegate has the complete and exclusive discretionary authority to remedy any ambiguities, inconsistencies, or omissions and to decide all questions about the Plan and its administration, including claims for benefits and appeals of such claims, subject to the Plan documents and applicable law. The Trustees' decisions are final and binding upon all interested persons.

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SUMMARY OF BENEFITS

This chart is a high-level overview only. Please refer to the applicable sections for coverage details and exclusions. If you are enrolled in the Kaiser Foundation medical plan, the benefits described in this booklet for medical, prescription drugs, and hearing do not apply (see page 28 for details). If you are enrolled in the Willamette dental plan, the benefits described in this booklet for dental do not apply (see page 30).

Medical		
Annual Deductible	$200/person/calendar year $600/family/calendar year	
Office Visit Copayment	$15/physician office visit; then subject to deductible and coinsurance	
Telehealth Virtual Visit Copayment	$0/virtual physician/behavioral health visit (during the COVID-19 crisis); not subject to deductible or coinsurance	
Coinsurance	Plan pays 80% for preferred providers; 70% for non-preferred providers and for prescription drugs; when out-of-pocket maximum is reached, the Plan pays 100% for the rest of that calendar year	
Out-of-Pocket Maximum	$2,200/person/calendar year $4,600/family/calendar year (includes only annual deductible and your 20% and 30% coinsurance)	
Prescription Drugs		
Retail Prescription Drug Card 30 Day Supply	Generic Preferred brand Non-preferred brand	$4 copay You pay 30% You pay 50%
Mail Order and Optional 90 Day Supply	Generic Preferred brand Non-preferred brand	$15 copay $30 copay $45 copay
Dental		
Annual Dental Deductible	$25/person/calendar year (doesn't apply to diagnostic or preventive procedures; see page 29)	
Hearing	Plan pays 70%, up to $500 per ear in 36 consecutive months	
Vision	Exams, lenses, and frames up to a certain limit (see page 31)	
Employee Life Insurance	$20,000	
Dependent Life Insurance	$5,000 for spouse or domestic partner $1,000 for each child	

Employee Accidental Death & Dismemberment	$10,000 or $20,000 depending on loss
Employee Accident and Sickness	$150/week up to 26 weeks

ELIGIBILITY

Hourly Employees

The Plan is financed by contributions from individual employers as specified in their particular collective bargaining agreements with the Union.

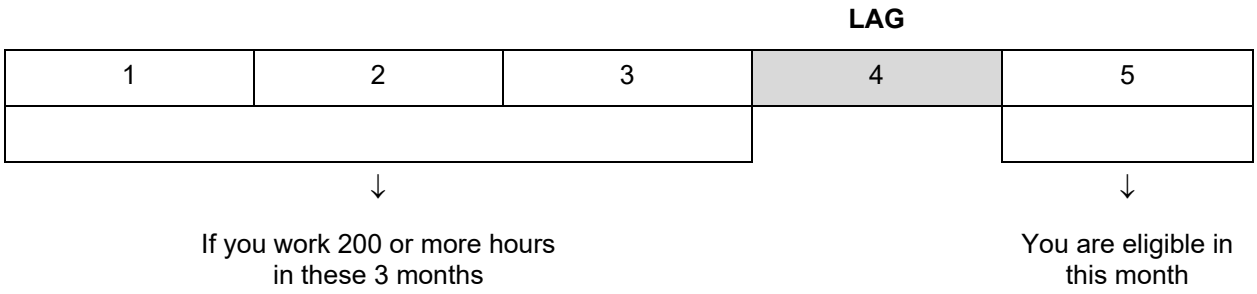
To be eligible to be a participant in the Plan, and therefore receive Plan benefits, you must have worked a certain minimum number of hours in previous months for which your employer is obligated to contribute to the Trust. Most employers pay on a timely basis and therefore ordinarily the Fund Office will have received your contributions and recorded them in your "hour bank" to determine your eligibility to be a participant in the Plan in a particular month. In the event your contributions from your employers are not received in a timely manner, the Fund Office will not have proof of all your eligibility hours.

Although the Trust has a program to find delinquent employers, you can help yourself and the Trust by checking periodically with the Fund Office (which you can do online at www.wcearhart.com), your employer, or the Union to make certain health and welfare contributions are being made for you by your employer if they are required. If your employer doesn't make the required contributions on time, you may still receive credit toward Plan eligibility, but you will need to prove the hours by sending copies of your pay stubs to the Fund Office. With valid pay stubs you'll receive immediate credit to your eligibility hour bank – without having to wait until your employer's payment is received. It's smart to save your recent pay stubs in case there is a problem.

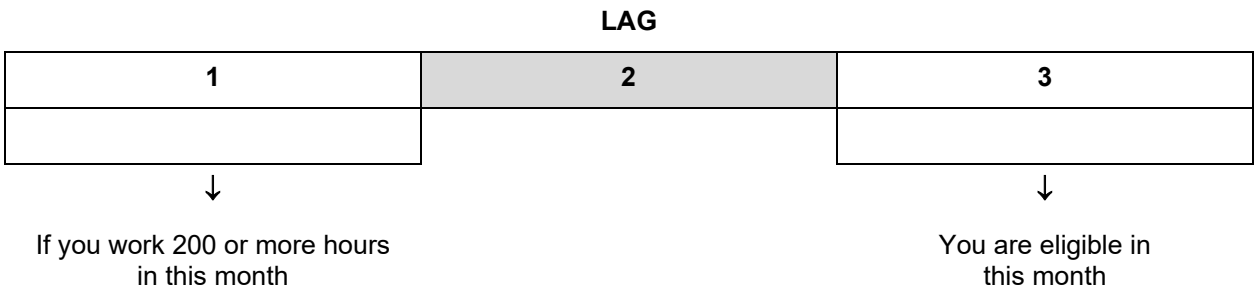
Initial Eligibility

You will be eligible on the first day of the second month after accumulating 200 or more work hours reported to the Trust within three consecutive months. The lag month is necessary for the Fund Office to process reported hours.

Examples:



If you work the 200 or more hours in one month, you are eligible on the first day of the second following month.



Continuing Coverage

Once you have met these initial eligibility requirements, your coverage can be continued in two ways:

- **By work hour credits** – The Fund Office establishes an "hour bank" of your credited work hours reported to the Trust or proven by your pay stubs. You will be eligible and covered as long as you have 140 or more hours in your hour bank. The Trust deducts 140 hours from your hour bank for each month you are covered as a participant in the Plan.
- **By self-payment** – If you have less than 140 hours in your hour bank, you may choose COBRA self-pay continuation coverage. Self-payments can be made for the 18 months following the last month you were eligible (see page 9).

For employees who elect to receive their medical benefits from the Kaiser Foundation Health Plan, 140 hours are also required for a month of coverage.

Note: You may have to work more than 140 hours if your employer contributes less than the rate specified in the Oregon Master Labor Agreement. Participants in Idaho should be particularly aware of this provision (see Prorated Hours below).

Hour Bank

All hours worked and reported (or proven by pay stubs) are credited to your hour bank; 140 hours are required to provide you with one month's coverage under the Plan. All hours worked over 140 in any month are accumulated in your hour bank to cover you during months of unemployment, subject to an 840-hour maximum (420-hour maximum if you are part of Vigor Metal Trades).

Example:

Hours worked in month	160 hours
Coverage hours for the month	– 140 hours
The 20 extra hours are added to your hour bank for future coverage	20 hours

After deducting 140 hours for the current month, you are allowed to have a maximum of 840 hours in your hour bank as of the end of that month (420 hours if you are part of Vigor Metal Trades).

If you become disabled by illness or injury while eligible for this Plan as an active employee, 8 hours will be credited to your hour bank for each regular workday you're disabled, up to 40 hours per week and 840

hours for any one disability (420 hours if you are part of Vigor Metal Trades). The Fund Office must receive confirmation of your disability from workers' compensation or your accident and sickness claim before crediting your disability hours to your hour bank.

Prorated Hours

If your employer contributes an hourly rate below the amount specified in the Oregon Master Labor Agreement, your hours actually credited to your hour bank will be reduced in proportion to that lower rate. For example, if your employer contributes $4.40 an hour and the Master Labor Agreement rate is $5.00, only 88% of each hour that is reported (or should be reported) by your employer is credited to your hour bank ($4.40 ÷ $5.00 = 88%). In this example you'll need to work 160 hours for each month of coverage (160 hours worked x 88% = 140 hours credited to your hour bank). The same type of calculation would apply if you elect Kaiser coverage which also requires 140 hours for a month of coverage. If you know or believe you may be working under a lower rate contract, contact the Fund Office to determine how many work hours you need each month to become eligible and to maintain your eligibility for the Plan.

Transfer of Eligibility

The Trust covers employees in Oregon and Southern Idaho. If you move from one to another of these states, notify the Fund Office immediately to ensure proper transfer of your hours and establish eligibility in the new state. Hours will be transferred only if you are not eligible in either state. Hours will be based on the rate that was paid into the original state (see Prorated Hours, above).

Reciprocity

The Trust is signatory to the Laborers International Union of North America National Reciprocal Agreement for Health and Welfare Funds. This means if you work under the jurisdiction of more than one Laborer health and welfare trust that signed the National Reciprocal Agreement and you don't work enough in any one trust to obtain and maintain eligibility, you might still be eligible by transferring hours. Contact the Fund Office for details on how reciprocity might benefit you.

Termination of Eligibility

If your hour bank has fewer than 140 hours of credit on the first day of a month, you will cease to be a Participant in the Plan effective on that day. See COBRA Self-Pay Continuation Coverage on page 9.

Reinstatement of Eligibility

When your eligibility terminates because your hour bank has fewer than 140 hours, any hours in your account will be carried for six months. Your eligibility will be reinstated on the first day of the second month after your account has again accumulated 140 hours of credit.

If you don't obtain reinstatement during the six months, the balance of any hours in your hour bank will be cancelled. You will have to satisfy the initial eligibility rules described in Initial Eligibility (page 3) to be covered again.

If you go into military service, your hour bank will be "frozen." This means you won't earn any new hours and no hours will be deducted from your hour bank (see page 8 for more details on benefits during military service).

Associate Employees

If your employer has signed an agreement covering you as an associate employee, you'll be eligible for Plan benefits if you are regularly scheduled to work for your employer and if your employer has paid the required contributions for you to the Trust. If your employer fails to make the required contributions on time, you may still receive credit. Send copies of your pay stubs to the Fund Office and you'll receive immediate credit; you will not have to wait until your employer's payment is received.

You will be covered on the first day of the second month after completing 80 hours for a single contributing employer. For example, if you worked 80 hours in January, you are eligible in March.

Once you satisfy the requirement for initial eligibility, each month you work 80 hours for a single contributing employer will give you eligibility for the second month after the month the work was performed.

Your eligibility will terminate at the end of the month after the month you first work less than 80 hours, unless you continue coverage through COBRA self-payments as described starting on page 9.

To determine whether you're covered as an associate employee, check with the Fund Office.

Associate I and B Plans

This booklet describes benefits under the Associate II and Associate A plans. If you are covered by the Associate I or Associate B plan, or if you're not sure which plan your benefits are under, contact the Fund Office. If you are covered under one of these other plans, a special insert will be mailed to you.

Eligible Dependents

Eligible dependents include your:

- Lawful spouse, if not divorced or legally separated.
- Children (including natural children, stepchildren, adopted children, children legally placed with you for adoption, children for whom you are legal guardian, foster children, and children of domestic partners) under age 26, without regard to marital, financial or student status. Proof of dependent status will be required.
- Unmarried children age 26 or older who depend on you for support and maintenance and are incapable of earning their own living due to a physical or mental condition, if the incapacity began before the limiting age shown above. You must give proof of the incapacity to the Fund Office no more than 31 days after the child reaches the limiting age. Coverage will continue as long as the following apply:
  - Your coverage remains in force.
  - You provide more than one-half of the child's support for the calendar year.
  - The incapacity and dependency continue.
- A domestic partner:
  - Registered with the State of Oregon according to the provisions of Oregon Revised Statutes, Chapter 106.

- Registered with a county or city of the State of Oregon in accordance with that county's or city's ordinances.
- Registered with the Trust who:
  - Is at least 18 years of age.
  - Is not legally married to another person or in a domestic partnership with another person.
  - Is not related to you by blood to a degree of closeness that would prohibit marriage.
  - Shares a mutual obligation of support and responsibility with you for each other's common welfare, including basic living expenses.
  - Shares a principal residence with you, has done so for at least six months, and intends to do so permanently.

You must submit your Certificate of Registered Domestic Partnership from the state, county, or city or a Trust-approved Affidavit of Domestic Partnership and Declaration of Partners to the Fund Office in order to cover a domestic partner.

In accordance with federal law, the Plan also provides medical, dental, and vision coverage to certain dependent children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. Contact the Fund Office for a description of the procedures governing QMCSO determinations.

No person may be covered as both an employee and a dependent child.

Your eligible dependents will become covered on the date your coverage begins.

Enrollment

When you become eligible for benefits, you will be enrolled in the Trust medical, prescription drug, hearing, and dental benefits.

- If you live within the service area of the Kaiser Foundation Health Plan of the Northwest (Oregon/Southwest Washington), you may elect medical, prescription drug, and hearing coverage through Kaiser. For more information, visit the Kaiser website at www.kaiserpermanente.org.
- If you live within the service area of Willamette Dental (offices throughout Oregon, Idaho, and Washington), you may choose either Trust dental benefits or Willamette Dental coverage.

You'll be enrolled automatically in the Trust's vision, employee life insurance, dependent life insurance, employee accidental death and dismemberment, and accident and sickness benefits.

Changing Plans

An open enrollment period is offered each year for eligible employees who want to change to or from Kaiser medical or Willamette Dental coverage. If you're eligible for benefits from this Plan and live in the Kaiser or Willamette Dental service areas, you'll receive an open enrollment notification in October or November. A full open enrollment packet will be sent upon request. If you don't want to change your coverage, no action is necessary. If you'd like to change your coverage, return your election form to the Fund Office by the deadline printed in the election package. Changes become effective on January 1.

If you change your residence and move out of the Kaiser or Willamette Dental service areas, you can request that you and your covered dependents change coverage to the Trust's self-funded medical and scheduled dental plans. Your new coverage will be effective on the first day of the following calendar month. Contact the Fund Office for assistance.

When Participation in the Plan Ends

You cease to be a participant in the Plan on the earliest of:

- The first day of any month on which your eligibility hour bank is credited with fewer than 140 hours.
- When the Plan is terminated or is amended so as to exclude you from eligibility.
- At the end of the month you enter the armed forces of any country. (However, your coverage will continue if you're absent from work due to service in the Armed Forces of the United States for a period under 31 days. For more information on Plan provisions for United States military service, see the next section.)

Your dependents' coverage under the Plan also ends when you cease to be a participant in the Plan. Your dependents' coverage under the Plan will also end as of the last day of the month in which:

- The dependent ceases to be an eligible dependent.
- Your eligible dependent enters military service.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue your group health benefits – including medical, dental, vision, and prescription drug coverage. If your military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts 31 days or longer, you and your dependents will be eligible to continue coverage through self-payment. When you return, your regular coverage will begin immediately, provided you meet the requirements summarized in this section.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless precluded by military necessity or other reasonable cause). You should also tell your employer how long you expect to be gone. Upon release from military duty, you must apply for reemployment as follows:

- Fewer than 31 days military service – apply immediately, taking into account safe transportation, plus an 8-hour rest period.
- 31-180 days military service – apply within 14 days.
- More than 180 days military service – apply within 90 days.

If you're hospitalized or convalescing, these re-employment deadlines are extended while you recover (but not longer than two years).

The preceding rules also apply to uniformed service in the National Guard and the Commissioned Corps of the Public Health Service.

To ensure proper crediting of service under USERRA, notify the Fund Office when you take USERRA leave, including how long you expect to be gone as well as when you apply for re-employment after your leave. Please call the Fund Office for details on service under USERRA.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') medical, dental, and vision coverage for up to 12 weeks during a 12-month period when you're on leave due to any of the following:

- Birth of a child or placement for adoption or foster care.
- Serious health condition of a child, spouse, or parent who is incapable of self-care.
- Your own serious health condition.

Contact your employer as soon as you think you're eligible for FMLA leave since the law requires you to give 30 days' notice or contact your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other obligations under FMLA.

When your coverage under FMLA ends, you and your dependents will be able to elect COBRA self-pay continuation coverage, as described in the next section.

COBRA Self-Pay Continuation Coverage

If you are a covered employee, you have a right to choose self-pay continuation coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) if you lose group health coverage because of a reduction in your hours of employment, the termination of your employment, or retirement.

If you are the covered spouse or domestic partner of an employee, you have the right to choose COBRA self-pay continuation coverage if group health coverage is lost due to any of these qualifying events:

- Termination of your spouse's or domestic partner's employment or reduction in their hours of employment.
- Death of your spouse or domestic partner.
- Divorce or legal separation from your spouse or domestic partner or termination of your domestic partnership

If you are a covered dependent child of an employee, you have the right to choose COBRA self-pay continuation coverage if group health coverage is lost due to any of these qualifying events:

- Termination of your parent's employment or reduction in your parent's hours of employment.
- Death of your parent.
- Your parents' divorce or legal separation or termination of their domestic partnership.
- You cease to be a dependent child as defined under this Plan.

Other Health Coverage Alternatives to COBRA

You may have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. The Marketplace helps people without health coverage find and enroll in a health plan. For Oregon residents, see www.healthcare.oregon.gov. For non-Oregon residents, see your state Health Insurance Marketplace at www.healthcare.gov. If you purchase health insurance in the Marketplace, you may be eligible for a tax credit that lowers your monthly premiums for that insurance coverage. Being eligible for COBRA does not limit your chances for purchasing coverage or for a tax credit.

You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Special Enrollment and Most COBRA Deadlines Are Suspended During the Coronavirus Crisis

Most COBRA deadlines described in this section are paused during the coronavirus outbreak period. This includes the 60-day period to elect COBRA following a divorce, legal separation, termination of domestic partnership, or a child's loss of dependent status and all COBRA payment deadlines.

The outbreak period is defined as beginning March 1, 2020 and ending 60 days after the national emergency period ends (whenever that might be). We will send a notification to members when the outbreak period ends.

How to Enroll for COBRA Self-Pay Coverage

Under the law, your employer has the responsibility to inform the Fund Office of termination of employment or reduction in hours.

You or a family member must notify the Fund Office within 60 days after a divorce, legal separation, termination of domestic partnership, or a child's loss of dependent status.

If the Fund Office is properly informed of these events, it will notify you (or your spouse, domestic partner, or child, as applicable) of your right to elect COBRA self-pay continuation coverage. Similarly, the Fund Office will notify you of that right when any other qualifying event occurs. It's your obligation to give the Fund Office your address and each dependent's address (if different). You and your dependents must keep the Fund Office informed of any change of address.

Under the law, you have 60 days to notify the Fund Office that you want COBRA self-pay continuation coverage. This 60-day period runs from either the date coverage ends or the date the Plan sends you notice of your right to continue coverage (whichever is later). If you don't choose continuation coverage, group health coverage for you and your family will end (however, an eligible spouse or domestic partner and/or dependent child may elect COBRA self-pay continuation coverage even if the employee doesn't).

If you choose COBRA self-pay continuation coverage, it will be identical to coverage under the Plan for similarly situated active participants or family members. This includes coverage for your spouse or domestic partner and dependent children. Under continuation coverage, each of you will have the choice of these coverages:

- Medical only (includes medical benefits, mail order pharmacy benefits, and hearing benefits or Kaiser medical, prescription drug, and hearing coverage).
- Medical and dental.
- Medical and vision.
- Medical, dental, and vision.

- Medical, dental, vision, life, AD&D, and accident and sickness benefits.

You may continue only the coverage you had immediately before your coverage ended.

Once you select your initial continuation coverage, you may not change to an option with more benefits, but you can elect an option with fewer benefits during open enrollment. However, you may change to an alternative medical plan (Trust or Kaiser) or alternative dental plan (Trust scheduled coverage or Willamette Dental) during any open enrollment.

Any new dependents acquired during the COBRA self-pay contribution period (such as by marriage, domestic partnership, birth, adoption, or placement for adoption), will immediately be eligible for coverage as long as they meet the eligible dependent requirements described on page 6.

Making COBRA Self-Payments

COBRA requires participants to make timely payment or lose coverage. You'll have 45 days from the date you elect COBRA self-pay coverage to pay your initial contribution. This initial contribution must equal the total accumulated contribution required for the period from the date you lost coverage through the last full month before your payment is made. This could mean paying for more than one month of coverage for your initial contribution. Subsequent monthly payments are due on the first of each month. All payments (except for the initial contribution) have a 30-day grace period; however, all payments must be consecutive.

Most COBRA Deadlines Suspended During the Coronavirus Crisis

Most COBRA deadlines described in this section are paused during the coronavirus outbreak period. This includes the 60-day period to elect COBRA following a divorce, legal separation, termination of domestic partnership, or a child's loss of dependent status and all COBRA payment deadlines.

The outbreak period is defined as beginning March 1, 2020 and ending 60 days after the national emergency period ends (whenever that might be). We will send a notification to members when the outbreak period ends.

Periods of COBRA Self-Pay Coverage

The maximum continuation coverage period for you and your covered family members is 18 months if you lose group health coverage because of termination of employment or reduction in hours. If your spouse, domestic partner or dependent children lose coverage because of your death, divorce, termination of the domestic partnership, or because the child is no longer eligible under this Plan, the maximum continuation coverage period is 36 months.

The 18-month maximum can increase to 29 months if you or a covered family member is totally disabled. To qualify for this additional coverage, during the first 18 months of COBRA self-pay continuation coverage the Fund Office must receive proof that Social Security considers the employee, spouse, domestic partner, or dependent child totally disabled at any time before or during the first 60 days of the 18 month period. You must provide the Fund Office a copy of the determination letter (indicating entitlement to Social Security disability benefits) within 60 days of receiving it. You also must notify the Fund Office within 30 days of the date Social Security no longer considers the person disabled.

The 18-month maximum can increase to a maximum of 36 months for your spouse, domestic partner, or dependent children if they have a second qualifying event during the first 18 months of COBRA self-pay continuation coverage. You or your dependent must notify the Fund Office within 60 days of the second qualifying event.

Oregon Continuation Coverage for Spouses or Domestic Partners – Age 55 or Over

If you and your dependents are covered under the Kaiser Foundation Health Plan of the Northwest, the 36-month limit described above does not apply if both the following circumstances are met:

- The qualifying event was your death, divorce, termination of domestic partnership, or legal separation.
- Your surviving, divorced, separated spouse or domestic partner, or terminated domestic partner was at least age 55 on the qualifying event date.

Under these circumstances, coverage for your spouse or domestic partner and any dependent children will generally continue until the earliest of these events:

- The premium is not paid when due (or within any grace period).
- The Kaiser plan terminates, unless the insurer makes a different group policy available.
- Your surviving, divorced, separated spouse or domestic partner, or terminated domestic partner becomes insured under any other group health plan (through marriage, domestic partnership, or otherwise) or becomes eligible for Medicare.

However, the Oregon continuation coverage period will not be longer than required by Oregon law. To be eligible for Oregon continuation coverage, your surviving, divorced, or separated spouse or domestic partner, or terminated domestic partner must notify the Fund Office within 60 days of the death, divorce, termination, or separation and must elect Oregon continuation coverage within 60 days after receiving notice from the Fund Office.

When COBRA Self-Pay Coverage Ends

The law states that your COBRA self-pay continuation coverage will end early for any of these reasons:

- You (employee, spouse, domestic partner, or child) first become entitled to Medicare after the date of your COBRA election.
- You (employee, spouse, domestic partner, or child) first become covered under another group health plan (as an employee or otherwise) after the date of your COBRA election.
- The contribution for your continuation coverage is not paid on time.
- The Trust no longer provides group health coverage.

If your COBRA self-pay continuation coverage ends because of any of the first three reasons listed in this section, your spouse or domestic partner and children may continue coverage as nonmembers if they're not covered under another group health plan or Medicare. They must enroll and pay their contributions promptly.

COBRA Deadlines Suspended During the Coronavirus Crisis

Most COBRA deadlines described in this section are paused during the coronavirus outbreak period. This includes the 60-day period to elect COBRA following a divorce, legal separation, termination of domestic partnership, or a child's loss of dependent status and all COBRA payment deadlines.

The outbreak period is defined as beginning March 1, 2020 and ending 60 days after the national emergency period ends (whenever that might be). We will send a notification to members when the outbreak period ends.

If your coverage ends because you become entitled to Medicare, your spouse, domestic partner, and dependent children may continue coverage for up to 36 months after the date you became entitled to Medicare, or 18 months after the date your active coverage ends, whichever is longer.

Retired Employees

Employees who retire from active coverage have the choice between electing COBRA self-pay continuation coverage for 18 months (or until entitled to Medicare if earlier) or the Trust's retiree health and welfare program with no time limit, as described in a separate booklet. A retired employee who chooses COBRA self-pay coverage (as described beginning on page 9) may switch to the retiree program after the self-pay coverage is exhausted. If you do not enroll in the retiree program when you retire or exhaust COBRA self-pay coverage, you'll have an opportunity to enroll within 90 days of reaching age 60 or within 90 days of becoming eligible for Medicare.

If you have any questions about COBRA self-pay continuation coverage, please contact the Fund Office. If your marital status changes, a child loses dependent status, or your address changes, you must notify the Fund Office.

If You Retire

If you meet certain conditions, you may qualify for coverage under a separate retiree plan sponsored by the Trust. The plan includes medical, hearing, prescription drug, and mail order pharmacy coverage only. Retirees under age 65 are also eligible for life insurance and AD&D benefits. You will be required to contribute toward the cost of this coverage.

MEDICAL BENEFITS

Depending on where you live, you may have a choice between either the Trust medical benefits described in this section or coverage under the Kaiser Foundation Health Plan of the Northwest described on page 28. Kaiser, an EPO, is only available if you live in the Kaiser service area. Kaiser offers a separate document to detail benefits. Each plan has its own prescription and hearing coverage.

If you live outside the Kaiser service area, you will receive Trust medical benefits described in this section.

Regence PPO Medical Plan

Medical benefits are designed to help you pay for needed medical care. Generally, you and the Trust both pay a portion of covered costs. Please note, not all services may be covered so read this section carefully and keep it for future reference. Contact Regence BlueCross BlueShield of Oregon (Regence BCBSO) with questions.

If you choose the medical benefits described in this section, you also receive mail order prescription benefits (see page 25) and hearing benefits (see page 27).

Preferred Provider Organization

The Trust Medical Plan is a preferred provider organization — or PPO. Preferred providers are physicians, hospitals, and others who have signed PPO contracts with the plan administrator, Regence BlueCross BlueShield of Oregon and its nationally affiliated BlueCross BlueShield partners.

Benefits are generally higher when you use a preferred provider and lower when you use an out-of-network provider. You may receive care from any licensed provider covered under the Plan. The choice is yours at the time service is needed.

When you use a preferred provider, the provider bills a pre-negotiated fee, so you and the Trust generally pay less for services received from preferred providers. The Plan also pays a higher percentage of the cost of services you receive from preferred providers: generally, 80% instead of 70%.

When you use an out-of-network provider, the Plan generally covers a lower portion of the bill (70%) and you may also have to pay any charges that are over the “reasonable and customary” charge. Please see the definition of reasonable and customary charge in the Definitions section beginning on page 45.

Preferred provider lists are available online at Regence BCBSO www.regence.com.

Your Costs

Deductible

Each year, you must satisfy a deductible before the Plan pays any benefits.

Annual Deductible	
Each person/calendar year	$200
Each family/calendar year	$600

This means you pay the first $200 of covered expenses in any calendar year. The deductible is limited to $600 for a family each calendar year. Once the family deductible is reached, no further deductible amounts will be required for any family member in the rest of that year. Noncovered charges do not apply to the deductible.

Any expenses applied against the deductible in the last three months of a calendar year will be applied to the deductible for the next year.

Coinsurance

After you satisfy the annual deductible, the Plan pays a percentage of the costs for most covered services and you pay the rest. This is your coinsurance. The following table details coinsurance amounts:

Plan Coinsurance	
Preferred providers	80%
Other covered providers	70% of reasonable and customary charges

The Plan covers 80% of a preferred provider's charge for covered services, and 70% of reasonable and customary charges made by other providers for services covered by the Plan. You are responsible for the remaining 20% for a preferred provider and 30% for other covered providers. You also are responsible for payment for noncovered services, including amounts that exceed the Plan's reasonable and customary limits.

See the list of Covered Expenses beginning on page 17 for details of how specific services are covered, and the Medical Exclusions beginning on page 23 for services and circumstances that are not covered.

Office Visits

For regular office visits with your physician, the Plan pays 80% or 70% (as explained above) after you pay a $15 copayment per visit and the annual deductible has been met.

Virtual Doctor Visits

With MDLIVE, you can talk with a board-certified doctor virtually by phone, online video, or mobile app no matter where you are, 24 hours a day, 7 days a week.

Virtual visits for general medicine, psychology, and psychiatry through MDLIVE are paid fully by the Trust and offered at no cost to you during the coronavirus emergency. That means you pay no deductible, no copays, and no coinsurance.

Virtual physicians can diagnose and prescribe medication for the following types of non-emergency conditions, as well as review symptoms that may be related to the coronavirus to determine if you should seek the next level of care.

All Ages		Mental Health	Kids
Allergies	Pink eye	Anxiety	Colds and flu
Colds and flu	Rashes	Depression	Constipation
Ear infections	Sinus infection	Addictions	Ear infections

All Ages		Mental Health	Kids
Headache	Sore throat	Relationship issues	Nausea
Infections	Sunburn and more	PTSD and more	Pink eye and more

Registration is easy:

- Go to MDLIVE.com/regence-or
- Enter the information requested
- That's it!

You may also call 1-888-725-3097 to speak do an MDLIVE representative. Out-of-Pocket Maximum

If you reach the out-of-pocket maximum, the Plan will pay 100% for most covered services for the rest of that calendar year.

Annual Out-of-Pocket Maximum	
Each person/calendar year	$2,200
Each family/calendar year	$4,600

Out-of-pocket expenses for purposes of the out-of-pocket maximums include only your deductibles and your 20% or 30% coinsurance amount. They do not include any charges for noncovered services (including charges in excess of the Plan's reasonable and customary limits), office visit copayments, or mail order prescription drug copayments.

BlueCard Program

Call customer service to learn how to have access to care through the BlueCard Program. This unique program enables you to access hospitals and physicians when traveling outside the four-state area that Regence BlueCross BlueShield of Oregon serves (Idaho, Oregon, Utah, and Washington), as well as receive care in 200 countries around the world.

Regence Website

This interactive website is your resource for health care information, health planning tools, wellness activities, coverage information, and earning rewards through Regence Rewards. To get started, log on to www.regence.com and have your identification card handy.

Preauthorization and Case Management

Providers should call Regence BCBSO to pre-certify inpatient hospital, skilled nursing facility, mental health, and chemical dependency treatment facility admissions, as well as home health care or hospice care – confirming the care is medically necessary and covered by the Plan.

Regence BCBSO also arranges individual case management for patients with severe or long-term illnesses or injuries. Through individual case management, these patients receive the most cost-effective care.

Registered nurses consult with patients and attending physicians to identify medically appropriate treatment alternatives that offer savings and enhancements to the patients' quality of life. All aspects of the program are voluntary.

If you have questions about arranging for these services, contact:

Regence BlueCross BlueShield of Oregon
Oregon Laborers Health and Welfare Trust
ATTN: Correspondence, Intake, and Appeals
P.O. Box 2998
Tacoma, WA 98401-2998

Or call the following numbers:

Portland area
(888) 370-6164

Outside the Portland area
(800) 810-BLUE (2583)

Covered Expenses

Covered expenses are the charges for services, supplies, and treatments listed in this section, when they are medically necessary and ordered by a physician. Preferred providers have special fee arrangements with the Trust, and you generally are reimbursed at 80% of this contracted rate. Nonpreferred providers do not have a special fee arrangement with the Trust, and you generally are reimbursed 70% of reasonable and customary charges for services covered by the Plan.

Ambulance transportation from professional, local ambulance services.

Approved clinical trials and routine patient costs in connection with an approved clinical trial in which you are enrolled and participating are covered subject to the deductible, coinsurance and/or copayments and maximum benefits. If a preferred provider is participating in the approved clinical trial and will accept you as a trial participant, these benefits will be provided only if you participate in the approved clinical trial through that provider. If the approved clinical trial is conducted outside your state of residence, you may participate, and benefits will be provided in accordance with the terms for other covered out-of-state care.

Cancer screenings for the following are covered at 100%, not subject to the deductible:

- Breast cancer: for women age 40 and over, one mammogram per calendar year.
- Colon and rectal cancer: beginning at age 50; one of the following test schedules:
  - Fecal occult blood test (FOBT) each calendar year.
  - Flexible sigmoidoscopy every 5 calendar years.
  - Yearly fecal occult blood test plus flexible sigmoidoscopy every 5 calendar years.
  - Double-contrast barium enema every 5 calendar years.
  - Colonoscopy every 10 calendar years.

- Cervical cancer: beginning at age 21, a regular Pap test each calendar year or liquid-based Pap test every two calendar years.
- Endometrial (uterine) cancer: for women age 35 and over at high risk for hereditary nonpolyposis colon cancer (HNPCC), screening with endometrial biopsy once each calendar year.
- Prostate cancer: for men age 50 and over (men at high risk, age 40 or over), prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) once each calendar year.

Chemical dependency and mental health treatment must be under an approved treatment plan provided by a licensed general hospital, health care facility, residential facility or program, day or partial hospitalization program, physician, psychologist, nurse practitioner, or clinical social worker. This coverage complies with the Mental Health Parity and Addiction Equity Act of 2008.

The provider must be licensed and approved by the Oregon Mental Health Division (or equivalent agency if services are received outside Oregon) or the Office of Alcohol and Drug Abuse Programs.

These benefits are paid in the same way as for any other illness

The Plan does not cover volunteer support groups or education programs related to driving while intoxicated that are referred by the judicial system.

Chemical dependency and mental health treatment benefits are limited, in all cases, to services provided in the least costly treatment setting which, in the judgment of the Trust, is medically appropriate for the patient's condition. The Trust will use the following criteria to determine the appropriate setting for care:

- Health facility care will be covered only when the facility's records show the patient's medical circumstances require 24-hour skilled nursing supervision and physician assessment not readily available in a less costly setting.
- Residential care or partial hospitalization will be covered only when the patient requires non-medical supervision, protection, assistance, and treatment. In determining the patient's need for residential care or partial hospitalization, these factors will be considered:
  - Existing social, occupational, and living situations that would adversely affect outpatient treatment
  - Potential life-threatening risk to the patient or others
  - The patient's readiness and/or willingness to participate consistently in treatment.
- Outpatient services will be covered when treatment is justified considering the patient's history and current medical, occupational, social, and psychological situation as well as the overall prognosis.

If services are provided in a treatment setting that the Trust considers inappropriate based on these criteria, benefits will be limited to the amount that would have been paid if those services had been provided in the least costly treatment setting appropriate for that care.

Chiropractic treatment by a licensed chiropractor, up to 24 visits/calendar year and $100/calendar year for lab and x-ray; you pay a $15 copayment for each office visit, in addition to coinsurance after the deductible is met.

COVID-19 testing including the office visit is covered at no cost to you if a provider determines a test is necessary. No pre-authorization is required.

Diabetes self-management education, under a program by health care professionals (such as physicians, nurses, pharmacists, or registered dietitians) who are knowledgeable about the disease process and treatment of diabetes. The Plan covers completion of one outpatient program for these services. This benefit is not subject to the deductible.

As an alternative, you may choose to participate in the Livongo Diabetes Management Program, a voluntary diabetes management program. When you enroll in Livongo, you will receive a Welcome Kit that contains a glucose meter, test strips, lancets, and other supplies. Future supplies are shipped directly to your home.

Extended care facility room, board, services, and supplies, up to 120 days/calendar year.

Home health care visits, up to a calendar year maximum of 50 home care visits by these types of providers:

- Registered or licensed practical nurse.
- Physical, occupational, or speech therapist.
- Home health aide.

A visit must be for intermittent medically necessary or palliative care of not more than four hours.

Once the 50-visit limit is reached, you or your covered dependent may apply for an extension of home care benefits.

Foot care benefits include additional diagnoses beyond diabetes, including care due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs and feet, subject to the deductible and then regular coinsurance.

Hospice care benefits are available for six months (after six months, you or your covered dependent may apply for an extension). Benefit details follow:

- The Plan covers charges for short-term hospice inpatient services and supplies up to 12 days during covered hospice care.
- The Plan also covers charges for respite care to the patient who requires continuous attendance. These benefits are limited to 120 hours in three months of covered hospice care, provided in the most appropriate setting, as determined by the Plan. Services and reasonable charges of a nonprofessional provider may be covered for respite care if you obtain approval in advance from Regence BCBSO.

After six months, you or your covered dependent may apply for an extension. Limited extensions may be granted if the Trust determines continued hospice care is medically appropriate.

Hospital room and board (up to the semiprivate room rate) and necessary services and supplies. Covered hospital services include care in an intensive care unit and a coronary care unit. Other covered services include outpatient surgery at a hospital and emergency room treatment of an accidental injury or illness.

Hospitalization for dentistry under the advice and direct care of a physician, surgeon, or dentist.

Kidney dialysis (case managed)

Initial Benefit

Covered services for participants who are beginning (or continuing) treatment for End Stage Renal Disease (kidney disease) include, but are not limited to hemodialysis, peritoneal dialysis, and hemofiltration.

The Plan covers professional services, supplies, medications, labs, and facility fees related to outpatient kidney dialysis. Expenses that are applied toward the deductible and services received prior to enrollment will be applied against the maximum benefit limit on these services.

Covered services of the initial dialysis benefit include the first 42 treatments received prior to Medicare coverage enrollment, as calculated from the initial kidney dialysis treatment. If more than 42 treatments are necessary prior to Medicare coverage enrollment, the Claims Administrator must be contracted to approve the additional treatment and document your progress until your dialysis benefits have begun with Medicare.

The Plan will pay regular Plan benefits when services are rendered outside the country.

Supplemental Outpatient Benefit

For any subsequent outpatient kidney dialysis after Medicare coverage enrollment (or 42 visits), the Plan will provide additional supplemental coverage as described here. Preferred providers have special fee arrangements with the Trust, and the Plan will pay 100% of that contracted amount. For non-preferred providers, the Plan will pay 150% of the current Medicare reimbursement amount. This benefit is not subject to any deductible, for the same or similar services as provided under the initial dialysis benefit. For the purpose of this benefit, "Medicare reimbursement amount" is the amount that a Medicare-contracted provider agrees to accept as full payment for a covered service. This is also referred to as the provider accepting Medicare assignment. If you are not enrolled in Medicare Part B, and you receive care from a non-preferred provider, you will pay the balance of billed charges, which will not apply toward the out-of-pocket maximum.

Dialysis Support Is Available

You can receive one-on-one help and support in the event your physician recommends dialysis. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed health care professional who will help you understand your treatment options, show you how to get the most out of your available Plan benefits, and work with your physician to support your treatment plan. To learn more or to make a referral to case management, please call 888-370-6164.

Important Note About End Stage Renal Disease

A participant with end stage renal disease (ESRD) is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the participant's ESRD treatment, as long as the participant continues to be enrolled under Medicare Part B and continues to be eligible for coverage under this Plan (proof of payment of the Medicare Part B premium will be required prior to reimbursement). The case manager at Regence will talk with you regarding what you need to do to have these expenses reimbursed, but it is very important that you sign up for Medicare Part B as soon as you are eligible.

Lab, x-ray, and other diagnostic tests.

Licensed registered nurse services.

Mastectomy-related benefits, which cover prosthesis and/or reconstruction of the breast on which the mastectomy was performed, and of the other breast to produce a symmetrical appearance, including treatment of lymphedema and other physical complications at all stages of mastectomy.

Maternity benefits for you, your spouse, or domestic partner, including childbirth and complications of pregnancy. These are covered the same as any other condition. As required by federal law, the Plan does not restrict hospital benefits for covered mothers and newborns to under 48 hours following a vaginal

delivery and 96 hours following a cesarean section. Authorization is not required for these lengths of stay, but your provider should call Regence BCBSO to arrange certification if a longer stay is medically required. Dependent children are not covered for expenses related to pregnancy or complications of pregnancy.

Medical supplies, which include:

- Artificial limbs and eyes
- Blood and blood plasma
- Braces
- Casts
- Crutches
- Oxygen and rental of the equipment for its administration
- Rental of wheelchair or hospital bed
- Rental of durable medical equipment
- Splints
- Surgical dressings
- Trusses.

Naturopathic office visits for routine and preventive care. You pay a $15 copay for each office visit, in addition to coinsurance, after the deductible is met. If a Naturopathic Doctor performs a surgical procedure within the scope of his/her license and the surgery would be payable under this Plan if an MD performed the procedure, then the surgery will be considered a covered expense. Charges for vitamins and supplements prescribed by the naturopath are not covered.

Physician services, which include:

- Visits at the home, office, and hospital (including routine physical exams, immunizations, and injections); you pay a $15 copayment for each physician office visit, in addition to coinsurance after the deductible is met.
- Second surgical opinions. If a physician recommends a surgical procedure, the Plan pays 100% for a second surgical opinion to determine medical advisability if all these conditions apply:
  - The second opinion is rendered by a physician not associated in any way with the physician recommending the surgery.
  - The physician who gives the second opinion will not perform or participate in the planned surgery.
  - You are examined by the physician who renders the second opinion.
  - The physician submits a claim for the second opinion.

  The Plan also pays 100% for a third surgical opinion if the second opinion does not confirm the procedure is medically advisable. Second and third surgical opinions are not subject to the deductible.

  Once the second (or third) opinion has been received, you decide whether to have the procedure performed – regardless of the opinions.

This benefit includes any lab or x-ray exams performed in connection with the second or third surgical opinion.

- Surgery, including charges for anesthesiologists and assistant surgeons

Physiotherapist services, when performed by a licensed physical therapist and prescribed by an MD, ND, or DO.

Prescription contraceptives, including both drugs and devices, examinations, procedures, and medical services necessary to prescribe, dispense, deliver, distribute, administer, or remove a prescription contraceptive.

Prescription drugs can be obtained only by a physician's prescription. See page 25 for details about the prescription drug program.

Preventive care, in accordance with criteria established by the Trust. Covered preventive care includes routine exams, immunizations, and tests. You pay a $15 copayment for each office visit, in addition to coinsurance after the deductible is met.

Smoking cessation benefits, up to a lifetime maximum of $500/person for the following covered expenses:

- Zyban, when prescribed by a physician for up to the FDA-approved dosage, limited to a 90-day supply.
- Nicotine replacement therapy with a written recommendation from a physician, limited to one course of treatment for up to three months.
- Charges for a smoking cessation program conducted by a qualified professional, limited to a lifetime maximum of one course or program.

These benefits are not subject to the annual deductible.

Speech and occupational therapy, when performed by a licensed speech or occupational therapist, to the extent the therapy will restore and improve a lost function following an illness, injury, or surgery, and prescribed by an MD, ND, or DO.

Transplant procedures that are medically necessary and conform to generally accepted medical practice and are not, in the Trust's judgment, experimental or investigational. Transplant benefits also have the following limits:

- The recipient must be covered under this Plan for at least 12 of the 24 months before incurring transplant-related expenses.
- If the recipient is covered under this Plan, the Plan pays up to $5,000 for donor costs – whether or not the donor is covered under this Plan. Donor costs refer to the covered expense of removing the tissue from the donor's body and preserving and transporting it to the site where the transplant is performed. If the donor is covered under this Plan and the recipient is not, the Plan will not pay any benefits toward donor costs. Complications and unforeseen effects of the donation will be covered as any other sickness.

Vaccines for flu and shingles (two-dose shot) are covered 100% once per year.

Medical Exclusions

In addition to General Exclusions on page 43, no medical benefits will be provided for:

- Acupuncture or acupressure treatment not authorized in advance by Regence BCBSO.
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education (such as air conditioners, humidifiers, air filters, whirlpools, heat lamps, tanning lights, exercise equipment, or health related publications).
- Charges or supplies that are not medically necessary to treat an accidental injury or sickness, except as specifically provided for routine physical exams, immunizations, and injections.
- Artificial insemination, in vitro fertilization, or treatment of infertility.
- Hospice care services and supplies for the following:
  - Food services, such as "Meals on Wheels."
  - Homemaker or housekeeping services, except by home health aides as ordered in the hospice treatment plan.
  - Legal or financial counseling.
  - Normal necessities of living, including but not limited to food, clothing, or household supplies.
  - Pastoral or spiritual counseling.
  - Separate charges for reports, records, or transportation.
  - Services or supplies not included in the hospice treatment plan or specified in the hospice benefit.
  - Services or supplies over the stated limits provided more than six months after the initial date of covered hospice care, unless specifically approved by Regence BCBSO.
  - Services performed by family members or volunteer workers.
  - Services to other than the terminally ill patient, including bereavement counseling for family members.
  - Supportive environmental materials, including but not limited to handrails, ramps, air conditioners, or telephones.
- Massage or massage therapy.
- Nonprescription drugs, vitamins (except prenatal vitamins requiring a prescription), nutritional supplements, special diets, or comfort or convenience services or supplies.
- Obesity or weight control treatment or publications, including surgery or any other treatment, as well as complications — whether or not you have other medical conditions related to or caused by obesity or treatment of obesity.
- Orthopedic shoes or orthotic devices.
- Pregnancy of dependent children, including childbirth or complications of pregnancy.
- Prescription drugs in excess of a 30-day supply.

- Private nursing service or personal items such as telephones, televisions, and guest meals in a hospital or skilled nursing facility.
- Refractive eye surgery.
- Reversal of sterilization operations.
- Self-help or training programs or publications, including but not limited to those to control weight, improve general fitness, use durable medical equipment, or care for a family member.
- Services or supplies that are, in the judgment of Regence BCBSO, Experimental or Investigational.
- Services primarily for cosmetic reasons (including complications) except for prompt repair of an accidental injury, those related to breast reconstruction in connection with a mastectomy, or treatment of gender identity disorder.

PHARMACY BENEFITS

The prescription drug card program features a network of pharmacies administered by Kroger Prescription Plans (Fred Meyer). When you purchase a prescription drug, you can use Kroger network pharmacies, which include most major chains and independent pharmacies.

You are allowed up to a 30-day supply per prescription or refill. You can also get a 90-day supply through retail only at local Fred Meyer (or other Kroger owned) pharmacies.

The pharmacy benefits described in this section do not apply if you receive your medical benefits through Kaiser. A separate pharmacy benefit is available through that program.

Your Costs

When you use your prescription card at a network pharmacy, you will be responsible for the following copayment or coinsurance, up to an out-of-pocket maximum of $1,000 per calendar year:

	Retail (30-day supply)	**Retail or Mail Order (90-day supply)**
Generic drugs	$4	$15
Preferred brand drugs	30%	$30
Non-preferred brand drugs	50%	$45

To determine your coinsurance, go to www.KPP-RX.com, register, and price your medication, or call Kroger customer service at (800) 482-1285.

To find out if your pharmacy is a Kroger network pharmacy, call Kroger customer service at (800) 482-1285.

Drug Formulary

The formulary is a list of medications available under the pharmacy plan, organized into categories – generic drugs, preferred brand drugs, and non-preferred brand drugs. You can access a copy of the complete formulary at www.KPP-RX.com.

The Kroger Prescription Plan is constantly monitoring the price and value of prescription medications. To help manage drugs costs and keep the plan affordable for all, they may make changes to the formulary at any time, even during the calendar year. Before renewing a prescription, it's always smart to check and see if the formulary has recently changed and affected a drug you take.

Mail Order Program

The mail order program is designed to provide a convenient way for you to obtain maintenance drugs needed on a regular long-term basis (such as blood pressure medication). This benefit allows you to obtain a 90-day supply of your medication.

Postal Prescription Service (PPS) located in Portland, Oregon is the mail order pharmacy. To use PPS, complete a Prescription Order Form (available from the Fund Office), attach your doctor's prescription, method of payment, and mail to Postal Prescription Service at the address on the form. You can also call PPS at (800) 552-6694 or create a personal account online at www.ppsrx.com.

If your physician sends your prescription to PPS, you will be contacted by the pharmacy to get your medical profile as well as billing information. You may pay by check, credit card, or debit card. Once your payment is processed, PPS will fill the prescription and ship it to your home. Medications are delivered by U.S. mail or UPS.

To make sure you don't run out of your medicine, allow at least 7 to 14 days to receive your prescription.

If you have a new prescription for a new medicine, request a three-week supply from your doctor or a local pharmacy while you wait for your mail order medication.

To change a current retail prescription to PPS, call (800) 552-6694 and a customer service representative will help you through the process.

Best Practice Rx Programs

Quantity Limits

Under pharmacy best practices, some types of medications have quantity limits to comply with FDA product label indications. If your prescription is not consistent with FDA quantity guidelines, Kroger will not approve filling the prescription without their prior authorization.

Step Therapy

Another best practice we use is step therapy, a pharmacy program that requires you to try a generic or preferred medication first (Step 1). If that medication is found to be ineffective or if your Rx history shows that the generic drug was previously dispensed, then the brand or higher-cost medication can be dispensed (Step 2). Not all nonpreferred or brand medications require step therapy. If your medication is covered under the step therapy program and there is no record of a generic drug previously being dispensed, then you must try the generic first or get prior authorization from Kroger.

Prior Authorization

For prior authorization, your physician submits a medication request form stating how your prescription complies with FDA quantity guidelines or why you must have the brand drug without trying the generic first. For a medication request form, your physician's office should call Kroger at (800) 482-1285.

HEARING BENEFITS

As an eligible participant of the Trust medical plan, if you or your dependent obtains a hearing evaluation and a hearing aid, this Plan will reimburse 70% of reasonable and customary charges up to $500 per ear in any one period of 36 consecutive months. The hearing benefits described in this section do not apply if you receive your medical benefits through Kaiser, which has a separate hearing benefit.

To receive this hearing benefit, you or your dependent must:

- Be examined by a physician or audiologist before obtaining a hearing aid.
- Provide Regence BCBSO with a written certification from the examining physician or audiologist that the participant or eligible dependent is suffering from a hearing loss that may be lessened by use of a hearing aid. Benefits will not be paid without this certification.

If a hearing aid is purchased, benefits will cover:

- An otologic exam by a physician.
- An audiologic exam and hearing evaluation by a certified or licensed audiologist including a follow-up consultation.
- The hearing aid prescribed as a result of the exam, including
  - Ear molds and the hearing aid instrument
  - Initial batteries, cords, and other necessary accessories
  - Warranty
  - Follow-up within 30 days after delivery of the hearing aid.

If you or your dependent has a hearing aid repaired, the Plan will cover 100% of the cost, up to $100 in every period of 36 consecutive months. The following conditions apply:

- You or your dependent must have an audiologic exam before the repair.
- 36 months must have elapsed since the last covered hearing aid was purchased for that ear.
- If the hearing aid is repaired again within 36 months, the benefit will be $100 minus the amount reimbursed for the first repair.
- If a new hearing aid is purchased for that ear within 36 months of the repair, the cost of the repair will count against the $500 hearing aid benefit maximum.

Hearing Exclusions

In addition to the General Exclusions on page 43, these hearing benefits do not cover:

- A hearing aid that exceeds the specifications prescribed to correct the hearing loss.
- Any exam that doesn't result in a hearing aid being obtained.
- Batteries or other accessories obtained after purchase of the hearing aid.
- Expenses incurred after termination of coverage under this Plan, except for a hearing aid ordered before and delivered within 30 days after termination.
- Replacement of a hearing aid for any reason more than once in 36 months.
- Servicing or alteration of the hearing aid.

KAISER MEDICAL BENEFITS

The Kaiser Foundation Health Plan of the Northwest covers medical, prescription drug, and hearing benefits. If you choose Kaiser coverage, you will receive only your dental, vision, accident and sickness, life, and AD&D coverage directly from the Trust.

If you live or work within the Kaiser service area (Oregon/southwest Washington), you may elect to obtain your medical coverage through Kaiser. You must meet the eligibility requirements as described beginning on page 3. To find out if you live or work within the Kaiser service area, call Kaiser Membership Services at (800) 813-2000. If you are in the Portland area, call (503) 813-2000. The TTY number in Oregon is (800) 735-2900. See page 7 for additional enrollment information.

Under Kaiser coverage, you must choose and receive routine care from a primary care provider. In most cases, you will need a referral to see a specialist. Primary care providers are doctors, nurse practitioners, or physician assistants in family practice, internal medicine, or pediatrics who are members of the Kaiser network. You automatically receive a list of primary care providers when you enroll. For a current list of providers, call Kaiser Membership Services or visit the Kaiser website at www.kaiserpermanente.org.

Medical, prescription drug, and hearing benefits are paid according to Kaiser benefit schedules. Details of Kaiser benefits and claim filing instructions are available by contacting the Fund Office. Benefits under the Kaiser coverage are set forth in Kaiser publications and schedules available to Kaiser enrollees which are incorporated by reference herein. The Trust has no obligation to provide directly any medical, prescription drug, or hearing benefits to any Plan participant enrolled in Kaiser, and the Plan's sole obligation is to pay Kaiser contracted aggregate premiums for covered participants.

DENTAL BENEFITS

You have a choice between the Regence Dental program described in this section or coverage under the Willamette pre-paid dental plan (described beginning on page 30), as long as you live in the Willamette Dental service area.

Both the Regence Dental program and Willamette Dental generally provide coverage for similar services but vary in the way they pay benefits and the flexibility of provider choice.

Regence Dental PPO Program

You may see any licensed dental provider you like, but your cost will be lower if you see a provider within the Regence Dental PPO network. PPO means "preferred provider organization," which is a broad network of providers with discounted fees for services.

After you satisfy the annual deductible, you must pay a percentage of the charges for covered dental services, to a maximum of $2,000/calendar year for each person. This $2,000 annual limit does not apply to pediatric dental care (for children under age 19).

	You Pay
Annual deductible	$25 per person
Preventive services	10%
Basic/restorative services	40%
Major services	50%
Annual benefit maximum	$2,000

If you see a dentist in the Regence network, you will be responsible for the percentage (shown above) of the negotiated discount fee for that service (up to the annual benefit maximum). If you see a non-Regence dentist, you'll have to pay the difference between the Regence discounted amount and the amount the non-Regence dentist charges.

How to Find a Participating Dentist

- Go to Regence.com and select "Find a doctor."
- You will have the option to sign into your Regence account, register for a new account, or search as a guest.
- Select the green button "Choose a network." In the "Network name" Search bar, type in Regence Dental Network and Confirm selection.
- To search for dentists, select "Doctors by specialty" and type "dentistry" in the search box. A list of in-network providers will be displayed on the screen. You can refine your search by distance, specialty, whether or not they're accepting new patients, and more.

- To search for a specific dentist, select “Doctors by name.” Type in the dentist’s name and press “enter.” If the name appears, select it. A list of in-network locations will display on the right. If the name does not appear, the provider is not in-network (based on the information entered).

Or call Regence Customer Service at (888) 370-6164 for assistance finding a Participating Provider or to confirm whether your provider is in network.

Dental Exclusions

In addition to the General Exclusions on page 43, no dental benefits will be provided for:

- Expenses for treatment by anyone other than a licensed Dentist (except fluoride treatment and cleaning or scaling of teeth by a licensed dental hygienist if supervised and under the direction of a licensed Dentist and services by a licensed Denturist practicing within the scope of his/her license).
- Orthodontic treatment or correction of occlusion, unless specifically listed in the Schedule of Dental Allowances.
- Prosthetic devices (including bridges and crowns) and their fitting if:
  - Ordered while you are not covered under this Plan.
  - Ordered while you are not covered under the Plan but installed or delivered more than 30 days after coverage ends.
- Replacement of a lost or stolen prosthetic device.
- Replacement of or addition to any denture, partial, or fixed bridgework unless Regence BCBSO receives proof that:
  - Replacement or addition of teeth is required to replace one or more additional natural teeth.
  - Existing denture, partial, or fixed bridgework was installed at least 60 months before it was replaced and cannot be salvaged.
  - Existing denture is an immediate temporary, and replacement by a permanent denture is required and takes place within 12 months from the date the immediate temporary was installed.
- Services or supplies covered under medical benefits, whether benefits are payable in whole or in part.

Willamette Dental Benefits

If you live within Willamette Dental’s coverage area, you may choose dental coverage through this program. The Willamette prepaid dental plan offers a network of dental providers. Similar to an HMO, you must select a Willamette Dental Group dentist for dental services and receive all services through this group.

To find out more about Willamette Dental coverage, including service area details, call the Fund Office.

Willamette offers a separate document to detail benefits which you may request from the Fund Office during open enrollment.

VISION BENEFITS

The Plan uses a provider network through Vision Service Plan (VSP). You will pay less if you use a provider in the VSP network. Visit regence.com/go/VSP Network or call 844-299-3041 for a list of VSP network providers.

The Plan pays for covered vision care expenses up to the maximums described in the following table.

What's Covered

	In-Network	Out-of-Network
Routine vision exam	Covered (1 per calendar year)	Covered up to $45 (1 per calendar year)
Contact lens evaluation and fitting	$60 copayment (1 per calendar year)	Included with contact lenses below
Lenses	Covered (1 pair per calendar year for glass or plastic single vision, lined bifocal, lined trifocal, lenticular, standard progressive)	Covered up to: $30 for single vision $50 for lined bifocal/standard progressive $65 for lined trifocal $100 for lenticular
Frames	Covered up to: $150 from VSP doctors $80 from VSP-approved wholesale/retail vendors (1 per calendar year)	Covered up to $70 (1 per calendar year)
Contact lenses*	Covered (1 per calendar year)	Covered up to $105 if elective or $210 if necessary (includes fitting/evaluation) (1 per calendar year)
Low vision supplemental testing**	Covered	Covered up to $125
Low vision supplemental aids**	You pay 25% coinsurance	You pay 25% coinsurance
*Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames and/or lenses until the next calendar year. | **Supplemental testing and supplemental aids limited to combined maximum of $1,000 once every 2 calendar years).		

Vision Exclusions

In addition to the General Exclusions on page 43, no vision benefits will be provided for:

- Medical or surgical treatment of the eyes, including services or supplies covered under the medical benefits of this Plan.
- Plain or prescription sunglasses or other special-purpose vision aids.
- Special procedures such as orthoptics and vision training.

COORDINATION OF BENEFITS

If you or your dependents have medical, hearing, dental, vision, or other health coverage in addition to coverage provided by the Trust, the Plan contains non-duplication provisions to coordinate the health coverage benefits of this Plan with other plans. The intent is that benefits from all plans will not exceed 100% of total allowable expenses.

The Kaiser medical plan and the Willamette Dental plan each have separate policies on coordination of benefit rules. Please contact those plans directly for details.

An allowable expense is any necessary, reasonable, and customary charge covered, even in part, under at least one of the plans covering the person who files a claim. The difference in cost between a private and semiprivate room will be an allowable expense only when medically necessary. If a plan provides benefits in the form of a service (such as an HMO) rather than a cash payment, the reasonable cash value of each service received will be considered both an allowable expense and a benefit paid.

A plan for purposes of this section means any of the following that provides benefits or services for, or because of, medical, hearing, dental, or vision care or treatment:

- Group health plan.
- Group, blanket, or franchise insurance.
- Service plan contracts, group practice, individual practice, and other group prepayment coverage.
- Labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- No fault insurance.
- Any coverage under governmental programs and any coverage required by any statute which provide benefits or services for hospital, medical, dental, and vision care or treatment.
- Individual health insurance and EPO/HMO coverage.

When a claim is made, the *primary plan* pays its benefits first and without regard to any other plans. The *secondary plans* pay benefits next and adjust their benefits so the total available benefit will not exceed allowable expenses. No plan pays more than it would without the coordination provision.

When this Plan is primary, it pays benefits first without consideration of the other plan. After you or your dependent receives payment from this Plan, you may submit a claim to a secondary plan and possibly receive additional reimbursement.

When this Plan is secondary and its payment is reduced to consider the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year to the extent any allowable expenses would not otherwise be fully paid by this Plan and the primary plan.

Order of Benefit Determination

Following is a brief description of the methods used to determine which plan is primary:

- A plan covering the individual as an active employee is primary over a plan covering the individual as a laid-off or retired employee.
- A plan covering the individual as a dependent of an active employee is primary over a plan covering the individual as a dependent of a laid-off or retired employee.
- For children, the plan of the parent whose birthday comes first in the calendar year is primary. However, if the other plan does not have this rule, but instead has a rule based on the parent's gender, the rule in the other plan will determine the order of benefits
- For children of divorced spouses or domestic partners, benefit payments are made by the plans in the following order:
  - Parent with court-ordered responsibility to provide primary group insurance coverage.
  - Parent with legal custody.
  - Stepparent with legal custody.
  - Parent without legal custody.
- A plan covering the individual as an active, retired, or laid-off person is primary over a plan covering the individual as a COBRA self-pay participant (except as required by law).

If two plans are primary under these rules, the plan that has covered the individual the longest is considered the primary plan.

Medicare

For active employees and their dependents, the benefits payable under this Plan will normally be primary and Medicare will be secondary. However, active employees have the option of electing Medicare as primary coverage. If an employee or dependent spouse of age 65 or older makes such an election, the Plan will pay no further medical benefits.

For retired members and their dependents, Medicare benefits will always be primary, and this Plan will be secondary.

An exception to these rules is Medicare coverage for a person with end stage renal disease (ESRD). A participant with end stage renal disease (ESRD) is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the participant's ESRD treatment, as long as the participant continues to be enrolled under Medicare Part B and continues to be eligible for coverage under this Plan (proof of payment of the Medicare Part B premium will be required prior to reimbursement). The case manager at Regence will talk with you regarding what you need to do to have these expenses reimbursed, but it is very important that you sign up for Medicare Part B as soon as you are eligible.

Third-Party Liability

In the event you are injured as the result of the act of a third party and the Trust believes you have a claim against such third party for recovery of medical expense or economic or punitive damages for such injury, the Plan may cease reimbursement for your medical expenses arising from such injury at any time in its discretion if you or your legal representative fail to execute such agreements as the Trust requires providing that any recoveries from such third person shall be first applied to reimburse the Trust for any costs and expenses incurred by the Trust in the provision of benefits under the Plan as a consequence of such injury.

If you receive benefit payments from the Plan for such an injury, and you make a liability claim against such third party, as a condition to acceptance of such benefit payments you agree that Plan benefits must be included in the claim and when the claim is settled, arbitrated, or adjudicated and you receive a recovery, the Trust must be reimbursed for the benefits provided to the extent of the recovery. This Plan requirement is further detailed in this section.

If Plan payments are made for any treatment, service, or loss of income because of injury to, or sickness of, an eligible individual with a lawful claim, demand, or right against a third party (including an insurer) for indemnification, damages, or other payment, the following will apply:

- The Plan has the right to recover the extent of payments it made.
- Before receiving benefits, the eligible individual must sign and/or submit documents the Trust reasonably requires to enforce this right.

Any individual who receives payment from the liable third party will reimburse the Trust from that payment (but not in excess of the amount received) for all Plan payments made for treatment, service, or loss of income because of the same injury or sickness.

EMPLOYEE LIFE INSURANCE BENEFITS

Amount of Coverage

If you die while covered under this Plan, LifeMap Assurance Company will pay the life insurance benefit of $20,000 when proof of death is received. This life insurance benefit will be paid to your beneficiary in a lump sum.

Designating a Beneficiary

Be sure to file a written designation of the person or persons who will receive your life insurance benefit with the Fund Office. Keep this designation up to date so the benefit will be paid according to your wishes. Permanent Record Cards for your beneficiary designation are available from the Fund Office. A beneficiary change is not effective until the Fund Office receives notice.

If you designate your spouse or domestic partner as your beneficiary and later divorce, the designation is automatically cancelled on the effective date of the divorce. If you designate your domestic partner as your beneficiary and later terminate that relationship, the designation is automatically cancelled on the effective date of the termination. The effective date of termination is defined as the date when the termination documents are filed with the county, city, or employer registry. You will need to complete a new Permanent Record Card designating your new beneficiary, who may be your former spouse, former domestic partner, or anyone else. The automatic cancellation is not exercised to the extent that a binding legal order specifically names your former spouse or domestic partner as your beneficiary or prohibits you from changing your beneficiary.

If you have not named a beneficiary (or have not filed a new beneficiary designation following divorce or termination of domestic partnership) or if your named beneficiary does not survive you, the life insurance benefit will be paid in the following order:

- Spouse or domestic partner.
- Child, or children, equally.
- Grandchild, or grandchildren, equally.
- Parent, or parents, equally.
- Sibling, or siblings, equally.
- Your estate.

Converting Your Coverage

If your group life insurance ends due to termination of eligibility, you may convert to any individual life insurance policy issued by Regence Life and Health (except term insurance) – less any amount of in-force life insurance previously converted – without proof of good health. You must apply and pay the required premium within 31 days after termination of eligibility. The premium will be determined by your age and class of risk.

The conversion amount is limited to the smaller of $10,000 or the amount of your life insurance terminated under this Plan (less any life insurance for which you're eligible under a group policy issued by Regence Life and Health or another insurer within 31 days after the termination).

If you die within the 31-day conversion period, Regence Life and Health will pay your beneficiary the amount of insurance you were entitled to convert — whether or not you requested a conversion policy.

If You Become Totally Disabled

If you become totally disabled before age 60, your life insurance will continue without you paying premiums – as long as you remain disabled, but not beyond your 65th birthday – if you furnish proof of disability at least every 12 months.

For this purpose, totally disabled means you're unable to work at any occupation for which you are qualified (or become qualified) by education, training, or experience and you are not engaged in any occupation for wage or profit because of a disability that:

- Is caused by injury or illness.
- Started while you are insured under this Plan.
- Existed continuously for at least six months.

If you believe you qualify for this free life insurance (waiver of premium), you can apply by submitting your first proof of disability within 12 months after termination of your coverage or the date your total disability began, whichever is later. Forms are available from the Fund Office.

Regence Life and Health will pay you $300/month, up to a maximum of $20,000, starting after six months of disability and after proof of disability is received if all the following apply:

- You become permanently and totally disabled before age 60.
- The disability is a direct result of bodily injury caused completely by external, violent, and accidental means.
- You cannot work for wage or profit.
- The disability occurs within 30 days after the accident.

Each payment under this disability provision reduces your total remaining life insurance amount. If you die during this period of disability, any unpaid balance of your life insurance will be paid to your beneficiary.

Regence Life and Health may require proof of your continued disability and may require an examination at any time. After your insurance has been in force under the disability provision for two years, these exams cannot be made more often than once in any 12 months.

If you recover from your total disability and are not eligible for employee coverage under this Plan, you may convert any balance of your remaining life insurance to an individual policy as described in this section.

DEPENDENT LIFE INSURANCE BENEFITS

Amount of Coverage

If your dependent dies while covered under this Plan, LifeMap Assurance Company will pay the following dependent life insurance benefits:

Loss	Amount
Spouse or Domestic Partner	$5,000
Each Child	$1,000

Proof of death of your spouse, domestic partner, and/or dependent child is required. In addition:

- The child must be an eligible dependent (see page 6) who depends on you for at least half of his or her support.
- Your spouse, domestic partner, or dependent child must not be an eligible employee under this Plan.

If both parents are eligible employees under this Plan, the children will be considered dependents of the parent who has been eligible under this Plan the longest.

Payment is made to you, if living, or otherwise as provided in the insurance policy between the Trust and Regence Life and Health.

Continuation of Coverage

Your dependent's life insurance will continue while you're totally disabled and entitled to waiver of premium (as described beginning on page 37) for your own life insurance benefits under this Plan.

If you're no longer eligible for waiver of premium and become eligible for coverage under this Plan, your dependents' insurance will continue only if premiums are paid.

If you're no longer eligible for waiver of premium and are then not eligible for insurance under this Plan, or if you die while covered under the waiver of premium provision, your dependent insurance will be cancelled immediately. The conversion privilege described in the following section will be available to your dependents during the first 31 days after cancellation of your insurance.

Converting Dependent Coverage

Your dependents may convert their group life insurance if coverage ends because of any of the following:

- You're no longer eligible for Plan benefits.
- The Plan is terminated or amended.
- You die and your surviving dependents would lose coverage.
- A dependent ceases to be qualified as a dependent.

You must apply for conversion and pay the first month's premium within the 31-day conversion period immediately after the group life benefit is discontinued.

The conversion amount is limited to the dependent's amount of life insurance in this Plan, less any life insurance they become eligible for under any group policy Regence Life and Health (or any other company) issues or reinstates within 31 days after coverage ends.

Conversion policies become effective on the first day after the 31-day conversion period. If your dependent dies within the 31-day conversion period, Regence Life and Health will pay the amount that would have been allowed under conversion, whether or not a conversion policy was requested.

EMPLOYEE AD&D BENEFITS

Amount of Coverage

LifeMap Assurance Company will pay the following accidental death and dismemberment (AD&D) benefit amounts if you suffer any of the following losses due to accidental injury.

Loss	Amount
Life	$20, 000
1 hand and 1 foot	$20,000
1 hand and sight of 1 eye	$20,000
1 foot and sight of 1 eye	$20,000
Use of both arms and both legs (quadriplegia)	$20,000
Both hands	$20,000
Both feet	$20,000
Sight of both eyes	$20,000
1 hand	$10,000
1 foot	$10,000
Sight of 1 eye	$10,000
Use of both legs (paraplegia)	$10,000
Use of 1 side of the body (hemiplegia)	$10,000

Payment will not exceed the principal sum ($20,000) for all losses due to the same accident.

Loss of a hand or foot means actual severance at or above the wrist or ankle joint. *Loss of sight* means the loss is total and can't be recovered. *Loss of the use of both arms and legs* means total and permanent quadriplegia. *Loss of the use of both legs* means total and permanent paraplegia. *Loss of the use of one side of the body* means total and permanent hemiplegia.

Conditions

Payment will be made only if all of the following apply – your injury or death:

- Happened while you were covered under this Plan.
- Occurred not more than 365 days after the accident.
- Was the direct result of an external and accidental cause.
- Was independent of any other cause.

Any amount payable for your loss of life will be paid according to the beneficiary provision described on page 36. Amounts payable for other losses will be paid directly to you.

AD&D insurance may not be converted to an individual policy.

AD&D Exclusions

In addition to the General Exclusions on page 43, these AD&D benefits will not be paid for any loss that results directly or indirectly from:

- Bodily or mental infirmity or disease, sunstroke, food poisoning, or bacterial infection (other than infections due to bodily injury).
- Participation in an assault or felony.
- Service in the military forces of any country.
- Suicide, attempted suicide, or intentionally self-inflicted injury.
- Taking part in a riot.
- Voluntary use of any poison, chemical compound, or drug (except as prescribed by a physician).
- War or any act of war, declared or undeclared.

EMPLOYEE ACCIDENT AND SICKNESS BENEFITS

This benefit is designed to help protect you from loss of income if you're unable to work due to an accident or sickness.

Benefit

The Plan will pay you a weekly benefit of $162.43 ($150 net after FICA tax) if all of the following apply:

- You are covered when you become disabled.
- You cannot do the major duties of your occupation because of an injury or illness.
- You are under the direct care of a physician.

Benefits begin the 1st day of disability for accidents and the 8th day of disability for sickness or pregnancy – up to 26 weeks for each disability period.

To comply with federal law, FICA taxes will be withheld from your benefit (making the net weekly benefit rate $150). For your records, the FICA tax will appear on a W-2 issued by the Trust at year-end.

If multiple disability periods are due to the same or related cause, not separated by either your return to active work or your availability to work for two weeks, the Plan will consider it one disability period.

Accident and Sickness Exclusions

In addition to the General Exclusions on page 43, the Plan will not pay for any disability period caused by:

- Accidental bodily injury that occurs when at work for wage or profit.
- Military service for any country.
- Sickness for which you're entitled to benefits under any workers' compensation or occupational disease law.

Termination of Benefits

Benefits will terminate immediately if any of the following events occur:

- Return to work or being released by the attending physician as able to return to work.
- Placement on an out-of-work list.
- Termination of eligibility.
- Entering into any type of work for profit, whether or not it is bargaining unit work.
- Expiration of the maximum benefit period of 26 weeks.
- Certification by the attending physician or the Plan's medical consultant that the individual is no longer unable to work.

GENERAL EXCLUSIONS

These exclusions apply to medical, mail order pharmacy, hearing, dental, vision, and accident and sickness benefits. No benefits are paid for:

- Any bodily injury or sickness for which you and your eligible dependents are not under the care of a provider who is recognized by the Plan as an eligible provider.
- Occupational injuries or sicknesses.
- Conditions caused by or arising out of an act of war, armed invasion, or aggression.
- Any supplies or services:
  - For which no charge is made.
  - For which you and your eligible dependents are not required to pay in the absence of this Plan.
  - Furnished by a hospital or facility owned or operated by the United States Government or any State Government or any authorized agencies thereof or furnished at the expense of such Governments or agencies except as required by federal law.
  - Which are provided without cost by any municipal, county, or other political subdivision.
  - Which are provided as part of court ordered care (not applicable to benefits received under a Qualified Medical Child Support Order).
- Injuries or sickness for which payment has been made by a third party.
- Services received by you or your eligible dependents which are performed by the spouse, domestic partner, child, brother, sister, or parent of the eligible participant.
- Any service or procedures which are Experimental or are not within the standards of general accepted medical or dental practice.
- Care or treatment in any penal institution or jail facility or jail ward of any State or political subdivision.
- Care or treatment performed by a provider not specifically covered under the Plan, regardless of whether or not the provider is licensed to perform such treatment.
- Services or supplies in connection with the treatment of infertility including, but not limited to, artificial insemination, in vitro fertilization, reversal of sterilization, and hormone therapy; with the exception of services and supplies for the diagnosis of infertility.
- Charges for medical services and supplies for surrogate mothers, except that if the surrogate mother is an eligible participant, medical expenses otherwise covered by the Plan which are incurred with respect to a pregnancy will be covered in accordance with the terms of the Plan, unless the eligible participant is receiving remuneration for surrogate motherhood, is covered by another group medical plan, or unless her medical expenses for pregnancy are being paid by another individual or entity.
- Any surgical procedure or any other treatment, service, or supply in connection with weight reduction, gain, or control regardless of whether or not a diagnosis of morbid obesity exists.

- Any surgical procedure or other treatment for complications of a procedure with is excluded under the Plan.
- Services, supplies, or treatments which are not medically necessary.
- Any charges that are in excess of allowable charges or are in excess of a specific Plan limit on allowable charges.
- Alopecia (loss of hair).
- Custodial care.
- Any services furnished by an institution which is primarily a place of rest, a place for the aged, a nursing or convalescent home or any institution of like character, or in a sanitarium, unless otherwise specifically provided herein.
- Health club memberships and the purchase and/or rental of exercise and health equipment, even if activities were recommended by a physician (such as exercise, swimming, massage, etc.).
- Recreational therapy, education therapy, or forms of nonmedical self-care or self-help training, and any related diagnostic testing.
- Services rendered through the internet, fax, telephone, video, or by any other electronic means.
- Care or treatment of injuries resulting from an eligible participant's commission of, or attempt to commit, an assault or felony.

DEFINITIONS

Accident, accidental bodily injury, and injury mean an unexpected incident that happens without the intent of injury and involves some external force, element, or object.

Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other life-threatening condition that is a study or investigation:

- Approved or funded by one or more of:
  - The National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid, or a cooperative group or center of any of those entities or of the Department of Defense (DOD), or the Department of Veteran's Affairs (VA)
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants, or
  - The VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review, or
- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

For the purpose of approved clinical trials, the following definitions apply:

Life-threatening condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine patient costs include items and services that typically are covered services for a claimant not enrolled in a clinical trial, but do not include:

- An investigational item, device, or service that is the subject of the approved clinical trial unless it would be covered for that indication absent a clinical trial
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the claimant
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis, or
- Services, supplies or accommodations for direct complications or consequences of the approved clinical trial.

Chemical Dependency is an addiction to any drug or alcohol that interferes with the individual's social, psychological, or physical adjustment to common daily problems. This dependency may be physical or psychological or both. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods. (See smoking cessation benefits under the Covered Benefits section starting on page 17.)

COBRA means the Consolidated Omnibus Budget Reconciliation Act.

Cosmetic Surgery means surgery or medical treatment to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structure of any feature of the human body, performed primarily for psychological purposes or not correcting or materially improving a bodily function. Cosmetic surgery is not a covered expense.

Reconstructive breast surgery performed in connection with a mastectomy is not considered cosmetic surgery.

Custodial Care means care that helps you or your eligible dependent conduct activities of daily living and can be provided by people without medical or paramedical skills, such as assistance in bathing, eating, dressing, or getting into or out of bed.

Custodial care also includes care primarily to separate patients from others or prevent patients from harming themselves.

Day or Partial Hospitalization Program is an organized full-day or part-day program of treatment for chemical dependency or mental illness provided by a facility approved by the Oregon Mental Health Division (or equivalent agency if services are received outside Oregon) or the Office of Alcohol and Drug Abuse Programs.

Dentist means an individual licensed to practice dentistry (DDS or DMD) in the State in which he/she renders treatment.

Denturist means an individual certified under state law to:

- Construct, repair, reline, reproduce, duplicate, supply, fit, or alter any denture for which a service in the following bullet is performed.
- The taking of impressions, bite registrations, try-ins, and insertions of or in the mouth for any purpose listed in the preceding bullet.

Durable Medical Equipment means equipment that:

- Can withstand repeated use.
- Is primarily and customarily used to serve a medical purpose.
- Is generally not useful to a person in the absence of injury or sickness.
- Is appropriate for use in the home.

Emergency means a sudden unexpected onset of a medical condition, not normally treatable in the provider's office, that manifests itself by acute symptoms of enough severity that urgent and immediate medical attention is required without regard to the hour of day or night to prevent significant impairment in bodily functions or serious and/or permanent damage to any bodily organ or part.

EPO means an "exclusive provider organization" that contracts with the Trust to provide most medical services for a flat fee to the Trust, and which is a medical care option under the Plan.

Extended Care Facility means an institution which is primarily engaged in providing patients with:

- Skilled nursing care and related services for patients who require medical or nursing care; or
- Rehabilitative services for the rehabilitation of injured, disabled or sick persons; and which meets all of the following requirements:

- It is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a Physician or a Registered Nurse.
- It has available at all times the services of a Physician who is a staff member of a Hospital.
- It has on duty 24 hours a day a Registered Nurse, licensed vocational nurse (LVN), or skilled practical nurse, and it has a Registered Nurse on duty at least eight hours per day.
- It maintains a clinical record for each patient.
- It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution.
- It complies with all licensing and other legal requirements and is recognized as an "Extended Care Facility" by the Secretary of Health and Human Services of the United States pursuant to Title XVII of the Social Security Amendments Act of 1965, as amended.

Health Care Facility means a hospital or other facility accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities that provides full-day or part-day acute chemical dependency or mental illness treatment and is licensed to admit patients who require 24-hour skilled nursing care.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

HMO means a "health maintenance organization" that contracts with the Trust to provide most medical services for a flat fee to the Trust, and which is a medical care option under the Plan.

Homebound means the patient's condition is such that leaving home could be harmful, involving a considerable and taxing effort, and the patient is unable to use transportation without assistance.

Home Health Aide means an employee of an approved hospice or home health care agency who provides intermittent care under the supervision of a registered nurse, physical therapist, or speech therapist.

Hospice means a facility, agency, or service that has all of these characteristics:

- Is licensed, accredited, or approved by the proper regulatory authority to establish and manage hospice care programs.
- Arranges, coordinates, and/or provides hospice care services for dying individuals and their families.
- Maintains records of hospice care services provided and bills for such services on a consolidated basis.

Hospice Treatment Plan means a written plan of care established and periodically reviewed by the patient's attending physician. The physician must certify in the plan that the patient is terminally ill and describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.

Hospital means an institution that provides diagnostic and treatment facilities for inpatient surgical and medical care of injured or ill persons. It must be licensed under applicable laws as a general hospital. Its services must be under the supervision of a staff of physicians and must include 24-hour nursing service by registered nurses. The following facilities are not considered hospitals:

- Facilities operated as a rest, old age, or convalescent homes.

- Facilities for the care and treatment of drug addicts or alcoholics.
- Facilities devoted to care of the aged or engaged in educating its patients.
- Facilities operated by agencies of the federal government.

Medically Necessary means services and supplies required for diagnosis or treatment of sickness or injury that are determined by the Trust (by the exercise of the exclusive and complete discretion of the Board or its delegate) to be:

- Consistent with the symptoms or diagnosis and treatment of the covered person's condition.
- Appropriate under standards of good medical practice.
- Not primarily for the convenience of the covered person or provider.
- The least costly of alternative supplies or levels of service that can be safely provided to the covered person. For example, care in a hospital inpatient setting or by a nurse in the patient's home is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility, without harm to the patient.
- The fact that a physician prescribes, orders, recommends, or approves a service or supply does not, in and of itself, make the service or supply "medically necessary."
- Medicare means the program established under Title XVII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.
- Palliative Care means care primarily for the relief or control of symptoms, not for cure.
- Physician means a doctor operating within the scope of his or her license as a medical doctor (MD), naturopathic doctor (ND), osteopath (DO), podiatrist (DPM), doctor of dentistry (DDS or DMD), chiropractor (DC), optometrist (OD), dispensing optician, psychologist (PhD), registered nurse (RN), or certified nurse practitioner.
- This Plan covers services by a licensed clinical social worker if services are recommended by a medical doctor or psychologist.
- If a DDS or DMD performs a surgical procedure within the scope of his/her license and the surgery would be payable under this Plan if an MD performed the procedure, then the surgery will be considered a covered expense.

This Plan also covers services by a physician's assistant (PA) providing services under the direction of an MD and for services by a surgical assistant (SA) if charges are billed by an MD, DO, or RN. Services must be rendered within the scope of the PA or SA license.

This Plan covers services by an RN or licensed practical nurse if the services have written referral of an MD, ND, or DO. This includes only services for which nurses customarily bill patients.

Preferred Provider means a hospital, physician, or other provider who has an effective PPO contract with Regence BlueCross BlueShield of Oregon.

Reasonable and Customary, as used herein, means:

- For non-PPO providers: the usual charge made by a physician, hospital, extended care facility, dentist or other health care professional, or firm having rendered or furnished services, treatments, or supplies for bodily injuries and sicknesses which do not exceed the general level of charges made by others rendering or furnishing such services, treatments, or supplies on persons

of the same sex, age, and income, within the area in which the charge is incurred for bodily injuries or illnesses comparable in severity and nature to the bodily injuries or illnesses treated or being treated.

- For PPO providers: the applicable PPO contracted fee for the service, treatment, or supply within the area in which the charge is incurred.
  - The term "area," as it would apply to any particular item for which an allowable charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross section of entities furnishing such items.
  - A charge is considered to have been incurred on the date on which the service or supply for which the charge is made is rendered or obtained.

Registered Nurse means a registered graduate nurse who is licensed as a registered nurse by the state where services are rendered.

Residential Facility means a facility approved by the Oregon Mental Health Division (or equivalent agency if services are received outside Oregon) or the Office of Alcohol and Drug Abuse Programs that provides an organized full-day or part-day program of treatment for chemical dependency or mental illness, but is not licensed to admit patients who require 24-hour skilled nursing care.

Respite Care means care to relieve persons residing with and caring for the patient.

Sickness and Illness mean a deviation from the healthy and normal condition of any body function or tissue, whether it has a known or unknown cause.

Terminally Ill means the patient's condition has reached a point where recovery can no longer be expected, and death is imminent.

HOW TO FILE A CLAIM

Trust Medical, Hearing, Dental, and Vision Benefits

(Kaiser EPO and Willamette Dental plans have separate claims processes.)

To receive prompt payment for your claims, follow this procedure:

1. Obtain a claim form from the Fund Office or Regence BCBSO.
2. Complete and sign your portion of the form.
3. Give the form to your doctor or other provider who will complete the physician or supplier information.
4. Attach the itemized bill or statement for services.
5. If you want to assign your benefits to your provider so the Trust will pay your provider directly, sign line 13 of the claim form.
6. Your claim and all bills must be submitted to Regence BCBSO within one year following the date expenses are incurred.
7. Send your claim to:

   Regence BlueCross BlueShield of Oregon
   P.O. Box 1106
   Lewiston, ID 83501
   (888) 370-6164

Health Care Claims and Appeals Deadlines Suspended During the Coronavirus Crisis

During the coronavirus outbreak period, claims and appeals deadlines for benefit claims, appeals of adverse determinations, and requests for external reviews of decisions are paused. This means that claims are not required to be filed until the end of the outbreak period.

The outbreak period is defined as beginning March 1, 2020 and ending 60 days after the national emergency period ends (whenever that might be). You will receive notification when the outbreak period ends.

If you use a preferred provider, your provider will send the claim directly to Regence BCBSO and you won't need to file a claim.

If you have questions about *eligibility*, please contact:

William C. Earhart Company, Inc.
P.O. Box 4148
12029 N.E. Glenn Widing Drive
Portland, OR 97208
(503) 460-5245
(877) 396-5845
Or go online to www.wcearhart.com to check your eligibility.

If you have questions about claims, please contact:

Regence BlueCross BlueShield of Oregon
P.O. Box 1106
Lewiston, ID 83501
(888) 370-6164

Prescription Drug Card Benefits

To use a Kroger Prescription Plan network pharmacy:

- Present your medical I.D. card to the pharmacy.
- Pay the discounted cost of the prescription.

To use a pharmacy that is not part of the Kroger Prescription Plan network:

- Pay the full cost of the prescription.
- Submit your claim to Kroger on a Direct Member Reimbursement form available on www.KPP-Rx.com or by calling Kroger at (800) 482-1285. The completed form and the prescription receipt should be mailed to the address on the form.

Mail Order Pharmacy Benefits

To use the mail order pharmacy program:

- Obtain a Prescription Order Form from the Fund Office.
- Complete the form and enclose the prescription(s) written by your physician with your check for the copayment for each prescription or refill.
- Mail all of the above items to the address on the form.

Accident and Sickness Benefits

To receive prompt payment for your claim, please follow this procedure:

1. Obtain a claim form from the Fund Office.
2. Complete and sign your portion of the form.
3. Give the form to your doctor who will complete the physician information.
4. Your claim must be submitted to the Fund Office within one year following the date of disability.
5. Send your claim to:

   William C. Earhart Company, Inc.
   P.O. Box 4148
   12029 N.E. Glenn Widing Drive
   Portland, OR 97208
   (503) 460-5245
   (877) 396-5845

Life Insurance and AD&D Benefits

Contact the Fund Office for assistance.

William C. Earhart Company, Inc.
P.O. Box 4148
12029 N.E. Glenn Widing Drive
Portland, OR 97208
(503) 460-5245
(877) 396-5845

CLAIMS PROCESSING

Claims which are properly filed (as described beginning on page 50) will be processed according to the following guidelines.

Medical, Hearing, Dental, and Vision Claims

Post-Service Claims

Any properly filed claim for benefits that is not an urgent care, pre-service, or concurrent care claim (as described in the Concurrent Care Claims bullet below) will be processed as a post-service claim. If additional information is needed, you or your dependent will be notified and given 45 days from receipt of the notice to provide the additional required information. The time period for making a benefit determination will not run from the date the request for additional information is sent until the date the requested information is received or until 45 days have passed from the mailing of the information, whichever is earlier.

A post-service claim will ordinarily be processed within 30 days of receipt. This may be extended by an additional 15 days if a notice giving the reason an extension is necessary, including a statement of unresolved issues and any information required to resolve those issues, is provided within the initial 30-day period.

Pre-Service Claims

The following procedures apply only to the processing of treatment plans submitted for a predetermination of benefits.

You or your dependent will be notified within five days if additional information is required to complete a pre-service claim or to allow processing and will be advised of the specific information required. You or your dependent will be provided 45 days from the receipt of the notice to submit any additional information requested. The time period for making a determination will not run from the date the information is requested but from the date the information is received or until 45 days have passed from the mailing of the request, whichever is earlier.

A decision on a pre-service claim will ordinarily be made within 15 days. If more time is necessary, this time may be extended for an additional 15 days if the Trust provides notice to you or your dependent giving the reason an extension is necessary, including a statement of unresolved issues and any information required to resolve those issues, prior to the expiration of the initial 15-day period.

If services which require predetermination have been provided and the issue is what payment (if any) will be made, the claim will be processed as a post-service claim.

Urgent Care Claims

Urgent care claims are for services where the application of the normal time frames for appeals could seriously jeopardize the health of you or your dependent or expose you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally or in writing, by you or your dependent or health care provider with knowledge of you or your dependent's condition. You or your dependent will be informed within 24 hours

if additional information is needed to process the claim and will be advised of the specific information required. The claim will be resolved no later than 48 hours after the date the Fund Office receives the additional information or after the end of the 48-hour period given to you or your dependent to provide the additional information. Determinations regarding whether a claim is urgent will be made by applying the judgment of a prudent layperson with average knowledge of health care.

If services which constitute urgent care have been provided and the issue is what payment (if any) will be made, the claim will be processed as a post-service claim.

Concurrent Care Claims

Concurrent care claims are ongoing claims that have received approval from the Trust. While the approved treatment is continuing, the provider may request additional or extended treatment that may result in a denial or reduction of the treatment plan. You or your dependent will be notified of any reduction or termination of a previously approved course of treatment at least 30 days prior to the date of the reduction or termination to allow you or your dependent sufficient time to appeal and obtain a determination on the appeal before the decision is effective.

Any claim involving urgent care with a request to extend a course of treatment beyond the period of time or number of treatments previously approved will be decided as soon as reasonably practical. You or your dependent will be notified of the determination within 24 hours of the time the Trust receives the claim, if it is received at least 24 hours prior to the expiration of the previously approved period of time or number of treatments.

Any appeal of a decision involving a concurrent care claim will be treated as either a post-service, pre-service, or urgent care claim appeal, as appropriate under the circumstances.

Disability Claims

Disability claims are claims for medical benefits, COBRA self-pay continuation coverage, or Weekly Disability Benefits for which the written certification from a physician states the applicant is disabled as defined in the Plan but the Plan nevertheless issues a disability benefit denial. To ensure all disability claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making determinations, decisions covered by the authority of this Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to benefits will not be made based upon the likelihood that the individual will support the denial of benefits.

The written notification of the denial of a disability claim when the written certification from a Physician states the applicant is disabled as defined in the Plan but the Plan nevertheless issues a disability benefit denial will set forth, in a manner calculated to be understood by the applicant, the following:

- A discussion of the decision, including the basis for disagreeing with or not following a treating physician or vocation professional who evaluated the claimant, the views of medical or vocational experts obtained by the plan, and any disability determination by the Social Security Administration;
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

- Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;
- A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request;
- A statement that no legal actions may be commenced or maintained against the Plan and/or the Board of Trustees more than one year after a claim has been denied, and
- Notifications shall be provided in a culturally and linguistically appropriate manner in accordance with the requirements described in DOL Reg. §2560.503-1(0).

Accident and Sickness Claims

A properly filed claim for benefits will ordinarily be processed within 45 days of receipt. This may be extended by an additional 30 days if the Trust provides notice to you or your beneficiary giving the reason an extension is necessary prior to the expiration of the initial 45-day period. If the claim cannot be processed during this initial 30-day extension, you or your beneficiary will be notified in writing, prior to the expiration of the initial 30-day extension period, that a second extension of up to 30 days is necessary.

Life Insurance and AD&D Claims

A properly filed claim for benefits will ordinarily be processed within 90 days of receipt. This may be extended by an additional 90 days if the Trust provides notice to you or your beneficiary giving the reason an extension is necessary prior to the expiration of the initial 90-day period.

HOW TO FILE AN APPEAL

In the event your claim for benefits is denied, the Trust has adopted the following procedures to review benefit claim denials.

Appeal of Denied Benefits

You, your dependent, your beneficiary, or an authorized representative will have the following number of days from the date of denial to appeal the denial:

- 180 days for medical, hearing, dental, vision, and accident and sickness claims.
- 60 days for life insurance and AD&D claims.

An appeal must be submitted in writing. It must be submitted to the Fund Office. An appeal must identify the claim involved, set forth the reasons for the appeal, and provide any pertinent information. Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate) which identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

Health Care Claims and Appeals Deadlines Suspended During the Coronavirus Crisis

During the coronavirus outbreak period, claims and appeals deadlines for benefit claims, appeals of adverse determinations, and requests for external reviews of decisions are paused. This means that claims are not required to be filed until the end of the outbreak period.

The outbreak period is defined as beginning March 1, 2020 and ending 60 days after the national emergency period ends (whenever that might be). You will receive notification when the outbreak period ends.

Failure to file a claim appeal within the preceding timeframes listed will serve as a bar to any claim for benefits or for any form of relief from the Plan.

Appeal Procedures

The following procedures shall be the exclusive procedures available to an employee, dependent, or beneficiary who is dissatisfied with an eligibility determination, benefit denial, or partial benefit award by the Plan or its authorized claims payers. These procedures must be exhausted before a claimant may file suit under Section 502(a) of ERISA.

Information to Be Provided Upon Request

You, your dependent, your beneficiary, and/or an authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents shall include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures, or protocols concerning the denied claim, without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Trust that disclosure is appropriate, relevant documents do not include any other individual's claim records or information specific to the resolution of other individuals' claims.

If a denial is based on a determination as to medical necessity, an explanation of that determination and its application to the claimant's circumstances will also be available upon request.

Review by Board

Except for urgent care and pre-service claims, an appeal will be presented to the Board at its next scheduled meeting following receipt of the appeal, unless it is received within 30 days of the next scheduled meeting, in which case it may be heard at the second regular meeting following receipt of the appeal. The Board will review the administrative file, which will consist of all documents relevant to the claim. It will also review all additional information submitted by or on behalf of you or your dependent. The review will be de novo and without deference to the initial denial. If a decision is not provided to you within this time, the claim shall be deemed denied.

If the denial is based on a health care related judgment, the Board will consult with a health care professional with appropriate training and experience in the field involved. The Board may have an individual with a different licensure review the matter if that individual is trained to deal with the condition involved. The professional consulted will not be the individual who made the initial benefit determination nor the subordinate of that individual. The Board will identify by name any individuals consulted for health care advice.

You, your dependent, your beneficiary, or an authorized representative will be notified of the Board's decision as soon as reasonably practical, but not later than five days after the decision is made.

Contents of Decision

If the Board denies an appeal, you, your dependent, or your beneficiary will be notified of the specific reasons for the denial and the specific Plan provisions(s) including those set forth in this booklet, on which it is based and advised that all information relevant to the claim is available without charge upon request. If the Board relied on an internal rule, guideline, or protocol, its decision will identify the rule, guideline, or protocol involved and explain that a copy will be provided without charge upon request. If the Board decision was based on a health care judgment, its decision will explain that judgment, applying the terms of the Plan to the claimant's circumstances. In the case of an appeal denied by the Board, you, your dependent, or your beneficiary will also be notified of rights under Section 502(a) of ERISA.

Modifications to Appeal Procedures for Pre-Service and Urgent Care Claims

The appeal procedures will be modified by the Board's establishing an Appeals Subcommittee consisting of at least one management trustee and one labor trustee for appeals involving pre-service or urgent care claims, and these additional requirements shall apply:

- **Pre-Service Claims.** Pre-service claim appeals will be conducted in accordance with the preceding procedures with the following modifications:
  - The Appeals Subcommittee's decision will be made within 30 days of the date the appeal is received, unless the claimant agrees to a different schedule. You or your dependent will be notified of the Appeals Subcommittee's decision as soon as practical, but not later than five days after the decision is made.
  - Appeals involving pre-service claims will be reviewed by the Appeals Subcommittee at its next scheduled meeting, time permitting, or by telephone conference call if necessary. You, your dependent, or an authorized representative may participate, as authorized by the

Subcommittee, to the extent the Subcommittee deems necessary to develop an adequate record. If you or your dependent wishes to appear in person, you or your dependent may elect to waive the 30-day time limit and schedule a formal hearing for a later meeting of the Subcommittee.

- **Urgent Care Claims.** Appeals involving denial of urgent care claims will be subject to the rules set forth in the preceding section for pre-service claims with the following modifications:
  - An initial decision will be made within 72 hours if the initial claim was complete when submitted. If additional information is necessary to process the claim, the claim will be resolved no later than 48 hours after the earlier of the date the Fund Office receives the additional information or after the end of the 48-hour period given to you or your dependent to provide the additional information.
  - An appeal may be made orally or in writing.
  - A health care professional with knowledge of your or your dependent's condition may act as an authorized representative of you or your dependent without prior written authorization.
  - Information will be provided to you, your dependent, or authorized representative via telephone, facsimile, or other expedited method, provided that a written or electronic verification is furnished not more than 72 hours later.

Modifications to Appeal Procedures for Disability Claims

The appeal procedures will be modified by the Board's establishing an Appeals Subcommittee consisting of at least one management trustee and one labor trustee for appeals involving disability claims, which are claims in which the written certification from a physician states the applicant is disabled as defined in the Plan but the Plan nevertheless issues a disability benefit denial. For disability claims, these additional requirements shall apply:

- Before the Board of Trustees can issue an adverse benefit determination on review of a disability claim when the written certification from a physician states the claimant is disabled as defined by the Plan but the Plan nevertheless issues a disability benefit denial, based on a new or additional rationale, the Board of Trustees shall provide the claimant automatically and free of charge, with any new or additional evidence and/or additional rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence/rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of appeal is required to be provided) to give claimant a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the disability claim filing or disability claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
- If the appeal is denied, in addition to the items set forth in the Appeal Procedures above, the notice of denial will also include:
  - A discussion of the decision, including the basis for disagreeing with or not following the views presented by the claimant to the Plan of healthcare professionals treating the claimant and vocational professionals who evaluated the claimant; the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in

making the benefit determination; and any disability determination by the Social Security Administration.

  - If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

- If a decision on appeal is not provided within the applicable time periods set forth herein, administrative procedures will not be deemed to be exhausted if the Plan's violation was *de minimis* and did not cause, and is not likely to cause, prejudice or harm to the claimant (if the Plan demonstrates that the violation was for good cause or beyond the control of the Plan and the violation occurred in context of good faith exchange of information between the Plan and the claimant). If the Plan does not provide a written explanation within 10 days of a written request, the claim will be deemed denied.

Limitations on Bringing a Lawsuit (Civil Action)

You may not bring a lawsuit for benefits against the Fund until you have requested an appeal of your benefit denial and the Board has reached and issued a final decision on your appeal. Such civil action must be commenced within one year of the written notice of the final decision on your appeal, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

By participating in the Fund, to the fullest extent permitted by law, you waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy, and you agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

Recovery of Benefits Paid by Mistake

If the Fund Office makes a payment (for you or your eligible dependent) you're not entitled to, or if the Plan pays benefits for a person who isn't eligible for payments at all, the Plan has the right to recover the payment from the person paid or anyone else who benefits from it, including the provider. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits.

SPECIAL DISCLOSURES AND OTHER PLAN INFORMATION

Official Name
Oregon Laborers - Employers Health and Welfare Plan for Active Laborers and Associates II and A.

Plan Sponsor and Plan Administrator
Board of Trustees
Oregon Laborers - Employers Health and Welfare Trust Fund
12029 N.E. Glenn Widing Drive
Portland, OR 97232

OR

P.O. Box 4148
Portland, OR 97208
(503) 460-5245 or (877) 396-5845

Employer Identification Number (EIN)
93-6024141

Plan Identification Number
501

Type of Plan
The Plan is a health and welfare plan providing benefits for medical, mail order prescriptions, hearing, dental, vision, life, accidental death and dismemberment, and accident and sickness.

Type of Administration
The Plan is administered by the Board of Trustees, with the assistance of William C. Earhart Company, Inc., a contract administrative organization.

Plan Documents
This booklet — together with the benefit descriptions of Kaiser Foundation Health Plan of the Northwest and Willamette Dental Insurance, Inc. coverage — summarizes major Plan provisions. In the event of a conflict between the Plan documents and this summary, the Plan documents will control. The Trustees have the complete and exclusive discretionary authority to remedy any contradictions between this summary and any other documents governing the Plan.

Agent for Service of Legal Process
For disputes arising under the Plan, service of legal process may be made upon a Plan Trustee or the Plan Administrator at the Fund Office, 12029 N.E. Glenn Widing Drive, Portland, OR 97232.

Board of Trustees

Union Trustees	***Employer Trustees***
Jeffrey D. Gritz	Kelly Dixon
Zack Culver	James R. Watts
Ben Nelson	Bob Timmons

c/o Oregon Laborers-Employers
Health and Welfare Trust Fund

12029 N.E. Glenn Widing Drive
Portland, OR 97232

OR

P.O. Box 4148
Portland, OR 97208

Collective Bargaining Agreements
The Plan is maintained pursuant to a Trust Agreement dated September 1, 1979 and various collective bargaining agreements the Oregon and Southern Idaho District Council of Laborers and affiliated Local Unions and various employer associations and individual employers. Participants and beneficiaries may obtain a copy of the Trust agreement and collective bargaining agreements by writing to the Fund Office, where they are also available for examination by Plan participants and beneficiaries during normal business hours. A reasonable charge may apply for copies.

Contributing Employers and Labor Organizations
Participants may obtain a complete list of employers and employee organizations sponsoring the Plan by writing to the Fund Office or may examine the list at the Fund Office. Participants also may receive from the Fund Office, by written request, information on whether a particular employer or employee organization is a Plan sponsor, and if so, the sponsor's address.

Eligibility
The requirements for eligibility for benefits are set forth beginning on page 3 of this booklet and in Article II of the Plan.

Loss of Eligibility
The circumstances that may result in a loss of eligibility for benefits are set forth beginning on page 5 of this booklet and in Article II of the Plan.

Continuation Coverage
The rights and obligations of participants with respect to continuation coverage are set forth beginning on page 9 of this booklet and in Article II of the Plan.

Contributions
The cost of Plan benefits is paid out of the assets of the Oregon Laborers-Employers Health and Welfare Trust Fund, which is funded by contributions paid by your employer, as set forth in the collective bargaining agreements with the Oregon and Southern Idaho District Council of Laborers, affiliated Local Unions, and other entities related to the Fund. However, self-payment is permitted under COBRA and the retiree program.

Plan Funding

Medical, mail order pharmacy, hearing, dental, vision, and accident and sickness benefits are paid directly from the Trust's assets. Stop-loss coverage is provided through Sun Life Assurance Company of Canada, One Sun Life Executive Park, Wellesley Hills, MA 02481.

Kaiser coverage is insured by Kaiser Permanente, 500 NE Multnomah Street, Portland, OR 97232.

Willamette Dental coverage is insured by the Willamette Dental Insurance, Inc., 6950 NE Campus Way, Hillsboro, OR 97124.

Life insurance and accidental death and dismemberment benefits are insured by Regence Life and Health Insurance Company, LifeMap Assurance Company, P.O. Box 1271, M/S E8L, Portland, OR 97207-1271.

Plan Year

The Plan's fiscal records are kept on a Plan year basis, beginning each January 1 and ending on December 31.

Claims for Benefits

The Plan's procedures governing claims for benefits, applicable time limits, and remedies available under the Plan for the redress of claims which are denied in whole or in part are set forth beginning on page 50 of this booklet and in Article XII of the Plan.

Future of the Plan

The Trustees intend to continue this Plan indefinitely. However, in accordance with the Trust Agreement, the Trustees reserve the right to change benefits and contribution rates at any time, or to terminate the Plan if necessary.

If the Trust were to terminate at any time in the future, the Trustees would be obligated to use the remaining funds for the exclusive purpose of providing health and welfare benefits for eligible employees and dependents.

Disclosure of Grandfathered Health Plan Status

The information in this section is required by the federal Patient Protection and Affordable Care Act (the Affordable Care Act).

The Board of Trustees believes the Health and Welfare Plan is a grandfathered health plan under the Affordable Care Act.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means the Active Employee Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, a requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Office whose address and telephone number are listed on page i of this booklet. You may also

contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to a grandfathered health plan.

Prohibition on Canceling Coverage

The Patient Protection and Affordable Care Act (PPACA) prohibits group health plans from rescinding coverage of individuals once they are enrolled in the Plan, except in cases of intentional misrepresentation or fraud. In the event of such cases of misrepresentation or fraud, the Plan would not revoke coverage without prior notification. Retroactive cancellation is not a rescission if termination of coverage is for non-payment of premiums.

YOUR ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan administrator's office and other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts, the trust agreement, 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.
- Obtain, upon written request to the Plan administrator, copies of all Plan documents mentioned above and an updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Health Plan Coverage

- Continue health care coverage for yourself, spouse, domestic partner, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan to learn your COBRA self-pay continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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 a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator 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 administrator. If you have a claim for benefits which 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 U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Fund 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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

HIPAA PRIVACY NOTICE

This notice describes how health information about you may be used and disclosed by the Plan and the Trust and how you can get access to this information. Please review it carefully.

In order to provide you with the benefits to which you are entitled, the Oregon Laborers-Employers Health & Welfare Trust (the "Trust") and the Oregon Laborers Employers Health and Welfare Plan for Active Laborers and Associates II and A (the "Plan") sponsored by the Trust must collect, create, and maintain information about you. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Trust is required to maintain the privacy of this information, which is referred to as "protected health information." This notice describes how the Trust uses and discloses your protected health information and explains certain rights you have regarding that information. The Trust is required by law to provide you with this notice and to comply with its terms during the period when it is effective.

How the Trust May Use and Disclose Your Health Information

The following is a list of the ways in which the Trust may use and disclose your protected health information. We will use and disclose your health information only for one of the purposes on this list. In certain cases, we provide examples of the types of uses or disclosures that fall within a particular category. These examples are intended to help you understand what these categories mean; they do not cover every type of use or disclosure within each category. Please note that, as discussed later in this notice, special rules apply to our disclosure of certain alcohol and drug abuse treatment records.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use and disclose your protected health information without your specific written authorization for the following purposes:

- **Treatment.** Use and disclosure to facilitate treatment by health care providers. For example, we may disclose to a health care provider that is treating your health information relating to other health care services you have received that may be relevant to the provider's treatment of you.
- **Payment.** Use and disclosure for our own payment purposes and to assist in the payment activities of other health plans and health care providers. Our payment activities include determining your eligibility for benefits, reimbursing health care providers that treat you, and obtaining payment from other insurers that may be responsible for providing coverage to you. For example, if a health care provider submits a bill to us for services received, we may use health information about you to determine whether these services are covered by the Trust and the appropriate amount of payment to which the provider may be entitled.
- **Health Care Operations.** Use and disclosure to carry out health care operations, which includes quality improvement activities, evaluating our own performance, and resolving any complaints or grievances you may have. For example, we may use information about your claims to refer you to a disease management program, project future costs, or audit the accuracy of our claims processing functions. We may also use and disclose your health information to assist other health plans and health care providers in performing certain health care operations, such as quality assessment and improvement, reviewing the competence and qualifications of health care providers, and conducting fraud detection or compliance. We are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage.

Other Allowable Uses and Disclosures

We may also use and disclose your protected health information without your specific written authorization for the following purposes:

- **As Required by Law.** Use and disclosure as required by state, federal, or local law.
- **For Public Health Activities.** Disclosure to public health authorities or other agencies and organizations conducting public health activities, such as preventing or controlling disease, injury, or disability and reporting births, deaths, child abuse or neglect, domestic violence, potential problems with products regulated by the Food and Drug Administration, or communicable diseases.
- **To Report Abuse, Neglect, or Domestic Violence.** Disclosure to an appropriate government agency if we believe you are a victim of abuse, neglect, or domestic violence and you agree to the disclosure or the disclosure is required or permitted by law. We will let you know if we disclose your health information for this purpose unless we believe that letting you know would place you at risk of serious harm or we believe that a person who usually receives information from us on your behalf is responsible for the abuse, neglect, or domestic violence.
- **For Health Oversight Activities.** Disclosure to health oversight agencies for oversight activities authorized by law such as audits, investigations, inspections, and licensing surveys.
- **For Judicial and Administrative Proceedings.** Disclosure in the course of any judicial or administrative proceeding in response to an appropriate order of a court or administrative body or in response to subpoena, discovery request, or other lawful process under the circumstances specified in 45 C.F.R. § 164.512(e).
- **For Law Enforcement Purposes.** Disclosure to a law enforcement official for a legitimate law enforcement purpose such as: identifying or locating a suspect, fugitive, or missing person; complying with a court order, subpoena, or administrative request; providing information about a victim of a crime or reporting a death that may be the result of a crime.
- **About Deceased Individuals.** Disclosure to a coroner or medical examiner for purposes such as identifying a deceased person or determining a cause of death. We may also disclose your health information to a funeral director as necessary to assist such a person in carrying out his or her duties.
- **For Organ, Eye, or Tissue Donations.** Disclosure to organ procurement organizations and similar entities for the purpose of assisting them in organ, eye, or tissue donation or transplantation activities.
- **To Prevent a Serious Threat to Health or Safety.** Use or disclosure to prevent or lessen a serious and immediate threat to your health or safety, to the health or safety of another person, or to the general public. We will disclose your health information for this purpose only to someone who may be able to prevent or lessen this type of threat.
- **For Specialized Government Functions.** Use or disclosure to provide assistance for certain types of government activities. If you are a member of the armed forces of the United States or a foreign country, we may disclose your health information to appropriate military authorities as they deem necessary to carry out military missions. We may also disclose your health information to federal officials for lawful intelligence or national security activities and for the purpose of

providing protective services to the President of the United States and other officials. In addition, if you are in the custody of a correctional institution or law enforcement official, we may disclose your health information to that institution or official for certain purposes.

- **For Workers' Compensation.** Use or disclosure as permitted by the laws governing the workers' compensation program or similar programs that provide benefits for work-related injuries or illnesses.
- **To Individuals Involved in Your Care.** Disclosure to a family member, other relative, close personal friend, or other person assisting you in receiving or obtaining payment for health care services. We will disclose your health information to these individuals only if you tell us to do this, or if we advise you that we will do so and you do not object. If you are incapacitated or cannot be given an opportunity to object because of an emergency, we may disclose your health information to these individuals if, in the exercise of our professional judgment, we determine that it is in your best interest to do so. We may also disclose your health information to disaster relief organizations such as the Red Cross to assist your family members or friends in locating you or learning about your general condition in the event of a disaster.
- **To Your Personal Representative.** Disclosure to your personal representative as determined by applicable state and federal laws.

Special Treatment of Certain Alcohol and Drug Abuse Records

Health information we may receive about you from federally assisted alcohol or drug treatment programs is subject to special protection under federal law. We will not disclose this information without your express written authorization except:

- To medical personnel who need this information for the purpose of providing you with emergency treatment.
- To the Food and Drug Administration for the purpose of identifying potentially dangerous products.
- To authorized persons conducting on-site audits of our records, subject to the requirement that these persons not remove the information from our facilities and agree in writing to safeguard the information.
- In response to an appropriate court order.

Obtaining Your Authorization for Other Uses and Disclosures

The Trust will not use or disclose your protected health information for any purpose not specified in this notice unless we obtain your express written authorization. If you give us your authorization, you may revoke it in writing at any time, in which case we will no longer use or disclose your protected health information for the purpose you authorized, except to the extent we have relied on your authorization in providing benefits.

Disclosures to the Plan Sponsor

We or a health insurer or an EPO/HMO that contracts with the Plan, may disclose your health information to the Board of Trustees of the Oregon Laborers-Employers Health & Welfare Trust Fund, which is the plan sponsor of the Plan, for plan administration.

Appointment Reminders

We may use and disclose your health information to remind you about appointments you have made to receive health care services or to encourage you to make such appointments.

Treatment Alternatives

We may use and disclose your health information to tell you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Your Rights Regarding Your Health Information

You have the following rights regarding your protected health information:

- **An Accounting of Disclosures.** You have the right to receive a list of disclosures of your health information that have been made by the Trust. The list will not include disclosures made for certain types of purposes, such as disclosures for treatment, payment, or health care operations or disclosures you authorized in writing. Your request should specify the time period for which you want this list, which can be no longer than six years prior to the date of your request. The first time you ask for a list of disclosures in any 12-month period, we will provide it for free. If you request additional lists during a 12-month period, we may charge you a fee to cover out costs in providing the additional lists. You may request a list of disclosures by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.
- **Request Restrictions or Preferences.** You have the right to request restrictions or tell us your preferences on the ways in which we use and disclose your health information for treatment, payment, and health care operations, or disclose this information to disaster relief organizations or individuals who are involved in your care or payment for your care. We do not have to agree to the restrictions you request, and we may decline your request if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. We will never sell your information or share your information for marketing purposes. You may request a restriction on the use or disclosure of your health information by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.
- **Inspect and Copy.** You have the right to inspect or request a copy of the health information that we maintain and that we may use in making decisions about your benefits. Your request

should describe the information you want to review and the format in which you want to review it; for example, whether you want to inspect your records at our offices, receive paper copies, or get the information on a computer diskette. We may refuse to allow you to inspect or obtain copies of this information in certain limited cases. We may charge you a reasonable fee for copies to cover our costs. You may ask to inspect or obtain copies of your information by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.

- **Request Amendments.** You have the right to request changes to health information that we maintain about you if you state a reason why this information is incorrect or incomplete. We do not have to agree to make the changes you request. If we do not believe the changes you requested are appropriate, we will notify you in writing about how you can have your objection to our decision included in our records. You may request changes to your health information by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.
- **Request Confidential Communications.** You have the right to ask us to send health information to you in a different way or at a different location if you believe that you may be endangered by our ordinary form of communication. For example, if you are afraid that someone living with you may open mail we send you and harm you as a result, you can ask us to send your mail to you at the address of a relative or an employer. You must state in your request that you believe you will be endangered by our ordinary form of communication, but you do not have to explain why you believe this is the case. Your request should also specify where and/or how we should contact you. We will accommodate all reasonable requests. You may ask us to send health information to you in a different way or at a different location by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.
- **Paper Copy of Notice.** You have the right to receive a paper copy of this notice at any time, even if you have previously requested to receive this notice electronically. You may obtain a paper copy of this notice, by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.
- **Choose Someone to Act for You.** If you have given someone medical power of attorney or someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Trust or the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Trust by writing to the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208. You may file a complaint with the U.S. Department of Health and Human Services and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. You will not be penalized or retaliated against by the Trust for filing a complaint.

Changes to this Notice

The Trust may change the terms of this notice at any time. If we change the terms of this notice, the new terms will apply to all of your protected health information, whether created or received by the Trust before or after the date on which the notice is changed. We will notify you of changes to this notice by mailing you a copy of the new notice within 60 days of the date on which it becomes effective.

Additional Information

If you have any questions or would like additional information about this notice or the Trust's privacy practices, please contact the Privacy Coordinator or the Privacy Officer at William C. Earhart Company, Inc., P.O. Box 4148, Portland, OR 97208.

FUND OFFICE

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Eligibility and Administration

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