2020 SUMMARY PLAN DESCRIPTION FOR:

BRIGHT WOOD CORPORATION HEALTH AND WELLNESS PLAN

Plus Plan

Group Number: 10016754

Medical Benefits

Regence

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

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- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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 at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

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。1-888-344-6347（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided for You by Your employer. Your employer has chosen Regence BlueCross BlueShield of Oregon to administer claims for Your group health plan. Throughout this Summary Plan Description, Your employer may be referred to as the "Plan Sponsor."

EMPLOYER PAID BENEFITS

Your Plan is an employer-paid benefits plan administered by Regence BlueCross BlueShield of Oregon (usually referred to as the "Claims Administrator" in this Summary Plan Description). This means that Your employer, not Regence BlueCross BlueShield of Oregon, pays for Your covered medical services and supplies. Your claims will be paid only after Your employer provides Regence BlueCross BlueShield of Oregon with the funds to pay Your benefits and pay all other charges due under the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Oregon has been chosen as the Claims Administrator of Your Plan.

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective **May 1, 2020**, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueCross BlueShield of Oregon and makes it void.

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends, COBRA Continuation of Coverage and Other Continuation Options sections, the terms "You" and "Your" mean the Participant only). The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Summary Plan Description, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

Federal law mandates coverage for certain breast reconstruction services in connection with a covered mastectomy. See Women's Health and Cancer Rights in the General Provisions Section of this Summary Plan Description for details.

GRANDFATHERED
The Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. For ERISA plans, You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. For information on preauthorization, contact Your Plan Administrator.

Notice of Privacy Practices: Regence BlueCross BlueShield of Oregon has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION
If You have questions or would like to learn more about Your coverage, talk with one of the Customer Service representatives. Phone lines are open Monday-Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

Customer Service: 1 (866) 240-9580
(TTY: 711)

Or visit the Claims Administrator's Web site at: **regence.com**

For assistance in a language other than English, please call the Customer Service telephone number.

Case Management. You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.

BlueCard® Program. Call Customer Service to learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueCross BlueShield of Oregon serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

Using Your Summary Plan Description

YOUR PARTNER IN HEALTH CARE

This Plan, administered by Regence, provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Providers and innovative tools. With this health care coverage, You will discover more personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

YOU SELECT YOUR PROVIDER AND CONTROL YOUR OUT-OF-POCKET EXPENSES

Your Plan gives You broad access to Providers and allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under three choices called: "Category 1," "Category 2" and "Category 3."

- **Category 1.** When You see a preferred Provider, You save the most in Your out-of-pocket expenses. Choosing this category means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 2.** When You see a participating Provider, Your out-of-pocket expenses will generally be higher than seeing a Category 1 Provider because larger discounts with preferred Providers may be negotiated that will result in lower out-of-pocket amounts for You. Choosing this category means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 3.** When You see a Provider that does not have a participating contract with the Claims Administrator, Your out-of-pocket expenses will generally be higher than seeing a Category 1 Provider. A Category 3 Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance (sometimes referred to as balance billing).

For each benefit, the Provider You may choose and Your payment amount is indicated. Categories 1, 2 and 3 are also in the Definitions Section of this Summary Plan Description. You can go to **regence.com** for further Provider network information or You can call Customer Service at 1 (866) 240-9580.

SERVICES RECEIVED FROM AN OREGON NONPARTICIPATING PROVIDER IN A PREFERRED OR PARTICIPATING HEALTHCARE FACILITY

Regardless of any provision of this Summary Plan Description to the contrary, if You receive services from an Oregon licensed or certified nonparticipating Provider at a preferred or participating Hospital, Ambulatory Surgical Center, freestanding birthing center, or outpatient renal dialysis center, You may not be responsible for their charges in excess of any Category 1 cost-share for:

- emergency services; or
- other inpatient or outpatient services, unless the nonparticipating Provider obtained Your informed consent in advance of the services in a manner established by the state.

This does not apply to: 1) a residential facility licensed by the Department of Human Services or the Oregon Health Authority under Oregon law; 2) an establishment furnishing primarily domiciliary care as described under Oregon law; 3) a residential facility licensed or approved under the rules of the Department of Corrections; 4) facilities established through the Oregon Health Authority for the treatment of substance abuse disorders; 5) community mental health programs or community developmental disabilities programs established under Oregon law; or 6) a long-term care facility.

ADDITIONAL ADVANTAGES OF PARTICIPATION

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com**. It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:

  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
  - discover discounts on select items and services*.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Plan, that also may create savings or administrative fees for the Claims Administrator. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Deductibles, (if any), Copayments, Coinsurance and Maximum Coinsurance. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Medical Benefits Section to see exactly how they are applied and to which benefits they apply.

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of days, visits, services, dollar amount, or a specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward any Deductible and against the specific Maximum Benefit that is expressed in this Summary Plan Description. Refer to the Medical Benefits Section in this Summary Plan Description to determine if a Covered Service has a specific Maximum Benefit.

MAXIMUM COINSURANCE

Claimants can meet the Maximum Coinsurance by their payments of Coinsurance as specifically indicated in the Medical Benefits Section. There are two Maximum Coinsurance amounts: one for Category 1 benefits, and another Maximum Coinsurance amount for Category 2 and 3 benefits combined. The Medical Benefits Section describes this more fully, but in this Summary Plan Description, the term is referred to simply as "the Maximum Coinsurance." A Claimant's Coinsurance payment for benefits listed in the Medical Benefits Section that show under the Category "All" will apply toward the Category 1 Maximum Coinsurance amount. Any amounts You pay for non-Covered Services, Deductible, Copayments or amounts in excess of the Allowed Amount do not apply toward the Maximum Coinsurance. You will continue to be responsible for amounts that do not apply toward the Maximum Coinsurance, even after You reach this Plan's Maximum Coinsurance.

Once You reach the Maximum Coinsurance, benefits subject to the Maximum Coinsurance will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance for some benefits of this Plan does not change to a higher payment level or apply to the Maximum Coinsurance. Those exceptions are specifically noted in the Medical Benefits Section of this Summary Plan Description.

There are two Family Maximum Coinsurance amounts: one for Category 1 benefits, and another Family Maximum Coinsurance amount for Category 2 and 3 benefits combined. The Family Maximum Coinsurance for a Calendar Year is satisfied when three or more Family members' Coinsurance for Covered Services for that Calendar Year total and meet the Family's Maximum Coinsurance amount. However, no one Claimant will be required to meet more than the individual Maximum Coinsurance amount toward the Family Maximum Coinsurance in a Calendar Year.

COPAYMENTS
Copayments are the fixed dollar amount that You must pay directly to the Provider for emergency room visits each time You receive a specified service (as applicable). The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)
Once You have satisfied any applicable Deductible and any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount and will be applied toward the Maximum Coinsurance unless otherwise specified in the Medical Benefits Section. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. A Preferred or Participating Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount if You choose Category 1 or Category 2. Nonparticipating Providers, however, may bill You for any balances over the Plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount if You choose Category 3. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES
The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies the Calendar Year Deductible. There are two Deductibles: one for Category 1 benefits, and another for Category 2 and 3 benefits combined. The Medical Benefits Section describes this more fully, but in this Summary Plan Description, the term is referred to simply as "the Deductible." A Claimant satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. A Claimant's Deductible amount, if any, paid toward Covered Services listed in the Medical Benefits Section for emergency room services and Covered Services that show under the Category "All" will apply toward the Category 1 Deductible amount.

There are two Family Calendar Year Deductible amounts: one for Category 1 benefits, and another for Category 2 and 3 benefits combined. The Family Calendar Year Deductible is satisfied when three or more covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. However, no one Claimant will be required to meet more than the individual Deductible amount toward the Family Deductible in a Calendar Year.

The Plan does not pay for services applied toward the Deductible. Refer to the Medical Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions of the Plan (for example, Deductibles, Maximum Coinsurance, and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits of the Plan have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections of this Summary Plan Description.

Medical Benefits

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the benefits of this coverage. For Your ease in finding the information regarding benefits most important to You, the Plan has listed these benefits alphabetically, with the exception of the Preventive Care, Office Visits and Other Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this plan. In some cases, the Claims Administrator may limit benefits or coverage to a less costly and Medically Necessary alternative item. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Summary Plan Description for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

Reimbursement may be available under Your coverage for some medical supplies, equipment and devices when purchased new from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. New medical supplies, equipment and devices, such as a breast pump or wheelchair, purchased through an approved Commercial Seller are covered at the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, please visit the Claims Administrator's Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's Web site, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service under the Plan.

If benefits under the Plan change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

CALENDAR YEAR MAXIMUM COINSURANCE
Category 1
Per Claimant: $2,850
Per Family: $8,550

Categories 2 and 3
Per Claimant: $5,700
Per Family: $17,100

COPAYMENTS AND COINSURANCE
Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES
Category 1
Per Claimant: $750
Per Family: $2,250

Categories 2 and 3
Per Claimant: $1,500
Per Family: $4,500

You do not need to meet any Deductible before receiving benefits for:

- preventive care;
- diabetes education;
- childhood immunizations;
- adult immunizations;
- maternity professional services for the enrolled spouse (the first $1,000 of Covered Services only);
- tobacco use cessation;
- virtual care, Category 1 and Category 2.

PREVENTIVE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
For Claimants age 30 and over the following visit limit applies: **Limit:** one visit per Claimant per Calendar Year For Claimants age 3 to 29 the following visit limit applies: **Limit:** unlimited For Claimants age 2 and under the following visit limit applies: **Limit:** 10 visit maximum for well-baby and well-child care		

The Plan covers preventive care services and supplies:

- routine visits for preventive care, including, but not limited to, well-baby care and routine physical exams, including annual women's examinations;
- routine radiology and laboratory services, including, but not limited to, routine mammography and prostate screening; and
- routine procedures, including, but not limited to, routine colonoscopies.

OFFICE VISITS – ILLNESS OR INJURY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers visits in the office, home, urgent care or Hospital outpatient department only for treatment of Illness or Injury. Office visits under this benefit do not include preventive care. However, when services are billed as preventive care, benefits under the Summary Plan Description will be paid according to the Preventive Care benefit. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (such as, separate facility fees billed in conjunction with the office visit) are not considered an office visit under this benefit. For example, the Plan will pay for a surgical procedure performed in the office according to the Other Professional Services benefit.

OTHER PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers services and supplies provided by a professional Provider subject to any Deductible and/or Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services and Supplies

The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Covered services and supplies also include those to treat a congenital anomaly, foot care associated with diabetes and Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet and osteopathic spinal manipulations.

The Plan also covers dental and orthodontic services that are for the treatment of craniofacial anomalies and are Medically Necessary to restore function. A "craniofacial anomaly" is a physical disorder, identifiable at birth, that affects the bony structures of the face or head, including, but not limited to, cleft palate, cleft lip, craniosynotosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is not provided

under this benefit for the treatment of temporomandibular joint disorder or developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

Additionally, the Plan covers some Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Diagnostic Procedures
The Plan covers services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress test, sleep studies and neurology/neuromuscular procedures. However, when the procedures are billed as preventive care, benefits under the Plan will be paid according to the Preventive Care benefit.

Professional Inpatient
The Plan covers professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by a preferred Provider and You are admitted to a preferred Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by participating and nonparticipating Providers at the Category 1 benefit level. However, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance.

Radiology and Laboratory
The Plan covers services for treatment of Illness or Injury. This includes, but is not limited to, Medically Necessary mammography and prostate screening. However, when services are billed as preventive care, benefits under the Plan will be paid according to the Preventive Care benefit.

Surgical Services
The Plan covers surgical services and supplies including cochlear implants and the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections
The Plan covers therapeutic injections and related supplies when given in a professional Provider's office.

Teaching doses for self-administrable injectable medications (by which a Provider educates the Claimant to self-inject) are covered up to a limit of three doses per medication per Claimant Lifetime. Teaching doses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

AMBULANCE SERVICES

Category: All
Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.

The Plan covers ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

AMBULATORY SURGICAL CENTER

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 90% and You pay 10% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) for Illness and Injury.

BLOOD BANK

Category: All
Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.

The Plan covers the services and supplies of a blood bank, excluding storage costs.

CHILD ABUSE MEDICAL ASSESSMENT

The Plan covers Child Abuse Medical Assessments including those services provided by a Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits, if any, as specified in the Medical Benefits of this Summary Plan Description. The services include, but are not limited to, a forensic interview and Mental Health treatment.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Child Abuse Medical Assessment benefit:

Child Abuse Medical Assessment means an assessment by or under the direction of a licensed Physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse. Child Abuse Medical Assessment includes the taking of a thorough medical history, a complete physical examination and an interview

for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the child.

Community Assessment Center means a neutral, child-sensitive community-based facility or service Provider to which a child from the community may be referred to receive a thorough Child Abuse Medical Assessment for the purpose of determining whether the child has been abused or neglected.

COMPLEMENTARY CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Limit: $300 for all complementary care combined per Claimant per Calendar Year		

The Plan covers the services and supplies of the following Providers: acupuncturists, chiropractors and naturopaths. The Plan also covers acupuncture and chiropractic care under this benefit when performed by any Provider.

DENTAL HOSPITALIZATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health.

DETOXIFICATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling or Orthotic Devices benefits in this Summary Plan Description for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers services and supplies for diabetic self-management training and education. Diabetic nutritional counseling and nutritional therapy are covered under the Nutritional Counseling benefit.

DIALYSIS – OUTPATIENT

Initial Outpatient Treatment Period

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Outpatient limit: 42 treatments per Claimant		

The Plan covers professional services, supplies, medications, labs and facility fees related to outpatient hemodialysis, peritoneal dialysis and hemofiltration services during the first treatment period. For the purpose of this benefit the "first treatment period" will be three months (42 treatments) of hemodialysis treatment (or 30 days of peritoneal

dialysis treatment). Dialysis treatments that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. If more than 42 treatments are necessary in the first treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. See the Supplemental Outpatient Treatment Period for coverage after the first 42 treatments in the first treatment period.

When Your Physician recommends dialysis, You should first contact the Claims Administrator to begin Case Management and confirm Your enrollment in the Supplemental Kidney Dialysis Program described below.

The Plan will pay regular Plan benefits when services are rendered outside the country, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay no cost-sharing. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** You pay no cost-sharing. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** The Plan pays 150% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You pay balance of billed charges, which will not apply toward the Maximum Coinsurance.

For any subsequent outpatient dialysis beyond the first treatment period, the Plan will provide supplemental coverage as described above.

In addition, a Claimant receiving supplemental dialysis is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the Claimant's dialysis treatment, as long as the Claimant continues to be enrolled under Medicare Part B and continues to be eligible for coverage under this Plan. Proof of payment of the Medicare Part B premium will be required prior to reimbursement.

For the purpose of this benefit, "Medicare allowed amount" is the amount that a Medicare-contracted Provider agrees to accept as full payment for a Covered Service. This is also referred to as the Provider accepting Medicare assignment.

Case Managed Dialysis and Supplemental Kidney Dialysis Program
Receive one-on-one help and support in the event Your Physician recommends dialysis. An experienced, compassionate case manager will serve as Your personal

advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, please call 1 (866) 240-9580.

DURABLE MEDICAL EQUIPMENT

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Limit: one wig per Claimant per Calendar Year		

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include oxygen equipment, wheelchairs and wigs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Additionally, the Plan covers new Durable Medical Equipment that is obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After $275 Copayment* per visit and Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You have a life-threatening medical emergency and are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. *Copayment is waived for an Accidental Injury and regular plan benefits apply.	**Payment:** After $275 Copayment* per visit and Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You have a life-threatening medical emergency and are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. *Copayment is waived for an Accidental Injury and regular plan benefits apply.	**Payment:** After $275 Copayment* per visit and Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You have a life-threatening medical emergency and are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis. *Copayment is waived for an Accidental Injury and regular plan benefits apply.

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening examinations that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be preauthorized. If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. However, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions. See the Definitions Section for coverage of services for the treatment of Accidental Injury.

FAMILY PLANNING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy, tubal ligation and insertion or removal of IUD or Norplant.

GENETIC TESTING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers genetic testing when performed for a medical reason or for a condition that requires genetic testing, provided the results of the testing have the potential to improve Health Outcomes.

HOME HEALTH CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPICE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Limit: 114 inpatient or outpatient respite care days per Calendar Year **Limit:** 24 inpatient hospital days per Calendar Year		

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available

24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness.
Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Inpatient hospital or respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers inpatient and outpatient services and supplies of a Hospital for Illness and Injury (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. However, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening examinations, in a Hospital's emergency room.

If benefits under the Plan change while You or a Beneficiary are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

IMMUNIZATIONS
Childhood Immunizations

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers immunizations for children (up to 19 years of age) not subject to the Deductible, as required by school district. For Category 1 and Category 2, child

immunizations are not subject to the Coinsurance. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

Adult Immunizations

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** The Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** The Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Limit: Zostavax (shingles immunization) for Claimants age 50 and over		

The Plan covers immunizations for adults according to the United States Preventive Services Task Force guidelines. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

MATERNITY CARE
Inpatient and Professional Services

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Summary Plan Description to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy (therapeutic abortion) only when done to preserve the life of the Claimant.

Surrogacy
Maternity and related medical services received by You while Acting as a Surrogate are not Covered Services, up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. By incurring and making claim for such services, You agree to reimburse the Plan the lesser of the amount described in the preceding sentence and the amount the Plan has paid for those Covered Services (even if payment or compensation to You or any other person or entity occurs after the termination of Your coverage under the Plan).

You must notify the Claims Administrator within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with the Claims Administrator as needed to ensure the Claims Administrator's ability to recover the costs of Covered Services received by You for which the Claims Administrator is entitled to reimbursement. To notify the Claims Administrator, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Please also refer to the Subrogation and Right of Recovery Section of this Summary Plan Description for more information.

Definitions
In addition to the definitions in the Definitions Section, the following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

Professional Services for the Enrolled Spouse

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Limit: The first $1,000 of Covered Expenses for the enrolled spouse only. After this limit is reached, regular Plan benefits will apply for maternity care professional services.		

Prenatal benefits are available to the pregnant spouse of a covered Claimant, even when that spouse is not enrolled in the Plan as follows:

- This benefit is not available to non-covered spouse if that person has other insurance coverage;
- First $1,000 professional services billed is paid at 100%;
- Proof of legal marriage is required and must be provided to access this benefit; and
- A completed form available through the Bright Wood Corporation Personnel Department is also required.

MEDICAL FOODS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers medical foods for inborn errors of metabolism, including, but not limited to, formulas for Phenylketonuria (PKU). For the purpose of this benefit, "medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Other services and supplies such as office visits and formula to treat severe intestinal malabsorption are otherwise covered under the appropriate provision in this Medical Benefits Section.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers inpatient and outpatient Mental Health and Substance Use Disorder Services and behavioral health assessments. Benefits include physical therapy, occupational therapy, speech therapy, laboratory and radiology services, durable medical equipment and surgery provided for treatment of a Mental Health Condition.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Habilitative means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

Mental Health and Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral

health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined to be Medically Necessary). These services include Habilitative and Rehabilitative services for Mental Health Conditions or Substance Use Disorders without any visit or day limits.

Mental Health Condition means any mental disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, including autism spectrum disorders and Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or intellectual disability. Mental disorders that accompany an excluded diagnosis are covered.

Rehabilitative means inpatient or outpatient physical, occupational and speech therapy services to restore or improve lost function caused by Illness or Injury.

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought, by the state in which the treatment is provided.

Substance Use Disorder means any substance-related disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

NEWBORN CARE

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Limit: Circumcision is covered within the first three months after birth		

The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges.

NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers services for nutritional counseling and nutritional therapy, such as discussions on eating habits, lifestyle choices and dietary interventions.

ORTHOTIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body.

Additionally, the Plan covers some orthotic devices that are new and obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts.

PRIVATE DUTY NURSING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

PROSTHETIC DEVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a Mastectomy and maxillofacial prostheses. For the purpose of this benefit, "maxillofacial prostheses" services are restoration and management of head and facial structures that are not replaceable with living tissue and are defective because of disease, trauma, or birth or developmental deformities. Covered maxillofacial prostheses services must be either for the purpose of controlling or eliminating infection or pain or for restoring facial configuration or functions (e.g., speech, swallowing, chewing). Restoration of facial configuration that is cosmetic to improve on the normal range of conditions is not covered. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital Care – Inpatient and Outpatient and Ambulatory Surgical Center) in this Medical Benefits Section. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

REHABILITATION SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Inpatient limit: Physical therapy limited to 30 days per Claimant per Calendar Year. Occupational and speech therapy limited to 30 days combined per Claimant per Calendar Year. **Outpatient limit:** Physical therapy limited to 20 visits per Claimant per Calendar Year. Occupational and speech therapy limited to 30 visits combined per Claimant per Calendar Year. Cardiac and pulmonary therapy limited to 30 visits per Claimant per Calendar Year.		

The Plan covers inpatient and outpatient rehabilitation services and accommodations as appropriate and necessary to restore or improve lost function caused by Illness or Injury that is not a Mental Health Condition or Substance Use Disorder. (Rehabilitation services for mental diagnoses are not subject to a visit limit and are covered under the

Mental Health or Substance Use Disorder Services benefit.) Rehabilitation services are physical, occupational and speech therapy services only and include services such as massage when provided as a therapeutic intervention. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition. Rehabilitation services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

REPAIR OF TEETH

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers services and supplies for treatment required as a result of damage to, or loss of, sound natural teeth, when such damage or loss is due to an Injury.

RETAIL CLINIC OFFICE VISITS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers office visits in a Retail Clinic for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, are not considered an office visit under this benefit. For example, the Plan will pay for a surgical procedure performed in the Retail Clinic according to the Other Professional Services benefit.

SKILLED NURSING FACILITY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.
Limit: 90 inpatient days per Claimant per Calendar Year		

The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

TOBACCO USE CESSATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers tobacco use cessation services. For the purpose of this benefit, a tobacco use cessation service means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products. The Plan does not cover tobacco use cessation services provided by the following Providers: acupuncturists, massage therapists, chiropractors and naturopaths.

TRANSPLANTS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Claimants can contact the Claims Administrator for a current list of covered transplants.

Donor Organ Benefits
The Plan covers donor organ procurement costs if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the organ, storage, and transportation of the surgical harvesting team and the organ.

Transplant Waiting Period
You will not be eligible for any benefits related to a transplant until the first day of the 13th month of continuous coverage under this or any previous medical plan, whether or not the condition is preexisting.

The duration of the transplant waiting period will be reduced by the amount of Your combined periods of creditable coverage if You have been covered by creditable coverage. For crediting to apply, there must have been no break in creditable coverage greater than 63 days immediately preceding Your enrollment date of coverage under the Plan or between any two successive creditable coverages for which You seek credit. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

You will be allowed a credit against this transplant waiting period for the combined amount of prior creditable coverages that You have had. If You have had more than one creditable coverage in effect at the same time, credit is given only for one (that is, a day on which You have creditable coverage in force under two coverages is not counted as two days of creditable coverage). In calculating Your creditable coverage credit, if You have had a break in coverage (that is, a period between the termination date of one creditable coverage and the enrollment date on next creditable coverage) of 63 days or more, no credit will be given for any creditable coverages prior to that break in coverage.

Creditable coverage means any of the following: group coverage (including self-funded plans); individual insurance coverage; S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high-risk pool coverage; Federal Employee Health Benefit Plan coverage; and public health plans (including foreign government and US government plans).

Creditable coverage is determined separately for each Claimant.

The following periods do not count in the calculation of the length of a break in coverage:

- days in a waiting period for eligibility for coverage under the Plan; and
- for an individual who elects COBRA continuation coverage during the second election period offered under the Trade Act of 2002, days between the loss of coverage and the first day of that second election period.

You have the right to demonstrate the existence of creditable coverage by providing the Claims Administrator with one or more certificates of creditable coverage from a prior group or individual plan or with other documentation. You may obtain a certificate of creditable coverage from a prior group health plan or insurer by requesting it within 24 months of coverage termination. The Claims Administrator can help You obtain a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of creditable coverage as provided by federal law.

TRANSPLANT TRAVEL EXPENSES

Category: All
Provider: All
Payment: After Category 1 Deductible, the Plan pays 80% and You pay 20% of the billed charges.
Limit: $10,000 for travel, meals and lodging per transplant. Travel benefit is for patient and one companion. Two companions are allowed if the patient is a minor.

The Plan covers transportation, lodging and meal costs only during the actual transplantation process. Transportation is covered for the recipient Claimant and a companion to and from site only when the recipient Claimant receives a transplant at a Transplant Network Centers of Excellence Facility, provided the patient resides more than 30 miles radius. Lodging and meals are covered, cost excluding alcohol incurred in the interim by such companion. When the recipient Claimant is a minor, transportation, lodging and meal costs of 2 persons who travel with the minor are included. A minor is under 19 years of age. Transportation is limited to: airline travel-coach class only (lowest available airfare); car rental-economic class only (if a car is rented, other local transportation charges will not be included); local transportation-taxi service to and from the airport, hotel, and transplant facility when economical services (hotel vans, shuttles, etc.) are not available.

VIRTUAL CARE

The Plan covers virtual care services from a Provider. Virtual care refers to the utilization of telehealth, telemedicine or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. To learn more about how to access virtual care services, visit the Claims Administrator's Web site or contact Customer Service.

MDLIVE, a preferred Provider, has also been chosen by Your Plan Sponsor as an additional source for some telehealth services. To find an MDLIVE telehealth Provider or for additional information on Covered Services provided by MDLIVE telehealth Providers, please visit MDLIVE Web site at **www.mdlive.com/regence-or** or contact MDLIVE Customer Service at 1 (888) 725-3097.

Store and Forward Services

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers store and forward services. For the purpose of this benefit, "store and forward services" mean secure one-way electronic asynchronous (not live or real-time)

electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. Store and forward services do not include, for example, non-secure HIPAA compliant telephone, fax, short message service (SMS) texting or e-mail communication. Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers telehealth services. For the purpose of this benefit, "telehealth" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when You are not in a healthcare facility.

Telemedicine

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers telemedicine services. For the purpose of this benefit, "telemedicine" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when You are at a healthcare facility.

Prescription Medication Benefits

Your prescription medication coverage is administered through OptumRx. Contact OptumRx at 1 (855) 505-8107 for Your prescription medication coverage. More information about prescription medication coverage is available at **www.Optumrx.com**. The Claims Administrator assumes no liability for the accuracy of Your prescription medication benefits information.

Generic prescription medications $10 retail / $25 mail order

Preferred brand-name prescription medications $30 retail / $75 mail order

Non-preferred brand-name prescription medications $100 retail / $250 mail order

Care Management and Wellness Programs

Because of Regence's involvement as the Claims Administrator, You have access to the following Group-sponsored care management and wellness programs. Your employer has chosen to provide these benefits to You. To the extent any part of these programs (e.g., medications for smoking cessation) is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

CASE MANAGEMENT
Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, please call 1 (866) 543-5765.

REGENCE CONDITION MANAGER
Regence Condition Manager is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claims Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help You get on track with Your care--and stay there. They can help You understand the care plan You've developed with Your Physician, and make smarter choices for better health.

To learn more, please call 1 (866) 543-5765.

BABYWISE
Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. BabyWise can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to their needs. Since BabyWise is most beneficial when a woman enrolls early in her pregnancy, call 1 (888) JOY-BABY (569-2229) or send an e-mail to BabyWise@regence.com right away to get started.

REGENCE EMPOWER
Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include a health assessment, incentives to reward participation in healthy activities and online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals. To get started and access the resources available, visit **regence.com**.

General Exclusions

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description.

SPECIFIC EXCLUSIONS
The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) services and supplies furnished in an emergency room for stabilization of a patient.

Applied Behavioral Analysis treatment by any Provider for any condition

Assisted Reproductive Technologies
The Plan does not cover any assisted reproductive technologies, including, but not limited to, cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo; in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception; or any associated surgery, medications, testing or supplies, regardless of underlying condition or circumstance.

Biofeedback Therapy

Clinical Trials

Circumcision
Circumcision for a Claimant over three months of age.

Complementary Care
Except as provided under the Complementary Care benefit in this Summary Plan Description, the Plan does not cover complementary care.

Conditions Caused By Active Participation In a War or Insurrection
The treatment of any condition caused by or arising out of a Claimant's active participation in a war in the service of a non-United States nation-state or similar entity or in an insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to be a service-connected disability, that is a disability incurred in performance of service in the uniformed services of the United States or to be aggravated in such service.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a congenital anomaly;
- to restore a physical bodily function lost as a result of Illness or Injury; or
- related to breast reconstruction following a Medically Necessary Mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights provision.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Mastectomy means the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Counseling in the Absence of Illness
Except as provided in this Summary Plan Description or as required by law, the Plan does not cover counseling in the absence of Illness, for example: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services, except as provided under the EAP Section, if applicable; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits under the Plan).

Custodial Care
The Plan does not cover non-skilled care and helping with activities of daily living.

Dental Services
Except as provided under the Repair of Teeth or Other Professional Services benefit in this Summary Plan Description, the Plan does not cover Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Elective Abortion
Termination of pregnancy (elective therapeutic abortion), except when performed to preserve the life of the enrolled Claimant.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Gender Transition Treatment and Surgery
Treatment, surgery or counseling services for sexual reassignment.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Growth Hormone Therapy

Hearing Care
Except as provided in this Summary Plan Description, the Plan does not cover hearing care.

Infertility
Except to the extent Covered Services are required to diagnose such condition, the Plan does not cover treatment of infertility, including, but not limited to, surgery, fertility drugs, uterine transplants and other medications associated with fertility treatment.

Investigational Services
The Plan does not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Mental Health Treatment For Certain Conditions
The Plan will not cover Mental Health Conditions for diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages. Additionally, the Plan will not cover any "V code" diagnoses except the following when Medically Necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger. "V code" means codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that describes Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law

requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Summary Plan Description.

Neurodevelopmental Therapy

Non-Direct Patient Care
Services that are not direct patient care, including charges for:

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;
- preparing itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person, except as provided under the Virtual Care benefit.

Non-Duplication of Medicare
When, by law, this coverage would not be primary to Medicare Part B had You properly enrolled in Medicare Part B when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare Part B regardless of whether or not You choose to accept those benefits.

Obesity or Weight Reduction/Control
Except as may be specifically provided in this Summary Plan Description, the Plan does not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery
Services and supplies for orthognathic surgery are not covered, except for orthognathic surgery due to an Injury, or sleep apnea or congenital anomaly (including craniofacial anomalies). Orthognathic surgery means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives
The Plan does not cover over-the-counter contraceptive supplies and oral contraceptives.

Palliative Care

Personal Items
Items that are primarily for comfort, convenience, contentment, cosmetics, hygiene, environmental control, education or general physical fitness. For example, the Plan does not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes, weight lifting equipment and therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment, including hot tubs or membership fees at spas, health clubs or other such facilities. This exclusion applies even if the program, equipment or membership is recommended by the Claimant's Provider.

Prescription Medications
Prescription medications dispensed by a pharmacy. Prescription medication coverage is administered by OptumRx. Please refer to Your prescription plan document for coverages and exclusions, or call 1 (855) 505-8107 for additional plan details.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by a Claimant's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Claimant arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care

Self-Help, Self-Care, Training or Instructional Programs
Except as may be specifically provided in the Summary Plan Description, the Plan does not cover self-help, non-medical self-care, training programs, including:

- diet and weight monitoring services;
- childbirth-related classes including infant care and breast-feeding classes; and
- instructional programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member.

This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Medical Benefits Section (for example, nutritional counseling, diabetic education and teaching doses for self-administrable injectable medications).

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means:

- You and Your parents, parents' spouses, spouse, children, stepchildren, siblings and half-siblings;
- Your spouse's parents, parents' spouses, siblings and half-siblings;
- Your child's or stepchild's spouse; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided in this Summary Plan Description, the Plan does not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services for Administrative or Qualification Purposes
Physical or mental examinations and associated services, such as laboratory or similar tests, primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, sports team, the military or other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment, marriage, insurance, occupational Injury benefits, licensure or certification; or immigration or emigration.

Sexual Dysfunction
Except for counseling services provided by covered, licensed mental health Practitioners when mental health services are covered benefits in this Summary Plan Description, the Plan does not cover services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You Acting as a Surrogate. For purpose of this exclusion, "maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Please refer to the Maternity Care and/or Subrogation and Right of Recovery Sections of this Summary Plan Description for more information.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.

Third-Party Liability
Services and supplies for treatment of Illness or Injury for which a third-party is or may be responsible.

Tobacco Addiction Treatment
Except as specifically provided in this Summary Plan Description, the Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

Travel and Transportation Expenses
Except as provided in this Summary Plan Description, the Plan does not cover travel and transportation expenses other than covered Ambulance Services and travel expenses specified in the Transplant Travel Expenses benefit provided under the Plan.

Travel Immunizations
Immunizations for purposes of travel, occupation or residency in a foreign country.

Vision Care
The Plan does not cover routine eye examinations, vision hardware; visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism and reversals or revisions of surgical procedures which alter the refractive character of the eye.

Wigs
Except as specifically provided in this Summary Plan Description, the Plan does not cover wigs or other hair replacements regardless of the reason for hair loss or absence.

Work-Related Conditions
Except when a Claimant is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement.

If an Illness or Injury could be considered work-related, a Claimant will be required to file a claim for workers' compensation benefits before the Claims Administrator will consider providing any benefits under the Plan. This exclusion shall also apply if a Claimant opts out of workers' compensation.

Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan.

PREAUTHORIZATION
Preauthorization refers to the process by which the Claims Administrator determines that a proposed service or supply is Medically Necessary and provides approval for it before it is rendered.

Preauthorization is performed to ensure that the medical services You receive are aligned with evidence-based criteria and to determine whether the requested service meets the Claims Administrator's Medical Necessity criteria. Preauthorization also ensures that services or supplies You receive are safe, effective and appropriate.

Contracted Providers may be required to obtain preauthorization from the Claims Administrator in advance for certain services provided to You. Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator in advance for services. You, however, may be liable for costs if You elect to seek services and those services are not considered Medically Necessary and/or not covered under this Plan. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

A comprehensive list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's Web site at: **https://www.regence.com/web/regence_provider/pre-authorization** or by calling 1 (866) 240-9580.

Preauthorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's Web site listed above.

Time Frame for Response
You will be notified in writing within 15 calendar days of the Claims Administrator's receipt of the preauthorization request whether the request has been approved, denied, or if more information is needed to make a determination.

When More Information is Needed to Make a Determination
Additional information requested by the Claims Administrator must be received within 45 calendar days of the date on the letter requesting information. The Claims Administrator will notify You in writing of the determination within 15 calendar days of receipt of additional information or within 15 calendar days of the end of the 45-day period if no additional information is received.

If You or Your Physician believes that waiting for a determination under the standard time frame could place Your life, health, or ability to regain maximum function in serious jeopardy, Your Physician should notify the Claims Administrator by phone or fax as a shorter time frame for response may apply.

Preauthorization does not guarantee payment. The Claims Administrator's reimbursement policies may affect how claims are reimbursed, and payment of benefits is subject to all Plan provisions, including eligibility for benefits at the time of services.

PLAN IDENTIFICATION CARD

When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

It is important to keep Your Plan identification card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims reimbursement is due, the Claims Administrator will decide whether to pay You, the Provider or You and the Provider jointly. Benefit payments may be made for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment under the Plan has died, is a minor or is incompetent, benefits under the Plan may be paid up to $1,000 to a relative by blood or marriage of that person when it is believed that person is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge the Plan to the extent of the payment.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Please refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Please refer to Your Blue plan network where the referring Provider is located for coverage of independent clinical laboratory services.

You will be responsible for the total billed charges for benefits in excess of Maximum Benefits, if any, and for charges for any other service or supply not covered under this Plan, regardless of the Provider rendering such service or supply.

If the Claims Administrator receives an inquiry regarding a properly submitted claim and believes that You expect a response to that inquiry, they will respond to the inquiry within 30 days of the date they first received it.

Calendar Year and Plan Year

The Deductible and Maximum Coinsurance provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, each Plan Year. A Plan Year is the 12-month period following either the Agreement's original effective date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar

Year. When the Agreement renews on other than January 1 of any year, any Deductible or Maximum Coinsurance amounts You satisfied before the date the Agreement renews will be carried over into the next Plan Year. If the Deductible and/or Maximum Coinsurance amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Agreement during that same Calendar Year.

Timely Filing of Claims
Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, appeal the denial in accordance with the appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider
Nothing contained in this Summary Plan Description is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

Category 1 and Category 2 Claims
You must present Your Plan identification card when obtaining Covered Services from a preferred or participating Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

Category 1 and Category 2 Reimbursement
A preferred or participating Provider will be paid directly for Covered Services. These Providers have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible, Copayment and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Category 3 Claims
In order for the Claims Administrator to pay for Covered Services, You or the nonparticipating Provider must first send the claim to the Claims Administrator. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;
- the place of service;
- the date treatment was given;
- the diagnosis; and
- the patient's name and the group and identification numbers.

If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send the claim to the Claims Administrator.

Category 3 Reimbursement
The Plan pays nonparticipating Providers directly for Covered Services.

Nonparticipating Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You generally are responsible for paying any difference between the amount billed by the nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. (See Services Received From An Oregon Nonparticipating Provider In A Preferred or Participating Healthcare Facility in the Medical Benefits Section for an exception to balance billing.) For nonparticipating Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples by Category

Here is an example of how Your selection of Category 1, 2 or 3 affects payment to Providers and Your cost sharing amount. For purposes of this example, let's assume the Plan pays 80 percent of the Allowed Amount for Category 1 and 60 percent of the Allowed Amount for Categories 2 and 3. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges.

Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for Categories 1, 2 and 3. Finally, let's assume that You have met the Deductible and that You have not met the Maximum Coinsurance. Here's how that Covered Service would be paid:

- Category 1: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
  - Amount preferred Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): $**800**
  - Total: $5,000
- Category 2: the Plan would pay 60 percent of the Allowed Amount and You would pay 40 percent of the Allowed Amount, as follows:
  - Amount participating Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount): $**1,600**
  - Total: $5,000

- Category 3: the Plan would pay 60 percent of the Allowed Amount. Because the nonparticipating Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus, the $1,000 difference between the nonparticipating Provider's billed charges and the Allowed Amount, as follows:

  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): $**2,600**
    Total: $5,000

The actual benefits of the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

Ambulance Claims
When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers. Payment for Covered Services will be paid directly to the ambulance service Provider.

Claims Determinations
Within 30 days of the Claims Administrator's receipt of a claim, You will be notified of the action taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

Claims Processing Report
You will be told how a claim has been acted on via a form called a claims processing report. Claims under the Plan may be denied or accumulated toward satisfying any Deductible. If all or part of a claim is denied, the reason for the denial will be stated on the claims processing report. The claims processing report will also include instructions for filing an Appeal if You disagree with the action.

OUT-OF-AREA SERVICES

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever You access health care services outside the geographic area the Claims Administrator serves, the claim for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside the Claims Administrator's service area, You will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") don't contract with the Host Blue. The Claims Administrator explains below how both kinds of Providers are paid.

BlueCard Program

Under the BlueCard Program, when You access Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what the Claims Administrator agreed to in fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You receive Covered Services outside the Claims Administrator's service area, and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for Your claim because they will not be applied after a claim has already been paid.

Value-Based Programs

If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordination Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

For the purpose of this section, the following definitions apply.

- Value-Based Program: An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
- Provider Incentive: An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside the Claims Administrator's Service Area
- Your Liability Calculation. When Covered Services are provided outside of the Claims Administrator's service area, by nonparticipating Providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for nonparticipating emergency services.
- Exceptions. In certain situations, the Claims Administrator may use other payment methods, such as billed covered charges, the payment the Claims Administrator would make if the health care services had been obtained within the Claims Administrator's service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE
If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when You receive care from Providers outside the BlueCard service area, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if You contact the service center for assistance, Hospitals will not require You to pay for covered inpatient services, except for Your applicable Deductible, Coinsurance, etc. In such cases, the Hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of services, You must submit a claim to receive reimbursement for Covered Services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

NONASSIGNMENT

Only You are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else and You (or a custodial parent or the state Medicaid agency, if applicable) may not delegate, in full or in part, benefits or payments to any person, corporation or entity. Any attempted assignment, transfer or delegation of benefits will be considered null and void and will not be binding on the Plan. You may not assign, transfer or delegate any right of representation or collection other than to legal counsel directly authorized by You on a case-by-case basis.

CLAIMS RECOVERY

If a benefit to which You or Your Beneficiary were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan reserves the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services. The Plan's right to recovery includes the right to deduct the mistakenly paid amount from future benefits that would have been provided the Participant or any of his or her Beneficiaries, even if the mistaken payment was not made on that person's behalf.

The Claims Administrator regularly works to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). All recovered amounts will be credited to the Plan.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by the Claims Administrator. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

The information requested or disclosed may be related to treatment or services received from:

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by the Claims Administrator may include, but is not limited to:

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;
- Hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

The Claims Administrator is required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting the Claims Administrator's Web site or contacting Customer Service.

You have the right to request, inspect and amend any records that the Claims Administrator has that contain Your personal health information. Please contact the Claims Administrator's Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while

receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

Under state law, Providers contracting with a health care service contractor like Regence BlueCross BlueShield of Oregon to provide services to its Claimants agree to look only to the health care service contractor for payment of services that are covered by the Plan and may not bill You if the health care service contractor fails to pay the Provider for whatever reason. The Provider may bill You for applicable Deductible, Copayment and/or Coinsurance and for non-Covered Services, except as may be restricted in the Provider contract.

In addition, the Claims Administrator will not be liable to any person or entity for the inability or failure to procure or provide the benefits of the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incur claims and are or have been covered by the Plan. No adult Claimant hereunder, may assign any rights that he or she may have to recover expenses from any tortfeasor or other person or entity to any minor child or children of said adult Claimant without the prior express written consent of the Plan. These provisions will apply to all claims arising from Your Illness or Injury, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Injury, Illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage, excess coverage or similar contract or insurance.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The "Right of Subrogation" means the Plan is entitled to pursue any claims that You may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of Your rights of recovery with respect to any claim or potential claim against any party, due to an Injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The

Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement
If You receive any payment as a result of an Injury, Illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, Illness or condition, up to and including the full amount of Your recovery. Benefit payments made under the Plan are conditioned upon Your agreement to reimburse the Plan in full from any recovery You receive for Your Injury, Illness or condition.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to You or made on Your behalf to any Provider) You agree that if You receive any payment as a result of an Injury, Illness or condition, You will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of Your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until this Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights
Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, You, Your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment
In order to secure the Plan's recovery rights, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have, whether or not You choose to pursue the claim.

First-Priority Claim
By accepting benefits from the Plan, You acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before You receive any recovery for Your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make You whole or to compensate You in part or in whole for the damages sustained. The Plan is not required to participate in or pay Your court costs or attorney fees to any attorney You hire to pursue Your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire Subrogation and Right of Recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits

the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses provided by the Plan. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to Your own negligence.

Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, Illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Workers' Compensation
If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Future Medical Expenses
Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which benefits would normally be provided. However, the amount of any Covered Services excluded under this provision will not exceed the amount of Your recovery.

Interpretation
In the event that any claim is made that any part of this Subrogation and Right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator shall have the sole authority to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the Plan, You agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, You hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of Your present or future domicile. By accepting such benefits, You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

COORDINATION OF BENEFITS
If You are covered under any other individual or group medical contract or plan (referred to as "Other Plan" and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Benefits Subject to this Provision
All of the benefits described in this Summary Plan Description are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that plan would base its benefit payment for a service, including Coinsurance or Copayments, if any, and without reduction for any applicable Deductible, except that the following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- When this Plan restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a preferred provider (except, if the Primary Plan is a closed panel plan and does not pay because a nonpanel provider is used, the Secondary Plan (if it is not a closed panel plan) shall pay as if it were the Primary Plan).
- A Primary Plan's deductible, if the Primary Plan is a high-deductible health plan as defined in the Internal Revenue Code and the Claims Administrator is notified both that all plans covering a person are high-deductible health plans and that the person

intends to contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging You.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday, for purposes of these coordination of benefits provisions, means only the day and month of birth, regardless of the year.

Claim Determination Period means a Calendar Year. However, a Claim Determination Period does not include any time when You were not enrolled under this Plan.

Custodial Parent means the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation is the Custodial Parent.

Group-type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to the covered person.

Other Plan means any of the following with which this coverage coordinates benefits:

- Group and blanket health insurance and prepayment coverage.
- Group, blanket, individual, and franchise health maintenance organization coverage.
- Group-type Coverage.
- Labor-management trust plan, union welfare plan, employer organization plan, and employee benefit organization plan coverage.
- Uninsured group or Group-type Coverage arrangements.
- Medical care components of group long-term care coverage, such as skilled nursing care.
- Hospital, medical, and surgical benefits of Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage.
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis."
- Group long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services received.
- Accident only coverage.
- Specified disease or specified accident coverage.
- Medicare supplement coverage.

- A state plan under Medicaid, or a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the plan that must determine its benefits for Your health care before the benefits of an Other Plan and without taking the existence of that Other Plan into consideration. (This is also referred to as that plan being "primary" to that Other Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

- The plan has no order of benefit determination provision;
- The plan is prohibited by law from using any order of benefits determination provision other than the one included herein and the plan contains a different order of benefit determination; or
- Both plans use the order of benefit determination provision included herein and under that provision the plan determines its benefits first.

Secondary Plan means a plan that is not a Primary Plan. You may have more than one Secondary Plan. If You are covered under more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year, for purposes of this Coordination of Benefits provision, means calendar year (January 1 through December 31).

Order of Benefit Determination
The order of benefit determination is identified by using the first of the following rules that applies:

Non-dependent Coverage: A plan that covers You other than as a dependent will be primary to a plan under which You are covered as a dependent.

Dependent Coverage: Except where the order of benefit determination is being identified among plans covering You as the dependent of Your parents who are separated or divorced and/or those parents' spouses, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents covering You as a dependent have the same Birthday, the plan of the parent who has been covered by his or her plan longer shall be primary to the plan of the parent who has been covered by his or her plan for a shorter period.

If a court decree specifies that Your parent is responsible for Your health care expenses or health care coverage and that parent's plan has actual knowledge of that term of the decree, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no coverage for You, but that parent's spouse does and the spouse's plan has actual knowledge of that term in the decree, the plan of the spouse shall be primary to the plan of Your other parent. If benefits have been paid or provided by a plan before it has actual knowledge of the term in the court decree, these rules do not apply until that plan's next Calendar Year.

If a court decree awards joint custody of You without specifying that one of Your parents is responsible for Your health care expenses or health care coverage, a plan that covers

You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents have the same Birthday, the plan of the parent who has been covered by his or her plan longer shall be primary to the plan of the other parent. If the Other Plan does not contain this dependent rule, the Other Plan's dependent rule will govern.

If none of the above dependent rules identifies the order of benefits determination among plans covering You as the dependent of parents who are separated or divorced and/or those parents' spouses:

- The plan of Your Custodial Parent shall be primary to the plan of Your Custodial Parent's spouse;
- The plan of Your Custodial Parent's spouse shall be primary to the plan of Your noncustodial parent; and
- The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

If You are covered under more than one plan of individuals who are not Your parents, the above Dependent Coverage rules shall be applied to determine the order of benefit determination as if those individuals were Your parents.

Active/inactive employees: A plan that covers You as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan under which You are covered as a laid off or retired employee (or as the dependent of a laid off or retired employee). If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Continuation coverage: A plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary over a plan that is providing continuation coverage. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the plan that has covered You for the longer period of time will be determined before the benefits of the plan that has covered You for the shorter period of time. To determine the length of time You have been covered under a plan, two plans will be treated as one if You were eligible under the second within 24 hours after the first ended. The start of a new plan does not include:

- a change in the amount or scope of a plan's benefits;
- a change in the entity that pays, provides or administers the plan's benefits; or
- a change from one type of plan to another (such as from a single-employer plan to that of a multiple employer plan).

Your length of time covered under a plan is measured from Your first date of coverage under that plan. If that date is not readily available for a group plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage under the present plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the plans shall share equally in the Allowable Expenses.

Each of the plans under which You are covered, and each of the benefits within the plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits
When, in accordance with the order of benefit determination, this coverage is the Primary Plan, the benefits in this Plan will be paid as if no Other Plan exists.

Secondary Health Plan Benefits
If, in accordance with the order of benefit determination, one or more Other Plans are primary to this Plan, the benefits of this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan will be calculated. The Allowable Expense under this Plan for that service will be compared to the Allowable Expense for it under the Other Plan(s) by which You are covered. This Plan will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved plans; or
- the benefits that would have been paid under this Plan for the service if this Plan were the Primary Plan.

Deductibles, Coinsurance and Copayments, if any, under this Plan will be used in the calculation of the benefits that would have been paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. This Plan's payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved plans and any amount that would have been credited to the Deductible if this Plan had been the only plan will be credited toward any Deductible under this Plan.

If this Plan is the Secondary Health Plan according to the order of benefit determination and any Other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those in this Plan, this Plan will pay its benefits first, but the amount paid will be calculated as if this Plan is a Secondary Health Plan. If the Other Plan(s) do not provide the Claims Administrator with the information necessary for them to determine appropriate secondary benefits payment within a reasonable time after their request, it will be assumed their benefits are identical to this Plan's and benefits under this Plan will be paid accordingly, subject to adjustment upon receipt of the information requested from the Other Plan(s) within two years of this Plan's payment.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered under this coverage. Further, in no event will this Coordination of Benefits provision operate to increase payment over what would have been paid under this Plan in the absence of this Coordination of Benefits provision.

In the event federal law makes Medicare primary to this Plan and You are covered under both this Plan and a Medicare Supplement plan, the Medicare Supplement plan also will be primary to this Plan. In that event, the benefits of this Plan will be reduced by the payments of Medicare and the Medicare Supplement plan.

Right to Receive and Release Needed Information
Certain facts are needed to apply coordination of benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits.

Facility of Payment
Any payment made under any Other Plan(s) may include an amount that should have been paid under this Plan. If so, that amount may be paid under this Plan to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. That amount will not have to be paid under this Plan again. The term "payment made" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If benefits under this Plan were provided to or on behalf of You in excess of the amount that would have been payable under this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to a recovery from You, Your assignee or beneficiary, or from the Other Plan(s) upon request.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There is one level of Appeal available through the Claims Administrator. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS
Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Oregon, P.O. Box 91015, Seattle, WA 98111-9115 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator at 1 (866) 240-9580.

Appeals, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing. You, or Your Representative on Your behalf, will be given a reasonable opportunity to provide written materials. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

Appeals
Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the Appeal.

CIVIL ACTION
You may be required to exhaust certain appeals before pursuing civil action. See Your Plan Administrator for details.

LEGAL ACTION
Before pursuing legal action for benefits under the Plan, You must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit You bring for Plan benefits must be filed within one year of the date on which Your claim is first denied under the Plan.

EXPEDITED APPEALS
An expedited Appeal is available if one of the following applies:

- the application of regular Appeal time frames on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or

- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal
The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level expedited Appeals are reviewed by the Claims Administrator's staff of healthcare professionals who were not involved in, or subordinate to anyone involved in, the initial denial determination. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. A written notification of the decision will be mailed to You within three calendar days of the verbal notification.

Further Appeals
If You have exhausted all possible levels of Appeal described here, You may contact Your Plan Administrator for possible continuation of the appeals process at (541) 475-2234 or You can write to the following address: Bright Wood Corporation, Attn: Director of Personnel, P.O. Drawer 828, Madras, OR 97741.

INFORMATION
If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at: 1 (866) 240-9580 or You can write to the Claims Administrator's Customer Service department at the following address: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Oregon, P.O. Box 91015, Seattle, WA 98111-9115 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS
Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made under the Plan concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a Claimant and the Plan; and
- other matters as specifically required by state law or regulation.

Post-Service means any claim for benefits under the Plan that is not considered Pre-Service.

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

Representative means someone who represents You for the purpose of the Appeal. The Representative may be an attorney, Your authorized Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purpose of the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old.

For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You or Your treating Provider only.

Who Is Eligible, How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual enrollment period. It also describes when coverage under the Plan begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly costs is required for coverage to begin on the indicated dates.

To enroll and remain eligible under the Plan, You must meet all of the following requirements in effect with the Plan Sponsor on a continuous basis (except that eligibility commences or continues while an employee is otherwise eligible but is confined to a Hospital, Skilled Nursing Facility or extended care facility):

- a regular, active, full-time employee of Bright Wood Corporation regularly scheduled to work a minimum of 64 hours per month (a Temporary Reduction in hours will not change the eligibility requirement).

Temporary Reduction in Hours: A temporary reduction in hours does not cause You to lose eligibility unless you work less than 64 hours in a month for two consecutive months.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS
You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Plan Sponsor and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date (1st day of the month following 60 days).

Bright Wood Corporation offers two options within the Bright Wood Corporation Health and Wellness Plan for the benefits of eligible employees and their dependents. Participants may not change to a different option except during the Open Enrollment Period, March 15th through April 15th of each year for coverage effective May 1st of that same year.

Except as described under the special enrollment provision, if You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees
You become eligible to enroll in coverage on the date You have worked for the Plan Sponsor long enough to satisfy any required probationary period.

Dependents
Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and the Claims Administrator has enrolled them in coverage under the Plan. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your child who is under age 26, who is not offered health insurance through their employer and who meets any of the following criteria:

- Your natural child, step child, adopted child or child legally placed with You for adoption;
- a child for whom You have court-appointed legal guardianship; and
- a child for whom You are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:

  - he or she is a Beneficiary immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site or by calling Customer Service.

NEWLY ELIGIBLE DEPENDENTS
You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request to the Claims Administrator. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 31 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 31 days).

NOTE: If more than one parent is an employee of Bright Wood Corporation, their child/children will be covered as dependents of only one of the parents. Likewise, employees may be covered as either an employee or dependent, but not both.

SPECIAL ENROLLMENT
There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period.

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the cost of coverage or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (e.g., terminating employment) that results in a loss of eligibility.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You, (unless already enrolled), Your spouse and any eligible children are eligible to enroll for coverage under the Plan within 31 days from the date of the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health

Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependents lose coverage under another group or individual Health Benefit Plan due to one of the following:
  - an employer's contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility, for instance, due to legal separation, divorce, death, termination of employment or reduction in hours
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the day after the prior coverage ended.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the qualifying event:

- You marry; or
- You acquire a new child by birth, adoption, or placement for adoption.

If You are already enrolled or if You declined coverage when first eligible and subsequently have the following qualifying event, You (unless already enrolled), Your spouse and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the qualifying event:

- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

For the above qualifying events, if enrollment is requested as specified, coverage will be effective on the first of the calendar month following the date of the qualifying event, except that where the qualifying event is a child's birth, adoption, or placement for adoption, coverage is effective from the date of the birth, adoption or placement.

ANNUAL ENROLLMENT PERIOD
The annual enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY
You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 30 days of the date on which a Beneficiary is no longer eligible for coverage.

Bright Wood Corporation may at any time terminate this Plan at its discretion. If the Plan is terminated, coverage ends for You and Your covered dependents on the date the Plan ends.

No person will have a right to receive benefits after the Plan terminates. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all obligations to provide You or Your Beneficiary benefits for Covered Services received after the date of termination. This applies whether or not You or Your Beneficiary is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Plan was in effect.

AGREEMENT TERMINATION
If the Agreement is terminated or not renewed, claims administration by Regence ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence, Regence may administer certain claims for services that Claimants received before that termination or nonrenewal).

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE
If You are no longer eligible as explained in the following paragraphs, Your and Your Beneficiaries' coverage ends on the date on which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the continuation of coverage provisions of this Summary Plan Description.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE
If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the earliest occurrence of the following dates:

- the date on which termination of the Plan occurs:
    - if Your employment is terminated on the 1st – 7th day of the month, coverage will terminate at midnight, on the 15th day of the month, in which termination occurs;
    - if Your employment is terminated on the 8th – 22nd day of the month, coverage will terminate at midnight, on the last day of the month, in which termination occurs; and
    - if Your employment is terminated on the 23rd through the last day of the month, coverage will terminate at midnight, on the 15th day, of the following of the month.
- the last day of the month in which You fail to meet the minimum eligibility requirements;
- the first day of the month for which there is failure to make any required contributions; or

- the date You begin active duty in the armed forces.

NONPAYMENT
If You fail to make required timely contributions to the cost of coverage under the Plan, Your coverage will end for You and all Beneficiaries.

FAMILY AND MEDICAL LEAVE
If Your employer grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
  - in order to care for Your newly born child;
  - in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
  - the placement of a child with You for adoption or foster care; or
  - You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to make payments for coverage through the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates.

If You and/or Your Beneficiaries elect not to remain enrolled during the FMLA leave, You (and/or Your Beneficiaries) will be eligible to be reenrolled under the Plan on the date You return from the FMLA leave. In order to reenroll after You return from a FMLA leave, You must sign a new enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Plan will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Beneficiaries) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Plan, although You and/or Your Beneficiaries will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to

comply. The Plan Sponsor must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

You also may have rights to continue this coverage during a leave pursuant to the requirements of the Oregon Family Leave Act. Contact Daryl Booren or Julie Cacho at the Bright Wood Personnel Department for details.

COVERAGE DURING ABSENCE FROM WORK DUE TO TOTAL DISABILITY
If You are absent from work due to total disability, Bright Wood Corporation will continue to make contributions for Your coverage for the first 90 days provided You continue to keep the premiums current. If at any time during the Leave of Absence premiums are not kept current You may be termed and would not qualify for Continuation of Coverage, (COBRA) as this would not be considered a Qualifying Event.

If You are entitled to leave under the Family and Medical Leave Act (FMLA), Your coverage may be continued under the FMLA provisions of this Plan.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the date in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions of this Summary Plan Description.

Divorce or Annulment
Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date a divorce or annulment is final.

If You Die
If You die, coverage for Your Beneficiaries ends on the date on which Your death occurs.

Loss of Dependent Status
A dependent's coverage will terminate at the earliest occurrence of any of the following dates:

- the date on which termination of the Plan occurs:
    - if Your employment is terminated on the 1st – 7th day of the month, dependent coverage under such Participant will terminate at midnight, on the 15th day of the month, in which termination occurs;
    - if Your employment is terminated on the 8th – 22nd day of the month, dependent coverage under such Participant will terminate at midnight, on the last day of the month, in which termination occurs; and
    - if Your employment is terminated on the 23rd through the last day of the month, dependent coverage under such Participant will terminate at midnight, on the 15th day, of the following of the month;

- the date the dependent enters the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
- the last day of the month in which the dependent fails to meet the Plan's definition of an eligible dependent;
- the first day of the month for which there is failure to make any required contributions; or
- the last day of the month in which the Participant becomes ineligible.

OTHER CAUSES OF TERMINATION

Claimants may be terminated for either of the following reasons. However, it may be possible for them to continue coverage under the Plan according to the continuation of coverage provisions of this Summary Plan Description.

Fraudulent Use of Benefits

If You or Your Beneficiary engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Plan will terminate for that Claimant.

Fraud or Misrepresentation in Application

Coverage under the Plan is based upon all information furnished to the Claims Administrator, for the benefit of the Plan by You or on behalf of You and Your Beneficiaries. In the event of any intentional misrepresentation of material fact or fraud regarding a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Plan Sponsor), any action allowed by law or contract may be taken, including denial of benefits or termination of coverage and may subject the person making the misrepresentation or fraud to prosecution for insurance fraud and associated penalties.

If the Plan rescinds Your coverage, other than for failure to make premium contributions, the Plan will provide You with at least 30 days advance written notice prior to rescinding coverage.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Plan should be directed to the Plan Sponsor, or to the Claims Administrator at P.O. Box 2998, Tacoma, WA 98401-2998.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You become entitled to Medicare benefits; or
- Your Beneficiary loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Beneficiaries under certain conditions if You are retired and Your employer files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules
Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation coverage, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights under COBRA, You or Your Beneficiaries must inform the Plan Sponsor in writing within 60 days of:

- Your divorce or annulment or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Beneficiary was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled for Social Security purposes, You or Your Beneficiary must provide the Plan Sponsor notice of that determination within 30 days of the date it is made.)

The Plan Sponsor also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep the Plan Sponsor informed of the current address of all Claimants who are or may become qualified beneficiaries.

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms described in the Summary Plan Description and claims under the Plan for services provided on and after the date

coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice

The complete details on the COBRA Continuation provisions outlined here are available from the Plan Sponsor.

Other Continuation Options

This section describes situations when coverage may also be extended for You and/or Your Beneficiaries beyond the date of termination.

Returning to Work after a Layoff, Leave of Absence or Military Service
If coverage for You and Your Dependents should lapse during a period of layoff or leave of absence, Your coverage is reinstated if You return to Active Work within 6 months of the start of Your layoff or leave period. In that event, Your coverage restarts immediately upon returning to work.

If You return to full-time active work after 6 months from Your last active date worked, You must satisfy a new eligibility waiting period as requested by the Plan.

If returning to work after a layoff, You must re-enroll Yourself and Your Family members by submitting an enrollment application within 31 days following Your return to work.

If You return from military service within 5 years You will not have to satisfy another waiting period. Your coverage will resume the day You return to work and meet the Bright Wood Corporation minimum hour requirement. If Your Family members were covered before Your leave, they can resume coverage at that time as well.

If You are returning to work after military service, Your re-employment must follow a release from military service under honorable conditions and You must re-enroll Yourself and Your Family members by submitting an enrollment application as follows:

- The first business day following completion of military service, leave of 30 days or less;
- Within 14 days of completion of military service, leave of 31 to 180 days; or
- Within 90 days of completion of military service, leave of more than 180 days.

Participants returning to work after a layoff or military service are not subject to new exclusion periods for pre-existing and other conditions.

Workers' Compensation Claim
If You are no longer eligible due to an Illness or Injury for which You have filed a Workers' Compensation claim, You can continue coverage for up to six months after Your eligibility ends, or until You obtain full-time employment with another employer, whichever happens first. You must make payment of premiums for the coverage to the Plan Sponsor within its established time frame in order to maintain coverage during this period. This six months of continued coverage runs simultaneously with any leave under the FMLA. Any continuation of coverage will apply following the conclusion of Your workers' compensation coverage.

General Provisions

This section explains various general provisions regarding Your benefits under this coverage.

CHOICE OF FORUM
Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Oregon.

GOVERNING LAW AND DISCRETIONARY LANGUAGE
The Plan will be governed by and construed in accordance with the laws of the United States of America and by applicable laws of the state of Oregon without regard to its conflict of law rules. The Plan Administrator, the Plan Sponsor, delegates the Claims Administrator discretion for the purpose of paying benefits under this coverage only if it is determined that You are entitled to them and of interpreting the terms and conditions of the plan. Final determinations pursuant to this reservation of discretion do not prohibit or prevent a claimant from seeking judicial review of those determinations in federal court. The reservation of discretion made under this provision only establishes the scope of review that a court will apply when You seek judicial review of a determination of the entitlement to and payment of benefits or interpretation of the terms and conditions applicable to the plan. The Claims Administrator is not the Plan Administrator, but does provide claims administration under the Plan, and the court will determine the level of discretion that it will accord determinations.

NO WAIVER
The failure or refusal of either party to demand strict performance of the Plan or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of the Plan will be considered waived unless such waiver is reduced to writing and signed by one of the Plan Sponsor's authorized officers.

NOTICES
Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant or to the Plan Sponsor will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

PLAN SPONSOR IS AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Oregon. You are entitled to health care benefits

pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Summary Plan Description. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Regence to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and in Clark County in the state of Washington and that Regence is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

TAX TREATMENT

The Claims Administrator does not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Plan, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Claims Administrator.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a Mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (subject to the same provisions as any other benefit) for:

- reconstruction of the breast on which the Mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis and treatment of physical complications of all stages of Mastectomy, including lymphedemas; and
- inpatient care related to the Mastectomy and post-Mastectomy services.

The Claims Administrator will provide a single determination of prior authorization for all services related to a covered Mastectomy that are part of Your course or plan of treatment.

Definitions

The following are definitions of important terms used in this Summary Plan Description. Other terms are defined where they are first used.

Accidental Injury means an Injury sustained by a Claimant which is the direct result of an accident, independent of illness or any other cause. Accidental Injury does not mean bodily injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Affiliate means a company with which the Claims Administrator has a relationship that allows access to providers in the state in which the Affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For preferred and participating Providers (see definitions of "Category 1" and "Category 2" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For nonparticipating Providers (see definition of "Category 3" below) who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be Reasonable Charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For nonparticipating Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.

Charges in excess of the Allowed Amount are not considered Reasonable Charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact the Claims Administrator.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. Ambulatory Surgical Center does not mean: 1) individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a Physician's or dentist's office using local anesthesia or conscious sedation; or 2) a portion of a licensed Hospital designated for outpatient surgical treatment.

Beneficiary means a Participant's eligible dependent who is listed on the Participant's completed enrollment form and who is enrolled under the Plan.

Calendar Year means the period from January 1 through December 31 of the same year; however, the first Calendar Year begins on the Claimant's Effective Date.

Category 1 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a preferred Provider as well as Providers outside the area that the Claims Administrator or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Preferred Provider Organization ("PPO") Network") to provide services and supplies to Claimants in accordance with the provisions of this coverage. Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Category 2 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a participating Provider as well as Providers outside the area that or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "Participating Network") to provide services and supplies to Claimants in accordance with the provisions of this coverage. Category 2 reimbursement is generally a lower payment level than Category 1, but You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Category 3 means the benefit reimbursement level for services that are received from a Provider who does not have an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates to provide services and supplies to Claimants. Category 3 reimbursement is generally the lowest payment level of all categories, and You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Claimant means a Participant or a Beneficiary.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this Summary Plan Description.

Custodial Care means care that is for the purpose of watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the patient from others or preventing self-harm.

Dental Services means services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Effective Date means the date Your coverage under the Agreement begins after acceptance for enrollment under the Plan.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a Hospital emergency room to result in any one of the following:

- placing the Claimant's health, or with respect to a pregnant Claimant, the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- a behavioral health crisis which means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a Hospital to prevent a serious deterioration in the individual's mental or physical health.

Emergency Medical Condition also includes a condition with respect to a pregnant Claimant who is having contractions, for which there is inadequate time for a safe transfer to another Hospital before delivery or for which transfer may pose a threat to the health or safety of the woman or unborn child.

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

Family means a Participant and his or her Beneficiaries.

Health Benefit Plan means any Hospital-medical-surgical expenses policy or certificate including any benefit plan provided by a multiple employer welfare arrangement or by another benefit arrangement, as defined in the Federal Employee Retirement Income Security Act of 1974 as amended (ERISA).

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, Illness, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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

Hospital means a facility that is licensed as a general acute or specialty Hospital by the state in which the Hospital is located. A Hospital provides continuous 24-hour nursing services by registered nurses. A Hospital has an attending medical staff consisting of one or more Physicians. A Hospital under this definition is not, other than incidentally, a place for rest, a nursing home or a facility for convalescence.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does

not include any state of mental health or mental disorder which is otherwise defined in the Mental Health or Substance Use Disorder Services Section.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean Injury to teeth due to chewing and does not include any condition related to pregnancy.

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

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

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

Lifetime means the entire length of time a Claimant is covered under the Plan (which may include more than one coverage) through the Plan Sponsor with the Claims Administrator.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider, and not more costly than an alternative service or sequence of services or

supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

Participant means an employee of the Plan Sponsor who is eligible under the terms described in this Summary Plan Description, has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and surgeon. Physician also includes a podiatrist practicing within the scope of a license issued under ORS 677.805 to 677.840.

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include podiatrists who do not meet the definition of Physician, Physician's assistants, chiropractors, acupuncturists, naturopaths, psychologists, licensed clinical social workers, certified nurse practitioner, a registered physical, occupational, speech or audiological therapists; registered nurses or licensed practical nurses, (but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients), dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other health care professionals practicing within the scope of their respective licenses.

Provider means a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Reasonable Charges means an amount, determined by the Claims Administrator, that falls within the range of average payments they make to Providers, who have an effective participating contract with them, for the same or similar service or supply in the Claims Administrator's service area. Regardless of anything in this Summary Plan Description to the contrary, if the Claims Administrator is required by applicable law to base payment on another amount, that amount will be Reasonable Charges.

Regence refers to Regence BlueCross BlueShield of Oregon.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include an office or independent clinic outside a retail operation, or an Ambulatory Surgical Center, urgent care center or facility, Hospital, Pharmacy, rehabilitation facility or Skilled Nursing Facility.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of

the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor. Note that the terms "You" and "Your" in this Summary Plan Description Section by and large refer to the Participant.

PLAN NAME
BRIGHT WOOD CORPORATION HEALTH AND WELLNESS PLAN

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR
Bright Wood Corporation
P.O. Drawer 828
Madras, OR 97741
(541) 475-2234

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS
93-0720678

PLAN NUMBER
501

TYPE OF PLAN
Welfare Benefit Plan: medical benefits.

TYPE OF ADMINISTRATION
The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the Plan Sponsor which hereinafter is referred to as the Claims Administrator.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS
Bright Wood Corporation
Attn: Director of Personnel
P.O. Drawer 828
Madras, OR 97741
(541) 475-2234

Legal process may also be served upon the Plan Sponsor's address above.

SOURCES OF CONTRIBUTIONS TO THE PLAN
Contributions for plan expenses are obtained from Plan Sponsor and Participants.

FUNDING MEDIUM
Plan Sponsor will maintain an account for the receipt of money and property to fund the Plan, for the management and investment of such funds, and for the payment of Plan benefits and expenses from such funds.

All funds and earnings received by the Plan Sponsor will be applied toward payment of Plan benefits and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan documents. The Plan Sponsor may appoint an

investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent representative, or other person performing services to or for the Plan shall be entitled to reasonable compensation for services rendered and for the reimbursement of expenses properly and actually incurred, unless such person already receives full-time pay from Plan Sponsor.

Enrollees shall look only to the Plan Sponsor's funds for payment of Plan benefits and expenses.

PLAN FISCAL YEAR ENDS ON
April 30

PLAN TERMINATION PROVISIONS
The Plan Sponsor expects and intends to continue the Plan indefinitely, but reserves its right to end the Plan at any time in its sole discretion. The Plan Sponsor also reserves the right to amend the Plan at any time in its sole discretion.

The Plan Sponsor's decision to end or amend the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the IRS or ERISA, or for any other reason. A Plan change may transfer assets and liabilities to another plan or split this plan into two or more parts. If the Plan Sponsor does change or end the Plan, it may decide to set up a different plan providing similar or identical benefits.

If the Plan is terminated, plan participants and beneficiaries will not have any further rights. The amount and form of any final benefit will depend on any contract provisions affecting the Plan, and the Plan Sponsor's decisions.

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

Receive Information About Your Plan And Benefits
Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Continue Employer Health Plan Coverage
Continue health care coverage for Yourself, spouse, or children if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or Your Beneficiaries may have to pay for such coverage. Review this Plan Document and the documents governing the Plan for a description of the rules governing Your COBRA continuation coverage rights.

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

Enforce Your Rights
No one, including the Plan Sponsor or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a health and welfare benefit under the Plan or exercising Your rights under ERISA. If Your claim for a health and welfare benefit is denied in whole or in part, You must receive a written explanation of the reasons for the denial. You have the right to have the Plan Sponsor review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to provide the material and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

Procedures For Filing Claims
If You have a claim for benefits (for Yourself or for one of Your Beneficiaries) which is denied or ignored in whole or in part, You have the right to a hearing before the Plan Sponsor at which You may present Your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of Your choice. Further, if You are dissatisfied with the Plan Sponsor's determination, You may pursue an action pursuant to 29 USC§1132(a).

For detailed information on how to submit a claim for benefits or how to file an appeal on a processed claim, refer to the Submission Of Claims and Reimbursement and Appeals provisions of this Plan Summary Plan Description.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the US Department of Labor, or You may file suit in Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions
If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of

Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For more information contact the Claims Administrator at
1 (866) 240-9580

regence.com

Regence

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the BlueCross and
BlueShield Association