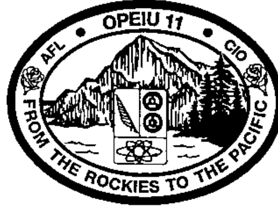

Western States Health & Welfare Trust Fund of the OPEIU

Welfare Benefits Plan

Summary Plan Description

Amended and Restated Effective

January 1, 2016

This document, together with the attached documents listed on the final page, constitutes the Summary Plan Description required by ERISA § 102.

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1. General Definitions

Capitalized terms used in the Plan have the following meanings:

“Administrative Office” means BeneSys, Inc. which represents the Western States Health & Welfare Trust Fund of the OPEIU in administering the Plan.

“Claims Administrator” means an entity with which the Trust contracts to administer the Plan’s self-insured benefit components. Currently this entity is BeneSys, Inc.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended.

“Dependent” means**:**

- The enrolled employee's legal spouse or domestic partner, and the enrolled employee’s/domestic partner’s unmarried children under 26 years of age (coverage ends at the end of the month of your child’s 26th birthday); Domestic Partner is defined as a Registered Domestic Partner as defined by Oregon statute, or one who has completed a Declaration of Domestic Partnership that has been properly executed and accepted by The Plan Administrator.

- Children are

  - the enrolled employee's, spouse’s, or domestic partner’s natural children;
  - the enrolled employee's, spouse’s, or domestic partner’s adopted children, or children placed for adoption with the enrolled employee;
  - stepchildren living in the enrolled employee's home, or nonresident stepchildren if there is a qualified medical child support order that requires the spouse or domestic partner to provide health insurance coverage; and
  - children related to the enrolled employee, spouse, or domestic partner by blood or marriage, which may include grandchildren if the natural mother or father is an eligible family dependent and enrolled in this plan, or for whom the employee is the legal guardian (the enrolled employee will need to give us a court order showing legal guardianship).

“Early Retiree” means a current participant who has satisfied all of the requirements necessary to obtain Early Retiree coverage as described in Section 11.

“Employee” means any common-law employee of a participating Employer who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of an applicable component benefit program.

“Employer” means an employer participating in the Western States Health & Welfare Trust Fund of the OPEIU.

“Enrollee” (also called Subscriber) means either the enrolled employee (also called employee) or the enrolled dependent.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“Plan” means this Western States Health & Welfare Trust Fund of the OPEIU Welfare Benefits Plan.

“Plan Administrator” means BeneSys, Inc.

“Trust” means the Western States Health & Welfare Trust Fund of the OPEIU, or any successor thereto.

“Union” means OPEIU or Office & Professional Employees International Union Local No. 11.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994.

2. Introduction

The Trustees of the Western States Health & Welfare Trust Fund of the OPEIU maintain the Plan for the exclusive benefit of qualified employees of participating employers and their eligible spouses, domestic partners, and dependents. The activities of the Trust are governed by a Board of Trustees and administered at their direction by the Plan Administrator. Only the Administrative Office represents the Board of Trustees in administering the plan and providing information related to the benefits available. Statements by any other persons, including your Employer or Local Union, are not authorized by, and will not be binding on, the Board of Trustees or the Trust.

The Plan provides benefits through the following benefit programs:

- **Regence BlueCross BlueShield of Oregon – insured medical and pharmacy** (Attachment #1);
- **Kaiser Permanente – insured medical** (Attachment #2);
- **Vision Service Plan – self-insured vision** (Attachment #3);
- **Hearing aid benefit description** (Attachment #4);
- **Standard Insurance – basic life and accidental death and dismemberment (AD&D) insurance** (Attachment #5);
- **Standard Insurance – short-term disability** (Attachment #6);
- **Trust Dental Plan – self-insured dental** (Attachment #7)**;**
- **Willamette Dental Group –** insured dental coverage (Attachment #8);
- **Kaiser Permanente –** insured dental coverage (Attachment #9).

Some of these benefit programs require completion of enrollment application forms, annual elections, and/or other administrative forms, which will be provided by the Administrative Office for coverage to be effective and available. The details of these administrative requirements are described in the Attachments.

Each benefit program is summarized in a member handbook or certificate of insurance booklet issued by an insurance company or prepared by the Trust. A copy of each booklet, Evidence of Coverage (EOC), summary, or other governing document is attached to this document in Attachments #1 through #7. Note: All of the benefit plans are subject to ERISA.

You are being provided this document to give you an overview of the Plan and to provide certain information that may not be described in the Attachments. This document, together with the Attachments, is the summary plan description (SPD) required by ERISA § 102. This document is not intended to give you any substantive rights to benefits that are not already provided by the Attachments. If you have not received a copy of the Attachments, contact the Plan Administrator. You must read the Attachments and this document to understand your benefits.

Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent or made by electronic means.

3. General Information About the Plan

Plan Name

Western States Health and Welfare Trust Fund of the OPEIU Welfare Benefits Plan

Type of Plan

The Plan is a welfare plan that provides medical, prescription drug, vision, hearing aid, short-term disability, and basic life and AD&D benefits.

Plan Year

The plan year is January 1 – December 31.

Fiscal Year

The Trust's fiscal year is March 1 – February 28.

Plan Number

The Plan number is 501.

Plan Sponsor

The Board of Trustees of the Western States Health and Welfare Trust Fund of the OPEIU (the Trust)

Plan Sponsor's Employer Identification Number

93-6028906

Plan Administration

Western States Health & Welfare Trust Fund of the OPEIU is jointly administered by six Trustees who provide direction to the Plan Administrator and are responsible for administration of the Plan. Half of the Trustees represent employers and half represent the Union.

The names and addresses of the Trustees are as follows:

Trustees Representing the Employer
Mr. David Williams
Northwest Natural Gas Co.
220 NW 2nd Avenue
Portland, OR 97209

Ms. Niki Jordan
Northwest Natural Gas Co.
220 NW 2nd Avenue
Portland, OR 97209

Trustees Representing the Union
Mr. Mike Richards
OPEIU Local No. 11
3815 Columbia Street
Vancouver, WA 98660

Mr. Rick Wilson
OPEIU Local No. 11
3815 Columbia Street
Vancouver, WA 98660

Trustees Representing the Employer

Pending

Trustees Representing the Union

Ms. Maureen Colvin
OPEIU Local No. 11
3815 Columbia Street
Vancouver, WA 98660

Plan Administrator

BeneSys, Inc.
1220 SW Morrison Street
Suite 300
Portland, OR 97205-2222
503.224.0048 phone
800.547.4457 Toll Free
503.228.0149 fax

westernstates@aibpa.com email

www.westernstates.aibpa.com Plan Website

Effective Date

The effective date of this Plan amendment and restatement is January 1, 2016. The Plan has been amended several times since its original effective date.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Trust's administrative office c/o BeneSys, Inc., 1220 SW Morrison, Suite 300, Portland, OR 97205-2222; Tel: 503.224.0048; Toll free: 800.547.4457; Fax: 503.228.0149. Because the benefit programs through which medical coverage is provided are subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/ health reform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Funding Medium and Type of Plan Administration

Some benefits under the Plan are self-insured, and other benefits are fully insured. As discussed below under the heading "How the Plan Is Administered," the Trust and the insurance companies share responsibility for administering the benefit programs under the Plan.

The medical and pharmacy insurance benefit programs are fully insured. The basic life insurance, short-term disability, group term life, and AD&D programs are also fully insured. The hearing aid program, the vision program, and Dental Plans 10, 11, and 12 are self-insured by the Trust.

The Claims Administrators with which the Trust contracts are responsible for paying claims with respect to the self-insured benefit programs. The insurance companies, not the Trust, are responsible for paying claims with respect to the insured benefit programs.

Participating employers contribute to Western States Health & Welfare Trust Fund of the OPEIU at a rate specified in a collective bargaining agreement, which is typically adjusted annually. All employer contributions are made to the Trust Fund. Insurance premiums for employees and their eligible family members are paid by the Plan Administrator out of Trust assets. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the benefit programs, as applicable.

Insurance Companies / Claims Administrators

Certain benefits are provided through insurance contracts with the insurance companies listed below and are administered by the respective companies.

Regence BlueCross BlueShield of Oregon
Kaiser Foundation Health Plan of the Northwest
Willamette Dental Group
Standard Insurance Company

Certain other benefits are provided on a self-insured basis by the Trust and administered by the Claims Administrators listed below.

Vision Service Plan
BeneSys, Inc. for the Trust Dental and Hearing Aid Plan

Named Fiduciary (for Benefit Claims)

For each of the insured benefit programs, the insurance company is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Agent for Service of Legal Process

Michael H. Korpi
The Korpi Law Firm PLLC
135 Second Avenue North, Suite 202
PO Box 1525
Edmonds, WA 98020-1525

Service of legal process may also be made on a Trustee of the Plan.

Collective Bargaining Agreements

The Western States Health & Welfare Trust Fund of the OPEIU is the subject of certain collective bargaining agreements. Some provisions of the collective bargaining agreements relate to health and welfare benefits. The parties to the collective bargaining agreements are:

- Office & Professional Employees International Union (OPEIU), Local No. 11
- Individual Employers

Future of the Plan and Trust

The Trustees of Western States Health & Welfare Trust Fund of the OPEIU have established a Trust Fund. The Trust Fund is the entire estate of the Trust as it may from time to time be constituted, including but not limited to policies of insurance, investments and income from any and all investments, employer contributions, and any or all other assets, property, or money received by or managed by the Trustees for the uses and purposes of this Trust.

The Trust Fund is created, established, and maintained, and the Trustees agree to receive, hold, and administer the Trust Fund, for the purpose of providing benefits as now are, or hereafter may be, authorized or permitted by law for employees and their beneficiaries and in accordance with the provisions of this Plan.

This Plan may be terminated should the Trust Fund, in the opinion of the Trustees, be inadequate to meet the payments due or that become due under the Plan; should there be no individuals living who can qualify as employees or beneficiaries under the Plan; or should a termination be necessary as otherwise provided by law.

In the event of termination, the Trustees shall:

- Make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and the expenses incidental to such termination;
- Arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship; and
- Apply the Trust Fund to pay any and all obligations of the Trust and distribute and apply its capital and surplus in such a manner as will, in their opinion, best effectuate the purposes of the Trust for the continuance of the benefits provided by the then-existing benefit plans, until such moneys and assets have been exhausted.

Important Disclaimer

Benefits hereunder are provided in accordance with an insurance contract or governing written plan document adopted by the Trust. If the terms of this document conflict with the terms of the insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

4. Eligibility and Participation Requirements

Eligibility and Participation

Eligibility for coverage is based on contributions made on your behalf for hours worked for a contributing employer under the jurisdiction of the Trust.

The rules for initial and continuing enrollment are identical: any time you work sufficient hours in one month, you will receive a month of coverage in another month.

You and your eligible dependents will become covered on the first day of the second month following a month in which you work the qualifying hours according to your labor contract. Your employer pays a contribution on your behalf in the month following your qualifying work on the basis of those qualifying hours which, provides you coverage in the next, subsequent month. For example:

First Month: This is the work month in which you must work enough hours under the labor contract.
Second Month: This is the month your employer sends the contribution to the Trust. This is sometimes called the "lag month."
Third Month: This is the month you and your eligible dependents are covered.

This is what the schedule looks like on an ongoing basis:

Work Month:	Jan.	Feb	Mar.	Apr.	May	June
Lag Month:	Feb.	Mar.	Apr.	May	June	July
Coverage Month:	Mar.	Apr.	May	June	July	Aug.

Need for Enrollment: Time Limits

In general, eligible employees must complete an application form (available from the Plan Administrator) to enroll themselves and their eligible spouses and dependents. New employees must enroll within certain time periods after being hired, as described in the Attachments. After the initial time period, enrollment is generally limited to the annual open enrollment period that is announced in November each calendar year.

The newborn child of an enrolled employee, of an enrolled employee's spouse or domestic partner, or of an enrolled dependent will be covered for 31 days after it is born. We must have notice of the birth and in the case of a newborn of a male dependent, proof of paternity. To continue the newborn's coverage beyond this 31-day period, the child must be eligible under the terms of the Plan and the enrolled employee must sign a new application within 31 days listing the child as a dependent. If this is not done, coverage for the child will lapse at the end of 31 days.

In addition, incapacitated children can remain enrolled past the age of 26. An incapacitated child is an unmarried child who is incapable of self-support because of a physical handicap or mental retardation. The incapacitating condition must have existed before the child's 26th birthday. In order to obtain continued coverage for an incapacitated child, the enrolled employee must complete a special application and have it approved by us before the child's 26th birthday.

Enrollees may obtain from the Plan Administrator, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations.

Newly Acquired Dependents

If an enrolled employee marries while he or she is enrolled under the Plan, his or her spouse and the spouse's children become eligible to apply for coverage on the date of the marriage. Application for coverage must be made within 31 days after the date of marriage; if application is made within this time period, coverage shall become effective on the date of the marriage. If the application is not mailed within 31 days, the new spouse may not enroll in this Plan until open enrollment. The new stepchildren must meet the eligibility requirements for all children in order to be enrolled.

Your domestic partner is eligible if you are registered as domestic partners or if he or she meets the criteria on the Declaration of Domestic Partnership supplied by the Plan Administrator. The domestic partner and his or her dependents are eligible to enroll within 31 days after the date on which you and your partner have registered or both signed the declaration. A complete and signed application must be submitted within 31 days after the date on the declaration.

An enrolled employee's or an enrolled female dependent's newborn child will automatically be enrolled for 31 days after it is born. To continue the newborn's coverage beyond this 31-day period, the child must be eligible under the terms of the Plan.

Adopted Children

A child will be enrolled as an enrolled employee's dependent child for 31 days after the date the child is placed with the enrolled employee for the purpose of adoption. "Placement" means the enrolled employee has assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

In order to continue this coverage beyond the first 31 days, the enrolled employee must sign a new application within the first 31 days listing the child as a dependent, along with proof of placement. If this is not done, coverage for the child will terminate at the end of the 31st day after placement.

Special Enrollment

An eligible individual will not be considered a late enrollee in the following situations:

- If you and/or your eligible dependents lose coverage under another group or individual health benefit plan because of:
    - the exhaustion of federal COBRA or Oregon state continuation coverage;
    - the loss of eligibility due to legal separation, divorce, death, termination of employment, or reduction in hours, or because the employer contributions were terminated; or
    - involuntary loss of coverage under Medicaid, Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan, like Oregon Health Plan.

- If you declined coverage when you were first eligible and you subsequently marry, you become eligible for coverage under this Plan on behalf of yourself, your spouse, and any eligible dependent children on the date of marriage.

- If you declined coverage when you were first eligible and you subsequently acquire a new dependent child by birth, adoption, or placement for adoption, you become eligible for coverage under this Plan along with your eligible spouse and eligible dependent children, including the newly acquired child, on the date of the birth, adoption, or placement.

- If a spouse or domestic partner and/or dependent child for whom you declined coverage becomes eligible for coverage under this Plan on the date a court has issued an order for you to provide such coverage.

- If you and/or your eligible dependents enroll during an open enrollment period under the Plan.

In all of the above situations, you and/or your eligible dependents become eligible for coverage under this Plan on the date the other coverage ends. Note that loss of eligibility does not include a voluntary termination of coverage, a loss because premiums were not paid in time, or termination of coverage because of fraud.

Family and Medical Leave Act of 1993 (FMLA)

The federal Family and Medical Leave Act of 1993 requires certain employers to allow eligible employees up to 12 weeks of unpaid leave during a 12-month period.

The federal eligibility requirements do not require coverage for all participants in the Western States Health & Welfare Trust Fund of the OPEIU (Plan).

The Board of Trustees reviewed the application of the FMLA to the Plan's participants. The Board of Trustees determined that the Plan will provide more liberal benefits than required by FMLA to all employees in the Plan. An employee is eligible for these benefits if an employee satisfies all of the following requirements:

- is on unpaid leave because of FMLA or equivalent leave required by state law, or under the collective bargaining agreement;
- is taking the leave for:
    - the care of the employee's child (birth, placement for adoption, or foster care); or
    - the care of an immediate family member (spouse, domestic partner, child, or parent) with a serious health condition; or
    - a serious health condition that prevents the employee from working;
- worked at least 1,250 hours for the employer within the previous 12 months.

If you satisfy all three requirements, you will receive health benefits equivalent to those required by FMLA.

The Board of Trustees will constantly monitor its decisions. The results of the monitoring could require a change in the Board of Trustees' policy decisions.

Strike or Lockout

If you are employed under a collective bargaining agreement and are involved in a work stoppage because of a strike or lockout, your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by the group, directly to the union or trust that represents you. And the union or trust must continue to pay the Plan Administrator the premiums on the Premium Due Date. Coverage cannot be continued if fewer than 75 percent of those normally enrolled continue coverage or if you otherwise lose eligibility under the Plan.

These six months of continued coverage are in lieu of and not in addition to any continuation of coverage provisions of the Plan.

When Participation Begins

Once you, as an eligible employee, have satisfied the requirements of eligibility and completed the necessary enrollment paperwork, your coverage under the Plan may begin. Requirements may vary depending on the benefit program. For specific information about when coverage begins, please read the eligibility and participation information contained in the Attachments or contact the Plan Administrator.

Termination of Participation

If you fail to work enough qualifying hours in any month, your employer is not obligated to make a contribution to the Trust on your behalf. If you lose eligibility, all Trust benefits that you are enrolled in will terminate on the last day of the month following the month that you failed to work sufficient hours.

Coverage for your spouse and dependents stops when your coverage ends and for other reasons specified in the Attachments (for example, divorce or a dependent's attaining the eligibility age limit). Coverage also ceases for employees, spouses, and dependents upon termination of the Plan.

Eligibility for Coverage as an Early Retiree

Certain participants losing coverage under this plan may be eligible to continue coverage as Early Retirees. All requirements described in Section 11 of this document must be satisfied to obtain Early Retiree coverage.

Waiver of Premium

If you suffer an accident or illness and your disability causes you to lose coverage (during a rolling 24-month period), you may be eligible for continued benefits for up to six months, at no cost to you, according to a special Waiver of Premium provision of the Plan. It is your responsibility to notify the Plan Administrator of your disability and to request a disability waiver. In addition, you may make self-payments to extend your medical/prescription drug/vision/hearing aid coverage according to the COBRA provisions.

Continuation Coverage under COBRA and USERRA

If your medical/prescription drug/vision/hearing aid coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. Qualifying events are such life events as:

- Termination of employment
- Reduction in available work hours
- Death of the enrolled employee
- Divorce
- Termination of domestic partnership
- Eligibility for Medicare
- A dependent child reaches age 26

If you have any questions about your COBRA rights, please contact BeneSys, Inc.

Continuation and reinstatement rights may also be available under the Uniformed Services Employment and Reemployment Act (USERRA) if you are absent from employment because of service in the uniformed services. More information about coverage available under USERRA is included in the Attachments.

Western States Health & Welfare Plan Of The OPEIU
Notice of Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Western States Health & Welfare Trust Fund of the OPEIU (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you in accordance with HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

(1) your past, present, or future physical or mental health or condition;

(2) the provision of health care to you; or

(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Telephone: (503) 224-0048
Toll-Free: 1-800-547-4457
Fax: (503) 228-0149

Effective Date

This Notice is effective September 23, 2013.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

  We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material

change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices in the Plan's next annual mailing.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

Other Covered Entities. The Plan may use or disclose Your Protected Health Information to assist Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose Your Protected Health Information to a Provider when needed by the Provider to render treatment to You or the Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.

Disclosures to the Centers for Medicaid and Medicare Services. The Plan may disclose Your Protected Health Information, as permitted by federal regulations, to the Centers for Medicaid and Medicare Services, in order to comply with mandatory Medicare coordination of benefit requirements. The Plan may share required data, including health information, with the Centers for Medicaid and Medicare Services and state Medicaid agencies.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose protected health information to the Plan's Trustees. However, the Trustees will use or disclose that information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or

(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make:

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request it, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed in accordance with your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (e.g., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or

(2) treating such person as your personal representative could endanger you; and

(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouse, Family Members, and Close Personal Friends. The Plan may make Your Protected Health Information known to a spouse, family member, or close personal friend. Disclosure of Your Protected Health Information will be determined based on how involved the person is in your health care or payment of your health claims. For example, the Plan will normally provide information to a spouse or family member confirming eligibility for health coverage or if a health claim was paid but not the specific treatment or diagnosis or the reason the Provider was consulted. The Plan may release Protected Health Information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of Your Protected Health Information, the Plan, through the Trust Office or Board of Trustees, may use professional judgment to determine whether the disclosure is in your best interest. If You do not want Your Protected Health Information disclosed to a spouse, family member, or close personal friend as outlined in this paragraph, You must notify the Plan as described in the Right to Request Restrictions section on page 7.

With only limited exceptions, we will send all mail to the employee participating in the Trust. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will be made only with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the Trust administration office. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Trust administration office.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222

In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made in accordance with your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Trust administration office. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222

We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, www.westernstates.aibpa.com.

To obtain a paper copy of this notice, contact:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Telephone: (503) 224-0048
Toll-Free: 1-800-547-4457
Fax: (503) 228-0149

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Telephone: (503) 224-0048
Toll-Free: 1-800-547-4457
Fax: (503) 228-0149

All complaints must be submitted in writing.You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Adequate Separation:

The Board of Trustees represents that adequate separation exists between the Plan Administrator and the Board of Trustees so that Protected Health Information will be used only for Plan administration purposes. Independent contractors of the Trust with oversight responsibility for claims administration, plan design, claims management, accounting, and analysis will have access to participants' Protected Health Information for the purposes set forth under number 1 above.

Restriction to Access and Adequate Separation Certification:

The Board of Trustees certifies that the individuals and entities identified above are the only ones that will have access to and use of participants' Protected Health Information in regard to the uses and disclosure related to the Plan sponsor's function set forth in paragraph 1.

Effective Mechanism for Resolving Issues of Noncompliance:

The Board of Trustees certifies that any individual or entity described in paragraph 5 that suspects an improper use or disclosure of Protected Health Information may report the occurrence to the Plan Administrator's Privacy Official at the following address:

BeneSys, Inc.
Attn: Privacy Official
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Telephone: (503) 224-0048
Toll-Free: 1-800-547-4457
Fax: (503) 228-0149
Email: westernstates@aibpa.com

Qualified Medical Child Support Orders

With respect to the benefit programs, the Plan will extend benefits to an employee's noncustodial child, as required by any qualified medical child support order (QMCSO), under ERISA § 609(a). The Plan has procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of those procedures from the Plan Administrator.

Administrative Requirements and Timelines

As described in the Attachments, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult the Attachments.

5. How the Plan Is Administered

Plan Operations

Because benefits under the Plan are provided both through insurance contracts and on a self-insured basis, the Plan is administered by BeneSys, Inc., RegenceRx, Vision Service Plan, and the insurance companies.

Plan Administration

BeneSys, Inc. is the Plan Administrator. As the Plan Administrator, BeneSys, Inc. is responsible for satisfying certain legal requirements under ERISA with respect to the Plan—such as, for example, distributing this Summary Plan Description (SPD) and any attachments. The Trustees have agreed to indemnify BeneSys, Inc. for any liability that BeneSys, Inc. incurs as a result of acting on behalf of the Trustees, unless such liability is due to BeneSys, Inc.'s gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms, and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits for the self-insured programs, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator has full discretionary authority, in its sole discretion, to interpret and administer the terms of the plan, to determine eligibility for and the amount of benefits for the self-insured programs, and to make factual determinations.

The Trust will bear the incidental costs of administering the Plan.

Power and Authority of Insurance Companies

Certain benefits under the Plan are fully insured and are provided under a group insurance contract entered into between the Trust and the insurance companies. Claims for benefits are sent to the insurance companies and they are responsible for determining appropriate benefit levels and paying claims, not the Trust.

For fully insured benefit programs, the insurance companies are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms, if any, to be used by eligible individuals in accordance with the Plan.

As the named fiduciary for benefit determinations, the insurance companies have the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular benefit program offered through the Plan, or the amount of any benefit payable under the self-insured benefit plans), please contact the Plan Administrator.

If you have any questions regarding the amount of any benefit payable under the fully-insured benefit plans, please contact the insurance companies directly.

6. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4.

Your benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied under the medical or dental benefit programs if you have a preexisting condition and incur costs within the exclusionary period. See the Attachments for additional information.

7. Amendment or Termination of the Plan

Amendment or Termination

The Trust's Board of Trustees, as the sponsor of the Plan, has the general right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the Trust co-chairpersons, both of whom together are authorized to act on behalf of the full Board to amend or terminate the Plan and to sign insurance contracts with the insurance companies, including amendments to those contracts.

8. No Contract of Employment

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and your Employer to the effect that you will be employed for any specific period of time.

9. Claims Procedures

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the insured benefit programs, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to provide claims submission information to the provider or to complete, sign, and submit a written claim on the insurer's form. (See the Attachments for more information.)

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If you do not appeal within the specified timeframe, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review by an expert outside of the Plan). (See the Attachments for more information.)

Claims for Self-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs provided on a self-insured basis and funded through Trust Fund assets, the Plan Administrator has the full discretion and power to make factual determinations, and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement.

To obtain benefits from a self-insured benefit program, you must supply the provider with the appropriate information so that they can submit a claim on your behalf, or you may complete, execute, and submit to the Claims Administrator a written claim on the form made available. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Claims Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Claims Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial. (See the attached Claims and Appeals Procedures for more information.)

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you do not appeal within the specified timeframe, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights, which is a prerequisite to bringing a suit in state or federal court. You may not undertake any legal action with respect to a claim, in either state or federal court, until you have exhausted all of your rights under the claims appeal procedures. This exhaustion requirement applies to claims for recovery of benefits under the Plan, enforcement of your rights under the terms of the Plan, and clarification of your right to future benefits under the terms of the Plan.

See the Attachments for information about how to appeal a denied claim and for details regarding the Plan Administrator's appeals procedures.

Coordination of Benefits

Please consult with the appropriate Medical carrier for more details. Information is available to you at no charge.

There is no Coordination of Benefits for prescription drugs.

Third Party Recovery

The text in this section applies only to the VSP Vision Plans. Consult plan documents supplied by your medical/pharmacy carrier for procedures specific to its plan.

The Plan excludes medical, prescription medication, dental, and vision benefits for any injury or illness caused by the act or omission of another person (known as a "third party"), including any injury or illness covered by a liability policy of the third party, or charges incurred for which coverage is available under an automobile, homeowners, commercial premises, renters, medical malpractice, or other insurance or liability policy. If a Covered Person has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the Covered Person, may advance benefits pending the resolution of the claim on the following conditions:

(1) By accepting or claiming benefits, the Covered Person agrees that the Plan is entitled to first-dollar priority and 100% reimbursement from the Covered Person with respect to any judgment, settlement, disputed claim settlement, or other full or partial recovery, award or otherwise, up to the full amount of all benefits provided by the Plan, and unreduced by any legal or other costs expended by the Covered Person, but not to exceed the amount of the recovery. The Plan is entitled to reimbursement, regardless of whether the Covered Person is made whole by the recovery, and regardless of the characterization of the recovery.

(2) The Plan will require a Covered Person to execute and deliver instruments and papers, disclose the circumstances resulting from the injury or illness, and do whatever else is necessary to secure the Plan's right to reimbursement (including an assignment of rights). The Plan will also require the Covered Person to sign an agreement to reimburse the Plan from the proceeds of any recovery before the Plan will advance any benefits.

(3) A Covered Person must do nothing after payment of benefits to prejudice the Plan's right of recovery.

(4) When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan's reimbursement amount must be paid by the Covered Person 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 amount are not placed in an escrow or trust account, the Covered Person or the individual named to hold the funds in trust shall be personally liable for any loss the Trust suffers as a result.

(5) The Plan may cease advancing benefits if there is a reasonable basis to determine that the Covered Person will not honor the terms of the Plan or the agreement to reimburse, or the Board of Trustees modifies the Plan provisions related to the advancement of benefits. The Plan may also deny coverage for expenses incurred after judgment or settlement of the claim, if such expenses are related to the third-party recovery.

(6) If the Plan is not reimbursed upon recovery on a third-party claim, the Plan may bring an action against the Covered Person to enforce its right to reimbursement or the agreement to reimburse, or both, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefit payments of the Covered Person and the Covered Person's family members, or by recovery from the source to which benefits were paid.

(7) If the Plan is forced to bring a legal action against the Covered Person to enforce the terms of this Plan Provision, it shall be entitled to its reasonable attorney fees, costs of collection, and court costs.

The Covered Person expressly agrees not to raise ERISA jurisdiction and procedural issues and affirms the Plan's right to bring an action for breach of contract in state court to enforce the Plan's right to reimbursement under this Plan provision, and affirms the Plan's right to seek a constructive trust in federal court under ERISA § 502(a)(3) to recover the funds received by the Covered Person from a third party according to this Plan provision.

10. Statement of ERISA Rights

Your Rights

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500 financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the attachments for the rules governing your COBRA continuation coverage rights.

The reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become

entitled to elect COBRA continuation coverage, or 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 pre-existing condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), 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 BeneSys, Inc., as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 10), you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. 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.

11. Eligibility for Early Retiree Coverage

Coverage

An eligible Early Retiree, as defined below, or a dependent of an eligible Early Retiree, will be eligible for coverage under the Early Retiree Plan. Early Retirees and Dependents, as defined, of Early Retirees will be allowed Retiree Plan coverage (1) if they enroll within sixty days after the Early Retiree's retirement date, or (2) when either the Early Retiree or the Dependent sustains a loss of other coverage obtained through marriage, domestic partnership, or employment. The Retiree Plan will provide coverage for hospital, medical, and surgical benefits and for prescription drugs.

Eligibility

An Early Retiree is eligible for coverage under the Early Retiree Plan only if ALL of the following requirements are satisfied:

a. The individual is not less than fifty-five (55) years of age and less than sixty-five (65) years of age and not eligible for Medicare;

b. The individual applies to participate in the Early Retiree Plan after becoming eligible for the plan and the individual makes all required payments;

c. The individual is eligible to receive, or is receiving, benefits from a pension plan to which an employer participating in the Western States Health & Welfare Trust Fund of the OPEIU contributes. If an individual receives a lump-sum distribution from a plan described in the preceding sentence, the individual will be considered to be "receiving benefits" for purposes of eligibility;

d. The individual was covered by the Trust for sixty (60) of the seventy-two (72) consecutive months immediately before the individual became eligible for Early Retiree benefits. For the purpose of calculating the sixty (60) months, all Trust coverage will be included, whether provided by employer contribution, waiver of premium, or self-payment; and

e. The individual's employer, immediately before the Early Retiree's eligibility for the Retiree Plan, had a labor agreement requiring contributions to the Trust.

If the individual re-retires after being covered by the Active Plan and had previously been covered by the Early Retiree Plan and returned to work to obtain coverage under the Active Plan, the individual will not be required to comply with subparagraphs c or d, above.

Dependent Eligibility under Early Retiree Coverage

Dependents of Early Retirees will be allowed Early Retiree Plan coverage (1) when they enroll at the time of the initial enrollment of the Early Retiree, or (2) when they sustain a loss of other coverage obtained through marriage, domestic partnership, or employment.

Dependent means the following:

The enrolled Early Retiree's legal spouse or Domestic Partner as defined in the definitions section of this document, and the eligible dependent children of the Early Retiree and his or her spouse or Domestic Partner.

The following are considered children:

- The enrolled Early Retiree's/spouse's/Domestic Partner's natural child;

- The enrolled Early Retiree's/spouse's/Domestic Partner's adopted child, a child placed for adoption with the enrolled Early Retiree/spouse/Domestic Partner, a stepchild living in the enrolled Early Retiree's home, or a nonresident stepchild if there is a qualified medical child support order (QMCSO) that requires the spouse to provide health insurance coverage; and

- Children related to the enrolled Early Retiree/spouse/Domestic Partner by blood or marriage (which may include grandchildren if their natural mother or father is an eligible family dependent and enrolled in this plan), or for whom the Early Retiree is the legal guardian (the enrolled Early Retiree will need to provide a court order showing legal guardianship).

In addition, incapacitated children can remain enrolled past the age of 26. An incapacitated child is an unmarried child who is incapable of self-support because of a physical handicap or mental retardation. The incapacitating condition must have existed before the child's 26th birthday.

Enrollees may obtain from the Plan Administrator, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations

12. Attachments

Attachment #1: Regence BlueCross BlueShield of Oregon Benefit Booklet – fully insured

Attachment #2: Kaiser Permanente medical plan Evidence of Coverage – fully insured

Attachment #3: Vision Service Plan Self-insured vision benefit description and Evidence of Coverage (EOC) – administered by Vision Service Plan

Attachment #4: Hearing Aid Benefit Description and Evidence of Coverage – self-insured and administered by BeneSys, Inc.

Attachment #5: Standard Insurance Basic Life and AD&D Insurance Certificate – fully insured

Attachment #6: Standard Insurance Short Term Disability Certificate – fully insured

Attachment #7: Dental Plan Benefit Description and Evidence of Coverage – self-insured and administered by BeneSys, Inc.

Attachment #8: Willamette Dental Group dental plan – fully insured

Attachment #9: Kaiser Permanente dental plan – fully insured