PAT PFSP DCU ATU

SCHOOL DISTRICT NO. 1 HEALTH AND WELFARE TRUST

LEGAL NOTICES

HEALTH & WELFARE TRUST
SCHOOL DISTRICT NO.1

12205 SW Tualatin Rd., Suite 200 • Tualatin, OR 97062
833-255-4123 (toll-free) or 503-486-2107 • **sdtrust.com**

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

The School District No. 1 Health & Welfare Trust is required to provide you with certain legal notices on an annual basis. Please read them carefully, and keep this document for reference. No other action is required.

The following items are discussed in this Notice:

- Introduction
- Enrollment
- Special Enrollment Provisions
- Appeal Rights and Procedures Through the Trust
- Continuation of Coverage Rights
- Alternative Ways to Continue Coverage
- Children's Health Insurance Program
- HIPAA Privacy Notice
- Designation of Primary Care Provider (Kaiser Plan Only)
- Women's Health and Cancer Rights Act
- Creditable Prescription Drug Coverage and Medicare
- Nondiscrimination Notice
- Plan Information

Introduction

The School District No. 1 Health and Welfare Trust (Trust) provides benefits to:

- Employees covered by collective bargaining agreements with the Portland Association of Teachers (PAT), Portland Federation of School Professionals (PFSP), District Council of Unions (DCU) and the Amalgamated Transit Union (ATU) who meet Trust eligibility requirements
- Dependent children, spouses and domestic partners of eligible employees as provided for in the applicable collective bargaining agreement.

The Trust offers employees multiple medical and prescription drug options depending on the individual employee's bargaining group. Dental and vision coverage is provided to most employees and dependents. Long-term disability, life and accidental death and dismemberment (AD&D), voluntary AD&D and optional life benefits are also available to most employees. These benefits are described in booklets available through the Trust Office or the entity providing or administering the benefits.

You can also find up-to-date information about all Trust benefit plans at the Trust's web site **sdtrust.com**. From the web site, you can download and print plan booklets and forms. If you have questions about the Trust, the benefits it provides or how Trust eligibility or procedural requirements apply to you, contact the Trust Office at 833-255-4123 (toll free) or 503-486-2107.

The following provides notice of general legal requirements applicable to the Trust and its participants and beneficiaries.

Enrollment

You can elect coverages offered by the Trust at the following times:

- **Initial enrollment**—when you and/or a dependent first becomes eligible or first enrolls for coverage. You must submit your enrollment application within 31 days of your first email notification or of your start date, whichever is later. Please contact the Trust Office for further information.
- **Annual open enrollment**—during a period each fall when you may make benefit elections for the upcoming plan year
- **Bi-annual enrollment** (ATU Type 10 Drivers)—based on eligibility, ATU Type 10 Drivers may enroll for benefits coverage from October 1–March 30 and from April 1–September 30.
- **Special enrollment**—following a change in family status you may make mid-year benefit changes related to the status change within 31 or 60 days of the status change. See "Special Enrollment Provisions" for more information.

Special Enrollment Provisions

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan 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 toward the cost of your or your dependents' other coverage). However, you must request enrollment within **31 days** after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage) and provide evidence of other coverage.

In addition, if you have a new dependent as a result of marriage, or establishment of a domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **31 days** after the marriage, or establishment of a domestic partnership, **60 days** after the birth, adoption, or placement for adoption.

Also, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (the Act) if you or your dependents:

- Lose coverage under a Medicaid or State Plan; or
- Become eligible for group health premium assistance under a Medicaid plan or State Plan.
- If a special enrollment right is provided pursuant to the Act, you may change your election consistent with such special enrollment event within 60 days as long as the election made is consistent with the special enrollment event.

To request special enrollment or obtain more information, contact the Trust Office at 833-255-4123 (toll free) or 503-486-2107.

WAIVER OF COVERAGE

If you elect to waive coverage for yourself or your dependents (including your spouse or domestic partner), you acknowledge that you and your spouse and/or dependent child(ren) can only enroll later during an annual open enrollment period or if a special enrollment event occurs as described above.

Appeal Rights and Procedures

IMPORTANT INFORMATION ABOUT APPEALS

The Trust provides benefits through either insured arrangements or self-funded benefits that are administered by third-parties. The procedures for an initial appeal of denied benefits are set forth in your benefit booklets from those entities. Basic information about appealing a benefit denial made by the Trust's insurers or claims administrative agents is set forth below:

ELIGIBILITY/ENROLLMENT APPEALS

If an enrollment or eligibility request is denied in whole or in part, the Trust Office will provide you with a notice identifying the reason(s) for the denial, any other information needed to consider your request and your right to obtain additional information about the Trust's eligibility and enrollment rules. You may appeal an adverse eligibility or enrollment decision by filing a written appeal with the Trust Office within 180 days of the denial. Appeals should be sent to the following address:

School District No. 1 Health and Welfare Trust Appeals
12205 SW Tualatin Rd., Ste 200
Tualatin, OR 97062
833-255-4123 (toll free) or 503-486-2107

The appeal shall identify the eligibility or enrollment determination involved, set forth the reasons for the appeal and provide any additional information you believe is relevant. Your appeal will not be considered and the denial will be final if no appeal is received within 180 days of the adverse benefit determination you are appealing.

REVIEW OF INSURER OR CLAIMS ADMINISTRATOR'S DENIAL

For any appeal of a benefit denial involving a participant in a Kaiser medical and prescription drug or dental option contact:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Phone: 1-800-813-2000
Fax: 503-813-3985 (Medical and Prescription Drug)
Fax: 855-347-7239 (Dental)

For any denial involving a self-funded Providence medical option (network provider and claims administrator for the Trust's self-funded medical benefits):

PROVIDENCE HEALTH PLAN
Appeals and Grievance Department
P.O. Box 4158
Portland, OR 97208-4158
Phone: 503-574-7500 or 1-800-878-4445
Fax: 503-574-8757 or 1-800-396-4778

Or hand deliver appeals to:
Providence Health Plan
3601 SW Murray Blvd., Ste. 10
Beaverton, OR 97005

For any denial involving the Trust's prescription drug coverage (except for participants in the Kaiser plan):

EXPRESS SCRIPTS
P.O. Box 66587
St. Louis, Mo 63116-6587
Fax:1-877-328-9660
Phone: 1-800-753-2851

- **Initial administrative coverage review:** Fax or mail completed Benefit Coverage Request Form to Attn: Benefit Coverage Review Department.
- **Level 1 or Level 2 appeals:** Fax or mail patient name, member ID, phone number, drug name, brief description of reason for appeal and additional supporting documentation to Attn.: Administrative Appeals Department.
- **External Appeals:** Fax or mail correspondence to Attn.: External Appeals Department.

For any denial involving the Trust's dental coverage (except for participants in the Kaiser plan):

DELTA DENTAL OF OREGON
Attn: Appeal Unit
PO Box 40384
Portland, OR 9240
Fax: 1-503-412-4003 or 1-866-923-0412

For any denial involving the Trust's vision coverage:

VISION SERVICES PLAN
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
Phone: 1-800-877-7195

For any denial involving The Standard for short term disability benefits:

- Please include the claim number associated with the appeal.

THE STANDARD
Employee Benefits Dept.
P.O. Box 2800
Portland, OR 97208
Phone: 1-800-368-2859
Fax: 1-888-378-6053

For any denial involving The Standard for Life and Accidental Death and Dismemberment (AD&D) benefits:

- Include the claim number associated with the appeal.

THE STANDARD
Employee Benefits Dept.
P.O. Box 2800
Portland, OR 97208
Phone: 1-800-628-8600
Fax: 1-888-414-0389

In addition to the appeal procedure provided through these insurers or claims administrators, the Trust provides the following appeal procedures:

APPEAL PROCESS THROUGH THE TRUST

The Trust also provides participants the opportunity to have benefit denials reviewed by the Trust's Appeal Panel. You must request a review of any denial by the Trust within 180 days of when the entity which made the initial denial completed its review of your appeal.

ADMINISTRATIVE REVIEW OF APPEAL

The initial review of any appeal will be an administrative review done by the Trust Office. The Trust Office will notify you of its decision within 30 days of receipt of your appeal. The administrative review decision shall:

- State the specific reason for the denial;
- Reference the plan provision(s) relied upon;
- Describe any additional information necessary to perfect your claim and the reason it is necessary;
- Explain the Trust's claims procedures; and
- Describe what information is available to you.

The Trust Office's administrative review will be final and binding unless you submit a written request for review within 60 days of the denial. Upon receipt of a request for review the Trust Office may refer the matter to the Administrative Committee at its next meeting for informal consultation and comment. If this consultation does not resolve the appeal, the matter will be referred to the Appeal Panel for formal review.

YOUR RIGHTS ON APPEAL

If you appeal, you or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to your claim appeal. Relevant documents include documents relied on, submitted, considered, or generated in making the benefit determination, including any internal guidelines or policies considered in processing your appeal. If the denial is based on a medical determination, an explanation of that determination, and its application to your medical situation, is also available upon request.

If you are not satisfied with the decision of the Internal Grievance or Appeal and your appeal involves an Adverse Benefit Determination, you may request a voluntary second level internal appeal which will be reviewed by the Appeal Panel.

TRUST APPEAL PANEL

The Trust's Administrative Committee serves as the Appeal Panel. The Appeal Panel will consider properly filed appeal requests at the next regularly scheduled Administrative Committee meeting following receipt of the appeal and the completion of any informal consultation process. If your request for Appeal Panel review is received within 20 days of the next regularly scheduled Administrative Committee meeting, your appeal will be heard at the second regularly scheduled Administrative Committee meeting.

The Appeal Panel will review all documents relevant to the appeal. The review will be de novo (i.e., without any deference to the original decision).

You or your authorized representative will be allowed to appear before the Appeal Panel and present evidence or witnesses upon request. The Appeal Panel may in its discretion set conditions related to the conduct of an appeal, the testimony or attendance of any individual or other procedural and evidentiary matters.

The Appeal Panel will notify the claimant of its decision within 10 days of the hearing. If any part of the appeal is denied, the written decision will set out the specific reason for the adverse decision, reference the plan provision involved, identify any internal rules or guidelines considered in making its decision, and a statement identifying what information is available to you upon request.

A vote by three of the four members of the Appeal Panel is required to constitute a decision. An appeal decision by the Appeal Panel will be final and binding. If the Appeal Panel cannot reach a decision the existing decision on the appeal shall continue in effect. In situations where the Appeal Panel cannot reach a decision, either the Appeal Panel or the Claimant may request the full Board of Trustees consider an appeal pursuant to the procedures described below.

REFERRAL TO BOARD OF TRUSTEES

If a matter is referred to the Board of Trustees from the Appeal Panel, a decision will be made at the next regularly scheduled Board of Trustees meeting. You or your authorized representative may appear before the Board of Trustees if you appeared before the Appeal Panel. If the Board of Trustees is unable to make a decision at its next regularly scheduled meeting, you will be notified and the matter will be heard at its next subsequent meeting. The decision issued by the Board of Trustees will contain the same information as decisions issued by the Claim Appeal Panel. The Board of Trustees' decision will be final and binding.

EXHAUSTION OF CLAIM(S) APPEAL PROCEDURES AND STANDARD OF REVIEW

You must exhaust these claim(s) appeal procedures prior to undertaking any legal action with respect to a claim. In any action challenging a denial of benefits the standard of review shall be whether the Trustees were in error upon an issue of law, acted arbitrarily or capriciously or entered findings of fact that were unsupported by substantial evidence.

Continuation of Coverage Rights

INTRODUCTION

This notice contains important information about your right to continuation coverage, which is a temporary extension of coverage under the Plan, if your coverage terminates because of a qualifying event in the future. **This notice generally explains continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

WHAT IS CONTINUATION COVERAGE?

Continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect continuation coverage must pay for continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse or registered domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your spouse/domestic partner dies;
- Your spouse/domestic partner's hours of employment are reduced;
- Your spouse/domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse/domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your spouse; or
- Your domestic partnership is terminated.
- If your spouse/domestic partner is over the age of 55 when you divorce, you are eligible for continuation coverage until he or she becomes eligible for Medicare.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced, legally separated or terminate a domestic partnership recognized by the Trust; or
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN IS CONTINUATION COVERAGE AVAILABLE?

The Plan will offer continuation coverage to qualified beneficiaries only after the Trust Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the District will notify the Trust Office of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For certain other qualifying events (divorce, end of domestic partnership or legal separation of the employee and spouse or domestic partner, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Trust Office within 60 days after the qualifying event occurs.

HOW IS CONTINUATION COVERAGE PROVIDED?

Once the Trust Office receives notice that a qualifying event has occurred, continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. Covered employees may elect continuation coverage on behalf of their spouses or domestic partners, and parents may elect continuation coverage on behalf of their children.

Continuation coverage is a temporary continuation of coverage. If you have a qualifying event as a result of a termination of employment or reduction of hours you may continue coverage for up to 24 months.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, end of a domestic partnership or a dependent child's losing eligibility as a dependent child, continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 24 months before the qualifying event, continuation coverage for qualified beneficiaries other than the employee can last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months after the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, continuation coverage generally lasts for only up to a total of 24 months. There are two ways in which this 24-month period of continuation coverage can be extended which are discussed below.

DISABILITY EXTENSION OF 24-MONTH PERIOD OF CONTINUATION COVERAGE

If you or any dependent under the Plan is determined by the Social Security Administration to be disabled and you notify the Trust Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 5 months of continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 24-month period of continuation coverage. You must provide notice of the Social Security Disability Determination to the Trust Office within 60 days of the later of the notice of your qualifying event or the receipt of the Determination.

SECOND QUALIFYING EVENT EXTENSION OF 24-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 24 months of continuation coverage, the spouse/domestic partner and dependent children in your family can get up to 12 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Trust Office within 60 days of the second qualifying event. This extension may be available to the spouse/domestic partner and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

ALTERNATIVE WAYS TO CONTINUE COVERAGE

There are other ways to continue coverage in specific situations.

Waiver of Premium While Receiving Disability Benefits

If you, as the Employee are unable to work because of a Total Disability, you and any eligible Dependents, are eligible to continue the medical, dental and vision coverage you had when employed, at no cost until the earlier of:

- Your recovery from the Total Disability; or
- The end of 30 calendar months from when your long-term disability benefits began

Your Total Disability must be certified by the Trust's long-term disability carrier (Standard), the Oregon Public Retirement System (PERS) or Social Security. If you are relying on a Total Disability determination by PERS or Social Security, you must submit documentation to the District's HR Department to receive a waiver.

Extension of Coverage for Disability Condition Only

If you, or a Dependent, is receiving coverage for a Totally Disabling Condition when your coverage ends, you can elect to receive coverage for treatment of the Totally Disabling Condition only. This is provided at no cost. No other coverage is provided other than care for the Totally Disabling Condition. To utilize this extension, you must provide the Trust Office proof of your continuing Total Disability within 90 days of your coverage ending.

Dependent Coverage Following Employee's Death

If you as the Employee die while covered by the Trust, your eligible Dependents can receive all Trust coverages for which they are eligible for three (3) months following your death. This coverage is provided at no cost. Once this three months of coverage ends, your eligible Dependents can elect to continue coverage on a self-pay basis. Your Dependents must apply for this coverage within 60 days of your Dependents' coverage otherwise ending.

Coverage Through an Exchange

Effective January 1, 2014, you may also be eligible to participate in Oregon's or Washington's Health Care Exchange. However, if you enrolled in continuation coverage and it terminated before the end of the continuation rights period, you will not be able to enroll in a plan offered through the Exchange until the next annual open enrollment period. For 2025, the Open Enrollment Period is anticipated to be November 1, 2024, to December 15, 2024. Coverage can start as early as January 1, 2025. If you do not enroll during the annual enrollment period, you will not be able to enroll in an exchange plan for 2025 unless you have a special enrollment event. For more information, please contact your state's Exchange at:

Oregon Health Plan	
Website	**healthcare.oregon.gov**
Phone	1-800-699-9075
Washington Health Benefit Exchange	
Website	**wahealthplanfinder.org**
Phone	1-855-923-4633

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW or visit **insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor at **askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in Oregon or Washington, you may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility:

OREGON—Medicaid	
Website	**healthcare.oregon.gov**
Medicaid & CHIP Phone	1-800-699-9075
WASHINGTON—Medicaid	
Website	**hca.wa.gov**
Phone	1-800-562-3022

To see if any other states have added premium assistance, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration	
Website	**dol.gov/ebsa**
Phone	1-866-444-EBSA (3272)
U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services	
Website	**cms.hhs.gov**
Phone	1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Trust health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan—whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for the Trust and its health and welfare plans. The plans covered by this notice may share health information with each other

to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Trust as an employer. Different policies may apply to other Trust programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH TRUST

The Plan, or its health benefit provider or HMO, may disclose your health information without your written authorization to the Trust for plan administration purposes. The Trust may need your health information to administer benefits under the Plan. The Trust agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Here's how additional information may be shared between the Plan and Trust, as allowed under the HIPAA rules:

The Plan, or its benefit provider or HMO, may disclose "summary health information" to the Trust, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

and other identifying information have been removed.

The Plan, or its benefit provider or HMO, may disclose to the Trust information on whether an individual is participating in the Plan or has enrolled or disenrolled in a benefit option or HMO offered by the Plan.

In addition, you should know that the Trust cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Trust from other sources—for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs—is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made—for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities listed in the table on page 11.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed on page 11. This section of the notice describes how you may exercise each individual right.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death—or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider;

enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice took effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, all active participants will be provided with a revised privacy notice, mailed to the address on file.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Trust Office. You won't be retaliated against for filing a complaint. To file a complaint, contact the Trust Office at 833-255-4123 (toll free) or 503-486-2107.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Trust Office at 833-255-4123 (toll free) or 503-486-2107.

Designation of Primary Care Provider (for Kaiser Plans only)

This is required notification of primary care provider rights under Patient Protection and Affordable Care Act (PPACA), also referred to as Health Care Reform.

You have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to **kp.org** or call 503-813-2000 (Portland) or 1-800-813-2000.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, go to **kp.org** or call 503-813-2000 (Portland) or 1-800-813-2000.

The Women's Health & Cancer Rights Act of 1998

If you or one of your covered dependents has had or is going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided for the following services in a manner determined in consultation with the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits available under your medical plan.

For information on WHCRA benefits or details about any state laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

- Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours).

Please keep this information with your other group health plan documents. If you have any questions regarding this notice, please contact Member Services at the number found on your ID Card. This notice is provided to you for informational purposes, no action is required on your part.

Important Notice About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage with Trust is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in Trust medical plans during 2024 and are or will become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription

drug plan enrollment. You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

Please read this notice carefully. It has information about prescription drug coverage with Trust and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the Trust health plan, you'll be interested to know that the prescription drug coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue coverage under the Trust plans. In this case, the Trust plan(s) will continue to pay as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Trust coverage, Medicare will be your only payer. You can re-enroll in Trust coverage during Open Enrollment or if you have a special enrollment event for the Trust coverage.

You should know that if you waive or leave coverage with the Trust and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future—such as before the next period you can enroll in Medicare prescription drug coverage, if this Trust coverage changes, or upon your request.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help,

visit SSA online at **ssa.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Date:	August, 2024
Contact Name:	The Trust Office
Phone Number:	833-255-4123 (toll free) or 503-486-2107

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you're required to pay a higher premium (a penalty).

Nondiscrimination Statement: Discrimination is Against the Law

The School District No. 1 Health & Welfare Trust complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, or sex. The School District No. 1 Health & Welfare Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, or sex.

School District No. 1 Health & Welfare Trust:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters;
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters;
  - Information written in other languages

If you need these services, contact Pati Piro-Bosley, Civil Rights Coordinator.

If you believe that the School District No. 1 Health & Welfare Trust has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, or sex, you can file a grievance with:

Pati Piro-Bosley
12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
Email: **ppirobosley@zenith-american.com**
Phone: 503-486-2045
Fax: 503-612-0855

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pati Piro-Bosley, Civil Rights Coordinator, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or email at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Email: **OCRComplaint@hhs.gov**
Complaint forms are available at
www.hhs.gov/ocr/office/file/index.html

The Trust reserves the right to terminate, suspend, withdraw, or modify the benefits described in this document, in whole or in part, at any time. No statement in this or any other document, and no oral representation, should be construed as a waiver of this right.

Plan Information

PLAN NAME

The legal name of this plan is the School District No. 1 Health and Welfare Trust.

TYPE OF PLAN

The plan is a health and welfare plan that provides benefits to persons covered under certain Trust-provided plans. The benefits available are described in Plan Booklets.

ADMINISTRATIVE INFORMATION

- Employer Identification Number (EIN) of the plan sponsor: 93-6090239
- Plan Number (PN): 001
- Benefit Year: January 1 through December 31
- Substitute Teachers Benefit Plan Year: October 1 through September 30
- Financial Plan Year: January 1 through December 31

PLAN ADMINISTRATOR

The Plan is sponsored and administered by a joint labor-management Board of Trustees with the assistance of Zenith American Solutions, a contract administration organization. Zenith American Solutions is referred to as the Trust Office throughout this handbook and may be contacted at the following address:

12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
833-255-4123 (toll free) or 503-486-2107

BOARD OF TRUSTEES

Tammy Adams	Jennie Johnson
Michelle Batten	Stacey Lukas
David Donachie	Nahir Perez
Brian Halberg	Russ Peterson
Ligena Hein	Gwen Sullivan

Elizabeth Held (Alternate)	Molly Romay (Alternate)
Steve Lancaster (Alternate)	Kerry Young (Alternate)
Emily Linnertz (Alternate)	

All Trustees can be contacted through:

School District Trust Office
12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
833-255-4123 (toll free) or 503-486-2107

AGENT FOR SERVICE OF LEGAL PROCESS

The person designated as the plan's agent for service of legal process is:

David Barlow
Barlow Coughran Morales & Josephson
1325 Fourth Avenue, Suite 910
Seattle, WA 98101

In addition, legal process on the plan may be served on the Board of Trustees at the Trust Office address or on any individual Trustee.

TYPE OF ADMINISTRATION

The plan is administered directly by the Board of Trustees of the School District No. 1 Health and Welfare Trust.

FUTURE OF THE PLAN AND TRUST FUND

The Board of Trustees has the authority to terminate the Trust Fund. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund. In the event of termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund after payment of the expenses shall be

used for the continuation of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted. Additionally, retiree benefits are not guaranteed. They are provided to the extent that funding is available through negotiated employer contributions or employee or dependent self-payment. The Board of Trustees reserves the right to modify, alter or terminate retiree benefits as future events may require.

FUNDING OF BENEFITS

The plan pays premiums to the following entities:

Kaiser Foundation Health Plan of the Northwest
Kaiser Permanente Building
500 NE Multnomah Street, Suite 100
Portland, OR 97232
503-813-2000
1-800-813-2000

The Standard Insurance Company
900 SW 5th Ave.
Portland, OR 97204
1-800-348-3226

SOURCE OF CONTRIBUTIONS

The plan is funded by contributions the District makes to the Trust for eligible Employees, retirees and their Dependents, and payments made by individuals eligible for benefits under this Trust, on a month-to-month basis, according to collective bargaining agreements or special agreements.

INTERPRETATION OF THE PLAN

Benefits are provided according to the written terms of the Trust's plans, or where applicable, insurance policies. The Trustees have the discretionary authority to determine eligibility for benefits and to construe the terms of the Trust's plans. The Trustees have also authorized its claims administrators to utilize their internal polices and protocols to determine what benefits are payable under the Plan options they administer. Statements made by persons other than the Board of Trustees or the Board's authorized representatives are not authorized by, and will not be binding on, the Trust. The terms of the Trust's plans may be amended periodically by the Board of Trustees to change eligibility or benefits, subject to the terms and conditions of collective bargaining agreements providing for participation in the Trust and any applicable laws or regulations. Any benefit option may also be modified, suspended or terminated at any time by the Trustees. The Trust or its benefit options are not a guarantee of future employment. It is complementary to, and does not affect, any requirement for coverage by workers' compensation insurance.

COLLECTIVE BARGAINING AGREEMENTS

The plan is maintained according to one or more collective bargaining agreements. Upon written request to the unions and payment of any copying charges, plan participants and beneficiaries may obtain copies of any such agreements. They may also inspect the agreements at the unions' principal offices.

Please refer to the summary plan description for detailed information. This document is not intended to cover every option detail. Complete details are in the legal documents, contracts, and administrative policies that govern benefit operation and administration. If there should ever be any differences between the summaries in this document and these legal documents, contract, or policies, the documents, contracts and policies will take precedence.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-486-2102 (TTY: 1-503-486-2102).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-486-2102 (TTY: 1-503-486-2102).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-503-486-2102（TTY：1-503-486-2102）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-503-486-2102 (телетайп: 1-503-486-2102).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-503-486-2102 (TTY: 1-503-486-2102)번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-503-486-2102 (телетайп: 1-503-486-2102).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-503-486-2102（TTY:1-503-486-2102）まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 503-486-2102-1 (رقم هاتف الصم والبكم: 503-486-2102-1).

ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi la 1-503-486-2102 (TTY: 1-503-486-2102).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-503-486-2102 (TTY: 1-503-486-2102)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-503-486-2102 (TTY: 1-503-486-2102).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-503-486-2102 (TTY: 1-503-486-2102).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-503-486-2102 (TTY: 1-503-486-2102) تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-503-486-2102 (ATS : 1-503-486-2102).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-503-486-2102 (TTY: 1-503-486-2102).