2025 SUMMARY PLAN DESCRIPTION FOR:

BRIGHT WOOD CORPORATION HEALTH AND WELLNESS PLAN

Plus Plan

Group Number: 10016754

Medical Benefits

Regence

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1-800-985-3059.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

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

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 medical 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.

Mental Health Parity and Addiction Equity Act of 2008
This coverage complies with the Mental Health Parity and Addiction Equity Act of 2008.

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.

Case Management: Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information, refer to the Medical Benefits Section or call Case Management at 1 (866) 543-5765.

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

Using Your Summary Plan Description

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for care or treatment of an Illness or Injury. All Claimants must select a primary physician or practitioner. If a primary physician or practitioner is not selected within 90 days one will be assigned by Us. Contact Customer Service for further information and guidance. You control Your out-of-pocket expenses by choosing between "Category 1," "Category 2" and "Category 3" benefit levels.

- **Category 1.** Choosing preferred Providers saves You the most in Your out-of-pocket expenses. Preferred Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 2.** Choosing participating Providers means Your out-of-pocket expenses will be higher than choosing a preferred Provider. Participating Providers will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Category 3.** Choosing nonparticipating Providers means Your out-of-pocket expenses will be higher than choosing a preferred or participating Provider. Also, a nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. This is referred to as balance billing.

For each benefit, the Provider You may choose and Your payment amount for each Provider option is indicated. See the Definitions Section for a complete description of Categories 1, 2 and 3. You can go to **regence.com** for further Provider network information.

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

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

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

This does not apply to:

- a residential facility licensed by the Department of Human Services or the Oregon Health Authority under Oregon law;
- an establishment furnishing primarily domiciliary care as described under Oregon law;
- a residential facility licensed or approved under the rules of the Department of Corrections;

- facilities established through the Oregon Health Authority for the treatment of substance use disorders;
- community mental health programs or community developmental disabilities programs established under Oregon law; or
- a long-term care facility.

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to the Claims Administrator's website and mobile application to help You navigate Your way through health care decisions. For access, You just set up Your free account once and it is always up to You whether to participate. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR SPD.** Additional information about some programs and services can be found in the Value-Added Services Appendix at the end of the SPD.

- **Go to regence.com or the Claims Administrator's mobile application.** You can use the Claims Administrator's secure applications to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider;
    - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
    - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs; 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 applications, 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 (if any), Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical 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 days, visits, services, supplies, dollar amount or specified time period) has been reached. Refer to the Medical 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. Only Allowed Amounts for Covered Services are applied to satisfy the Deductible. There is an individual Deductible amount and a Family Deductible amount for Category 1 and 2 benefits combined and also for Category 3 benefits.

The Family Deductible is satisfied when any combination of Family members' payments toward each of their individual Deductibles total the Family Deductible amount. No one Family member may contribute more than their individual Deductible amount toward the Family Deductible in a Calendar Year. A Family member does not have to satisfy their individual Deductible if the Family Deductible has already been satisfied.

The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible.

COPAYMENTS
Copayments are a specific dollar amount that You pay directly to the Provider at the time You receive a specified service. A Provider may or may not request any applicable Copayment at the time of service. Refer to the benefit sections to see what Covered Services are subject to a Copayment.

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 and/or any applicable Copayment 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 Providers for charges above the Allowed Amount.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most You could pay in a Calendar Year for Covered Services. Your payments of any Deductible, Copayments and/or Coinsurance apply to the Out-of-Pocket Maximum, unless specified otherwise. There is an individual Out-of-Pocket Maximum amount and a Family Out-of-Pocket Maximum amount for Category 1 and 2 benefits combined and also for Category 3 benefits.

The Family Out-of-Pocket Maximum is satisfied when any combination of Family members' payments of their cost-shares for Covered Services total the Family Out-of-Pocket Maximum. No one Family member may contribute more than their individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year. A Family member does not have to satisfy their individual Out-of-Pocket Maximum if the Family Out-of-Pocket Maximum has already been satisfied.

A Claimant's payment of any Deductible, Copayment and/or Coinsurance for ambulance, blood bank and emergency room services will apply toward the Category 1 and 2 Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the benefit sections to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and 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. A Plan Year may or may not be the same as a Calendar Year. If the Agreement renews on a day other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the Agreement's renewal date will carry over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amounts increase during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Agreement during that same Calendar Year.

Medical Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. Referrals are not required before You can use any of the benefits of this coverage. All benefits are listed alphabetically, with the exception of Upfront Benefits, Preventive Care and Immunizations, Office or Urgent Care Visits and Other Professional Services.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, the Plan may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

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

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit the Claims Administrator's website or contact Customer Service.

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

CASE MANAGEMENT

Case management is a program designed to provide early detection and intervention in cases of serious Illness or Injury that have the potential for continuing major or complex care. Case managers are experienced, licensed health care professionals. They will provide information, support and guidance and will work with Your Physicians or other health care professionals in supporting Your treatment plan and proposing alternative benefits.

PRIOR AUTHORIZATION

Some Covered Services may require prior authorization. Those services require contracted Providers to obtain prior authorization from the Claims Administrator before providing such services to You. You will not be penalized if the contract Provider does

not obtain prior authorization from the Claims Administrator in advance and the service is determined to be not covered.

Non-contracted Providers are not required to obtain prior authorization from the Claims Administrator prior to providing services. You may be responsible for cost of services provided by a non-contracted Provider if those services are not Medically Necessary or a Covered Service. You may request that a non-contracted Provider prior authorize services on Your behalf to determine Medical Necessity prior to receiving those services.

A complete list of services and supplies that require prior authorization may be obtained by visiting the Claims Administrator's website at: **regence.com/web/regence_provider/pre-authorization** or by calling Customer Service.

Prior authorization requests should be faxed by Your Provider following the instructions on the Claims Administrator's website.

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

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

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

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

PREVENTIVE VERSUS DIAGNOSTIC SERVICES
Covered Services may be either preventive or diagnostic. "Preventive" care is intended to prevent an Illness, Injury or to detect problems before symptoms are noticed. "Diagnostic" care treats, investigates or diagnoses a condition by evaluating new symptoms, following up on abnormal test results or monitoring existing problems.

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this SPD will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the

recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

CALENDAR YEAR DEDUCTIBLES
Categories 1 and 2
Per Claimant: $900
Per Family: $1,800

Category 3
Per Claimant: $1,800
Per Family: $3,600

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
Categories 1 and 2
Per Claimant: $4,000
Per Family: $8,000

Category 3
Per Claimant: $8,000
Per Family: $16,000

UPFRONT BENEFITS
Three Upfront Primary Care Visits

	Category: 1	**Category: 2**	**Category: 3**
	Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Primary Care	**Payment:** No charge.	**Payment:** Not applicable.	**Payment:** Not applicable.
Behavioral Health Office or Psychotherapy	**Payment:** No charge.	**Payment:** Not applicable.	**Payment:** Not applicable.
Virtual Care Telehealth and Store and Forward **Virtual Care Vendor**	**Payment:** No charge.	**Payment:** Not applicable.	**Payment:** Not applicable.
Limit: first three combined Upfront Primary Care visits per Claimant per Calendar Year. Once this limit is reached, any additional visits are covered elsewhere in the Medical Benefits Section based upon service type. For purposes of this benefit "Primary Care" means in-person office visits, outpatient behavioral health office or psychotherapy, virtual care telehealth and store and forward or virtual care vendor services.			

Upfront Benefits for Your first three Primary Care visits per Calendar Year for the purpose of promoting or maintaining behavioral and physical health and wellness, and diagnosis, treatment, or management of acute or chronic conditions caused by disease, injury or illness are covered.

PREVENTIVE CARE AND IMMUNIZATIONS

Preventive Care

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Immunizations – Adult

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Immunizations – Childhood

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** You pay 0% of the Allowed Amount and the balance of billed charges.

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), or as required by state or federal guidance for a specific time period as a result of a

government declared disease outbreak, epidemic, or other public health emergency, are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings (including screening and counseling for some cancer genes such as BRCA1 or BRCA2);
- Provider counseling for tobacco use cessation;
- immunizations for adults and children;
- routine colonoscopies and colorectal cancer examinations, including for those Claimants at high-risk or follow-up colonoscopies performed as a result of a positive non-invasive stool-based screening test or direct visualization screening test. Colonoscopy services include all associated services such as double contrast barium enemas, anesthesia and pathology;
- breast pumps (including its accompanying supplies) per pregnancy as follows:
    - new non-Hospital grade breast pumps at the Category 1 benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value.

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic colonoscopies) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, the Claims Administrator has up to one year before coverage of the related services must be available and effective in this SPD.

For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit the Claims Administrator's website or contact Customer Service. You can also visit the HRSA website at: **hrsa.gov/womensguidelines/** for women's preventive services guidelines, and the USPSTF website at: **uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** for a list of A and B preventive services.

Expanded Immunizations

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

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Contact Customer Service to verify what expanded immunizations are covered.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

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

Office (including home, Retail Clinic or Hospital outpatient department) and urgent care visits are covered for treatment of Illness or Injury. Coverage does not include other professional services performed in the office or urgent care that are specifically covered elsewhere in the Medical Benefits Section, including, but not limited to, separate facility fees or outpatient radiology and laboratory services billed in conjunction with the visit.

NOTE: Office visits for primary care, not including urgent care, may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, office visits for primary care will be covered as specified here.

OTHER PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount. **Payment for tobacco use cessation services and Virtual Care service facility fees:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount. **Payment for tobacco use cessation services and Virtual Care service facility fees:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges. **Payment for tobacco use cessation services:** You pay 0% of the Allowed Amount and the balance of billed charges.

Services and supplies provided by a professional Provider are covered, subject to any Deductible and/or Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services and Supplies
Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider.

Services and supplies also include:

- treatment of a congenital anomaly;
- Virtual Care service facility fees;
- foot care associated with diabetes; and
- Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Dental and orthodontic services that are for the treatment of craniofacial anomalies and are Medically Necessary to restore function are also covered. A "craniofacial anomaly" is a physical disorder, identifiable at birth, that affects the bony structures of the face or head, including, but not limited to, cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage does not include treatment of temporomandibular joint disorder or developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

Additionally, coverage includes some Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the Category 1 benefit level, with reimbursement based on the lesser of either the amount paid to a preferred Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for

claiming benefits or for additional information on Covered Services, visit the Claims Administrator's website or contact Customer Service.

Breast, Pelvic and Pap Smear Examinations
Breast, pelvic and Pap smear examinations not covered in the Preventive Care and Immunizations benefit.

Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress test, sleep studies and neurology/neuromuscular procedures.

Medical Colonoscopy
Diagnostic medical colonoscopies not covered in the Preventive Care and Immunizations benefit.

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

Surgical Services
Surgical services and supplies including cochlear implants, vasectomies and the services of a surgeon, an assistant surgeon and an anesthesiologist.

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

ACUPUNCTURE

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year		

Acupuncture is covered.

AMBULANCE SERVICES

Category: All
Provider: All
Payment: After Category 1 and 2 Deductible, You pay 20% of the Allowed Amount.

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger Your health and the transportation is not for personal or convenience purposes. Covered Services include licensed ground and air ambulance Providers.

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group and Your identification numbers. Payment for Covered Services will be paid directly to the ambulance service Provider.

AMBULATORY SURGICAL CENTER

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

Outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury.

APPROVED CLINICAL TRIALS

If a preferred Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits Section. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other Life-threatening Condition that is a study or investigation:

- approved or funded by one or more of:

- the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities; or a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
- a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
- the VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.

- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

Life-threatening Condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

- an Investigational item, device or service that is the subject of the Approved Clinical Trial unless it would be covered for that indication absent a clinical trial;
- items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Claimant; or
- a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

BEHAVIORAL HEALTH SERVICES

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible,* You pay 20% of the Allowed Amount. *The Deductible does not apply to outpatient therapy services.	**Payment:** After Deductible,* You pay 20% of the Allowed Amount. *The Deductible does not apply to outpatient therapy services.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

Inpatient and outpatient Behavioral Health Services, including Applied Behavioral Analysis (ABA) therapy services and behavioral health assessments are covered. Benefits include the following when provided for treatment of a Behavioral Health Condition:

- physical therapy;
- occupational therapy;

- speech therapy;
- radiology and laboratory services;
- durable medical equipment; and
- surgery.

NOTE: Behavioral Health Services may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, Behavioral Health Services will be covered as specified here.

Definitions
The following definitions apply to this Behavioral Health Services benefit:

Applied Behavioral Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. ABA therapy services must be provided by a licensed Provider qualified to prescribe and perform ABA therapy services.

Behavioral Health Condition means any mental or substance use disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases, including autism spectrum disorders and Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or intellectual disability. Mental disorders that accompany an excluded diagnosis are covered. Behavioral Health Condition does not include addiction to or dependency on tobacco, tobacco products, or foods.

Behavioral Health Services mean services to treat any mental or substance use disorder, Medically Necessary outpatient services, detoxification, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of court ordered treatment (unless the treatment is Medically Necessary). These services include Habilitative and Rehabilitative services for Behavioral Health Conditions without any visit or day limits.

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

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

Residential Care means care in a facility setting that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision and structure, and is licensed by the appropriate state and local authority to provide such services. Patients also must be medically

monitored with 24-hour medical availability and 24-hour onsite clinician services. Residential Care does not include half-way houses, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and would otherwise be a Covered Service.

BLOOD BANK

Category: All
Provider: All
Payment: After Category 1 and 2 Deductible, You pay 20% of the Allowed Amount.

Services and supplies of a blood bank are covered, excluding storage costs.

CHILD ABUSE MEDICAL ASSESSMENT

Child Abuse Medical Assessments including those services provided by a Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan are covered as specified in the Medical Benefits Section. The services include, but are not limited to, a forensic interview and mental health treatment.

Definitions

The following definitions apply to this Child Abuse Medical Assessment benefit:

Child Abuse Medical Assessment means an assessment by or under the direction of a licensed Physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse. Child Abuse Medical Assessment includes the taking of a thorough medical history, a complete physical examination and an interview for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the child.

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

DENTAL HOSPITALIZATION

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

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DIABETIC EDUCATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** You pay 0% of the Allowed Amount and the balance of billed charges.

Services and supplies for diabetic self-management training and education are covered. Diabetic nutritional counseling and nutritional therapy are covered in the Nutritional Counseling benefit.

DIALYSIS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period		

Services and supplies for outpatient and home dialysis are covered as described below. Dialysis received while inpatient is covered elsewhere in the Medical Benefits Section, such as the Hospital Care – Inpatient and Outpatient benefit.

Outpatient Initial Treatment Period
Hemodialysis, peritoneal dialysis, and hemofiltration services, supplies, medications, labs, and facility fees are covered during the initial treatment period when Your Physician prescribes outpatient dialysis. You should first contact the Claims Administrator to begin Case Management. A case manager will help You enroll in the Supplemental Kidney Dialysis Program. The "Supplemental Kidney Dialysis Program" is a supplemental program available to Claimants following the initial treatment period.

The "initial treatment period" will be three months of hemodialysis (42 treatments) or peritoneal dialysis (30 days). Once the initial treatment period limit is reached, outpatient dialysis may be covered according to the Outpatient Supplemental Treatment Period benefit below. If more than three months of treatment is necessary in the initial treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. Dialysis treatments that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

Services that are rendered outside the country are covered, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Outpatient Supplemental Treatment Period

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** The Plan pays 150% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You pay the balance of billed charges, which will not apply toward the Out-of-Pocket Maximum.

Supplemental treatment is covered for any outpatient dialysis that is required beyond the initial treatment period.

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

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

Case Managed Dialysis and Supplemental Kidney Dialysis Program
Receive one-on-one help and support in the event Your Physician recommends dialysis. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to enroll in Case Management, call the Claims Administrator's Customer Service.

DURABLE MEDICAL EQUIPMENT

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

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs, wigs and supplies or equipment associated with diabetes (such as insulin pumps or therapeutic continuous glucose monitors, and their supplies).

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

Generally, claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the location in which the equipment was received.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

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

Emergency room services and supplies are covered, including outpatient charges for patient observation, medical screening examinations, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be prior authorized. See the Definitions Section for coverage of services for the treatment of Accidental Injury.

"Stabilization" means to provide Medically Necessary treatment:

- to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Claimant from a facility; and
- in the case of a covered Claimant, who is pregnant, to perform the delivery (including the placenta).

If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. Contact Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: All Other Providers
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Claimants who fulfill the Medical Necessity criteria.

To be covered at the Centers of Excellence (COE) benefit level, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's COE facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from a preferred or participating Provider to be covered at the COE benefit level. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service as the lists are subject to change.

Travel Expenses

Payment: You pay 100% of all expenses. Your travel expenses may be reimbursed subject to Your Category 1 and 2 Deductible and travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion(s), for transportation, lodging and meal expenses. Additional limitations included below.

Transportation, lodging and meal expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from a preferred or participating Provider;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to $300 per night for the Claimant and companion(s) combined;
- meal expenses are limited to $80 per day for each Claimant or companion(s); and
- covered transportation expenses to and from the treatment area include only:
    - commercial airfare;
    - commercial train fare; or
    - documented auto mileage (calculated per IRS medical expense allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of treatment. The Plan will reimburse You

for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Customer Service for further information and guidance.

Coverage does not include incidentals outside of transportation, lodging and meals.

HOME HEALTH CARE

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

Home health care is covered when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Inpatient Hospital Limit: 24 days per Calendar Year **Respite Care Limit:** 114 inpatient or outpatient days per Calendar Year		

Hospice care is covered when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and their family during the final stages of Illness.

Respite care is also covered to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Inpatient

hospital or respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

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

Services and supplies of a Hospital (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. A nonparticipating Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

INFUSION THERAPY

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

Inpatient, outpatient and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered. Covered Services also include parenteral and enteral therapy, and intravenous immunoglobulin therapy for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) when certain conditions have been met.

MASSAGE THERAPY

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 12 visits per Claimant per Calendar Year		

Massage therapy services are covered as a therapeutic intervention when provided by a licensed massage therapist. Services provided by a physical therapist or chiropractor may be specifically covered elsewhere in the Medical Benefits Section.

Maintenance therapy services are not covered.

MATERNITY CARE

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

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient. Coverage also includes termination of pregnancy (therapeutic abortion) only when done to preserve the life of the Claimant.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered in the Preventive Care and Immunizations benefit.

Coverage of labor and delivery services provided at a participating or nonparticipating healthcare facility due solely to the diversion of the patient from a preferred healthcare facility during a state or federally declared public health emergency is covered at the Category 1 benefit level. If services were not covered at the Category 1 benefit level, contact Customer Service for further information and guidance.

Surrogacy

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

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

Definitions

The following definition applies to this Maternity Care benefit:

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

MEDICAL FOODS

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

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

NEURODEVELOPMENTAL THERAPY

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

Physical therapy, occupational therapy or speech therapy services by a Physician or Practitioner are covered for neurological conditions that are not a Behavioral Health Condition (e.g., failure to thrive in newborn, lack of physiological development in childhood) to restore or improve function based on developmental delay. Covered Services include maintenance services if significant deterioration of a Claimant's condition would result without the service. (Services for Behavioral Health Conditions are covered in the Behavioral Health Services benefit and are not subject to age or visit limits.)

Neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

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

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in the Eligibility and Enrollment Section. There is no limit for the newborn's length of inpatient stay. "Newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, unless otherwise covered in the Preventive Care and Immunizations benefit.

NEWBORN HOME VISITS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.
Limit: within six months of age, at least one visit during the first three months of life with an opportunity to choose up to three more visits		

Home visits provided as part of the Oregon Health Authority's (OHA's) home visiting program are covered for enrolled newborns up to six months of age if:

- the newborn resides in an area of the state that is served by a universal newborn nurse home visiting program approved by the OHA; and
- the home visits are provided by an Oregon licensed registered nurse who is certified by the OHA to participate in that program.

NUTRITIONAL COUNSELING

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

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

ORTHOTIC DEVICES

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

Medically Necessary orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body are covered, including, but not limited to:

- braces;
- splints; and
- orthopedic appliances.

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

The Plan may elect to provide benefits for a less costly alternative item. Covered Services do not include orthopedic shoes and off-the-shelf shoe inserts.

PALLIATIVE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year		

Palliative care is covered when a Provider has assessed that a Claimant is in need of palliative services for a serious Illness (including remission support), life-limiting Injury or end-of-life care. "Palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living.

Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. All other Covered Services for a Claimant receiving palliative care remain covered the same as any other Illness or Injury.

PROSTHETIC DEVICES

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

Prosthetic devices for functional reasons are covered to replace a missing body part, including:

- artificial limbs;
- external or internal breast prostheses following a mastectomy; and
- maxillofacial prostheses.

"Maxillofacial prostheses services" are restoration and management of head and facial structures that are not replaceable with living tissue and are defective because of disease, trauma, or birth or developmental deformities. Covered maxillofacial prostheses services must be either for the purpose of controlling or eliminating infection or pain or for restoring facial configuration or functions (e.g., speech, swallowing, chewing). Restoration of facial configuration that is Cosmetic to improve on the normal range of conditions is not covered.

Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

RADIOLOGY AND LABORATORY SERVICES

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

Diagnostic services for treatment of Illness or Injury are covered, including services not covered in the Preventive Care and Immunizations benefit. Covered Services include the following:

- genetic testing, when performed for a medical reason or for a condition that requires genetic testing, provided the results of the testing have the potential to improve Health Outcomes;
- complex imaging;
- HIV testing; and
- diagnostic and supplemental breast examinations used to screen for breast cancer, evaluate a detected or suspected abnormality, evaluate where no abnormality is detected or suspected, or Medically Necessary based on personal factors or family medical history are covered and are not subject to any cost-sharing when provided by an In-Network Provider; diagnostic and supplemental breast examinations include: diagnostic mammography, digital breast tomosynthesis, breast magnetic resonance imaging, and breast ultrasounds.

"Complex imaging" means:

- bone density screening;
- computerized axial tomography (CT or CAT) scan;
- magnetic resonance angiogram (MRA);
- magnetic resonance imaging (MRI);
- positron emission tomography (PET); and
- single photon emission computerized tomography (SPECT).

Generally, claims for independent clinical laboratory services will be submitted to the Blue plan in the location in which the referring Provider is located.

REHABILITATION SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible,* You pay 20% of the Allowed Amount. *The Deductible does not apply to outpatient services.	**Payment:** After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.
Inpatient limit: 30 days for physical therapy per Claimant per Calendar Year. 30 days combined for occupational and speech therapy per Claimant per Calendar Year. **Outpatient limit:** 20 visits combined per Claimant per Calendar Year		

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury that is not a Behavioral Health Condition. (Rehabilitation services for mental diagnoses are covered in the Behavioral Health Services benefit.)

"Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention.

Rehabilitation services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

A separate program, available at no cost to You, may provide services for acute injuries with assistance from a physical therapist. Such services will not be subject to the limitations and cost-sharing of this benefit. Refer to the Joint, Spine, and Muscle Program in the Value-Added Services Appendix for more information.

REPAIR OF TEETH

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

Services and supplies for treatment required as a result of damage to or loss of sound natural teeth are covered when such damage or loss is due to an Injury.

SKILLED NURSING FACILITY

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

Inpatient services and supplies of a Skilled Nursing Facility are covered for treatment of Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is necessary.

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SPINAL MANIPULATIONS

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: You pay 20% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount.	**Payment:** You pay 50% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits combined per Claimant per Calendar Year		

Chiropractic and osteopathic spinal manipulations are covered.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

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

Inpatient and outpatient services are covered for treatment of TMJ disorders which have one or more of the following characteristics:

- an abnormal range of motion or limitation of motion;
- arthritic problems;
- internal derangement; and/or
- pain in the musculature.

Covered Services include services that are:

- reasonable and appropriate for the treatment of a TMJ disorder;
- effective for the control or elimination of one or more of the following TMJ disorders:
    - pain;
    - infection;
    - disease;
    - difficulty in speaking; or
    - difficulty in chewing or swallowing food.

TRANSPLANTS

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

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

- heart;
- lung;
- kidney;
- pancreas;

- liver;
- cornea;
- multivisceral;
- small bowel;
- islet cell; and
- hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors:

  - either autologous (self-donor);
  - allogeneic (related or unrelated donor);
  - syngeneic (identical twin donor); or
  - umbilical cord blood (only covered for certain conditions).

For a list of covered transplants, contact the Claims Administrator's Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit.

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

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

Travel Expenses

Payment: After Category 1 and 2 Deductible, You pay 20% of billed charges. Your payment may be reimbursed up to the travel expense limit.
Limit: $10,000 per Claimant per transplant episode (limit is combined for Claimant and companion(s)). Additional limitations included below.

Transportation, lodging and meal expenses are covered only when the Claimant receives the transplant at a Transplant Network Centers of Excellence Facility, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States as verified through Your case manager, the transplant would require an overnight stay that is greater than 30 miles away from home and within reasonable proximity to the treatment area;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to the Claimant and companion(s) combined;
- meal expenses, excluding alcohol, are limited to each Claimant or companion(s); and

- covered transportation expenses to and from the treatment area include only:
    - commercial coach class, or the lowest available, airfare; or
    - documented auto mileage (calculated per IRS medical allowances).

Additionally, local ground transportation (economy car rental, hotel shuttle or taxi service) within the treatment area to and from the treatment site is covered during the course of the transplant treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Case Management for further information and guidance.

Coverage does not include travel expenses for the donor or incidentals outside of transportation, lodging and meals.

VIRTUAL CARE

Virtual care services are covered for the use of telehealth or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

"Virtual care vendors" mean a select group of Providers that have entered into an agreement with the Claims Administrator to provide virtual care services at a lower cost. To learn more about how to access virtual care services or Providers and virtual care vendors that may offer lower-cost services, visit the Claims Administrator's website or contact Customer Service.

NOTE: Virtual care services may be covered in the Upfront Benefits. Once any applicable Upfront Benefit limit is reached, virtual care services will be covered as specified here.

Store and Forward Services

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

"Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. For example, store and forward services include using a secure patient portal to send a picture of Your swollen ankle to Your Provider for review at a later time. Store

and forward services that are not secure and HIPAA compliant are not covered, including, but not limited to:

- telephone;
- facsimile (fax);
- short message service (SMS) texting; or
- e-mail communication.

Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

Provider: Virtual Care Vendor	**Category: 1**	**Category: 2**	**Category: 3**
	Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: No charge.	**Payment:** No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and the balance of billed charges.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform, including when You are in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider or using the equipment at Your local Provider's office to have a live video call with a cardiologist in a different city. Separate charges for facility fees are covered in the Other Professional Services benefit.

Prescription Medications

Your prescription medication coverage is administered by Your Pharmacy Benefit Manager (PBM). Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of Your prescription drug benefits information. Visit Your PBM's website or contact Your PBM's Customer Service at 1 (833) 842-9273 if you have questions.

Out-of-pocket maximum $1,500 individual / $3,000 family

Generic prescription medications $10 retail / $25 mail order

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

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

General Exclusions

The following are the general exclusions from coverage, other exclusions may apply as described elsewhere in this SPD.

SPECIFIC 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 federal law;
- a preventive service as specified in the Preventive Care and Immunizations benefit; or
- services and supplies furnished in an emergency room for stabilization of a patient.

Activity Therapy
The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps
Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing; or
    - a Behavioral Health Condition.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this SPD.

Assisted Reproductive Technologies
Assisted reproductive technologies, regardless of underlying condition or circumstance are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Biofeedback Therapy

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

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

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

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

Counseling in the Absence of Illness
Except as required by law, counseling in the absence of Illness is not covered.

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

Dental Services
Except as provided in the Repair of Teeth or Other Professional Services benefit, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

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

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

Family Counseling
Except when provided as part of the treatment for a child or adolescent with a covered diagnosis, family counseling is not covered.

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 Provider 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.

Gender Transition Treatment and Surgery
Treatment, surgery or counseling services for gender transition.

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, government facilities or government facilities outside the service area are not covered, except for the following:

- facilities contracting with the local Blue Cross and/or Blue Shield plan; or
- as required by law for emergency services.

Growth Hormone Therapy

Hearing Care
Except as provided in the Medical Benefits Section, hearing care is not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- behavioral health; or
- for anesthesia purposes.

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 by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports, as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, 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.

Liposuction for the Treatment of Lipedema

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 Virtual Care 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.

Non-Therapeutic Continuous Glucose Monitors and Supplies

Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling benefit or as required by law, such as for Preventive Care and Immunizations, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including revisions, reversals, and treatment of complications); or
- programs.

Orthognathic Surgery
Orthognathic surgery is not covered, except for the treatment of the following:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomaly (including craniofacial anomalies).

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Over-the-Counter Contraceptives
Except as required by law, over-the-counter contraceptive supplies are not covered unless approved by the FDA.

Personal Items
Items that are primarily for comfort, convenience, contentment, Cosmetics, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

Prescription Medications
Prescription medications dispensed by a pharmacy.

Private-Duty Nursing
Private-duty nursing, including ongoing shift care in the home.

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

Routine Foot Care

Routine Hearing Examinations

Self-Help, Self-Care, Training or Instructional Programs
Except as provided in the Medical Benefits Section or for services provided without a separate charge in connection with Covered Services that train or educate a Claimant, self-help, non-medical self-care, and training or instructional programs are not covered, including, but not limited to:

- childbirth-related classes including infant care; and
- instructional programs that:

- teach a person how to use Durable Medical Equipment;
- teach a person how to care for a family member; or
- provide a supportive environment focusing on the Claimant's long-term social needs when rendered by individuals who are not Providers.

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 and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
  - school;
  - a camp;
  - a sports team;
  - the military; or
  - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
  - employment or return to work;
  - marriage;
  - insurance;
  - occupational Injury benefits;
  - licensure; or
  - certification.
- travel, immigration or emigration.

Sexual Dysfunction
Except for counseling services provided by covered, licensed Practitioners when behavioral health services are covered benefits in this SPD, services and supplies (including medications) are not covered for or in connection with sexual dysfunction regardless of cause.

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.

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

Therapies, Counseling and Training
The following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling;
- employee assistance program services; and
- job skills or sensitivity training.

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

Travel and Transportation Expenses
Except as provided in the Ambulance benefit or as otherwise provided in the Medical Benefits Section, travel and transportation expenses are not covered.

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

Vision Care
Vision care services are not covered, including, but not limited to:

- routine eye examinations;
- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

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.

Wigs
Except as specifically provided in this SPD, wigs or other hair replacements regardless of the reason for hair loss or absence are not covered.

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

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

Claims Administration

This section explains 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.

Category 1 and Category 2 Claims and Reimbursement
You must present Your identification card to a preferred or participating Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to the Claims Administrator for processing Your claim.

The Plan will pay a preferred or participating Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. Preferred and participating Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

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

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

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

Nonparticipating Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You generally are responsible for paying any difference between the amount billed by the nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. (See Services Received From An Oregon Nonparticipating Provider In A Preferred or Participating Healthcare Facility in the Medical Benefits Section for an

exception to balance billing.) For nonparticipating Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples by Category
Here are reimbursement examples for Category 1, 2 or 3. Let's assume the Plan pays 80 percent of the Allowed Amount for Category 1 and 60 percent of the Allowed Amount for Categories 2 and 3. The benefit table would appear as follows:

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

In this example, the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for Categories 1, 2 and 3. Let's assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum:

- Category 1: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
  - Amount preferred Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000
- Category 2: the Plan would pay 60 percent of the Allowed Amount and You would pay 40 percent of the Allowed Amount, as follows:
  - Amount participating Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount): **$1,600**
  - Total: $5,000
- Category 3: the Plan would pay 60 percent of the Allowed Amount. Because the nonparticipating Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus, the $1,000 difference between the nonparticipating Provider's billed charges and the Allowed Amount, as follows:
  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$2,600**

Total:	$5,000

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

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.

CONTINUITY OF CARE
You may qualify to receive 120 days of continued coverage (or 120 days from the date You are no longer a continuing care patient, whichever is earlier) at the Category 1 or Category 2 benefit level, if one of the following situations apply:

- Your Provider was a contracted preferred or participating Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to a failure to meet quality standards or for fraud); or
- Your Plan is terminated for reasons other than fraud, and Your Plan Sponsor's new health plan does not include Your In-Network Provider in its network.

To qualify for continued coverage, You must be:

- undergoing a course of treatment for a certain serious and complex condition from the Provider;
- undergoing a course of institutional or inpatient care from the Provider;
- scheduled to undergo non-elective surgery from the Provider (including postoperative care following surgery);
- pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- determined to be terminally ill and receiving treatment for such Illness from the Provider.

The Claims Administrator will notify You of Your right to receive continued care from the Provider or You may contact the Claims Administrator with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Plan and provided on the same terms and conditions as any other preferred or participating Provider. Your Provider must accept the Allowed Amount and cannot bill You for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact the Claims Administrator's Customer Service for further information and guidance.

OUT-OF-AREA SERVICES

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

When You receive care outside of the Claims Administrator's Service Area, You may receive it from Providers as described below. Providers contracted with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the preferred Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the participating Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Some Providers ("nonparticipating Providers") don't contract with the Host Blue.

BlueCard Program

In the BlueCard Program, when Covered Services are received within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what was agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Providers that participate in the BlueCard Program.

When Covered Services are received outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount the Claimant pays for Covered Services is calculated based on the lower of:

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

Often, this "negotiated price" is a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with a Provider or a group of Providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of Providers. Host Blues may use several factors to set an estimated or average price, including types of settlements, incentive payments, and/or other credits or charges. Estimated and average pricing may also take into account adjustments to correct Host Blue estimates of past prices. However, such adjustments will not affect the price used for the Claimant's claim because those adjustments will not be applied after a claim has already been paid.

Value-Based Programs
You may receive Covered Services under a Value-Based Program ("VBP") inside a Host Blue's service area. Host Blue may pay Providers that participate in a VBP for reaching agreed-upon cost and quality goals, meeting outcome measures, and coordinating care between its Providers. You will not be responsible for paying fees associated with a VBP, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

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

Nonparticipating Providers Outside the Claims Administrator's Service Area
When Covered Services are provided outside of the Claims Administrator's Service Area by nonparticipating Providers, the amount the Claimant pays will normally be based on either Host Blue's nonparticipating Provider local payment or pricing arrangements required by applicable state law. Other payment methods may be used in certain situations, such as billed charges for Covered Services, the payment that would have been made if the health care services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment to determine the amount that will be paid for services provided by nonparticipating Providers. In any of these situations, the Claimant may be responsible for the difference between the nonparticipating Provider's billed amount and the Plan's payment for Covered Services. Federal or state law, as applicable, will govern payments for nonparticipating emergency services.

BLUE CROSS BLUE SHIELD GLOBAL® CORE
If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global® Core ("BCBS Global® Core") when accessing Covered Services. BCBS Global® Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although BCBS Global® Core helps you access a provider network, the network is not served by a Host Blue.

You may have to pay the Provider upfront and submit any claims to the Claims Administrator Yourself in order to obtain reimbursement for those services. When You pay for Covered Services outside the United States, You should complete and submit a

BCBS Global® Core claim form with the Provider's itemized bill(s) to the service center (address is on the form) to initiate claims processing. If You contact the BCBS Global® Core service center for assistance, in most cases, Hospitals will not require You to pay for covered inpatient services (except for any applicable Deductible, Copayment, and/or Coinsurance). In such cases, the Hospital will also submit Your claims to the service center.

If You need medical assistance services or help locating a Provider outside the United States, or if You need assistance with a claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary. The claim form is available from the Claims Administrator, the service center, or online at **www.bcbsglobalcore.com**.

Covered Services received from Providers outside the United States may not be subject to state or federal protections from surprise or balance billing, and therefore You may be billed for balances beyond any Deductible, Copayment, and/or Coinsurance for Covered Services.

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 or Injury, including, but not limited to, wrongful death, survival or survivorship claims brought on Your, Your estate's or Your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" or "Your" includes anyone on whose behalf the Plan pays benefits.

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an 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 Medical Expenses
Benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which 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 under this section.

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.

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

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

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered 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 health 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 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 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 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 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, during a period of special enrollment 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, except as described in the Special Enrollment provision below.

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.

SPECIAL ENROLLMENT
There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period. You must submit an enrollment form on behalf of all individuals who become eligible based on the provisions below.

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Plan within 30 days from the date of one of the following qualifying events (except that where the qualifying event is involuntary loss of coverage under

Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

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

For the above qualifying events coverage will be effective on the day after the prior coverage ended. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Plan within 30 days from the date of one of the following qualifying events:

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

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

- You and/or Your eligible dependent(s) become eligible for premium assistance with Medicaid or CHIP.

For the above qualifying events coverage will be effective on the first of the month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption or placement for adoption, coverage is effective from the date of the birth, adoption or placement.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open enrollment period is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage 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 or the Other Continuation Options Sections.

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 premium contributions, 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 or the Other Continuation Options Sections.

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 or the Other Continuation Options Sections.

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 1106, Lewiston, ID 83501-1106.

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 were 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.

Other Continuation Options

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

Strike or Lockout
If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full payment, including any part usually paid by the Plan Sponsor, directly to the union or trust that represents You. The union or trust must continue to make payments to the Claims Administrator according to the Agreement. Coverage cannot be continued if less than 75 percent of those normally enrolled continue coverage or if You otherwise lose eligibility under the Plan. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

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

General Provisions 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, Copayment and/or Coinsurance and for non-Covered Services, except as may be restricted in the Provider contract.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT – STATEMENT OF RIGHTS

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain prior authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain prior authorization. Contact the Claims Administrator's Customer Service for additional information on prior authorization.

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

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

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

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

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

Definitions

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

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

Affiliate means a company with which the Claims Administrator has a relationship that allows access to Providers in the state in which the Affiliate serves and includes 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 preferred and participating Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For nonparticipating Providers who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be Reasonable Charges or have negotiated for Covered Services. The Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For nonparticipating Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.

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

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

Ambulatory Surgical Center does not mean:

- individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a Physician's or dentist's office using local anesthesia or conscious sedation; or
- a portion of a licensed Hospital designated for outpatient surgical treatment.

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

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

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

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

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

Center of Excellence means a Provider organization certified to deliver a gene therapy (or therapies) that meets or exceeds a set of clinical service and quality standards (including available clinical services, patient selection criteria, and outcome reporting), maintains a set of clinical protocols and certifications required for gene therapy delivery, and maintains or exceeds a foundation of rigorous and sustainable cost controls.

Claimant means a Participant or a Beneficiary.

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

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 a service, supply, treatment or accommodation that is listed in the benefit sections in this SPD.

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

Dental Service means services or supplies (including medications) 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.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home.

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

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

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

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

Family means a Participant and any Beneficiaries.

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

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

- disease;
- Illness 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.

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

Illness means a:

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

Illness does not include any state of behavioral health or mental disorder which is otherwise defined in the Behavioral Health Services benefit.

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.

An Injury does not mean Injury to teeth due to chewing and does not include any condition related to pregnancy.

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

- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the

use for a particular diagnosed condition, benefits for the medication may be provided when so used.

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

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

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat an Illness, Injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice. "Generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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.

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

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include, but are not limited to:

- podiatrists who do not meet the definition of Physician;
- Physician's associates;
- psychologists;
- licensed clinical social workers;
- certified nurse Practitioners;
- registered physical, occupational, speech or audiological therapists;
- registered nurses or licensed practical nurses, (but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients);
- dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist); and
- other health care professionals practicing within the scope of their respective licenses.

Provider means:

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

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

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center or facility;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

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

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

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

Upfront Benefit means those Covered Services designated as "Upfront" which are usually accessible to the Claimant without first having to satisfy any Deductible amount. There may not be any Coinsurance amount required for an Upfront Benefit. However, a Copayment may apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit visit maximum has been reached, additional coverage is available subject to any Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit to determine coverage.

Appendix: Value-Added Services

This Plan includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS SPD.** These value-added services may work alongside Your coverage. Such services are otherwise covered in the benefits provisions of this SPD.

For additional information regarding any of these value-added services, visit the Claims Administrator's website or contact Customer Service. Contact information for value-added services for specific program partners is also included below, if applicable.

CARE MANAGEMENT
Receive one-on-one help and support in the event You have a chronic, serious or sudden Illness or Injury. An experienced care management nurse will serve as Your single point of contact and personal advocate to help You understand Your Providers' instructions, help prepare You for an elective surgical procedure, assist in coordinating overall care, connecting to special medical expertise and accessing other Plan Sponsor services and programs. Your nurse is supported by a multidisciplinary team made up of doctors, social workers, Pharmacists and behavioral health experts that can be accessed for additional consultation. The goal is to offer assistance in navigating through Your health care needs, including working with Your community resources to provide a personalized touch and to enhance the quality of Your wellbeing. Care management nurses proactively outreach by telephone and educational mailings or You may request support by directly contacting a nurse. To learn more, call 1 (866) 543-5765.

DIABETES MANAGEMENT
If You are identified to participate, the Diabetes Management program is an online program that has extensive support tools such as glucose tracking, live coaching and mental and emotional care to help You improve health and manage diabetes. To better track blood sugar levels and provide more focused support, You will be provided a cellular-enabled glucose monitor.

DIABETES PREVENTION
The Diabetes Prevention program is an online program that has extensive support tools such as weight tracking, live coaching, online lessons of diabetes prevention-specific curriculum and mental and emotional care to help You track five key healthy behaviors (weight, food, mood, steps and exercise) and prevent diabetes. To provide more focused support, You will be provided a cellular-enabled weight scale.

HYPERTENSION MANAGEMENT
If You are identified to participate, the Hypertension Management program is an online program that has extensive support tools such as food and activity tracking, live coaching and medication optimization support to help You improve health and manage hypertension. To better track blood pressure levels and provide more focused support, You will be provided a cellular-enabled blood pressure monitor.

JOINT, SPINE, AND MUSCLE PROGRAM
The Joint, Spine, and Muscle program is a digitally delivered program that is provided at no cost to You, to help manage mobility and pain with Your joints, spine, and muscles. In addition, based upon Your specific health condition, You may have access to a customized care plan including guided exercise therapy, one-on-one video coaching with a care team, curated health education, and behavior change support. For those who do not have a way to participate in the digital program, visit the Claims Administrator's website or contact Customer Service. You may be eligible for the following at no cost to You:

- exercise bands;
- wearable motion sensors and chargers;
- wearable pain relief device; and/or
- yoga mat.

NURSE ADVICE
You have access to registered nurses to answer Your health-related questions or concerns and to help You make informed decisions on seeking the appropriate level of care (whether to seek care in an emergency room, urgent care, office visit or self-care at home). This service is available to You on an unlimited basis at no additional cost. However, if You are experiencing a medical emergency, immediately call 911 instead.

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

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit the Claims Administrator's website right away to get started.

REGENCE EMPOWER
Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning up to $25 in gift cards for completion of well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

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: medical benefits.

TYPE OF ADMINISTRATION
The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the Plan Sponsor which 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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