Essential Worker

Healthcare Trust

SUMMARY PLAN

ESSENTIAL WORKERS HEALTHCARE TRUST

Oregon Essential Workforce Health Care Fund

Summary Plan Description

Effective Date: January 1, 2023

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Message to Employees:

We are pleased to present this booklet describing the Oregon Essential Workforce Health Care Fund benefits available to eligible Employees and their enrolled Dependents. The Fund's Effective Date is January 1, 2023.

After reading the booklet carefully, contact the Fund Office at (833) 389-0027 if you have questions. Information can also be found on the Fund's website at *www.essentialworkerhealth.org*.

This booklet is both the Plan Document and the Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This Fund also is covered by some provisions of Oregon state law and those rules are included in this booklet.

All questions about benefit interpretations should be referred to the Fund Office. **The Fund Office does not guarantee eligibility for benefits or benefit payments. Although the Fund Office can provide you with general information on your plan of benefits, your eligibility for benefits and benefit payments will be determined only when a claim or prior authorization request is submitted to the Fund.**

To keep your eligibility records accurate, notify the Fund Office in writing about any change in:

- Address
- Dependent status (birth, adoption, legal placement for adoption, custody, death, marriage, legal separation, divorce, full-time student)

Submit any changes to the Fund Office on a new enrollment form; forms can be found on the Fund's website at: *www.essentialworkerhealth.org*.

Este documento contiene, en Ingles, un resumen de sus beneficios y derechos en el Fondo de Salud para Trabajadores Esenciales de Oregon . Si usted tiene dificultad entendiendo cualquier parte de este material, contacte a la oficina del Fondo. La direccion es:

Oregon Essential Workforce Health Care Fund
PO Box 34203
Seattle WA 98124
Telephone / Telefono: (833) 389-0027

The Trustees have full and exclusive authority, in their discretion, to interpret, construe and apply the terms of the Plan, Trust agreement and all policies, procedures, actions and resolutions adopted in administering or operating the Fund or the Plan, and to make factual determinations regarding the Plan's construction, interpretation and application. They have the authority to remedy possible ambiguities, inconsistencies or omissions and to decide all Plan questions. Trustee decisions are final and binding.

The Board of Trustees has the right and discretionary authority to amend this Plan at any time.

Only the Board of Trustees is authorized to interpret the benefits described in this booklet. *No Employer or Local 503 – or representative of any Employer or Local 503 – is authorized to interpret this Plan or to act as an agent of the Board of Trustees.*

Summary of Benefits

The Fund offers eligible Employees two different plan options: a self-funded "PPO Plan" and an insured "HMO Plan".

For the PPO Plan, the Fund contracts with Regence BlueCross BlueShield to provide a preferred provider network and contracts with Optum Rx to provide prescription drug benefits.

The Fund contracts with Kaiser Permanente Northwest to provide the insured HMO Plan. For benefits provided through Kaiser Permanente Northwest, please refer to the HMO Plan section on page 17.

See each benefit section for specifics about covered expenses as well as exclusions and limitations. All PPO Plan claims must be submitted within one year following the date expenses were incurred. No claim submitted after this deadline will be considered for payment.

PPO Plan Medical Benefits	
Annual Base Deductible (Medical and Prescription Drug Combined)	
• In- Network providers	$800 for individual; $1,600 for family
• Out-of-Network providers	$2,400 for individual; $4,800 for family For Employees with family coverage, the individual deductible applies to each person until the family deductible has been met.
Reimbursement Provisions (Participant's Coinsurance)	
• In- Network providers	20% after your deductible
• Out-of-Network providers	40% after your deductible
Annual Out-of-Pocket Maximum (Medical and Prescription Drug Combined)	Includes the annual deductible, Participant coinsurance, and Participant copayments
• In-Network providers	$2,000 for individual; $4,000 for family
Out-of-Network providers	$6,000 for individual; $12,000 for family For Employees with family coverage, the individual maximum applies to each person until the family maximum is met.

- Additional annual out-of-pocket maximums may apply for essential health benefits (see pages 20 and 32)

PPO Plan Prescription Drugs at In-Network Pharmacies		
Participant's Copays	30 Day Supply	31-90 Day Supply
Tier 1	$0	$0
Tier 2	$30	$60
Tier 3	$80	$160
Brand if generic available	You pay the appropriate Tier copay plus the difference in cost between the generic and the brand name drug	
Specialty Drugs	$100 (up to 30 day supply only), must use Optum Rx exclusive specialty pharmacy	

PPO Plan Prescription Drugs at Out-of-Network Pharmacies		
Participant's Coinsurance	30 Day Supply	31-90 Day Supply
Tier 1	40% after deductible	40% after deductible
Tier 2	40% after deductible	40% after deductible
Tier 3	40% after deductible	40% after deductible
Brand if generic available	You pay the appropriate Tier coinsurance based on the brand name drug	
Specialty Drugs	Not Covered	

Eligibility

Initial Eligibility

Employee-Only Coverage

If you are eligible for coverage under your Participating Employer's group health plan on the Effective Date of the Fund, you become covered for Employee-only coverage on the Effective Date if:

- You are employed by that Participating Employer in a position for which the Employer is obligated to contribute to the Fund on your behalf, and
- You complete the enrollment process to enroll yourself by submitting an enrollment form to the Fund Office, and
- Your Employer pays the required monthly contribution, and
- You pay the required Employee premium.

If you are NOT eligible for coverage under your Participating Employer's group health plan on the Effective Date of the Fund, you become covered for Employee-only coverage on the first day of the calendar month for which you are classified by the Employer as a full-time Employee after you meet the above four requirements.

If you are hired after the Effective Date, you become covered for Employee-only coverage on the first day of the calendar month after your hire date if you are classified by the Employer as a full-time Employee after you meet the above four requirements.

Full-time Employee is defined under your Participating Employer's collective bargaining agreement.

Family Coverage

You become eligible for family coverage (i.e. Employee + Spouse (or Domestic Partner), or Employee + Family) on the same day as you become eligible for Employee-only coverage, and

- You complete the enrollment process to enroll your family by submitting an enrollment form to the Fund Office.
- Your Employer pays the required monthly contribution, and
- You pay the required Employee premium (for family coverage).
- You must submit any required documentation to the Fund Office, such as a marriage certificate or birth certificate, to verify Dependent status within 90 days of your Dependent's effective date of coverage.

Continuation of Eligibility

Employee-Only Coverage

Once you become eligible for Employee-only coverage, you continue that eligibility on a monthly basis, as long as:

- You remain classified by the Employer as a full-time Employee, and
- Your Employer pays the required monthly contribution, and
- You pay any required Employee premiums.

Family Coverage

Once you attain initial eligibility for and elect family coverage, and enroll any Dependents, you continue to be eligible for family coverage on a monthly basis, as long as:

- You remain classified by the Employer as a full-time Employee, and
- Your Employer pays the required monthly contribution, and
- You pay any required Employee premiums (for family coverage).

Eligible Dependents

Dependents must be enrolled with the Fund Office before their benefits begin. Dependent documentation is required (e.g. marriage certificate for your spouse, or birth certificate or court documents for your dependent children). Please provide the documents with your request to enroll your Dependent. If the required documentation for your Dependents is not timely, your Dependents will not be enrolled in the Fund.

Your eligible Dependents include:

1. Your legally married spouse.

2. Your children under age 26 who are your biological children, stepchildren, adopted children, children placed with you for adoption, or foster children or children under age 26 for whom you are the legally appointed guardian who are placed with you.

   These children do not have to depend on you for support, do not have to attend school full time, and can be married. A child is considered placed with you for adoption if you have a legal obligation for total or partial support in anticipation of adopting. A foster child is one placed by an authorized placement agency or by judgment, decree, or other court order.

3. Your domestic partner who is registered with the state of residence as your domestic partner who meets all of the other eligibility requirements of the Fund as a Dependent. Please note that the IRS will consider the fair market value of the monthly benefits provided to your domestic partner and partner's children as taxable income to you.

4. Unmarried dependent children who reach any of the applicable limiting ages in #2 while covered by this Plan and are incapable of self-sustaining employment because of mental or physical handicap and are dependent on you for support.

Children are considered dependent on you for support if claimed as dependents on your or your spouse's (or former spouse's) federal income tax return.

You must provide proof of the incapacity and dependency to the Fund Office within 31 days after the child reaches the limiting age. You may be required to verify the incapacity and dependency from time to time.

For other than your natural children, you must provide the Fund Office copies of court papers or other official court documents demonstrating your legal relationship with or obligation to support the child.

Under federal law, the Plan also provides medical benefits to certain 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. The Fund will provide coverage to a child under a QMCSO even if the Employee does not have legal custody of the child, the child is not dependent upon the Employee for support, and regardless of enrollment season restrictions that otherwise may exist for Dependent coverage. If the Fund receives a QMCSO and the Employee does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. You and your Dependents may obtain a copy of the Plan's procedures for processing QMCSOs, without charge, from the Fund Office.

Note: If you have eligible Dependents, please notify the Fund Office as soon as possible within 60 days of any change in family status – marriage, birth, adoption or legal placement for adoption, marriage of any child, a child reaching their limiting age for coverage, death of any Dependent, divorce, legal separation or termination of domestic partnership. A new enrollment form for this purpose is available from the Fund Office.

Important: If you do not enroll your Dependents when they are first eligible or within 60 days of their becoming your Dependent, you must wait until the next open enrollment period to enroll your Dependents. Also, if you do not notify the Fund Office within 60 days of a loss in a Dependent's status, they will lose their ability to elect COBRA Coverage. In addition, any Employee premium changes due to family status changes will be adjusted to the effective date of the family status change.

Special Enrollment

If you acquire Dependents while eligible, their eligibility begins as follows, providing the Fund Office receives a completed enrollment form within 60 days of the event and you provide any documentation required (such as a marriage certificate or birth certificate).

- Your spouse – on the first of the month after your date of marriage.
- A child – on the first of the month after the date the child becomes a newly acquired Dependent. However, a newborn natural child is covered from birth, and a newborn adopted child is covered as of the date you take physical custody, if earlier than the adoption date.
- Your domestic partner – on the first of the month after the Fund Office receives the completed forms verifying the domestic partnership.

Enrollment is retroactive (within the 60-day period) to the date the Dependent first became eligible, provided you elect family coverage, enroll the Dependents with the Fund Office (within the 60-day period) and make the required weekly Employee premiums (for family coverage).

If you are declining enrollment for yourself or your Dependents because of other health insurance or group health coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must submit a completed enrollment form within 60 days after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

You may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for coverage under Medicaid or the State Children's Health Insurance Program (CHIP). However, to do so, you must submit a completed enrollment form within 60 days of the date that CHIP or Medicaid assistance is terminated for you or your Dependents.

To request special enrollment or obtain more information, contact the Fund Office.

Military Service Under USERRA

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Fund provides you the right to elect continued health coverage for up to 24 months if you are absent from employment due to qualified military service, including Reserve and National Guard Duty under federal authority, that meets the rules under USERRA ("USERRA Service").

If you are absent from employment by reason of USERRA Service, you can elect to continue coverage for you and your Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service.

The period of coverage begins on the date on which your absence begins and ends on the earlier of:

- The end of the 24-month period beginning on the date on which the absence begins; or
- The day after the date on which you are required to but fail to apply under USERRA for or return to a position of employment covered under the Fund. (For example, for periods of USERRA Service over 180 days, generally you must reapply for employment within 90 days of discharge.)

This right to continue group health coverage does not include any life insurance benefits, accidental death or dismemberment benefits, weekly disability benefits or other similar non-health benefits provided under the Fund. In addition to the rights under USERRA, you and your Dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See pages 11 to 15 for more information.

If you met the Fund's eligibility requirements at the time you entered USERRA Service, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan upon return from USERRA Service, if required under USERRA.

Notice and Election of USERRA Coverage

If you wish to elect USERRA coverage, you must notify the Fund Office within 60 days of the last day of employment unless you are excused from giving advance notice of service under the provisions of USERRA. While you may notify an Employer of service orally, the Fund requires that you elect USERRA coverage in writing. Call the Fund Office for the necessary forms.

Paying for USERRA Coverage

If the period of USERRA Service is less than 31 days, there is no charge for this coverage beyond the normal deductible, or co-payments that would be paid if you were employed. If the USERRA Service extends more than 31 days, you must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the cost for COBRA Coverage. You should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of the Employee's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is your responsibility to make timely payment of all required payments. The Fund will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to untimely payment.

Entering and Returning from Service

Under USERRA, you must notify your Employer before taking leave (unless prevented by military necessity or other reasonable cause) and should tell your Employer how long you expect to be gone. When you're released from USERRA Service, you must apply for reemployment:

- Less than 31 days of USERRA Service – apply immediately, considering safe transportation plus an eight-hour rest period.
- 31-180 days of USERRA Service – apply within 14 days.
- More than 180 days of USERRA Service – apply within 90 days.

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

Note: These rules also apply to uniformed service in the commissioned corps of the Public Health Service.

Be sure to let the Fund Office know how long you expect to be gone and notify them when you apply for reemployment after your leave. Please call the Fund Office for more details on coverage under USERRA.

Medical or Family Leave of Absence

The Family and Medical Leave Act of 1993 (FMLA) generally requires that an employer with 50 or more employees provide employees with up to 12 weeks per year of unpaid leave in the case of the birth or adoption of your child and for your own illness or to care for a seriously ill child, spouse or parent. You may also be entitled to FMLA leave for a qualifying reason that arises in connection with the active military service of your child, spouse, or parent. To be eligible, 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.

Your current medical, dental and vision benefits continue while you are on certain types of FMLA leave, if your Employer makes the required contributions. You and your Dependents may be entitled to coverage for up to 12 work weeks during a 12-month period if you are on FMLA leave due to:

- Birth of a child
- Placement of a child for adoption or foster care
- Serious health condition of a child, spouse, same sex domestic partner, or parent
- Your own serious health condition that makes you unable to perform the essential functions of your job
- A qualifying reason that arises in connection with the active military service of a child, spouse, or parent, including (a) notification of military deployment within 7 days of the deployment date; (b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; (c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; (d) making financial and legal arrangements; (e) attending counseling sessions; (f) up to 5 days of rest and recuperation; (g) attendance at post-deployment activities.

You may be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service.

If you think you may be eligible for a FMLA leave, contact your Employer immediately. Your Employer must make arrangements with the Fund Office to continue your coverage. (The Fund does not administer leave under the FMLA or determine eligibility for FMLA leave. The Fund only assists Employers in complying with the law by providing benefits when you qualify for FMLA leave.)

If you advise your Employer that you are not returning or if you do not return after your FMLA leave, coverage for all Plan benefits ends. You and your Dependents then may elect COBRA Coverage (see below). The qualifying event entitling you to COBRA Coverage is the last day of your FMLA leave. Contact the Fund Office for more details.

When Coverage Ends

Employees

Your coverage ends on the earliest of these dates:

- Last day of the month in which your employment terminated
- Last day of the month during which you met the definition of a full-time Employee but in the following month were not a full-time Employee
- Last day of the month you begin active duty with the armed services of any country if the active duty is to exceed 30 days (see Military Service Under USERRA, page 8, for details)
- The date this Plan is discontinued, in whole or in part
- Last day of the month in which your Employer ceases to be a Participating Employer
- Last day of the month in which the collective bargaining agreement or participation agreement covering your employment is terminated

However, if you have been continuously covered by the Fund for 36 months or more, your coverage ends, provided you pay the required Fund contribution rate to the Fund office, on the earlier of:

- The last day of the 3rd calendar month following the calendar month in which you were last classified by the Employer as a full-time Employee, or
- The last day of the calendar month in which your employment terminates.

Dependents

Coverage for your Dependents ends on the earliest of these dates:

- The date your coverage ends
- Last day of the month a child reaches their maximum age for coverage
- Last day of the month a Dependent enters active duty with the armed services of any country if the active duty is to exceed 30 days
- Last day of the month when a Dependent no longer qualifies as eligible (see page 6 for Dependent eligibility details)

COBRA Coverage

The Fund provides the right to continued coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Coverage may be available to you and other members of your family when group health coverage would otherwise end.

What is COBRA Coverage?

COBRA Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your children could become qualified beneficiaries if coverage under the Plan is lost because of the

qualifying event. Qualified beneficiaries who elect COBRA Coverage must pay for COBRA Coverage.

If you are an Employee, you become a qualified beneficiary if you lose your Plan coverage because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you become a qualified beneficiary if you lose your Plan coverage because of the following qualifying events:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than their gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You are no longer legally married to be the Employee; or
- Termination of your domestic partnership.

Your child will become a qualified beneficiary if they lose Plan coverage because of the following qualifying events:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than their gross misconduct;
- The Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parent is no longer married to the Employee; or
- The child stops being eligible for coverage as a "Dependent".

When is COBRA Coverage Available?

The Fund will offer COBRA Coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. The Employer must notify the Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or
- The Employer's initiation of bankruptcy proceedings.

For all other qualifying events (end of marriage of the Employee and spouse or a child's losing eligibility for coverage as a Dependent), you must notify the Fund Office within 60 days after the qualifying event occurs. You must provide this notice to:

Oregon Essential Workforce Health Care Fund
PO Box 34203
Seattle WA 98124

How is COBRA Coverage Provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Coverage. Covered Employees may elect COBRA Coverage on behalf of their spouses, and parents may elect COBRA Coverage on behalf of their children.

How Long is COBRA Coverage Provided?

Maximum Periods of COBRA Coverage for Each Qualifying Event

	Employee	**Spouse**	**Child**
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Dependent child ceases to be Dependent	N/A	N/A	36 months

Certain qualifying events, or a second qualifying event during the initial 18-month period of COBRA Coverage, may permit a beneficiary to receive a maximum of 36 months of COBRA Coverage.

Disability extension of 18-month period of COBRA Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Fund Office in a timely fashion, you and your Dependents may be entitled to get up to an additional 11 months of COBRA Coverage, for a maximum of 29 months. The disability must begin before the 60th day of COBRA Coverage and must last at least until the end of the 18-month period of COBRA Coverage. To extend coverage from 18 to 29 months due to disability, you or your Dependent must notify the Fund Office in writing during the initial 18-month continuation period, including a copy of the Social Security determination letter (within 60 days of the letter's date). Both you and the affected Dependent(s) are jointly responsible for these notices. If you or your Dependent fails to give written notice to the Fund Office within 60 days, the affected person will lose the right to the 11-month extension.

If, during the initial 18-month period, the SSA determines that the person is no longer disabled, the 11-month extension does not apply. If the SSA determines that the person is no longer disabled after the initial 18-month period, the period of COBRA Coverage ends with the first month that begins more than 30 days after the date of the SSA's determination, provided the period of COBRA Coverage does not exceed 29 months.

Second qualifying event extension of 18-month period of COBRA Coverage

If your family experiences another qualifying event during the 18 months of COBRA Coverage, your spouse and children can get up to 18 additional months of COBRA Coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension

may be available to the spouse and any children getting COBRA Coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); ceases to be legally married; or if the child stops being eligible under the Plan as a Dependent. This extension is only available if the second qualifying event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred.

Health Benefits

Under COBRA Coverage payment rules, you may choose from the coverage if you had the benefits in the month immediately before you lost coverage.

Other COBRA Coverage Provisions

- Once elected, COBRA Coverage may be terminated for any of these reasons:

  – The Fund no longer provides health coverage to any Employees
  – The required premium for COBRA Coverage is not paid when due
  – You or your Dependents become covered under another group health plan (unless the other plan limits coverage for a preexisting health condition, and the preexisting condition exclusion/limit applies to that individual)
  – The qualified beneficiary becomes entitled to Medicare

- COBRA Coverage requires timely election of the coverage. The Fund will, within 14 days of receiving notice of the qualifying event, send to the affected individual a COBRA enrollment form. This form will describe the cost of COBRA Coverage and the conditions under which the coverage will terminate. The COBRA Coverage enrollment form must be returned to the Fund Office within 60 days of the information letter being mailed from the Fund Office. Initial payment must:

  – Include all months not covered by Employer-paid contributions; and
  – Be received within 45 days of the Fund Office receiving your enrollment form.

- If the enrollment form is not returned or payments are not made within these timelines, COBRA Coverage is not available.

- Ongoing payments are due on the 20th of the month prior to each month of coverage. However, you will have a grace period of 30 days after the first of the month in which to make a payment.

  You will not receive a monthly bill from the Fund Office**. It is your responsibility to make payments to the Fund Office. Late payments will result in termination of COBRA Coverage.**

- The amount of the payment is subject to change.

- If you gain an eligible Dependent while participating in COBRA Coverage, the usual rules for enrolling new Dependents apply. To cover new Dependents, you must enroll the Dependent and make the required monthly payments, if eligible for family coverage. Coverage for newborn or adopted children will continue for the same time as coverage for children who

were properly enrolled in the Plan on the day before the qualifying event. Newborn or adopted children added to your COBRA Coverage also become qualified beneficiaries.

- To protect your family's COBRA Coverage rights, you should keep the Fund Office informed of any changes in the addresses of family members.

Contact the Fund Office for more details about available options and associated costs.

Cost of COBRA Coverage and Payment

The cost that you must pay to continue benefits is up to 102% of the cost of coverage, as determined annually by the Fund. However, the COBRA Coverage premium for the 11-month disability extension period (if applicable) may cost up to 150% of the cost of coverage. If your former Employer alters the level of benefits provided through the Fund to similarly situated active Employees, your coverage and cost also will change.

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at *www.healthcare.gov*.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

If You Have Questions

Call the Fund Office if you have questions concerning your COBRA Coverage. Please direct all COBRA related forms, correspondence, payment and inquiries to:

Oregon Essential Workforce Health Care Fund
PO Box 34203
Seattle WA 98124

For more information about your rights under ERISA, including COBRA, the Affordable Care Act (ACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit *www.dol.gov/agencies/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit *www.healthcare.gov*.

Enrolling in the Fund

You must enroll online or complete an enrollment form and submit it to the Fund Office. You must also submit any required documentation to the Fund Office.

Making Changes

Annual Open Enrollment

An open enrollment will be conducted once each year, usually in the fall, for Employees who want to change their Plan or add/delete Dependents. Changes made during open enrollment become effective January 1. *If you do not make changes during open enrollment, your current coverages will carry over to the next year; you will not be able to make changes until the next open enrollment unless certain events occur.*

Changes in Family Status

If you have a change in family status during the year (such as marriage, divorce, legal separation, starting or terminating a domestic partnership, birth or adoption of a child or death of any Dependent) or you lose coverage under your spouse's or domestic partner's plan, or a Dependent or domestic partner currently not enrolled loses other insurance coverage, you will be allowed to revise your coverage option, provided you notify the Fund Office within 60 days of the change. This change will be effective the first day of the month following the status change (except newborns who are effective the date of birth).

To make changes to your coverage, obtain a new enrollment form and return it to the Fund Office with appropriate documents.

HMO Plan Medical and Prescription Drug Benefits

The Fund offers an insured HMO plan. The eligibility conditions for the HMO Plan and PPO Plan are the same. The HMO Plan benefits are offered under an insurance policy with Kaiser Permanente Northwest. Medical and prescription drug benefits offered under the HMO Plan are described in a separate document provided by Kaiser Permanente Northwest.

To receive a copy of the HMO Plan summary plan description, please contact the Fund Office or contact Kaiser Permanente at (800) 813-2000.

PPO Plan Medical Benefits

The benefits described in this section apply to benefits under the Fund's PPO Plan option. If you selected the Fund's Kaiser Permanente Northwest HMO Plan option, see the HMO Plan section.

The benefits described in this section apply to you whether you use an In-Network provider or Out-of-Network provider.

In-Network Providers

The Fund has a Preferred Provider Organization (PPO) arrangement with Regence BlueCross BlueShield of Oregon. This network of hospitals, physicians and other healthcare professionals (called In-Network PPO providers) agree to provide eligible Employees and Dependents with efficient, cost-effective services and supplies at discounted rates.

Providers not in the network are called Out-of-Network PPO providers. Out-of-Network PPO providers are reimbursed at a lower level of benefits and charges are allowed only up to usual, customary and reasonable (UCR) fees. **This means that the Out-of-Network PPO provider may balance bill you for those unpaid amounts over UCR and those amounts do not apply toward your Out-of-Network PPO provider annual out-of-pocket maximum.**

Although you may see any provider covered by the Plan, you receive higher benefits if you use In-Network PPO providers – the choice is yours each time you use your benefits. Please note that not all network providers are covered providers under this Plan; see the definition of covered provider on page 57.

In-Network PPO providers have agreed to:

- Bill the Plan directly, without any payment up front from you, except your applicable copays for the visit
- Accept the Plan's contracted fee levels instead of usual, customary and reasonable (UCR) rates and may not charge more than the maximum amount under the contract, saving you out-of-pocket money

You can find out if your medical care provider is in the network by visiting Regence BlueCross BlueShield of Oregon's website at *www.regence.com*. You can also contact your provider and ask them. If you have any additional questions, please call the Regence BlueCross BlueShield of Oregon or the Fund Office.

Combined Medical and Prescription Drug Deductible

The deductible is the amount of covered medical expenses you and your eligible Dependents must pay each calendar year before the Plan begins to pay benefits.

Each year you will have a base deductible that is dependent on your level of coverage (Employee only or family) and whether you use In-Network PPO providers or Out-of-Network PPO providers.

Once the family deductible is met, no further deductible amounts are required for any family member for the rest of that year. Non-covered charges do not apply to the deductible.

Per Calendar Year	In-Network PPO Providers	Out-of-Network PPO Providers
Employee only coverage: • maximum deductible	$800	$2,400
Family coverage: • maximum deductible	$1,600	$4,800
For Employees with family coverage, the individual deductible applies to each person until the family deductible has been met.		
Medical and Prescription Drug benefits have combined deductibles.		

All services **e**xcept for those listed below will be subject to deductible and the coinsurance listed below. The services listed below, **if delivered by In-Network PPO providers**, will have a fixed co-pay per service as specified below.

a. Primary Care Office Visits ($20 copay)
b. Specialist Office Visits ($40 copay)
c. Chiropractic, Acupuncture, and Massage Therapy Visits ($40 copay)
d. Physical Therapy/ Occupational Therapy / Speech Therapy Office Visits ($40 copay)
e. Urgent Care Visits ($60 copay)
f. Outpatient Behavioral Health Visits ($20 copay)
g. Prescription Drugs (see page 36)

Cost sharing for all these services will be credited towards the Out-of-Pocket Maximums.

Reimbursement Provisions (Coinsurance)

Once you have met the deductible, the Plan covers most covered services at 80% of In-Network PPO provider charges or 60% of Out-of-Network-PPO provider UCR charges.

Combined Medical and Prescription Drug Out-of-Pocket (OOP) Maximum

After you or your family reach the annual combined medical and prescription drug out-of-pocket (OOP) maximum, the Plan pays 100% for most covered services for the rest of that calendar year.

Each year you will have a base combined medical and prescription drug out-of-pocket maximum that is dependent on your level of coverage (Employee only or family) and whether you use In-Network PPO network providers or Out-of-Network-PPO providers. Only the annual deductible,

the Participant's coinsurance amounts, and the Participant's copay amounts apply to the combined annual medical and prescription drug out-of-pocket maximum; benefits which exceed Plan limits do not apply nor do any Participant penalties (e.g. penalty applied for choosing a brand name drug when a generic is available) apply.

Per Calendar Year	In-Network PPO Providers	Out-of-Network PPO Providers
Employee	$2,000	$6,000
Family coverage:	$4,000	$12,000
For Employees with family coverage, the individual maximum applies to each person until the family maximum has been met.		
Medical and Prescription Drug benefits have combined out-of-pocket (OOP) maximums.		

Annual Out-of-Pocket Maximum for Essential Health Benefits

In addition to the Plan's out-of-pocket maximums above, the Affordable Care Act (ACA) imposes limitations on how much you pay out-of-pocket for certain in-network provider covered charges. See page 32 for the rules for preventive services.

Prohibition Against Balance Billing

The No Surprises Act is a federal law that prohibits out-of-network hospitals, physicians or other providers from directly billing you the difference between the amount they charge and the in-network rates paid by the Fund, plus any cost-sharing amounts ("balance billing") for certain services.

Balance billing is prohibited for the following services:

- Most Emergency Services, even if you get them out-of-network and without advance approval or prior authorization.
- Out-of-network charges for certain ancillary services (*e.g.*, anesthesiology, pathology, diagnostic or radiology) provided to you by out-of-network providers as part of a visit to an in-network Hospital, Ambulatory Surgical Center, freestanding birthing center, or outpatient renal dialysis center.
- Non-Emergency Services from out-of-network providers at in-network facilities, unless you receive a notice explaining the applicable balance billing protections and you provide written consent waiving these balance billing protections. An example of what this notice looks like can be found on the Fund's website.
- Services from out-of-network air ambulance service providers.

"Emergency Services" include medical exams in the emergency department of a hospital and any additional medical exams and treatment necessary to stabilize your condition, regardless of where in the hospital you receive the exam or treatment.

Emergency Services also include any services related to your emergency visit that you receive from an out-of-network provider or facility after you are stabilized until the provider or facility determines that you are able to travel. The Fund will not exclude coverage for Emergency Services that are required to be covered under the No Surprises Act.

You will not pay out-of-network cost-sharing (such as out-of-network coinsurance or co-payments) for the services described above, and you will not be charged more than in-network cost-sharing for these services. Any cost-sharing (co-pays and coinsurance) that you pay for these services will count towards your in-network annual medical out-of-pocket maximum.

This rule does not apply to:

- Residential facilities licensed by the Department of Human Services or the Oregon Health Authority under Oregon law;
- Establishments furnishing primarily domiciliary care as described under Oregon law;
- Residential facilities licensed or approved under the rules of the Department of Corrections;
- Facilities established through the Oregon Health Authority for the treatment of substance abuse disorders;
- Community mental health programs or community developmental disabilities programs established under Oregon law; or
- Long-term care facilities.

Please visit the Fund's website for more information about balance billing.

If you appeal a denial of your claim for one of the services covered by the No Surprises Act, and that appeal is then denied by the Board of Trustees, you may request external review of that appeal denial. Please contact the Fund Office to receive more information about the external review process.

Continuing Care

If your provider leaves Regence BlueCross BlueShield of Oregon's network and becomes a non-PPO provider, you may continue to receive care from that provider for up to 90 days as if the provider continued to be in-network so long as you satisfy the requirements of a "continuing care patient." This rule doesn't apply if the provider was terminated due to its failure to meet Regence's quality standards or due to its fraud.

You are considered a continuing care patient if you are:

- Receiving treatment for a serious and complex condition that requires specialized care or is a chronic illness or condition;
- Scheduled for a non-elective surgery;
- Pregnant or undergoing treatment for pregnancy;
- Terminally ill and receiving care; or
- Receiving inpatient care from a provider or hospital.

If you believe you are a continuing care patient, and your provider is leaving or has left Regence BlueCross BlueShield of Oregon's network, you should contact the Fund Office to understand your rights and to make an election to receive this temporary continuation of in-network coverage. This will give you more time to transition to a new in-network provider for future services.

If you have any questions about this notice, please contact the Fund Office at (833) 389-0027.

Coverage Requiring Prior Authorization

The Plan works with Regence BlueCross BlueShield of Oregon to provide prior authorization of services.

Prior authorization refers to the process by which the Plan determines that a proposed service or supply is medically necessary and provides approval for it before it is rendered. Prior authorization is performed to ensure that the medical services received are aligned with evidence-based criteria and to determine whether the requested service meets medical necessity criteria. Prior authorization also ensures that services or supplies received are safe, effective and appropriate.

In-Network PPO providers may be required to obtain prior authorization in advance for certain services provided to you. You will not be penalized if the In-Network PPO provider does not obtain those approvals in advance and the service is determined to be not covered.

Out-of-Network PPO providers are not required to obtain prior authorization of any service or supply in order to be eligible for coverage of that service or supply. A claim for an Out-of-Network PPO provider service or supply that is otherwise covered by the Plan will not be denied solely for lack of prior authorization. Benefits will be paid for services and supplies covered under the Plan only if all terms and conditions of the Plan are met, including (unless specified to the contrary) medical necessity. You may request that an Out-of-Network provider prior authorize services on your behalf to determine medical necessity prior to receiving those services. If services or supplies are not prior authorized and it is determined that the services or supplies are not covered under the Plan or lack medical necessity, no benefits will be provided.

The below list provides examples of services which require prior authorization.

- Elective inpatient hospital admissions
- Skilled Nursing Facility admissions
- Inpatient rehabilitation admissions
- Long-term acute care hospitalizations admissions
- Applied Behavior Analysis Therapy
- Certain durable medical equipment
- Certain surgeries
- Genetic testing
- Transplants

A comprehensive list of services and supplies that must be prior authorized may be obtained by visiting *www.regence.com* or calling Regence BlueCross BlueShield at (866) 240-9580. Prior authorization requests should be submitted by your Provider following the instructions on

www.regence.com. The Plan will not require prior authorization for Emergency Room services or other services and supplies which by law do not require prior authorization.

You will be notified in writing within two business days after Regence BlueCross BlueShield of Oregon receives the prior authorization request to let you know whether the request has been approved, denied, or if more information is needed to make a determination. When more information is needed to make a determination, Regence BlueCross BlueShield of Oregon will notify you in writing of the determination within two business days after it receives the additional information or within 15 calendar days of the original two business days if no additional information is received unless a longer time period to respond is allowed under federal law.

Covered Medical Expenses

The Plan provides benefits for the following services and supplies, if medically necessary and performed by a physician or other covered provider.

Unless otherwise specified, if treatment/services are provided by an In-Network PPO provider, the covered benefit will be paid at 80% after the deductible is met. If the treatment/services are provided by an Out-of-Network PPO provider, the covered benefit will be paid at 60% of charges (not to exceed UCR) after the deductible is met.

Also, please refer to the medical exclusions and limitations as listed on page 35.

Acupuncture

The Plan covers treatment by an acupuncturist. The Plan has a 36-visit combined visit limit per calendar year (not more than one visit per day) for chiropractic treatment, acupuncture, and massage therapy delivered by a massage therapist.

Ambulance (local and air)

The Plan pays for medically necessary transportation to and from a local hospital or the nearest hospital equipped to provide medically necessary treatment not available in a local hospital. The Plan also pays for medically necessary transportation for a transfer between hospitals.

Transportation for personal or convenience are not covered.

Ambulatory Surgical Center

The Plan pays for benefits for covered services and supplies at an ambulatory surgical center *except* for:

- Private duty or special nursing services (by whatever name they're called)
- Services or supplies received more than 24 hours after a surgical procedure

Anesthesia

The Plan pays for medically necessary anesthesia services.

Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) therapy is a covered service when prescribed by a licensed provider experienced in the diagnosis and monitoring of patients with autism spectrum disorders and when used in the treatment of autism/autism spectrum disorders as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Coverage requires utilization of individuals appropriately licensed by the state and/or certified by the Behavior Analyst Certifying Board**, whether the services are provided by In-Network PPO providers or Out-of-Network PPO providers.** Prior authorization is required. Call Regence BlueCross BlueShield of Oregon at (866) 240-9580.

Approved Clinical Trials

If an In-Network PPO Provider is participating in an Approved Clinical Trial and will accept you or your Dependent as a trial participant, benefits will be provided only if you or your Dependent participate in the Approved Clinical Trial through that provider. If an Approved Clinical Trial is conducted outside your or your Dependent's state of residence, you or your Dependent may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which you or your Dependent are enrolled and participating are covered as specified elsewhere in this document.

Blood Transfusions

Coverage includes the cost of blood, plasma or any other blood-like infusion. Storage of blood and the cost of harvesting or collecting for autologous transfusion or directed donations (e.g. platelet pheresis) are not covered benefits.

Chemotherapy

Coverage includes treatment that is FDA approved for the diagnosis.

Chiropractic Treatment

Benefits include treatment by a chiropractor for a musculoskeletal disorder (bone, muscle, joint and tendon). The Plan has a 36-visit combined visit limit per calendar year (not more than one visit per day) for chiropractic treatment, acupuncture, and massage therapy delivered by a massage therapist.

COVID-19 Over the Counter Testing

Federal and state law may require coverage for over-the-counter COVID-19 tests ("OTC Tests") with no cost sharing (including deductibles, co-payments, and co-premiums) and no requirement of prior authorization. OTC Tests are those generally taken at home with the results read at home – this does not include PCR home tests that are sent to a lab. In addition, only OTC Tests authorized by the FDA are covered.

These governmental rules change frequently. Please contact the Fund Office for the information on the types and numbers of tests that the Plan will cover. In addition, you may purchase OTC

Tests at any network pharmacy or other retailer. As an alternative to buying OTC Tests, at the time of this SPD, you also can obtain OTC Tests at no cost to you the following way:

- Visit *www.COVIDtests.gov* to order four (4) free OTC Tests that will be mailed to you from the federal government.

There may be additional options in your local area for obtaining OTC Tests at no cost.

Diagnostic X-ray and Laboratory

X-rays and imaging procedures, audiology exams and testing for a condition other than hearing loss, and laboratory exams if medically necessary for diagnostic purposes are covered.

Diagnostic x-rays and laboratory expenses related to accidental dental injuries may also be covered.

Dialysis Treatment

Dialysis treatment is covered. The Plan opts-in to Regence BlueCross BlueShield of Oregon's Supplemental Kidney Dialysis Program. Benefits will be provided in accordance with this program.

If your kidney diagnosis makes you Medicare-eligible and you are enrolled in Medicare Part B on any basis and receive dialysis from a Medicare-participating Provider, you may not be responsible for additional out-of-pocket expenses after the first 42 visits.

In the Supplemental Treatment Period, after your initial 42 visits, you may be eligible to have Medicare Part A and Part B premiums reimbursed as an eligible expense for the duration of your dialysis treatment, as long as you continue to be enrolled in Medicare Part A and Part B and continues to be eligible for coverage. Proof of payment of the Medicare Part A and Part B premium will be required prior to reimbursement.

Contact Regence BlueCross BlueShield of Oregon at (866) 240-9580 if you or a Dependent are on dialysis or are expected to begin dialysis treatment.

Emergency Treatment

In addition to the deductible and co-insurance, a $160 copay applies to each emergency room visit. This copay is waived if you are admitted to the hospital as an inpatient. Life endangering medical emergency treatment provided at Out-of-Network PPO hospitals will be paid as if they were provided at In-Network PPO hospitals, after the deductible, co-insurance, and $160 copay.

Gender Dysphoria Treatment

Treatment of gender dysphoria will be considered a covered expense, provided that other relevant terms of the Plan are met. Prior authorization of all treatment and services is required.

Genetic Testing

Genetic testing, when performed for a medical reason or for a condition that requires genetic testing, provided the results of the testing have the potential to improve health outcomes. Prior authorization of all treatment and services is required.

Hearing Care

Hearing aids are covered for up to age 19 or for students up to age 26. Coverage is limited to one hearing aid per ear every 36 months unless modifications to an existing hearing aid is needed to meet the needs of the Participant.

One box of replacement batteries for each hearing aid per year is covered.

Bone-conduction sound processors are covered once every 36 months, if necessary for the appropriate amplification of the hearing loss.

Ear molds and replacement ear molds are covered up to four times per calendar year for Participants up to age eight, and at least once per calendar year for Participants eight years of age up to age 19, or 19 years of age up to age 26 and enrolled in a secondary school or an accredited educational institution.

Hearing assistive technology systems every 36 months for Participants up to age 19, if necessary for appropriate amplification of hearing loss.

Necessary diagnostic and treatment services at least twice per calendar year for Participants up to age four and at least once per calendar year for all other Participants.

Covered Services include the following:

- hearing aids and supplies;
- hearing assistive technology systems;
- diagnostic and treatment services including hearing tests appropriate for a Participant's age or developmental need;
- hearing aids checks and aided testing; and
- bone conduction sound processors when necessary for the treatment of hearing loss.

"Hearing aid" means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachment or accessory for the instrument or device. "Hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

Routine hearing exams are also covered by the Fund once per year.

Over-the-counter (OTC) hearing aids are not covered.

Home Healthcare

Home healthcare services are covered, up to 130 visits annually. Services must be provided by a licensed home healthcare agency or facility and be in place of confinement in a hospital or skilled nursing facility.

Your physician must call (866) 277-0913 to preauthorize any home healthcare services. More information about prior authorization is on pages 22 and 23.

Home healthcare services are covered provided that:

- Home healthcare services must be for the medically necessary treatment of an illness, injury or pregnancy related condition covered under the Plan
- The person must be homebound, which means that leaving home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another
- The physician must submit a written plan of treatment and certify that confinement in a hospital or skilled nursing facility would be required in the absence of home healthcare benefits

Covered charges include only:

- Home health aide services when acting under the direct supervision of one of the covered therapists and performing covered services specifically ordered by the physician
- Laboratory services
- Medical supplies and drugs prescribed by a physician and dispensed by the home healthcare agency
- Services of a registered nurse (RN) and licensed practical nurse (LPN)
- Services of a registered physical therapist, certified occupational therapist, certified speech therapist and certified respiration therapist

No benefits are payable for:

- Any supplies or services not specifically mentioned in this section
- Homemaker or housekeeping services
- Maintenance or custodial care
- Private duty nursing
- Separate transportation charges
- Services performed by family members
- Supportive environmental materials (handrails, ramps, etc.)
- Social services

In addition, home healthcare benefits are subject to review for medical necessity, appropriateness, level of care and the setting in which the care is provided.

Hospice Care

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This

program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of illness.

Your physician must call (866) 277-0913 to preauthorize any hospice care services. More information about prior authorization is on pages 22 and 23.

Covered home care benefits of a hospice agency are listed below. All services except for those of a physician must be provided and billed by the hospice agency. Covered charges include:

- Drugs dispensed by or through the hospice agency, that are legally obtainable only upon a physician's written prescription or that would have been provided on an inpatient basis, and insulin
- Home health aide services that are specifically ordered by the physician in the treatment plan
- Medical social services
- Medical supplies normally used by hospital inpatients and dispensed by the hospice agency
- Nursing services by a registered nurse (RN) or a licensed practical nurse (LPN)
- Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation
- Physical therapy services by a licensed physical therapist
- Physician services
- Rental (or purchase if approved by Regence Blue Cross Blue Shield of Oregon) of durable medical equipment. Repair or replacement of durable medical equipment necessary due to normal use is covered. Equipment ordered prior to the effective date of coverage is not covered. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.
- Respiratory therapy services
- Speech therapy services by a certified speech therapist

No benefits are payable for charges for any of the following:

- Environmental supportive services or equipment, such as, but not limited to, wheelchair ramps or support railings
- Food, clothing, or housing
- Homemaker services
- Services of financial legal counselors
- Services of volunteers
- Services or supplies not included in the written treatment plan, or not specifically set forth as a covered benefit
- Services provided by household members, family, or friends
- Services to other family members, including bereavement counseling
- Spiritual counseling

Hospital

Benefits include room and board (semiprivate room) as well as medically necessary inpatient services and supplies to treat an accidental injury or illness or other covered condition including:

- Administration of blood and plasma (including blood bank service charges)
- Diagnostic tests
- General nursing care
- Intensive care unit or coronary care unit
- Drugs
- Nursery charges for an eligible newborn child
- Operating rooms and equipment
- Physical therapy
- Speech therapy
- X-rays, imaging procedures, and laboratory services

The Plan does not cover hospitalization primarily for diagnostic tests or laboratory tests that could be performed as an outpatient, or for hospital admissions the Plan considers not medically necessary.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continued hospitalization. Hospital benefits may be reduced or denied if hospitalization is determined to be no longer medically necessary.

Infertility Treatment

The Plan covers services related to restoring fertility or promoting conception, including assisted reproductive procedures subject to Plan benefits. The annual amount of Plan paid benefits provided is limited to $35,000 and the lifetime amount of Plan paid benefits provided is limited to $70,000. These limits are combined across medical and prescription drug services.

Coverage does not include uterine transplants.

Infertility treatment is not covered for dependent children.

Injectable Prescription Drugs

Provider administered injectable drugs are covered, subject to all other applicable provisions of the Plan. Certain self-injectable drugs may be covered under the Prescription Drug benefit.

Massage Therapy

Massage therapy received by a licensed massage therapist is covered. The Plan has a 36-visit combined visit limit per calendar year (not more than one visit per day) for chiropractic treatment, acupuncture, and massage therapy delivered by a massage therapist.

Mastectomy

The Women's Health and Cancer Rights Act of 1998 requires that the Plan provide benefits for mastectomy-related services due to disease or cancer if you have had or are going to have a mastectomy. For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: all stages of reconstruction of the breast on which the mastectomy was performed, reconstruction and surgery to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedema.

The Plan does not provide benefits for prophylactic mastectomies except as may be required under the Women's Health and Cancer Rights Act.

Maternity Benefit

The Plan provides maternity benefits on the same basis as any other illness or injury. Covered expenses also include the services of a licensed midwife during childbirth but does not cover midwives for newborn baby visits or follow-up visits.

The Plan does not provide benefits for any services or supplies provided while acting as a surrogate for charges related to pregnancy or childbirth, including all complications, prenatal or postnatal care, or well-baby care of a newborn, except to the extent required by law.

The Plan does not provide any benefits if coverage has terminated prior to the delivery.

In accordance with federal law, the Plan does not restrict hospital benefits for covered mothers and newborns to less than 48 hours after normal vaginal delivery or 96 hours after a cesarean section or require that a provider obtain authorization from the Plan for prescribing a length of stay within those time periods. Regence BlueCross BlueShield of Oregon will extend hospitalization if a longer stay is medically necessary.

Medical Equipment and Prostheses

Artificial limbs or eyes, casts, splints, trusses, braces, crutches and other similar appliances are covered, as well as the rental of a wheelchair, hospital-type bed and other equipment for medically necessary treatment. Covered expenses will be limited to the standard model of medically appropriate level of performance and quality required for the diagnosed condition; deluxe or luxury equipment or items for convenience or comfort are not covered by the Plan. Rental of equipment is covered up to the purchase price of the equipment only. Repair of a damaged covered item or replacement of a damaged covered item, including as a result of normal wear and tear, that cannot be repaired will be covered up to the cost of a new item.

Expenses for supplies prescribed while covered under the Plan will be covered if delivered within 30 days of the loss of coverage.

The Plan does not cover the following:

- Equipment for lifestyle changes or recreational purposes
- Equipment set-up or training on the use of the equipment
- Equipment to control or enhance the environmental setting
- Items that are not for therapeutic use in direct treatment of a covered illness or injury
- Items that are not prescribed by a physician
- Replacement of lost or stolen supplies or equipment; replacement of equipment due to neglect
- Sports equipment or supplies; home exercise equipment or supplies; and fitness center memberships

Mental and Nervous Disorder Treatment

Inpatient hospital expenses are paid on the same basis as any other illness or injury.

Outpatient services performed by a covered provider for individual therapy are paid on the same basis as any other illness or injury.

Services of a mental health counselor, clinical social worker or marriage and family therapist certified or licensed by the state where services are received are covered. Expenses for drugs are covered under the prescription drug benefit.

Hospital benefits may be reduced or denied if hospitalization is determined to be no longer medically necessary.

Neurodevelopmental Therapy

Physician-recommended neurodevelopmental therapy – including speech, physical and occupational therapy – is covered for Dependent children under age 18. See the rehabilitation benefit on pages 32 and 33.

Nutritional Counseling

Services are covered for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity.

Orthotics

Orthotics or other supportive devices are covered when prescribed by a covered provider or chiropractor to treat an injury or medical condition of the foot. Benefits include braces, splints, insoles and foot supports as well as impression casts for fitting these devices and the cost of any repairs. The device must be intended for wear at all times that shoes are worn and not just for specific activities.

This benefit does not cover shoes or supports that are available without a prescription.

Physician Visits

Hospital, home and office visits are covered for illness or injury.

The Plan does not cover the following:

- Follow-up treatment within four weeks after the date surgical benefits are payable
- Hospital visits after the period covered under the hospital benefit
- Phone or other consultation fees when a patient is not physically seen by a physician

Podiatry

Services by a podiatrist or physician for routine foot care are covered for the following:

- Performing routine hygienic care, metatarsalgia and bunion care (except when a cutting operation is involved)
- Treating fallen arches and other symptomatic complaints of the feet
- Trimming nails, corns and calluses

Preventive Care – In-Network PPO Providers

Preventive care services are covered at 100% of charges (not subject to the deductible**), *if an In-Network PPO provider is used***. Covered preventive services for PPO providers include the following:

- United States Preventive Services Task Force (USPSTF) Grade A and B recommended services such as physical exams, certain cancer screenings and immunizations
- Centers for Disease Control (CDC) child, adolescent, catch up and adult immunizations schedules
- Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents and women

See *www.healthcare.gov* for more information about the preventive services guidelines and recommendations listed above. The same preventive care service received from both a PPO provider and non-PPO provider is only covered once under the Plan.

Preventive Care – Out-of-Network PPO Providers

Preventive care services are covered at 60% of charges (subject to the deductible) ***if an Out-of-Network PPO provider is used***. Covered preventive services for Out-of-Network PPO providers are the same as those listed above for In-Network PPO providers.

Note: The same preventive care service received from both an In-Network PPO provider and an Out-of-Network PPO provider is only covered once under the Plan.

Rehabilitation

Rehabilitation services are limited to a combined maximum of 40 outpatient visits per calendar year. Inpatient stays are limited to a maximum of 30 days per calendar year. Therapy must be by

a referral from a physician, ARNP or PA and meet specific Plan criteria; contact Regence BlueCross BlueShield of Oregon for those criteria.

The Plan covers medically necessary rehabilitation services for disabling conditions to restore or significantly improve function that was lost due to acute injury or illness.

The Plan does not cover the following:

- Services for palliative, recreational, relaxation or maintenance therapy
- Services for on-the-job injuries or work-related injuries or illnesses
- Services provided by a registered or licensed therapist who resides in your home or is related by blood or marriage

Skilled Nursing Facility Care

Benefits are covered for confinement in a skilled nursing facility ordered by a physician, up to 60 days annually. The confinement must be for medically necessary treatment of a covered illness (including pregnancy) or injury.

Your physician must call (866) 277-0913 for prior authorization (see pages 22 and 23).

Benefits include:

- Necessary services and supplies furnished by the facility
- Room and board up to the average semiprivate room rate, except where a private room is necessary

The Plan does not cover any confinement primarily for rehabilitation or care that can be provided on an outpatient basis. Custodial care, residential treatment or benefits for any personal comfort items are not covered.

Substance Abuse Treatment

Inpatient hospital expenses are paid on the same basis as any other illness or injury. Outpatient services performed by a covered provider for individual therapy are paid on the same basis as any other illness or injury. Covered expenses include services at an approved alcoholism and/or drug abuse treatment facility, an approved hospital or a covered provider's office. Expenses for drugs are covered under the prescription drug benefit.

Benefits may be reduced or denied if inpatient confinement is determined to be no longer medically necessary.

To the extent permitted by law, the Plan does not cover alcoholism and/or drug abuse treatment charges for:

- Information or referral services
- Residential care

Surgical Services

Medically necessary surgeries resulting from illness or injury are covered. Benefits include covered surgical procedures performed in the physician's office, hospital or ambulatory surgical center. If you're hospitalized, surgical benefits are in addition to hospital benefits.

Assistant Surgeon. Medically necessary services are covered for a surgical procedure when performed by an assistant surgeon or physician (other than a hospital intern or resident).

Second Surgical Opinion. To help you understand surgery risks and alternatives, this Plan covers a second surgical opinion for nonemergency procedures. Contact Regence BlueCross BlueShield at (866) 277-0913 for more information.

Prior authorization is required for some surgeries (see pages 22 and 23).

Transplants

Transplants are covered, including transplant-related services and supplies. Covered services for a transplant recipient include the following:

- heart;
- lung;
- kidney;
- pancreas;
- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:
    - either autologous (self-donor);
    - allogeneic (related or unrelated donor);
    - syngeneic (identical twin donor); or
    - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact Regence BlueCross BlueShield at (866) 277-0913, as the list is subject to change.

Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage; and
- transportation of the surgical harvesting team and the organ.

X-ray and Radiation Therapy

Medically necessary treatments are covered.

Medical Exclusions and Limitations

In addition to the General Exclusions (see page 45), the Fund does not cover:

1. Aquatic therapy.
2. Charges for counseling, education, self-help instruction or training. These include, but are not limited to, services for behavior modification, learning disabilities, vocational assistance, marital counseling, social counseling, conduct disorders, impulse control, cognitive disorders, sexual lifestyle counseling, family therapy, fitness guidance, anger management, or nutritional counseling, except as provided under the nutritional counseling benefit.
3. Charges for treatment of temporomandibular dysfunction or temporomandibular joint dysfunction (TMJ).
4. Dental treatment (except natural teeth restorations due to accidental injuries).
5. Eye exercises; visual or orthoptic training/therapy.
6. Eyeglasses, eye refractions or eye exams to correct vision or fitting of glasses.
7. Food supplements, including formula for enteral feeding, except medical foods for inborn errors of metabolism (such as PKU).
8. Genetic counseling, testing, treatment, or other services except as expressly stated in the Genetic Testing benefit on page 26.
9. Medical exams or tests not connected with an illness or injury, except as provided under preventive care benefits.
10. Postage, handling and taxes related to medical services or supplies.
11. Preventive medicine (except as specified under preventive care benefits).
12. Private room charges exceeding the hospital's most common charge for semiprivate (two-bed) accommodations, unless medically necessary.
13. Refractive eye surgery to correct vision deficiencies.
14. Reversal of tubal ligation or vasectomy.
15. Services by an institution that is primarily a place of rest, place for the aged, nursing home, convalescent home, residential facility, or similar institution, except for covered hospice services.
16. Services performed on teeth, gums or alveolar processes (except to treat tumors or accidental injury).
17. Shoes or foot supports available without prescription.
18. Smoking cessation program, whether or not you have other medical conditions related to or caused by smoking, except to the extent required by law.
19. Weight loss treatment or services, unless preauthorized by Regence BlueCross Blue Shield of Oregon.
20. Hypnotherapy, and all services related to hypnotherapy.

PPO Plan Prescription Drugs

Optum Rx administers the Fund's prescription drug benefit through a network of retail pharmacies and mail order.

Some prescription drugs may have limited quantities, may need to be preauthorized or may not be covered.

Copays at In-Network Pharmacies

For each drug (or refill) administered or prescribed by a physician and filled at a network pharmacy, the Plan pays for a 30-day supply or 90-day supply for (maintenance drugs only) after these copays:

Type of Drug	30-day Supply	90-day Supply*
Tier 1	$0	$0
Tier 2	$30	$60
Tier 3	$80	$160
Brand if generic is available	**	**
Specialty	$100	Not covered

*Maintenance-only. Maintenance drugs in excess of a 30-day supply must be purchased through a CVS retail network pharmacy or by mail. The Fund will allow for two (2) 30-day grace fills for maintenance drugs. After two grace fills, a 90-day supply must be obtained through a CVS retail pharmacy or through the Optum Rx mail order pharmacy. Otherwise, there will be no coverage.

**Appropriate Tier copay plus the difference in cost between the generic and the brand name drug.

Coinsurance at Out-of-Network Pharmacies

For each drug (or refill) administered or prescribed by a physician and filled at a non-network pharmacy, the Plan pays for a 30-day supply or 90-day supply for (maintenance drugs only) after the stated coinsurance and deductible:

Type of Drug	30-day Supply	90-day Supply*
Tier 1	40% after deductible	40% after deductible
Tier 2	40% after deductible	40% after deductible
Tier 3	40% after deductible	40% after deductible
Brand if generic is available	**	**
Specialty	Not covered	Not covered

*Maintenance-only. Maintenance drugs in excess of a 30-day supply must be purchased through a CVS retail network pharmacy or by mail. The Fund will allow for two (2) 30-day grace fills for

maintenance drugs. After two grace fills, a 90-day supply must be obtained through a CVS retail pharmacy or through the Optum Rx mail order pharmacy. Otherwise, there will be no coverage.
**Coinsurance will be based on the cost of the brand name drug when a generic is available.

- Tier 1 – generics and potentially some cost-effective brand name drugs.
- Tier 2 – most brand name drugs, or more costly or less desirable generics.
- Tier 3 – non-preferred brand drugs and some more costly brand and generic drugs.

You can contact Optum Rx at (844) 368-0083 or visit *www.optumrx.com* to see which tier your prescription is in.

Retail Pharmacies

The program features a network of pharmacies. You can use any pharmacy – the choice is yours each time you fill a prescription. Pharmacies in the Optum Rx network provide discounted prescriptions to the Plan. To receive the most cost-effective copayments, always use the network and mail order pharmacy as described below.

- **Optum Rx Network.** When you use an Optum Rx network pharmacy, simply take your prescription and your Fund ID card to the pharmacy and pay the appropriate copay.
- **Out of Network.** If you fill your prescription at a pharmacy that is not in the Optum Rx network, you pay the full cost at the time of purchase, then file a claim with the Optum Rx and wait for reimbursement.

If you need help locating a network pharmacy, call Optum Rx at (844) 368-0083 or visit *www.optumrx.com*.

If your Dependents have other insurance and the other coverage is primary, they will need to follow that plan's procedures when purchasing prescriptions. Then, to get reimbursed by the Fund for the copay, submit a copy of the prescription receipt and any explanation of benefits form to Optum Rx.

Optum Home Delivery

You also have the option of using Optum Home Delivery through Optum Rx. Choose from the following ways to order your prescriptions from home delivery: electronically prescribed via your doctor, go to *www.optumrx.com*, use the Optum Rx app or call the number on your member Fund ID card.

To use Optum Home Delivery, complete a new prescription order form (available from the Fund Office and online at *www.optumrx.com*), attach your prescription and your check for the appropriate copay and mail to the address on the form. Instead of a check, you may also include your credit card number on the form. After Optum Rx receives your copay, Optum Home Delivery will fill the prescription and ship it to you. The reorder form is printed and mailed with your first fill. The form is available with every order in the digital version. For your convenience your doctor can send an e-prescription to Optum Home Delivery.

To make sure you don't run out of your medicine on your initial fill, allow two or three weeks for receiving your prescription. If you send in a prescription for a new medicine, request a two-to-

three week supply from your doctor or a local pharmacy while you wait for your mail-order medication. For refills through Optum Home Delivery, please allow seven business days for processing.

You can contact Optum Home Deliver at (844) 368-0083 with questions.

Specialty Drugs

Certain specialty drugs are provided through the program with Optum Rx. Specialty drugs must be obtained through the Optum Rx exclusive specialty pharmacy network, otherwise they are not covered. Specialty drugs include, but are not limited to, the following:

- Certain self - injectable drugs (excluding insulin)
- Oral medications for oncology (cancer), and a variety of other medications that may require special monitoring or handling, or are extremely costly

You can contact Specialty Optum Rx at (877) 838-2907 during the hours of 7:00 a.m. to 9:00 p.m. Pacific Time if you have any questions.

Maintenance Prescription Drugs

Maintenance drugs are certain medications used to treat chronic or long-term conditions such as diabetes, arthritis, heart conditions, high cholesterol, digestive, asthma and high blood pressure.

The Fund will cover two (2) 30-day supply prescriptions for maintenance drugs. After two (2) 30-day grace fills, you must obtain a 90-day supply from either a CVS retail pharmacy or through Optum Home Delivery, otherwise the prescription will not be covered.

Combined Medical and Prescription Drug Out-of-Pocket (OOP) Maximum

The annual prescription drug out-of-pocket (OOP) maximum is combined with the annual medical out-of-pocket maximum. Please refer to pages 19 and 20 for the combined annual medical and prescription drug OOP maximum.

Prescription drug copays apply to the out-of-pocket maximum, but any processing fees, cost differentials or non-covered prescription drug expenses will not apply.

Covered Prescription Drug Expenses

The Plan covers charges for:

- FDA approved legend prescription drugs when used for an FDA approved condition
- Cysteamine, phosphocysteamine, and dietary supplements recommended by a physician for treating cystinosis
- Hospital take-home prescription drugs, birth control products and diabetic supplies (including insulin, insulin syringe, needles, test strips or equivalent) prescribed by a physician for use outside the hospital
- Prescription drugs, birth control products and diabetic supplies (including insulin, insulin syringe, needles, test strips and equivalent) from licensed pharmacists

- Self-injectable drugs prescribed by a physician
- Prescription drugs used to treat substance abuse

Prescription Drug Exclusions and Limitations

The Plan does not cover:

1. Appliances, devices, bandages, heat lamps, braces or splints.
2. Blood and blood plasma.
3. Cosmetics or health and beauty aids.
4. Drugs administered or taken while confined in the hospital.
5. Drugs lost, stolen or damaged by neglect.
6. Drugs reimbursable by any government program – national, state, county or municipal.
7. Drugs taken in conjunction with home health, hospice or skilled nursing care.
8. Maintenance prescription drugs in excess of a 30-day supply that are purchased from other than the mail or network pharmacies, except for 2 30-day grace fills.
9. Medicines not requiring a prescription, unless otherwise indicated or as required by law.
10. Growth hormones, unless preauthorized.
11. Refills before eligible (refill too soon).
12. Diagnostic agents and products used to examine the body in a medical setting.
13. Digital applications for patient and prescriber to aid in outpatient therapy.
14. Anesthetics used prior to surgery.
15. Prescription multivitamins similar to OTC formulations.
16. Prescription multivitamins with fluoride.
17. Prescription multivitamins with iron.
18. Products available without a prescription.
19. Repackaged products.
20. Gene therapy drugs.
21. Homeopathic drugs.
22. Weight loss products.
23. Electrolyte replacement products.
24. Prescription drugs with OTC equivalents.
25. Immunizations for travel purposes.
26. Fluoride products.
27. Nutritional supplements, except for folic acid supplements related to pregnancy.
28. Medical food products.

Some of these items may be covered under your medical benefits; contact the Fund Office for details.

Coordination of Benefits

You may have medical and/or dental or other health coverage, such as through your spouse's employer, in addition to these benefits. The other plan is taken into account when your benefits under this Plan are determined. This provision, known as coordination of benefits, may change how benefits are paid under the Plan.

The plan that pays benefits first is considered the primary plan and pays benefits without regard to those payable under other plans. When another plan is primary, the Fund pays an amount that, when added to other plan benefits, does not exceed 100% of allowable expenses under this Plan.

This provision applies whether or not a claim is filed under Medicare or another plan. The Fund is authorized to obtain information about benefits and services available from Medicare or other plans to implement this rule.

Allowable expenses are any usual, customary and reasonable charges, part or all of which are covered under any of the other plans. Allowable expenses under a health maintenance organization include only the copayments you are required to pay.

The following rules determine which group plan is primary:

- A plan that has no coordination of benefit provisions pays before a plan that includes such provisions
- A plan that covers a person as an active employee pays before an active employer health plan that covers the person as a dependent.
- Benefits of the plan covering the person as an active employee or dependent of an active employee is primary before benefits of the plan covering the person as a retired, COBRA, terminated or laid-off employee or dependent of a retired, COBRA, terminated or laid-off employee.
- If a dependent child is covered under both married parents' plans, the child's primary coverage is through the parent whose birthday comes first in the calendar year, with secondary coverage through the parent whose birthday comes later. If the other plan relies on gender instead of this "birthday rule" to coordinate benefits, the "gender rule" is used. However, for a child who is a child under this Plan and the spouse of an active employee under another plan, the plan that covers that person for the longest is primary.
- If a dependent child's parents are not married, and a court decree and/or parenting plan establishes financial responsibility for the child's healthcare coverage, the plan of the parent with responsibility is primary. If the divorce decree is silent, the following guidelines apply:
  - The plan of the parent with custody pays benefits first if that parent has not remarried. The plan of the parent without custody pays second.
  - If the parent with custody has remarried, the plans pay in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody and plan of the spouse of the parent without custody.
- For children whose parents were never married, the same rules apply as for divorced parents
- If none of the above rules establishes which group plan would pay first, then the plan that has covered the person longer is considered primary

The Fund excludes coverage for services or charges that would be provided or covered by a health maintenance organization (HMO) or other prepaid arrangement if such HMO or other prepaid arrangement were the only source of coverage. The reason for this exclusion is that an HMO will not coordinate benefits with the Fund for services provided by a non-HMO provider.

This Plan coordinates with:

- Any type of group coverage, whether insured or not
- Motor vehicle no-fault coverage

Coordination of benefits does not apply to any individual policy you have.

Note: If you or your eligible Dependents have other coverage and this Plan is secondary, you receive faster claim service if you submit the claim to the primary plan first. Then attach a copy of their explanation of benefits and your itemized bill to your claim submission for this Plan.

Medicare

- The Fund will be the primary payor of medical costs for Employees over 65, and spouses over age 65 of Employees of any age, with Medicare providing secondary coverage. This means you will be reimbursed first under this Plan (except in the case of End Stage Renal Disease (ESRD), as set forth below). If there are covered expenses not paid by the Fund, Medicare may reimburse you. To get reimbursement from Medicare, you must enroll for Medicare. In addition, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium.
- Employees have the option of electing Medicare as primary coverage. However, an Employee over age 65 or an Employee's spouse over age 65 will automatically continue to be covered by the Fund as primary unless you notify the Fund Office, in writing, that you do not want coverage under the Fund. If you elect your coverage under Medicare to be primary, the Fund cannot by law, pay benefits secondary to Medicare. If an Employee or Dependent age 65 or older makes this election, it will mean that the individual making this election will not have any Fund coverage.

Disabled Employees or Disabled Dependents Under 65

If you are employed and you or your Dependent(s) are under age 65 and are entitled to Medicare due to disability, other than for end stage renal disease (ESRD), the Fund will pay benefits as primary.

End Stage Renal Disease (ESRD)

If you or your Dependent(s) are entitled to Medicare on the basis of age or disability and then become entitled to Medicare based on ESRD, and the Fund is currently paying benefits as primary, the Fund will remain primary for the first 30 months of your entitlement to Medicare due to ESRD. If the Fund is currently paying benefits secondary to Medicare, the Fund will remain secondary upon your entitlement to Medicare due to ESRD.

The Plan opts-in to Regence BlueCross BlueShield of Oregon's Supplemental Kidney Dialysis Program. Contact Regence BlueCross BlueShield of Oregon at (866) 240-9580 if you or a

Dependent have been diagnosed with ESRD or have questions about coordination of benefits under this Plan with Medicare benefits.

Subrogation (Right of Recovery)

Were you or your Dependent injured in a car accident or other accident for which someone else is liable? If so, that person (or his/her insurance) may be responsible for paying your (or your Dependent's) medical and other expenses, and these expenses would not be covered under the Plan.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court). Because of this, as a service to you, the Fund will pay you (or your Dependent) benefits based on the understanding that **you are required to reimburse the Fund in full for any** recovery you or your Dependent may receive, no matter how it is characterized. The Fund advances benefits to you and your Dependents only as a service to you. You must reimburse the Fund if you obtain any recovery from another person or entity.

You and/or your Dependent are required to notify the Fund within 10 days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within 10 days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgement or payment relating to the accident in any lawsuit initiated to protect the Fund's claims.

The Plan does not provide benefits for services or supplies to the extent that benefits are payable for such services or supplies under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage (collectively referred to as the "third party").

If the covered person requests benefits for services or supplies for an illness or injury for which there is an actual or potential right of recovery against a third party, the Plan will advance the requested benefits subject to the following conditions:

1. By accepting or claiming benefits, the covered person agrees that the Plan is entitled to reimbursement from any judgment, direct payment, settlement, disputed claim settlement or any other recovery, up to the full amount of all benefits provided by the Plan. However, in no event shall the Plan's reimbursement exceed the gross amount of your recovery.

2. The Plan is entitled to reimbursement regardless of whether the covered person is made whole by the recovery, and regardless of the characterization or apportionment of the recovery. The Plan is entitled to first dollar priority from the covered person's recovery after payment of your attorney fees and costs, to the extent applicable.

3. Before the Plan will provide benefits, the Plan requires the covered person and the covered person's attorney or personal representative to sign an agreement acknowledging the obligation to reimburse the Plan from the proceeds of any recovery. The Plan requires the covered person to do whatever else is necessary to secure the Plan's right of reimbursement (including an assignment of rights).

4. The covered person has an affirmative obligation to notify the Plan in the event the covered person requests or has requested benefits for services or supplies for an illness or injury for

which there is a right of recovery against a third party. This obligation arises on the earlier of the date the covered person makes a formal or informal claim against the third party or investigates whether to make a formal or informal claim against the third party. In the event the Plan pays benefits prior to learning or discovering the covered person's third-party claim, such benefits are treated as overpaid benefits until the above conditions are met. The covered person agrees and the Plan reserves the right to recoup any overpaid benefits by offsetting future benefits otherwise payable to the covered person or the covered person's family members, or by recovering the benefits from a source to which benefits were paid.

5. The covered person must do nothing to prejudice the Plan's right of reimbursement.

6. When any recovery is obtained, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan's reimbursement claim are not placed in an escrow or trust account, the covered person or any failing party will be personally liable for any loss the Plan may suffer as a result.

7. The Plan may cease providing benefits if there is a reasonable basis for concluding the covered person will not honor the terms of the Plan or the agreement to reimburse, or the Trustees of the Plan modify the Plan provisions relating to reimbursement rights.

8. In the case of a deceased person, the Plan's rights apply to the decedent's estate, and the estate is required to comply with the Fund's rules and procedures to the same extent as an injured person. The Fund's right to reimbursement applies to any funds recovered from any other party by or on behalf of the estate and to any wrongful death recovery received by the decedent's survivors.

9. The Plan has a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any overpaid or advanced benefits received by the Employee, Dependent, their estate or a representative of the Employee or Dependent (including an attorney) that is due to the Plan, and any such amount is deemed to be held in trust by the Employee or Dependent for the benefit of the Plan until paid to the Plan. By accepting benefits from the Plan, the Employee and Dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the Employee and Dependent agree to cooperate with the Plan in reimbursing it for all of its costs and expenses related to the collection of those benefits.

10. The Plan specifically disavows any claims that a covered person may make under any federal or state common law defense, including but not limited to the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Plan's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the individual from any source without regard to legal fees and expenses of the individual and the individual will be solely responsible for paying all legal fees and expenses. The Plan has a priority, first-dollar security interest and a lien on any recovery received from any source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such injury, illness, accident or condition.

11. If the Plan is not reimbursed within a reasonable period of time following the recovery or if there is a reasonable basis for concluding that the covered person will not honor the terms of the Plan or the agreement, the Plan may bring an action against the covered person to enforce its right to reimbursement. Also, the Plan may elect to recoup the reimbursement amount by offsetting future benefits otherwise payable to the covered person or the covered person's family members, or by recovery from a source to which benefits were paid. If the Plan is forced to bring legal action to enforce the terms of the agreement to reimburse, it shall be entitled to its reasonable attorneys' fees, costs of collection and court costs.

This reimbursement and subrogation program is a service to you and your Dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for your injuries.

General Plan Exclusions

With respect to all benefits, unless otherwise specifically provided, the PPO Plan does not cover.

1. Any service or supply that is not medically necessary for the care and treatment of illness or injury (except as specified for preventive care benefits).
2. Any expense incurred before your date of coverage. An expense is considered incurred on the date you receive the service or supply for which the charge is made.
3. Any expense incurred after the termination of your coverage under this Plan, except as specifically indicated.
4. Charges for missed appointments or completion of claim forms.
5. Charges for treatment, services or supplies that exceed usual, customary and reasonable fees.
6. Cosmetic procedures (except as part of treatment of a functional disorder covered by this Plan or as a result of an accidental injury occurring while the individual is covered), complications from any cosmetic surgery and cosmetic procedures for psychological or self-esteem reasons.
7. Custodial care or care when no significant clinical improvement is expected as a result (except hospice care).
8. Experimental or investigational treatment.
9. Complications of non-covered services, except for emergency services required for stabilization.
10. Lodging, food or transportation, unless otherwise provided under this Plan.
11. Any illness, disease or injury for which an employer is required to furnish hospital care or other benefits in whole or in part by state or federal Workers' Compensation laws or other legislation, including Employee's Compensation or Liability Laws of the United States, or a program which provides equivalent coverage, even though the Employee or Dependent waives his or her rights to such benefits.
12. Any service or supply for which no charge is made or no payment is required.
13. Services performed by a provider not licensed in the state where services are performed and not within the scope of the provider's license.
14. Services or supplies covered by other group insurance or medical service program or for which no charge is made or no payment is required from you or your Dependents as a condition of receiving coverage.
15. Services or supplies that are solely for the convenience of the patient, provider, or caregiver.
16. Any services or supplies not specifically covered under the Plan.
17. Claims received after the 12-month filing limit.
18. Conditions or injuries caused by or arising from war or any act of war, declared or undeclared, armed invasion or aggression. For injuries resulting from military service, this exclusion only applies if coverage is available through Veterans Affairs benefits, a military service-related disability program, or a similar veterans benefit program.
19. Court-appointed treatment not covered by the Plan.
20. Late fees, finance charges or collection charges imposed by the provider.
21. Services or supplies received from a physician or other provider who usually lives in your home or is related by blood or marriage.
22. Treatment for injuries sustained while committing or attempting to commit a felony.

Submitting a Claim

NOTE: This section does not apply to HMO Plan enrollees. For HMO Plan enrollees, contact the Fund Office or Kaiser Permanente Northwest at (800) 813-2000.

How to File a Claim - General

Claims must be submitted within the following time periods:

Claim	Time Period
Medical	12 months from the date the service or supply was received
Prescription Drug	12 months after filling the prescription

Subject to special provisions for urgent care claims (see page 47), claims must be submitted in writing and to the proper address. Regence also has an internal process to assist you in resolving your claim before filing an appeal with the Fund- see page 49. The Plan may require more details to process claims. Not providing required information to the Plan within 12 months of the original request may result in the denial of your claim for untimely filing.

Submitting incomplete forms or bills that aren't itemized will delay claim processing.

Fund PPO Medical Benefits

Many providers will file claims for you if they have all the needed information. If your provider does not submit a claim on your behalf, you will need to do the following:

1. Obtain a claim form online at *www.essentialworkerhealth.org* or from the Fund Office.
2. Complete all sections on the front of the form.
3. Attach a fully itemized bill from your provider.
4. If you have other medical coverage and this Plan is secondary, submit the claim to the primary plan first. Once that plan pays, send a copy of its explanation of benefits and a fully itemized bill when you submit your claim to this Plan. (See pages 40 to 44 for coordination of benefit rules.)
5. Mail the fully completed form and any attachments to the address at the top of the form.
6. For claim assistance, contact the Fund Office.

Incomplete forms and bills that are not itemized will be returned to you for completion and will delay payment of your claims. No claim will be accepted unless the complete form and the necessary information is filed within 12 months from the date the service or supply was received.

General Procedures for Processing Claims

Claims are processed according to these guidelines:

Post-Service Claims

Any properly filed claim for health benefits that is not a pre-service, urgent care or concurrent care claim (as defined on the following pages) is processed as a post-service claim. If more information is needed, you (or your Dependent) are notified via an explanation of benefits. A post service claim ordinarily is processed within 30 days of receipt.

Pre-Service Claims

These procedures apply only to processing treatment plans submitted for prior authorization. See pages 22 and 23 for more information regarding prior authorization.

The claimant is notified within five days if more information is required to complete a pre-service claim or to allow processing, with specifics on the information needed. The claimant has 45 days from receiving the notice to submit the information. The Plan's time for making a determination does not include the period from the date the information is requested until the earlier of the date the requested information is received, or 45 days after the request for information is mailed to the claimant.

A decision on a pre-service claim ordinarily is made within 15 days. This period may be extended for an additional 15 days if the Fund Office determines that the extension is necessary due to matters beyond the control of the Plan and provides the reason for the extension – including a statement of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision– within the initial 15 days.

If services requiring prior authorization have been provided, and the issue is payment, the claim is processed as a post-service claim.

Urgent Care Claims

Urgent care claims are for services where following the normal claims processing timing rules could seriously jeopardize the claimant's health or ability to regain maximum function, or in the opinion of a physician familiar with the claimant's medical condition, would subject the claimant 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 the claimant, physician or covered provider with knowledge of the condition. The Fund will notify the claimant of its benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Fund, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If more information is required to process the claim, the claimant is informed regarding the specific information necessary to complete the claim as soon as possible, but not more than 24 hours after the claim is received.

The claim is then resolved as soon as possible, but no more than 48 hours after the Fund receives the additional information or the end of the 48 hours the claimant has to provide the information, whichever is earlier.

If urgent care services have been provided, and the issue is payment, the claim is processed as a post-service claim.

Concurrent Care Claims

Concurrent care claims are claims involving an ongoing course of treatment that has received medical necessity approval. While the approved treatment is continuing, the provider or claimant may request additional or extended treatment that results in denial or reduction of the treatment plan. In addition, the Fund may issue notice that approval will be withdrawn before the full course of treatment is completed. The claimant is notified of any denial or reduction sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on the appeal before the decision takes effect.

Any request to extend treatment that involves urgent care is decided as soon as possible, taking into account the medical exigencies. The claimant is notified of the determination within 24 hours of when the Plan receives the claim, if it is received at least 24 hours before the previously approved treatment ends.

Any appeal of a concurrent care claim is treated as a post-service, pre-service or urgent care claim appeal, as appropriate.

Notice of Denial

A benefit denial will contain this information:

1. The reason for the denial.
2. The denial code (if any) and its corresponding meaning.
3. A statement regarding the availability of the diagnosis and treatment codes upon request.
4. Information sufficient to identify the claim, including the date of service, health care provider and claim amount, if applicable.
5. Reference to the Plan provision(s) relied on.
6. Description of any additional material needed for the claim, with an explanation of why it is necessary.
7. Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.
8. An explanation of the medical judgment – applying Plan terms to your circumstances – if the denial is based on the service or supply being medically necessary or experimental or investigational, or an equivalent exclusion.
9. An explanation of the Plan's appeal procedures and the available external review procedures, including applicable time limits.
10. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.

The denial will be mailed to the claimant at the last known address.

Important Terms

- Pre-Service means any claim for benefits which the Claims Administrator must approve in advance, in whole or in part, in order for a benefit to be paid.

- Post-Service means any claim for benefits that is not considered Pre-Service.
- Representative means someone who represents you for the claims and appeal process. The Representative may be an attorney, your treating Provider or another party, such as a family member, as long as you (or your legal guardian) designate that person as your representative in writing. No authorization is required from the parent(s) or legal guardian of a dependent child who is less than 13 years old. Even if you have previously designated a person as your Representative for a previous matter, an authorization designating that person as your Representative in a new matter will be required. If no authorization exists and is not received in the course of the review, the determination and any personal information will be disclosed to you and your Representative only.

Regence Internal Process

Regence also has an internal process to assist you in resolving your claim.

Reviews can be initiated through either written or verbal request using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign-in to Your account at **regence.com**, navigate to appeals and complete an appeal request.
Phone	Verbal requests can be made by calling Regence Customer Service.
Fax	1 (877) 663-7526
Mail	Attn: ASO Appeals and Grievances Regence BlueCross BlueShield of Oregon P.O. Box 91015 Seattle, WA 98111-9115

Regence will follow the timing above for the internal review. Internal reviews are conducted by an employee(s) of Regence who was not involved in, or subordinate to anyone involved in, the initial decision that you are appealing. In reviews that involve issues requiring medical judgment, the review is made by Regence's staff of health care professionals.

Optum Rx Internal Process

Optum Rx also has an internal process to review claims. This process involves Optum Rx's prior authorization team reviewing claims. If the claim is denied, a letter will be mailed or emailed to you and a copy of the letter will be sent to your prescribing provider. Following receipt of the initial denial, you can request an additional review through Optum Rx by calling (844) 368-0083. After receiving the first denial letter, you have the right to appeal to the Board of Trustees as described in the **Filing an Appeal** section of this document.

Filing an Appeal

NOTE: This section does not apply to HMO Plan enrollees. For HMO Plan enrollees, contact the Fund Office or Kaiser Permanente Northwest at (800) 813-2000 regarding appeals.

The Board of Trustees has adopted the following procedures to review benefit claim denials.

Appeal of Benefit Denial

The claimant has 180 days from the date of denial to appeal the denial. An appeal must be submitted in writing by the claimant or an authorized representative to the Fund Office. An appeal must identify the claim involved as well as reasons for the appeal and provide any pertinent information. The claimant has a right to submit written comments, documents, records, and other information relating to the claim for benefits. Except for urgent care claims, appeals are accepted from an authorized representative only if accompanied by a signed statement from the claimant (or from a parent or legal guardian where appropriate) identifying the representative and authorizing that person to seek benefits. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim appeal within 180 days of the denial will serve as a bar to any claim for benefits or for any form of relief from the Plan.

Appeal Procedures

The procedures below and in the external review section are the exclusive procedures available to you if you are dissatisfied with an eligibility determination, benefit denial by the Fund or its authorized claim payers. These procedures must be exhausted before you may request an external review or may file suit under Section 502(a) of ERISA.

Information To Be Provided Upon Request and Automatically (if applicable)

You or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents 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 treatment, without regard to whether such document or advice was relied on in making the benefit determination.

If a denial is based on a determination as to medical necessity, an explanation of that determination and how it applies to your circumstances also are available upon request.

In addition, you will automatically be provided with any and all new information considered, relied upon or generated in connection with your appeal, and/or any new or additional rationale for the decision, as soon as reasonably possible. You will be offered the opportunity for a full and fair review on appeal.

Review by Appeals Committee

Except for urgent care and pre-service claims, an appeal is presented to the Fund's Appeals Committee at its next scheduled meeting after receiving the appeal. The Appeals Committee reviews the administrative file, taking into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review is new and independent of the initial denial.

If the denial is based on a medical or dental judgment, the Appeals Committee consults a medical professional with appropriate training and experience in the applicable field of medicine. This professional will not be the individual who made the initial benefit determination or their subordinate. The Appeals Committee will identify by name any individuals consulted for medical or dental advice.

The claimant will be notified of the Committee's decision as soon as reasonably practical, but not later than five days after the decision is made.

Appeal Procedures for Pre-Service and Urgent Care Claims

Appeal procedures are modified as follows for appeals involving pre-service or urgent care claims:

Pre-Service Claims. Pre-service claim appeals follow the above procedures, with these modifications:

- There is one level of review by the Appeals Committee at its next scheduled meeting after the claimant's appeal is received. The claimant is notified of the Committee's decision as soon as practical, but not later than five days after the decision is made.

Urgent Care Claims. Urgent care claim appeals follow the above procedures, with these modifications:

- An initial decision is made within 24 hours after the Plan receives the Urgent Care Claim appeal if the initial claim is complete when submitted. If more information is necessary to process the claim, the claim will be resolved no later than 48 hours after the Fund receives the additional information or the end of the 48 hours the claimant has to provide the additional information, whichever is earlier. In addition:
  - An urgent care appeal may be made orally or in writing
  - A medical or dental professional with knowledge of the claimant's condition may act as an authorized representative without prior written authorization
  - Information can be provided to the claimant or authorized representative by phone, fax or other expedited method, as long as written or electronic verification is furnished not more than 72 hours later

Contents of Decision

If the Appeals Committee denies an appeal, you will be notified of specific reasons for the denial as well as specific Plan provision(s) involved, the denial code (if any) and its corresponding meaning, and a statement regarding the availability of the diagnosis and treatment codes upon

request, and that all information relevant to the claim is available without charge upon request. The notice will also include information sufficient to identify the appeal, including the date of service, health care provider and claim amount, if applicable. If the Committee relied on an internal rule, guideline or protocol, the notice will identify it and explain that a copy is available without charge upon request. If the Committee's decision was based on a medical or dental judgment, the notice will explain that judgment, applying the terms of the Plan to your circumstances. In the case of an appeal denied by the Appeals Committee, you also will be notified of your rights under Section 502(a) of ERISA and the available external review procedures. You also will be notified of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.

You have a right to file suit in federal or state court under Section 502(a) of the Employee Retirement Income Security Act (ERISA) on your claim for benefits; however, you must exhaust your administrative remedies before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit as described in "Your ERISA Rights" below.

For all claims and appeals, the Board of Trustees or its designee has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

Request for External Review

You must exhaust the Fund's internal claims and appeals process, as described above, before requesting an external review. Once the Fund's internal claims and appeals process is completed, you have 180 days from the date you receive the final adverse benefit determination (the notice of appeal denial) to file a request for an external review. If the deadline would fall on a Saturday, Sunday or Federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

You may request external review for any denied appeals that involve (1) a question of medical judgment, which includes decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, or (2) a denial due to a rescission of coverage (meaning a retroactive termination of coverage). External review is not available for any other types of denials, including claims related to eligibility or a legal or contractual interpretation of the Plan's terms. When you file a request for external review, you will be required to authorize the release of any records, including medical records of the patient, that may be required to be reviewed for the purpose of reaching a decision in the external review.

Requests for external reviews must be sent to:

Attn: Appeals
Oregon Essential Workforce Health Care Fund
PO Box 34203
Seattle WA 98124-1203

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Fund will complete a preliminary review of the external review request to determine whether:

- You were covered under the Fund at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Fund at the time the health care item or service was provided;
- The adverse benefit determination that is being appealed does not relate to your failure to meet the applicable eligibility requirements, or to a legal or contractual interpretation of the Plan's terms;
- You have exhausted the Fund's internal claims appeal process; and
- You have provided all the information and forms required to process an external review.

Within one business day after completion of this preliminary review, the Fund will issue notification of its decision to you. If the request is not eligible for external review, the Fund's notice will explain the reasons for its ineligibility and provide any other information required, including contact information for the Employee Benefits Security Administration and the Oregon Division of Financial Regulation. If the request for external review is incomplete, the Fund will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Fund will refer the matter to an Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization that is independent of the Fund and the IRO.

Review by Independent Review Organization

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Upon receipt of any information you submitted, the assigned IRO will, within one business day, forward the information to the Fund. Upon receipt of any such information, the Fund may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Fund will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Fund will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Fund and the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo, which means that it is not bound by any decisions

or conclusions reached during the Fund's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO will consider the following in reaching a decision:

1. Your medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Fund, you and your treating provider;
4. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines;
6. Any applicable clinical review criteria developed and used by the Fund, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision to the Fund and to you within 45 days after the IRO has received the request to review. The assigned IRO's decision notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the availability of diagnosis codes and their corresponding meaning, the denial codes (if any); and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards considered in reaching its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Fund or to you;
6. A statement that judicial review may be available to you; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act to assist individuals with the internal claims and appeals and external review process.

After a final external review decision, the IRO will make the record available for examination by you, the Fund or State or Federal oversight agency upon request, except where such disclosure would violate State and Federal privacy laws.

Expedited External Review

You may request an expedited external review if you receive:

- An adverse benefit determination involving your medical condition for which the time frame for completion of the Fund's expedited internal review process would seriously jeopardize

your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from a facility.

If the Fund receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Fund determines that you are eligible for a standard external review, the Fund will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by telephone or facsimile or by any other available expeditious method.

The assigned IRO will consider other appropriate information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo, which means that it is not bound by any decisions or conclusions reached during the Fund's internal claims and appeals process.

The IRO will notify the Fund and you of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Fund.

Actions Following the Decision of the IRO

If the IRO directs that benefits be paid, the Fund will provide benefits under its Plan in accordance with the decision. If the decision is adverse to you, or if the Plan fails to comply with the decision of the IRO, you have the right to pursue a suit pursuant to ERISA Section 502(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected you must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Fund; or the IRO's denial.

If you have questions about external review you may contact the Fund Office at (833) 389-0027 or the Oregon Division of Financial Regulation (toll-free) at (888) 877-4894.

Definitions

The following definitions apply to the benefits described in this booklet. **Except where otherwise indicated, whenever the following terms are used in this booklet, they have the following meanings:**

Accident means an event that is unintentional, unexpected, unusual and unforeseen.

Alcoholism and/or Drug Abuse Treatment Facility means an institution engaged primarily in treating alcoholism and/or drug abuse and licensed or approved for this purpose in the state where it is located.

Ambulatory Surgical Center means an institution engaged primarily in providing outpatient surgical services at the patient's expense and certified by the applicable licensing department of the State, to receive Medicare benefits as an ambulatory surgical center.

Approved Clinical Trial means a clinical trial 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 a cooperative group or center 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.
- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Behavioral health crisis means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

Child or Children means your natural children, stepchildren, adopted children, children placed with you for adoption and foster children, as well as children who are dependent on you for support **and** children for whom you are legal guardian, who meet all of the eligibility requirements of the Fund as Dependents.

Cosmetic Procedures are services to improve, change or restore physical appearance and/or self-esteem due to deformity or abnormality without materially correcting a functional disorder, or to prevent or treat a psychological disorder through a change in bodily appearance.

Covered Employment means employment in a position for which a Participating Employer obligated to contribute on your behalf to the Fund under a collective bargaining agreement or special agreement.

Covered Provider means:

- A physician
- For podiatry (foot care) benefits – podiatrist
- For pregnancy benefits – midwife
- For nursing benefits – Registered Nurse (RN), Licensed Practical Nurse (LPN) or Advanced Registered Nurse Practitioner (ARNP)
- For mental and nervous as well as alcoholism and/or drug abuse treatment benefits – psychologist
- For mental and nervous benefits – mental health counselor, clinical social worker or marriage and family therapist
- For rehabilitation benefits – occupational therapist, physical therapist, speech therapist and massage therapist
- Physician's Assistant employed by the physician or clinic (under direction of the physician).
- Advanced Registered Nurse Practitioner (ARNP)
- Surgical assistant
- Optometrist
- Dentist
- Acupuncturist
- Audiologist
- Chiropractor
- Naturopath

All covered providers must be licensed in the state which services are performed and the services must be within the scope of the provider's license. For certain services, the Fund requires that you use a credentialed provider, which is a covered provider with certain expertise in the area of treatment, as determined by the Trustees. Please contact the Fund Office for more information.

Custodial Care means any care or service designed primarily to assist with the activities of daily living and basic personal needs. These activities may include bathing, dressing, feeding, preparing meals, assisting with walking or getting in and out of bed, and supervising medication that can normally be self-administered.

Deductible means the amount of covered expenses you and your Dependents must pay each calendar year before the Plan begins to pay benefits.

Dependent means your spouse, domestic partner and children who meet all the eligibility requirements of the Fund.

Drugs mean any article that may be dispensed lawfully, as provided under the federal Food, Drug and Cosmetic Act, only with a written or oral prescription from a physician or chiropractor licensed by law to administer it.

Emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would (i) place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; (ii) result in serious impairment to bodily functions; or (iii) result in serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, "emergency medical condition" includes a medical condition for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child. The term "emergency medical condition" includes a behavioral health crisis as defined in this SPD.

Employee means any person employed by an Employer who meets all the applicable eligibility requirements of the Fund.

Employer or Participating Employer means any Employer obligated by a collective bargaining agreement or special agreement to make contributions to the Fund, under the rules of the Participation Agreement and Trust Agreement.

Experimental or Investigational Treatment means a Health Intervention that fails to meet any of the following criteria:

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

In applying the above criteria, Scientific Evidence will be reviewed from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat, or palliate the following:

- disease,
- illness or injury,
- genetic or congenital anomaly,
- pregnancy,
- biological or psychological condition that lies outside the range of normal age-appropriate human variation, or

- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Health Outcome means an outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

Home Health Aide means an individual employed by an approved home healthcare agency or an approved hospice agency who:

- Provides part-time or intermittent personal care, ambulation and exercise
- Performs household services essential to healthcare at home
- Assists with medications ordinarily self-administered
- Reports changes in patients' condition and needs
- Completes appropriate records
- Is under the supervision of an RN or a physical or speech therapist

Home Healthcare Agency means a public or private agency or organization that administers and provides home healthcare and is either a Medicare-certified home healthcare agency or is certified by the applicable Oregon State department or equivalent department of another state, as a home healthcare agency.

Hospice Agency means a public or private agency or organization that administers and provides hospice care and is either a Medicare-certified hospice agency or certified by the applicable Oregon State department, or equivalent department of another state, as a hospice care agency.

Hospital means an institution that:

- Operates according to laws governing hospitals in the jurisdiction where it is located
- Is engaged primarily (for compensation from or on behalf of patients) in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons by or under supervision of a staff of physicians and surgeons
- Provides 24-hour nursing service by RNs

This definition specifically excludes:

- Any institution that is primarily a place of rest, place for the aged, nursing home, residential treatment facility, or convalescent home
- Any facility operated by a federal or state government or its agencies, unless the patient has a legal responsibility for the expenses incurred in that facility

Illness means any condition marked by a pronounced change from the normal healthy state.

In-Network PPO Provider (Preferred or Network Provider) for medical services means a hospital, physician or other covered provider who has agreed to participate in the Regence BlueCross BlueShield or Oregon network as a preferred provider.

Medically Necessary or Medical Necessity means a procedure, service or supply that meets all the following criteria and limitations:

- It is appropriate to the diagnosis and/or treatment of the patient's illness or injury
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient
- When applied to an inpatient, it cannot safely be provided to the patient as an outpatient

A service or supply may be medically necessary in part.

The fact a procedure, service or supply may be furnished, prescribed, recommended or approved by a physician or other covered provider does not, in itself, make it medically necessary.

Out-of-Network PPO Provider means a hospital, physician or other covered provider who has NOT agreed to participate in the Regence BlueCross BlueShield of Oregon network as a preferred provider. If there is not an In-Network provider who can deliver the service within 30 miles from the patient's house, the Fund will pay claims for this provider at the In-Network Provider benefit level.

Participant means an Employee or Dependent who is eligible and enrolled for benefits under this Plan.

Plan means the plan of benefits described in this booklet.

Routine Patient Costs means items and services that typically are covered services for a Participant not enrolled in a clinical trial, but do not include:

- an Experimental or 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 Participant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility that provides primarily convalescent care for patients transferred from an accredited general hospital and is approved by the Joint Commission for Accreditation of Hospitals or by Medicare.

Spouse means the individual who is legally married to the Employee, as recognized under the laws of the state or jurisdiction in which the marriage was performed and who meets all of eligibility requirements of the Fund as a Dependent.

Usual, Customary and Reasonable (UCR) means one or all the following will be considered to determine the actual amount payable for any given service or supply:

- Usual fee the provider most frequently charges to most of their patients for a similar service or procedure
- Fees that fall within the customary range charged in a locality by most providers with similar training and experience for performing a similar service or procedure
- Fees resulting from unusual circumstances or complications requiring additional time, skill and experience in connection with a service or procedure

The Fund will make the final determination on whether the fee is UCR. For In-Network PPO providers (preferred providers), the Usual, Customary and Reasonable charge is its contracted fee amount.

Summary Plan Description

Name of Plan

This Fund is the Oregon Essential Workforce Health Care Fund. The trust fund through which these benefits are provided is the Oregon Essential Workforce Health Care Fund.

Plan Sponsor and Plan Administrator

The Board of Trustees of the Oregon Essential Workforce Health Care Fund is the Plan Sponsor and Plan Administrator. Its address and phone number are:

Oregon Essential Workforce Health Care Fund
PO Box 34203
Seattle WA 98124
(833) 389-0027

Employer Identification Number/Plan Number

The employer identification number assigned by the Internal Revenue Service is EIN 32-0674647. The plan number is 501.

Type of Plan

This Plan is a health and welfare plan providing medical and prescription drug benefits.

Type of Administration

This Board of Trustees has contracted with Welfare & Pension Administration Service, Inc. (WPAS), a contract administrative organization, to provide administrative services. WPAS is the "Fund Office".

Plan Documents

This booklet is the Plan document and summarizes the major Plan provisions. The Trustees have the complete and exclusive discretionary authority to remedy any contradictions between this booklet and any other documents governing the Plan.

Name and Address of Agent for Service of Process

The Fund Office is an agent for accepting services of legal process on behalf of the Fund. Each Trustee is an agent for accepting service of legal process on behalf of the Fund. Trustee names and addresses follow.

Names and Addresses of Trustees

Employer Trustees

Ryan Delamarter
Prestige Care
7700 NE Parkway Dr.
Suite 300
Vancouver, WA 98662

Andrew Loomis
Avamere Skilled Advisors, LLC
25115 SW Parkway Ave.
Suite B
Wilsonville, OR 97070

Cindy Cour
EmpRes Healthcare Management, LLC
4601 NE 77th Ave.
Suite 300
Vancouver, WA 98683

Cheryl Emerson
Dakavia Management
4676 Commercial St. SE #167
Salem, OR 97302

Union Trustees

Melissa Unger
SEIU Local 503
525 NE Oregon St.
Portland, OR 97323

Sean Staub
SEIU Local 503
525 NE Oregon St.
Portland, OR 97323

Evan Paster
SEIU Local 503
525 NE Oregon St.
Portland, OR 97323

Andrew Lucas
SEIU Local 503
525 NE Oregon St.
Portland, OR 97323

Description of Collective Bargaining Agreements

This Fund is maintained under multiple collective bargaining agreements between Employers and SEIU Local 503 and other written agreements with the Fund. You may obtain copies by writing to the Fund Office. The agreements also are available at the Fund Office, and at Local 503's office. The Fund may make a reasonable charge to cover the cost of furnishing the agreements. You may want to ask the amount up front.

Participation, Eligibility and Benefits

You are entitled to participate in this Plan if you work under a collective bargaining agreement described above and other written agreement with the Fund and your Employer contributes to the Fund on your behalf and you pay the required weekly Employee premiums.

Certain employees not covered by a collective bargaining agreement also are eligible to participate through special agreements between their Employers and the Board of Trustees. Eligibility rules governing which employees and Dependents are entitled to benefits begin on page 5. Descriptions of the benefits begin on page 17.

Circumstances That May Result in Ineligibility or Denial of Benefits

The circumstances that may result in disqualification, ineligibility, denial or loss of benefits appear throughout this booklet. The Board of Trustees has the authority to terminate the Fund. The Fund

will also terminate at the expiration of all collective bargaining agreements and special agreements requiring contributions to the Fund. If the Fund terminates, any and all monies and assets remaining in the Fund, after payment of expenses, will be used as permitted by the Fund, until the monies and assets are used up, unless some other disposition is required by law.

Sources of Contributions

This Plan is funded through Employer and Employee contributions, with the amount determined through collective bargaining between Employers and labor organizations, as specified in the collective bargaining agreements and the participation agreement. You can find out whether an Employer is a Participating Employer and, if so, the Employer's address, by writing to the Fund. The Fund may make a reasonable charge to cover the cost of providing this information. You may want to ask the amount up front.

Employee COBRA-payments also are permitted as described on pages 11 to 15, with the amount determined from time to time by the Board of Trustees.

Type of Funding

- Employer contributions, Employee premiums and COBRA payments are received and held by the Board of Trustees in the Oregon Essential Workforce Health Care Fund to pay benefits and administrative expenses.

The Fund's PPO Plan medical and prescription drug benefits are self-funded with these payments – benefits are not provided under an insurance policy.

The Fund's HMO Plan medical and prescription drug benefits are provided under an insurance policy with Kaiser Permanente Northwest and insurance premiums are paid with these payments.

Plan Year

This Plan Year is January 1 through December 31.

Right to Receive and Release Necessary Information

For the purpose of applying the terms of this Plan, this Plan may (without the consent of or notice to any person) release to or obtain from any insurance company or other organization or person any information with respect to any person that the Fund considers to be necessary for those purposes. Any person claiming benefits under this Plan must furnish to the Fund any information that may be necessary to implement this provision.

Facility of Payment

Whenever payments that should have been made under this Plan have been made under any other health plan, the Fund will have the right in its sole discretion, to pay over to any organization making the other payments any amounts that it may determine, in order to satisfy the intent of this Plan. Amounts so paid will be benefits paid under this Plan and to the extent of those payments the Fund will be fully discharged from liability under this Plan.

Overpayments

If you, your Dependents or providers receive more benefits than you are entitled to under the Plan, you must restore the full amount of the overpayment to the Fund. Otherwise, any benefits payable to you, your Dependents, or any providers can be reduced by the overpayment. If the Fund pays benefits another plan should have paid (such as an account of coordination of benefits), the Fund may recover these benefits from you, your Dependent, any provider or the other plan. Whenever payments have been made by the Fund in excess of the correct or maximum amount under the Plan, the Fund has the right to recover these payments from any persons to or for or with respect to whom these payments were made; any insurance companies any other organizations.

The Fund has constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this section, and any such amount is deemed to be held in trust by you or your Dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your Dependent agree that a constructive trust, lien and/or equitable lien by agreement in favor of the Fund exists regarding any overpayment or advancement of benefits. Under that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent agree to cooperate with the Fund in reimbursing it for all its costs and expenses related to the collection of those benefits.

In the event you, or if applicable, your Dependent, fail to reimburse the Fund and the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the Fund, you or your Dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. You or your Dependent also are required to pay interest at the rate determined by the Trustees from time to time from the date that the Fund is paid the full amount owed.

Your ERISA Rights

As an Oregon Essential Workforce Health Care Fund Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to the following:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund'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 coverage for yourself, Spouse or other Dependents if there is a loss of Plan coverage as a result of a qualifying event. You or your Dependents may have to pay for this coverage. Review this Summary Plan Description and documents governing the Plan to learn your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your group health plan or health insurer when you lose coverage under the Plan, become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases (if you request it before losing coverage), or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for plan operation. The people who operate your plan, called "fiduciaries," 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 health or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health or 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 materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the Administrator's control. If your claim for benefits 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 of decision concerning the qualified status of a domestic relations order or 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Your Rights Under Oregon Law

You have the right to participate in decisions regarding your health care and to be treated with dignity, respect and confidentiality.

You may obtain the following information upon request from the Fund Office:

1. An annual report on grievances and internal appeals submitted to the Oregon Department of Business and Consumer Services;
2. Information about the Fund's procedures for credentialing network providers;
3. A description of the Fund's efforts to monitor and improve the quality of health services;
4. An annual summary that describes all utilization review policies, including delegated utilization review functions, and documents the Fund's procedures for monitoring of utilization review activities.

You have the right to file a complaint or seek other assistance from the Oregon Division of Financial Regulation. Assistance is available by calling (503) 947-7984 or the toll-free message line at (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, Oregon 97309-0405, through the Internet at http://www.insurance.oregon.gov; or by email at cp.ins@state.or.us.

Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to regulations issued by the federal government, the Fund is providing you this Notice about the possible uses and disclosures of health information about you. Your health information is information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Fund has established a policy to guard against unnecessary disclosure of your health information. *The following summarizes the circumstances under which and purposes for which your health information may be used and disclosed:*

- ***To make or obtain payment*:** The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or healthcare treatment to other health plans to coordinate payment of benefits.
- ***To facilitate treatment:*** The Fund may disclose information to facilitate treatment which involves the provision, coordination or management of healthcare or related services.
- ***To conduct healthcare operations:*** The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Healthcare operations include contacting healthcare providers and participants with information about treatment alternatives and other related functions such as:
  - Clinical guideline and protocol development
  - Case management and care coordination
  - Activities designed to improve health or reduce healthcare costs
  - Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits
  - Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs, quality assessment and improvement activities, business planning and development, including cost management and planning-related analyses and formulary development

  For example, the Fund may use your health information to conduct case management, quality improvement and utilization review or to engage in customer service and the resolution of claim appeals.

- ***In connection with judicial and administrative proceedings:*** If required or permitted by law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Fund will make reasonable efforts either to notify you about the request or to obtain an order protecting your health information.

- ***When legally required for law enforcement purposes:*** The Fund will disclose your health information when required to do so by any federal, state or local law. In addition, as permitted or required by law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.
- ***For treatment alternatives:*** The Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- ***For distribution of health-related benefits and services:*** The Fund may use or disclose your health information to provide your health-related benefit and service information that may be of interest to you.
- ***For disclosure to the Plan Trustees:*** The Fund may disclose your health information to the Board of Trustees and necessary advisors for plan administration functions performed by the Board of Trustees on behalf of the Fund, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan.
- ***To conduct health oversight activities:*** The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of healthcare or public benefits.
- ***In the event of a serious threat to health or safety****:* The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
- ***For specified government functions:*** In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
- ***For workers' compensation:*** The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.
- ***For notice of a breach of unsecured health information:*** The Fund may release your health information to notify appropriate authorities of a breach of unsecured protected health information.
- ***For emergency situations:*** Your health information may be used or disclosed to a family member or close friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as previously stated, the Fund will not disclose your health information other than with your written authorization. If you have authorized the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

In addition, your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Fund maintains:

- ***Right to request restrictions:*** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund generally is not required to agree to your request. The Fund is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out-of-pocket. If you wish to request restrictions, please make the request in writing to the Fund's Privacy Contact Person listed below.
- ***Right to receive confidential communications:*** You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain phone number or by email. If you wish to receive confidential communications, please make your request in writing to the individual identified as the Fund's Privacy Contact Person below. The Fund will attempt to honor your reasonable requests for confidential communications.
- ***Right to inspect and copy your health information:*** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.
- ***Right to amend your health information:*** If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made if the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Contact Person listed below. The Fund may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting be amended is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.
- ***Right to an accounting*****:** You have the right to request a list of disclosures of your health information made by the Fund for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the period for which you are requesting the information. Accounting requests may not be made for periods going back more than six years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.
- ***Right to a paper copy of this notice:*** You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You also may obtain a copy of the current version of the Fund Notice at *www.essentialworkerhealth.org*.

  Request access to your health information in an electronic form by writing to the Privacy Contact Person listed below.

Receive notice of a breach of unsecured protected health information if it affects you by writing to the Privacy Contact Person listed below.

PRIVACY CONTACT PERSON/PRIVACY OFFICIAL

To exercise any of these rights related to your health information, contact the Privacy Official at the Fund Office.

The Fund has designated the Client Service Manager as its Privacy Official. This person has the same address and phone/fax numbers as listed above.

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured – for example, computer data that is encrypted and inaccessible without a password – or if it is determined that there is a low probability that your health information has been compromised.

DUTIES OF THE FUND

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of duties and privacy practices. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Official identified above. The Fund encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.