2025 SUMMARY PLAN DESCRIPTION FOR:

BRIGHT WOOD CORPORATION HEALTH AND WELLNESS PLAN

Plus Plan

Group Number: 10016754

Dental 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 less favorably because of race, color, national origin, age, disability, or sex.

Regence:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service
Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

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' hódíilnih 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

NOTE: THIS SUMMARY PLAN DESCRIPTION PROVIDES DENTAL BENEFITS ONLY.

This Summary Plan Description (SPD) provides the written description of the terms and benefits of coverage available under the Plan. All covered benefits are subject to the terms, conditions, exclusions, and limitations in this SPD. The administrative services contract between Your employer and Regence BlueCross BlueShield of Oregon (called the "Agreement") contains all the terms of coverage. Your employer has a copy.

This SPD describes benefits effective **May 1, 2025**, or the date Your coverage became effective. This SPD replaces any plan description, SPD or certificate previously issued by Regence BlueCross BlueShield of Oregon and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this SPD, the term "Claims Administrator" refers to Regence BlueCross BlueShield of Oregon and the term "Plan Sponsor" refers to Your employer. References to "You" and "Your" refer to the Participant and/or Beneficiaries. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

EMPLOYER PAID BENEFITS
This self-funded group health plan (hereafter referred to as "Plan") is an employer-paid benefits plan administered by the Claims Administrator. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. This means that the Plan Sponsor, not Regence BlueCross BlueShield of Oregon, pays for Your covered dental services and supplies. Your claims will be paid only after the Plan Sponsor provides the Claims Administrator with the funds to pay Your benefits and pay all other charges due under the Plan.

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

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 website listed below.

CONTACT INFORMATION
Customer Service: 1 (866) 240-9580

(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m., Pacific Time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's website, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via the Claims Administrator's website); or
- for assistance in a language other than English.

Using Your Summary Plan Description

ACCESSING PROVIDERS
You are not restricted in Your choice of Dentist for dental care or treatment. You control Your out-of-pocket expenses by choosing between "In-Network Dentist" and "Out-of-Network Dentist."

- **In-Network Dentist.** Choosing In-Network Dentists saves You the most in Your out-of-pocket expenses. In-Network Dentists will not bill You for balances beyond any Deductible and/or Coinsurance for Covered Services.
- **Out-of-Network Dentist.** Choosing Out-of-Network Dentists means Your out-of-pocket expenses will be higher than choosing an In-Network Dentist. Also, an Out-of-Network Dentist may bill You for balances beyond any Deductible and/or Coinsurance. This is referred to as balance billing.

For each benefit, the Dentist You may choose and Your payment amount for each Provider option is indicated. See the Definitions Section for a complete description of In-Network Dentist and Out-of-Network Dentist. You can go to **regence.com** for further Provider network information.

ADDITIONAL ADVANTAGES OF PARTICIPATION
The Claims Administrator provides access to discounts on select items and services, personalized health/dental care planning information, health/dental-related events and innovative health/dental-decision tools, as well as a team dedicated to Your personal dental care needs. You also have access to the Claims Administrator's website to help You navigate Your way through treatment decisions. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR SPD.**

- Go to **regence.com.** Use the Claims Administrator's secure website to:
    - view recent claims, benefits and coverage;
    - find a contracting dental Provider; and
    - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure website, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*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 PLAN, BUT ARE NOT INSURANCE.**

Table of Contents

Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles and Coinsurance. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Dental Benefits Section to see what Your benefits are.

MAXIMUM BENEFITS
Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the Dental Benefits Section to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this Plan, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES
The Deductible is the amount You must pay each Calendar Year before the Plan will provide payments for Covered Services. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Family Deductible is satisfied when the 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 Dental Benefits Section to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Deductible.

COINSURANCE (PERCENTAGE YOU PAY)
Your Coinsurance is the percentage You pay when the Plan's payment is less than 100 percent. The Coinsurance varies, depending on the service or supply You received and who rendered it. Your Coinsurance applies once You have satisfied the Deductible for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. The Plan does not reimburse Dentists for charges above the Allowed Amount.

HOW CALENDAR YEAR BENEFITS RENEW
The Deductible and certain Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year.

The Agreement is renewed each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. If the Agreement renews on a day other than January 1 of any year, any Deductible You satisfied or amount accumulated toward a Maximum Benefit before the Agreement's renewal date will carry over into the next Plan Year. If the Deductible amount increases during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Agreement during the same Calendar Year.

Dental Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. All benefits are listed alphabetically, with the exception of Preventive and Diagnostic Dental Services.

CALENDAR YEAR DEDUCTIBLES
Per Claimant: $50
Per Family: $150

Deductible does not apply to the following:

- preventive and diagnostic dental services; and
- orthodontic dental services.

MAXIMUM BENEFITS
Basic and Restorative, and Major Dental Services:
Per Claimant: $2,000 per Calendar Year

Orthodontic Dental Services:
Per Claimant: $2,000 per Lifetime

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: No charge.	**Payment:** No charge up to the Allowed Amount and You pay the balance of billed charges.

Preventive and diagnostic dental services are covered, subject to any specified limits as explained in the following:

- Bitewing x-rays, limited to two sets per Claimant per Calendar Year.
- Complete intra-oral mouth x-rays, limited to one in a five-year period.
- Preventive oral examinations, limited to two per Claimant per Calendar Year.
- Problem focused oral examinations.
- Panoramic mouth x-rays, limited to one per Calendar Year.
- Sealants, limited to once per tooth for the first and second permanent bicuspids and molars in a five-year period.
- Space maintainers for Claimants under 12 years of age.
- Teledentistry for limited oral evaluation, re-evaluation and post-operative re-evaluation services. "Teledentistry" means delivering health services using information and telecommunication technologies, including, but not limited to, real-time audio only, video only or audio and video communication with a remote Provider through a secure HIPAA compliant platform.
- Topical fluoride application for Claimants under 18 years of age, limited to two treatments per Claimant per Calendar Year; limited to one treatment per Claimant 18 years of age or older per Calendar Year.

- Cleanings, limited to two* per Claimant per Calendar Year (however, in any Calendar Year a Claimant will be entitled to no more than two* cleanings whether standard cleaning or periodontal maintenance).

  *A third and fourth cleaning may be covered, in the same Calendar Year, for a Claimant with one or more of the following conditions:

  - acid reflux;
  - cancer;
  - chronic kidney disease and/or kidney failure;
  - coronary atherosclerosis;
  - diabetes;
  - gingivitis;
  - heart condition;
  - high blood pressure;
  - pregnancy;
  - progressive periodontal disease;
  - stomach ulcers; or
  - suppressed immune system disorder.

  In this instance, a Claimant will be entitled to no more than four cleanings in a Calendar Year, whether standard cleaning or periodontal maintenance.

BASIC AND RESTORATIVE DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount and You pay the balance of billed charges.

Basic and restorative dental services are covered, subject to any specified limits as explained in the following:

- Behavior management analgesic, limited up to $100 maximum per Claimant per Calendar Year.
- Complex oral surgery procedures including:

  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty;
  - vestibuloplasty;
  - residual root removal;
  - excision of pericoronal gingival;
  - exostosis or hyperplastic tissue;
  - excision of oral tissue for biopsy;
  - re-implantation of a natural tooth;
  - excision of a tumor or cyst and incision; and
  - incision and drainage of an abscess or cyst.

- Emergency treatment for pain relief.

- Endodontic services consisting of:

  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.

- Fillings consisting of composite and amalgam restorations, silicate, acrylic synthetic porcelain and pin retention fillings. Composites are reduced to amalgam rates.
- General dental anesthesia or intravenous sedation administered for:

  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Claimant's health.

- Nitrous oxide, including the administration and supply.
- Occlusal adjustments.
- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery), limited to once per Claimant per quadrant in a five-year period;
  - debridement;
  - gingivectomy and gingivoplasty, limited to once per Claimant per quadrant in a three-year period;
  - scaling and root planing; and
  - periodontal maintenance, limited to two* per Claimant per Calendar Year (however, in any Calendar Year a Claimant will be entitled to no more than two* cleanings whether periodontal maintenance or standard cleaning).

  *A third and fourth periodontal maintenance may be covered, in the same Calendar Year, for a Claimant with one or more of the following conditions:

  - acid reflux;
  - cancer;
  - chronic kidney disease and/or kidney failure;
  - coronary atherosclerosis;
  - diabetes;
  - gingivitis;
  - heart condition;
  - high blood pressure;
  - pregnancy;
  - progressive periodontal disease;
  - stomach ulcers; or
  - suppressed immune system disorder.

  In this instance, a Claimant will be entitled to no more than four cleanings in a Calendar Year, whether periodontal maintenance or standard cleaning.

- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay the balance of billed charges.

Major dental services are covered, subject to any specified limits as explained in the following:

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than five years after placement.
- Gold or porcelain crowns, crown build-ups, inlays and onlays, except that benefits will not be provided for any of the following:
    - any crown, inlay or onlay replacement made fewer than five years after placement (or subsequent replacement) whether or not originally covered in this SPD;
    - additional procedures to construct a new crown under an existing partial denture framework; and
    - temporary crowns, limited to one per tooth per Claimant Lifetime, must be in place for a minimum of six months.
- Dental implant crown and abutment related procedures, limited to one per Claimant per tooth in a five-year period.
- Dentures, full and partial, including:
    - denture rebase, limited to one per Claimant per arch in a three-year period;
    - denture relines, limited to one per Claimant per arch in a three-year period;
    - denture rebasing and relining of existing removable full or partial dentures, but only if it has been at least one year since the denture placement, and not more than once in any two-year period;
    - partial denture implant and abutment related procedures, limited to one per Claimant per tooth in a seven-year period;
    - addition of one or more teeth to an existing partial denture; and
    - temporary denture, limited to one per arch per Claimant Lifetime, must be in place for a minimum of six months.
- Denture benefits will **not** be provided for:
    - any denture replacement made fewer than five years after denture placement (or subsequent replacement) whether or not originally covered in this SPD;
    - interim partial or complete dentures; or
    - pediatric dentures.

- Endosteal implants, limited to one per tooth per Claimant Lifetime.
- Recement crown, inlay or onlay.
- Repair of crowns, limited to one per tooth per Claimant Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Claimant Lifetime.

ORTHODONTIC DENTAL SERVICES

Provider: All Dentists
Payment: You pay 50% of the Allowed Amount and You pay the balance of billed charges.
Limit: $2,000 per Claimant Lifetime

Orthodontic dental services are covered, subject to any specified limits as explained in the following:

- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending Provider). The treatment plan should include all of the following information:
  - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
  - the estimated length of required treatment;
  - the initial banding fee; and
  - the total orthodontic treatment charge.
- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.

General Exclusions

The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for 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 law.

Aesthetic Dental Procedures
Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents
Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens
Collection of cultures and specimens are not covered, including, but not limited to:

- saliva; or
- tissue of the oral cavity.

Connector Bar or Stress Breaker
A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

Cosmetic/Reconstructive Services and Supplies
Except for Dentally Appropriate treatment of the following, Cosmetic and/or reconstructive services and supplies are not covered:

- a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

"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.

Desensitizing
Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models
Services and supplies provided in connection with diagnostic casts or study models including taking the impression and pouring the study models.

Duplicate X-Rays

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.

Facility Charges
Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

Fees, Taxes, Interest
Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Dentist might bill;
- 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.

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Government Programs
Except as required by law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with the Claims Administrator, benefits that are covered (or would be covered in the absence of this Plan) by any federal, state or government program are not covered.

Additionally, except as required by law for emergency services, government facilities outside the service area are not covered.

Home Visits

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's **voluntary participation in** an activity where the Claimant is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, the Plan may recover the payment from the person paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies
Services, substances, and supplies that are illegal as defined under state or federal law.

Implants
Except as provided in the Major Dental Services benefit, implants and any associated services and supplies are not covered (whether or not the implant itself was covered), including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lifts;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Indirect Pulp Capping and Pulp Vitality Tests

Investigational Services
Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Medications and Supplies
Charges in connection with medications and supplies are not covered, including, but not limited to:

- take-home drugs;
- pre-medications; and
- therapeutic drug injections.

Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage;
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care
Except as provided in the Preventive and Diagnostic Dental Services benefit, non-direct patient care services are not covered, including, but not limited to:

- appointments scheduled and not kept (missed appointments);
- charges for preparing or duplicating medical reports and chart notes;
- itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person.

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.

Occlusal Treatment
Except as provided in the Basic Dental Services benefit, dental occlusion services and supplies are not covered, including, but not limited to:

- occlusal analysis; and
- occlusal guards.

Oral Hygiene Instructions

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Personal Items
Items that are primarily for comfort, convenience, Cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

Photographic Images

Precision Attachments
Device to stabilize or retain a prosthesis when seated in mouth.

Prosthesis
Dental prosthesis services and supplies are not covered, including, but not limited to:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting
Interim or temporary stabilization of loose/mobile teeth.

Replacements
Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures or retainers.

Self-Help, Self-Care, Training or Instructional Programs
Except for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-dental self-care and training or instructional programs are not covered.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

- any supplies;
- local anesthesia; and
- sterilization.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

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

Services Performed in a Laboratory

Subscription, Membership and Access-Related Fees
Fees for accessing care, treatment, or advice are not covered, whether the access is for virtual or in-person care. Excluded fees include, but are not limited to:

- concierge fees;
- subscription fees;
- membership fees;
- retainer fees;
- VIP or priority access fees; and
- any other access-related fees.

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures are not covered:

- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Disorder Treatment
Except for surgical correction required as the result of an Injury, TMJ disorder treatment and any associated services and supplies are not covered.

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

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation are not covered, including, but not limited to:

- reimplantation from one site to another;
- splinting; or
- stabilization.

Travel and Transportation Expenses

Veneers
Thin laminated restoration that covers the facial surface and/or the incisal edge of a tooth, and/or may extend between the adjoining surfaces of adjacent teeth.

War-Related Conditions
The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces unless not covered by the Claimant's military or veterans coverage.

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 and if You or Your Beneficiaries opt out of workers' compensation.

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 coverage.

Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than the Plan. Payment of benefits will be made in accordance with the terms and conditions of this SPD.

SUBMISSION OF CLAIMS AND REIMBURSEMENT
When claims are submitted and payment is due, the Claims Administrator decides whether to pay You, the Provider or You and the Provider jointly. The Plan may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child.

In-Network Dentist Claims and Reimbursement
You must present Your identification card to an In-Network Dentist and furnish any additional information requested. The In-Network Dentist will submit the necessary forms and information to the Claims Administrator for processing Your claim.

The Plan will pay an In-Network Dentist directly for Covered Services. In-Network Dentists may require You to pay any Deductible and/or Coinsurance at the time You receive care or treatment. In-Network Dentists have agreed not to bill You for balances beyond any Deductible and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Out-of-Network Dentist Claims and Reimbursement
In order for the Claims Administrator to pay for Covered Services, You or the Out-of-Network Dentist must first send the Claims Administrator a claim. In most cases, the Plan will pay the Dentist directly for Covered Services provided by an Out-of-Network Dentist. Be sure the claim is complete and includes the following information:

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

Out-of-Network Dentists have not agreed to accept the Allowed Amount as payment in full for Covered Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Dentist and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Out-of-Network Dentists, 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
Here are reimbursement examples for an In-Network Dentist or Out-of-Network Dentist. Let's assume that In-Network Dentist services are subject to a 20 percent Coinsurance and Out-of-Network Dentist services are also subject to a 20 percent Coinsurance. The benefit table would appear as follows:

Provider: In-Network Dentist	Provider: Out-of-Network Dentist
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 20% of the Allowed Amount and the balance of billed charges.

In this example, the Dentist's charge for a service is $500 and the Allowed Amount for that Dentist's charge is $400. Let's assume that You have met the Deductible:

- In-Network Dentist: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
  - Amount In-Network Dentist must "write-off" (that is, cannot charge You for): $100
  - Amount the Plan pays (80% of the $400 Allowed Amount): $320
  - **Amount You pay** (20% of the $400 Allowed Amount): **$80**
  - Total: $500
- Out-of-Network Dentist: the Plan would pay 80 percent of the Allowed Amount. Because the Out-of-Network Dentist does not accept the Allowed Amount, You would pay 20 percent of the Allowed Amount, plus the difference between the Out-of-Network Dentist's billed charges and the Allowed Amount, as follows:
  - Amount the Plan pays (80% of the $400 Allowed Amount): $320
  - **Amount You pay** (20% of the $400 Allowed Amount and the $100 difference between the billed charges and the Allowed Amount): **$180**
  - Total: $500

The actual benefits may vary, so review the benefits sections to determine how Your benefits are paid. For example, the Allowed Amount may vary for a Covered Service depending upon the selected Dentist.

Timely Filing of Claims
Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are 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. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may appeal the denial in accordance with the appeal process to demonstrate that the claim could not have been filed in a timely manner.

Claim Determinations
Within 30 days of the Claims Administrator's receipt of a claim, the Claims Administrator will notify You of their action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. The Claims Administrator will notify You of the extension within the initial 30-day period and provide an explanation of why the extension is necessary.

If the Claims Administrator requires additional information to process the claim, the Claims Administrator must allow You at least 45 days to provide it to them. If the

Claims Administrator does not receive the requested information within the time allowed, the Claims Administrator will deny the claim.

Explanation of Benefits
The Claims Administrator uses a form called an Explanation of Benefits (EOB). It is not a bill. It explains how a claim was processed and includes the date of service, the amount billed, the amount covered, the amount the Plan paid and any balance You may be responsible for. If all or part of a claim is denied, the reason for the denial will be stated on the EOB. The EOB will also include instructions for filing an Appeal if You disagree with the action.

CLAIMS RECOVERY

If the Plan pays a benefit to which You or Your Beneficiaries were not entitled, or if the Plan pays a person who is not eligible for benefits at all, the Plan has the right to recover the payment from the person the Plan 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 the Plan would provide the Participant or any 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.). The Plan will be credited all amounts recovered.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the Subrogation and Right of Recovery provision for additional information.

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 they 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, Injury or condition, 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 Illness, Injury 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 Illness, Injury 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 Illness, Injury 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 Illness, Injury 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 Illness, Injury 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 Illness, Injury 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 in 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 Illness, Injury 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 Illness, Injury or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their 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 Related 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 the Plan would normally provide benefits. However, the amount of any Covered Services excluded in 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 per this provision.

COORDINATION OF BENEFITS
If You are covered by any other individual or group medical contract or plan (referred to as "Other Plan" and defined below), the benefits in this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section. NOTE: This section refers to a broad range of benefits, even though this Plan is a dental only Plan.

Definitions
The following are definitions that apply to this Coordination of Benefits provision:

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 and without reduction for any applicable Deductible. 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.

- Any expenses for other types of coverage or benefits when this Plan restricts coordination of benefits to certain types of coverage or benefits. This Coordination of Benefits provision applies to all benefits provided in this SPD.
- 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 means only the day and month of birth, regardless of the year.

Claim Determination Period means a Calendar Year. 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, blanket, individual, and franchise health insurance and prepayment coverage;
- group, blanket, individual, and franchise health maintenance organization or other closed panel plan 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; and
- hospital, medical, and surgical benefits of Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- independent noncoordinated 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 Medicaid state plan; 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 by 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 by 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 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 apply:

Non-dependent Coverage: A plan that covers You other than as a dependent will be primary to a plan for 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 their plan longer shall be primary to the plan of the parent who has been covered by their 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 their 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.
- Then the plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

If You are covered by 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.

If You are covered by either or both of Your parents' plans and as a dependent under Your spouse's plan, the rule in the Longer/shorter length of coverage section below shall be applied to determine the order of benefit determination. If Your coverage under Your spouse's plan began on the same date as Your coverage under one or both of Your parents' plans, the order of benefit determination between or among those plans shall be determined by applying the birthday rule in the first paragraph of this Dependent Coverage section to Your parent(s) and spouse.

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 by 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 to 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 by a plan, two plans will be treated as one if You were eligible by 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 by a plan is measured from Your first date of coverage with 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 with 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 by 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 with 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/or copayments 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 by 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 by any Other Plan(s) may include an amount that should have been paid by 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 by 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 were provided to or on behalf of You in excess of the amount that would have been payable in this SPD by reason of Your coverage with any Other Plan(s), this Plan will be entitled to recover 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

This provision describes the process for submitting an appeal. You may submit an appeal, as detailed below, if You or Your Representative want a review of a claim denial or other action under the Plan. There is one level of appeal, as well as additional voluntary appeal levels You may pursue. Situations that require a faster decision may also qualify for an expedited appeal.

NOTE: For all appeals, written materials provided in support of the appeal that include others' medical or dental records and other personal health information should not be submitted.

Appeals, including expedited appeals, must be pursued within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing. 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. You will be given the opportunity (within the constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf.

INTERNAL APPEAL
Internal appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial decision that You are appealing. In appeals that involve issues requiring medical or dental judgment, the decision is made by the Claims Administrator's staff of health care professionals.

What You May Appeal – Internal Appeal
- 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 law or regulation.

INTERNAL EXPEDITED APPEAL
If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision from the regular appeal process, You or Your treating Provider may specifically request an expedited appeal within 180 days of Your receipt of the Claims Administrator's Adverse Benefit Determination.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Internal expedited appeals are reviewed by an employee(s) of the Claims Administrator who was not involved in, or subordinate to anyone involved in, the initial decision that You are appealing. In appeals that involve issues requiring medical or dental judgment, the decision is made by the Claims Administrator's staff of health care professionals.

What You May Appeal – Internal Expedited Appeal
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 either:
  - could jeopardize Your life, health or ability to regain maximum function; or
  - according to a Provider with knowledge of Your medical or dental condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

FILING AN INTERNAL APPEAL
Appeals can be initiated through either written or verbal request using any of the following methods:

Method of Request	Contact Information
Secure Online Account	Sign-in to Your account at **regence.com**, navigate to appeals and complete an appeal request.
Phone	Verbal requests can be made by calling the Claims Administrator's Customer Service.
Fax	1 (877) 663-7526
Mail	Attn: ASO Appeals and Grievances Regence BlueCross BlueShield of Oregon P.O. Box 1106 Lewiston, ID 83501-1106

INTERNAL APPEAL DETERMINATION TIMING
The Claims Administrator will send its decision on Your internal appeal as follows:

Type of Appeal	How and When to Expect a Response
Post-Service appeal	In writing, within 30 days of the Claims Administrator's receipt of the appeal.
Pre-Service appeal for prior authorization	In writing, within 15 days of the Claims Administrator's receipt of the appeal.
Expedited appeal	By phone, fax or e-mail within 72 hours of the Claims Administrator's receipt of the appeal, followed by written notice within 3 working days.

FURTHER APPEALS
If You have exhausted all possible levels of appeal described here, contact Your Plan Sponsor for possible continuation of the appeals process.

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

LEGAL ACTION
You are required to exhaust the Appeal Process before pursuing legal action. Any lawsuit must be filed within one year of the date in which Your claim was denied under the Plan. Contact Your Plan Sponsor for details.

DEFINITIONS
The following definitions apply to this Appeal Process Section:

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

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

Representative means someone who represents You for 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 appeal. No authorization is required from the parent(s) or legal guardian of an enrolled dependent child who is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical or dental 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, Your Representative or Your treating Provider only.

Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual open enrollment period. It describes when coverage under the Plan begins for You and/or Your eligible dependents. 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:

- 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 AND WHEN COVERAGE BEGINS
You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of initially becoming eligible for coverage per 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.

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 open 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 probationary period required by the Plan Sponsor.

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, stepchild, adopted child or child legally placed with You for adoption;

  - a child for whom You have court-appointed legal guardianship; or
  - a child for whom You are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your child who is age 26 or over and incapable of self-support because of developmental disability, mental illness or physical disability that began before the child's 26th birthday. You must 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:

  - the child is a Beneficiary immediately before their 26th birthday; or
  - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as a dependent on either a parent's or legal guardian's group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their website 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.

Enrollment requests must be made according to the following:

- within 31 days of the date of birth, adoption or placement for adoption for a new child.
- within 30 days of the dependent's attaining eligibility for all other newly eligible dependents.

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.

ANNUAL OPEN ENROLLMENT PERIOD
The annual open enrollment period is the only time, other than initial eligibility, 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 will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY
You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. The Claims Administrator must receive such information 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 any benefits after the date coverage is terminated. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all the Plan's 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 by the Plan Sponsor, claims administration by Regence BlueCross BlueShield of Oregon ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed. Regence BlueCross BlueShield of Oregon may administer certain claims for Covered Services that Claimants received before the Agreement termination or nonrenewal, if agreed between the Plan Sponsor and the Claims Administrator.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE
If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Beneficiaries 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 COBRA Continuation of Coverage provision.

Termination of Your Employment or You are 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, 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, coverage will end for You and all Beneficiaries.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Beneficiaries on the date in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the COBRA Continuation of Coverage provision.

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.

Death of the Participant
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 terminated for either of the following reasons may be able to continue coverage under the Plan according to the COBRA Continuation of Coverage provision.

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

The Plan is issued in reliance upon all information furnished to the Claims Administrator 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.

FAMILY AND MEDICAL LEAVE

If Your Plan Sponsor grants You a leave of absence under an applicable state or federal family and medical leave law the following rules will apply. The federal Family and Medical Leave Act is generally applicable to private employers of 50 or more employees and public employers of any size. State law may be applicable more broadly. You and Your Beneficiaries will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the applicable law:

- You will remain eligible to be enrolled under the Plan (with Your Beneficiaries) during the leave for a period of up to 12 weeks, or as required by law, during a 12-month period:
    - for You to care for Your (or Your spouse's or Eligible Domestic Partner's) newborn child;
    - for You to care for Your spouse or Eligible Domestic Partner, child, parent, or other relative as required by law with a serious health condition;
    - for You to care for a child placed with You (or Your spouse or Eligible Domestic Partner) for adoption or foster care;
    - if You suffer a serious physical or behavioral health condition; or
    - for another reason for which applicable law requires leave to be available.

During the 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 elect not to remain enrolled during the leave, You (and Beneficiaries You had enrolled immediately before the leave) will be eligible to be reenrolled under the Plan on the date You return from the leave. In order to reenroll after You return from a leave, You must sign a new enrollment form 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 any re-enrolled Beneficiaries) will receive credit for any waiting period served before the leave and You will not have to re-serve any probationary period under the Plan.

You and any Beneficiaries will not be entitled to any other extension of benefits described in this section for the same situation that entitles You and them to coverage according to this provision. Entitlement to leave does not constitute a qualifying event for COBRA continuation. However, You and Your Beneficiaries may be entitled to COBRA continuation coverage if You do not return to active employment following leave. The duration of that COBRA continuation will be calculated from the date You fail to return from FMLA leave.

The provisions and administration described here are based on the requirements of, and will be governed by, the applicable law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and applicable law, the minimum requirements of the law will govern. 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 an applicable leave.

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.

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.

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 per certain conditions if You are retired and Your Plan Sponsor 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
You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation, plus an administration fee, even if the Plan Sponsor contributes toward the cost of those not on COBRA continuation. The administration fee is two percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights with 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 per Social Security 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 per Social Security, 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 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 of the Agreement and the Plan will not pay claims for services provided on and after the date coverage ends.

Notice
The Agreement includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Plan Sponsor.

General Provisions and Legal Notices

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

CHOICE OF FORUM
Any legal action arising out of the Plan 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 this Plan, and the court will determine the level of discretion that it will accord determinations.

LIMITATIONS ON LIABILITY
You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide 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 and 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 in the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

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.

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.

NOTICES
Any notice to Claimants or to the Plan Sponsor required in the Plan will be considered 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 last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address (COA) form for a Participant, the Claims Administrator will update their records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor if they become aware that the Claims Administrator doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be mailed to the Claims Administrator's Customer Service address. However, notice to the Claims Administrator will not be considered to have been given to and received by the Claims Administrator until physically received.

PLAN SPONSOR IS AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the Claims Administrator's agent. You are entitled to health care benefits pursuant to the Agreement between the Claims Administrator and the Plan Sponsor. 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 this SPD. 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 SPD.

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 BlueCross BlueShield of Oregon, 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 the Claims Administrator 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 the Claims Administrator 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 BlueCross BlueShield of Oregon and that no person or entity other

than Regence BlueCross BlueShield of Oregon will be held accountable or liable to the Plan Sponsor or the Claimants for any of the Claims Administrator'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 BlueCross BlueShield of Oregon 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 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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND HEALTH 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 website 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. Contact the Claims Administrator's Customer Service 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.

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, 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 in the Plan; 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.

Definitions

The following are definitions of important terms, other terms are defined where they are first used.

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 only 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 In-Network Dentists, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Dentists, the amount the Claims Administrator has determined to be reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

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, contact the Claims Administrator's Customer Service.

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.

Claimant means a Participant or a Beneficiary.

Cosmetic means services or supplies (including medications) that are provided primarily to improve or change appearance to normal structures of the body.

Covered Service means Dentally Appropriate services or supplies that are 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). These services must be received from a Dentist or other Provider practicing within the scope of their license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and is all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Claimant's condition; and
- not primarily for the convenience of the Claimant, Claimant's family or Provider.

A dental service may be Dentally Appropriate yet not be a Covered Service.

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry, doctor of dental surgery or a denturist) or to practice as a dental hygienist who is permitted by their respective state licensing board to independently bill third-parties.

Effective Date means the date following the Claims Administrator's receipt of the enrollment form, as the date coverage begins for You and/or Your Beneficiaries.

Family means a Participant and any Beneficiaries.

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

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or
- to maintain or restore functional ability.

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

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

Illness means a:

- congenital malformation that causes functional impairment;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

In-Network Dentist means a Dentist who has an effective participating contract with the Claims Administrator that designates them as a Dentist of the Plan Sponsor's network, to provide services and supplies to Claimants in accordance with the provisions of this coverage.

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

- 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.
- 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.

Out-of-Network Dentist means a Dentist that is not an In-Network Dentist. For Out-of-Network Dentist services, You may be billed for balances over the Plan's payment level in addition to any Deductible and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

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

Provider means an individual health professional or organization duly licensed to provide the services covered in this SPD.

Scientific Evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of a Health Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the Health Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

Summary Plan Description

The Plan is an employee welfare benefit plan regulated by 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
1 (541) 475-2234

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

PLAN NUMBER
501

TYPE OF PLAN
Welfare Benefit Plan: dental 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 herein is referred to as the Claims Administrator.

NAME, ADDRESS AND PHONE NUMBER OF AGENT (PLAN ADMINISTRATOR) FOR SERVICE OF LEGAL PROCESS
Bright Wood Corporation
Attn: Director of Personnel
P.O. Drawer 828
Madras, OR 97741
1 (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 SPD 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 Plan Sponsor, Your union or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights
If 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 a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce 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. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a 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 or You can write to P.O. Box 1106, Lewiston, ID 83501-1106

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