

SUMMARY PLAN DESCRIPTION FOR:

BRIGHT WOOD CORPORATION HEALTH AND WELLNESS PLAN

Group Number: 10016754

Plus Dental Plan



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

Regence BlueCross BlueShield of Oregon

Introduction

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

EMPLOYER PAID BENEFITS

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

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

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective May 1, 2016, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueCross BlueShield of Oregon and makes it void.

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

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

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

CONTACT INFORMATION

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

And visit the Claims Administrator's Web site at: www.Regence.com

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

Using Your Summary Plan Description

YOUR PARTNER IN DENTAL CARE

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

ADDITIONAL PARTICIPATION ADVANTAGES

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

- **Go to www.Regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:
 - view recent claims, benefits and coverage;
 - find a contracting Provider; and
 - participate in online wellness programs and use tools to estimate upcoming healthcare costs.

GUIDANCE AND SERVICE ALONG THE WAY

This Summary Plan Description was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Your dental care coverage throughout this Summary Plan Description, some of which are highlighted here. If You have questions about Your dental care coverage, please contact the Claims Administrator.

- **Learn more and receive answers about Your coverage.** Just call Customer Service: 1 (866) 240-9580 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator's Web site at: www.Regence.com.

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Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Deductible, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Dentists for charges above the Allowed Amount. However, a Participating Dentist will not charge You for any balances for Covered Services beyond Your Deductible and/or Coinsurance amount. Nonparticipating Dentists, however, may bill You for any balances over the Plan payment level in addition to any Deductible and/or Coinsurance amount. See the Definitions Section for descriptions of Participating and Nonparticipating Dentists.

DEDUCTIBLES

The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies any Calendar Year Deductible. Your Plan may not include a Deductible. Check the Dental Benefits section to see if a deductible applies. If Your Plan does not have a Deductible, any references in this Summary Plan Description to Deductibles therefore do not apply to Your coverage. A Claimant satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Family Calendar Year Deductible is satisfied when three or more covered Family Members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Claimant may not contribute more than the individual Deductible amount. The Plan does not pay for services applied toward the Deductible. Refer to the Dental Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

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

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

Dental Benefits

In this section, You will learn about Your dental plan's benefits and how Your coverage pays for Covered Services. The explanation includes information about Maximum Benefits, Deductibles, Coinsurance, Covered Services and payment. For Your ease in finding the information regarding benefits most important to You, the Plan has listed these benefits alphabetically, with the exception of the Preventive Dental Services.

MAXIMUM BENEFITS

Preventive, Basic and Major Dental Services:

Per Claimant: \$1,500 per Calendar Year

Orthodontic Dental Services, per Claimant: \$1,500 per Lifetime

After any applicable Deductible is met, the Plan pays a portion of the Allowed Amount (or, for orthodontic dental services, a portion of the billed charges) for Covered Services, up to the Maximum Benefit amount for each Claimant each Calendar Year.

CALENDAR YEAR DEDUCTIBLES

Per Claimant: \$50

Per Family: \$150

Deductible does not apply to the following:

- Orthodontic dental services
- Preventive dental services

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: The Plan pays 100% of the Allowed Amount.	Payment: The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers the following preventive and diagnostic dental services:

- Bitewing x-ray series, limited to two per Claimant under 18 years of age per Calendar Year; limited to one per Claimant 18 years of age or older per Calendar Year.
- Complete intra-oral mouth x-rays, limited to one in a five-year period.
- Preventive oral examinations, limited to two per Claimant per Calendar Year.
- Problem focused oral examinations.
- Panoramic mouth x-rays, limited to one per Calendar Year.
- Cleanings, limited to two per Claimant per Calendar Year. (However, in no Calendar Year will any Claimant be entitled to more than two exams whether cleaning or periodontal maintenance.) In addition, pregnant Claimants who are enrolled in the BabyWise case management program and Claimants with the diabetes, acid reflux, stomach ulcers, chronic kidney disease, kidney failure, high blood pressure, cancer, heart condition, progressive periodontal disease, gingivitis, suppressed immune system disorder will be entitled to two additional cleanings per Calendar Year.
- Sealants, limited to once per tooth for permanent bicuspid and the first and second molars of Claimants up to age 17 in a five-year period.
- Space maintainers for Claimants under 12 years of age.
- Topical fluoride application for Claimants under 18 years of age, limited to two treatments per Claimant per Calendar Year; for Claimants 18 years of age or older, limited to one per Claimant per Calendar Year.

BASIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	Payment: After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges.

The Plan covers the following basic dental services:

- Behavioral management analgesic, limited up to \$100 maximum per Claimant per Calendar Year.
- Complex oral surgery procedures, as follows:
 - surgical extractions of teeth (including impactions);
 - alveoloplasty;
 - vestibuloplasty and residual root removal;
 - excision of pericoronal gingival;
 - exostosis or hyperplastic tissue,
 - excision of oral tissue for biopsy;
 - re-implantation of a natural tooth;
 - excision of a tumor or cyst and incision; and
 - incision and drainage of an abscess or cyst.
- Emergency treatment for pain relief.
- Endodontic services consisting of:
 - apicoectomy;
 - debridement;
 - direct pulp capping;
 - pulpal therapy;
 - pulpotomy; and
 - root canal treatment.
- Endodontic benefits will **not** be provided for:
 - indirect pulp capping; and
 - pulp vitality tests.
- Fillings consisting of composite and amalgam restorations, silicate, acrylic synthetic porcelain and pin retention fillings. Composites are reduced to amalgam rates.
- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Claimant's health (for example, a child under seven years of age).
- Nitrous oxide, including the administration and supply.
- Periodontal services consisting of:
 - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Claimant per quadrant in a five-year period;
 - debridement;
 - gingivectomy and gingivoplasty limited to once per Claimant per quadrant in a three-year period;
 - periodontal maintenance limited to two per Claimant per Calendar Year. (However, in no Calendar Year will any Claimant be entitled to more than two exams whether periodontal maintenance or cleaning);
 - occlusal adjustments; and
 - scaling and root planing.
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount.	Payment: After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges.

The Plan covers the following major dental services:

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

ORTHODONTIC DENTAL SERVICES

Provider: All Dentists
Payment: The Plan pays 50% of billed charges and You pay balance of billed charges.
Limit: \$1,500 per Claimant Lifetime

The Plan covers the following orthodontic dental services for Claimants under 24 years of age:

- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending provider). The treatment plan should include all of the following information:
 - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
 - the estimated length of required treatment;

- the initial banding fee; and
 - the total orthodontic treatment charge.
- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.

General Exclusions

The following are the general exclusions from coverage under the Plan. Other exclusions may apply and, if so, will be described elsewhere in this Summary Plan Description. Benefits under the Plan will not be provided for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for 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.

Aesthetic Dental Procedures

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

Antimicrobial Agents

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

Collection of Cultures and Specimens

Sample collections, such as, but not limited to, saliva or tissue of the oral cavity.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Connector Bar or Stress Breaker

A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

Cosmetic/Reconstructive Services and Supplies

Except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Injury or Illness, the Plan does not cover cosmetic and/or reconstructive services and supplies.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

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

Desensitizing

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

Diagnostic Casts or Study Models

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

Duplicate X-Rays

Additional copy of original x-rays.

Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan.

Facility Charges

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

Fees, Taxes, Interest

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

Fractures of the Mandible (Jaw)

Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Government Programs

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

Home Visits

House call by Provider to patient's home.

Implants

Services and supplies provided in connection with implants, whether or not the implant itself is covered, including but not limited to:

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

Investigational Services

Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Medications and Supplies

Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Motor Vehicle Coverage and Other Available Insurance

Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Summary Plan Description.

Non-Direct Patient Care

Services that are not direct patient care, including charges for:

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

Non-Duplication of Medicare

When, by law, this coverage would not be primary to Medicare had You properly enrolled in Medicare when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare (for example, Part A, B, C or D), regardless of whether or not You choose to accept those benefits. In addition, if You are eligible for Medicare, You or Your provider will not be paid for any part of expenses incurred if Your provider has opted out of Medicare participation.

Occlusal Treatment

Services and supplies provided in connection with dental occlusion, including the following:

- occlusal guards.

Oral Hygiene Instructions

Instruction and education materials for home care, including tooth brushing technique, flossing and use of special oral hygiene aids.

Oral Surgery

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

Personal Comfort Items

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

Photographic Images

Photographic images obtained by intraoral and extraoral cameras.

Precision Attachments

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

Prosthesis

Services and supplies provided in connection with dental prosthesis, including the following:

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

Provisional Splinting

Interim or temporary stabilization of loose/mobile teeth.

Replacements

Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Riot, Rebellion and Illegal Acts

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

Self-Help, Self-Care, Training or Instructional Programs

Self-help, non-dental self-care, training programs. This exclusion does not apply to services for training or educating a Claimant, when provided without separate charge in connection with Covered Services.

Separate Charges

Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

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

Services and Supplies Provided by a Member of Your Family

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

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

Services Performed in a Laboratory

Services rendered in/by a laboratory.

Surgical Procedures

Services and supplies provided in connection with the following surgical procedures:

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

Temporomandibular Joint (TMJ) Dysfunction Treatment

Services and supplies provided in connection with temporomandibular joint (TMJ) dysfunction.

Third-Party Liability

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

Tooth Transplantation

Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Travel and Transportation Expenses

Travel and transportation expenses.

Veneers

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

Work-Related Conditions

Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under the Plan. The Plan does not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if You and Your Beneficiaries are exempt from state or federal workers' compensation law.

Claims Administration

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

PLAN IDENTIFICATION CARD

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

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

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling the Claims Administrator's Customer Service department at: 1 (866) 240-9580. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site at www.Regence.com on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

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

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

Calendar Year and Plan Year

The Deductible and Maximum Benefit provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, each Plan Year. A Plan Year is the 12-month period following either the Agreement's original effective date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year. When the Agreement is renewed on other than January 1 of any year, any Deductible You satisfied or amount accumulated toward a Maximum Benefit before the date the Agreement renews will be carried over into the next Plan Year. If the Deductible amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Agreement during that same Calendar Year.

Timely Filing of Claims

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

Participating Dentist Claims

You must present Your Plan identification card when obtaining Covered Services from a Participating Dentist. You must also furnish any additional information requested. The Participating Dentist will furnish the Claims Administrator with the forms and information needed to process Your claim.

Participating Dentist Reimbursement

A Participating Dentist will be paid directly for Covered Services. Participating Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. A Participating Dentist may require You to pay Your share at the time You receive care or treatment.

Nonparticipating Dentist Claims

In order for Covered Services to be paid, You or the Dentist must first send the Claims Administrator a claim. Be sure the claim is complete and includes the following information:

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

Nonparticipating Dentist Reimbursement

In most cases, the Nonparticipating Dentist will be paid directly for Covered Services they provide.

Nonparticipating Dentists have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Nonparticipating Dentist and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Nonparticipating Dentists, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples

Here is an example of how Your selection of a Participating Dentist or Nonparticipating Dentist affects payment to providers and Your cost sharing amount. For purposes of this example, let's assume that Participating Dentist services are subject to a 20 percent Coinsurance and Nonparticipating Dentist services are also subject to a 20 percent Coinsurance. Let's also assume that there is a deductible. Check the Dental Benefits section to see if a deductible applies to Your Plan. The benefit table from the Dental Benefits Section would appear as follows:

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount.	Payment: After Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges.

Now, let's assume that the Dentist's charge for a service is \$500 and the Allowed Amount for that Dentist's charge is \$400. Finally, let's assume that You have met the Deductible. Here's how that Covered Service would be paid:

- Participating Dentist: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
 - Amount Participating Dentist must "write-off" (that is, cannot charge You for): \$100
 - Amount the Plan pays (80% of the \$400 Allowed Amount): \$320
 - **Amount You pay** (20% of the \$400 Allowed Amount): **\$80**
 - Total: \$500
- Nonparticipating Dentist: the Plan would pay 80 percent of the Allowed Amount. Because the Nonparticipating Dentist does not accept the Allowed Amount, You would pay 20 percent of the

Allowed Amount, plus the difference between the Nonparticipating Dentist's billed charges and the Allowed Amount, as follows:

- Amount the Plan pays (80% of the \$400 Allowed Amount):	\$320
- Amount You pay (20% of the \$400 Allowed Amount and the \$100 difference between the billed charges and the Allowed Amount):	\$180
- Total:	\$500

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

Freedom of Choice of Dentist

Nothing contained in this Summary Plan Description is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

Claims Determinations

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

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

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

Claims Processing Report

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

NONASSIGNMENT

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

CLAIMS RECOVERY

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

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

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL 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 calling the Claims Administrator's Customer Service department or visiting their Web site **www.Regence.com**.

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

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

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a dental care provider. Since neither the Plan nor the Claims Administrator provides any dental care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving dental services or supplies provided by professionals who are neither employees nor agents of the Plan and the Claims Administrator.

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Advancement of Benefits

If You have a potential right of recovery for Illnesses or Injuries from a third-party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third-party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
 - the third-party or third-party's insurer admits liability;
 - the health care expenses are itemized or expressly excluded in the recovery; or
 - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.
- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
 - the filing of a lawsuit;
 - the making of a claim against any third-party;
 - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
 - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

If You are involved in a motor vehicle accident, You may have rights both under motor vehicle insurance coverage and against a third-party who may be responsible for the accident. In that case, this right of Reimbursement and Subrogation Recovery provision still applies.

Workers' Compensation

Here are some rules which apply in situations where a workers' compensation claim has been filed:

- You must notify the Claims Administrator in writing within five days of any of the following:
 - filing a claim;
 - having the claim accepted or rejected;
 - appealing any decision;
 - settling or otherwise resolving the claim; or
 - any other change in status of Your claim.
- 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.

Fees and Expenses

Neither the Plan nor the Claims Administrator is liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that a proportional share of attorney's fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the Plan. The Claims Administrator has discretion whether to grant such requests.

Future Related Expenses

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

COORDINATION OF BENEFITS

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

Benefits Subject to this Provision

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

Definitions

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

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

- An expense or portion of an expense not covered by any of Your involved plans.
- The difference between the cost of a private hospital room and the cost of a semiprivate hospital room, unless one of Your involved plans provides coverage for private hospital rooms.
- When this Plan restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.

- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a preferred provider (except, if the Primary Plan is a closed panel plan and does not pay because a nonpanel provider is used, the Secondary Plan (if it is not a closed panel plan) shall pay as if it were the Primary Plan).
- A Primary Plan's deductible, if the Primary Plan is a high-deductible health plan as defined in the Internal Revenue Code and the Claims Administrator is notified both that all plans covering a person are high-deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging You.

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

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

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

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

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

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

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

Other Plan does not include:

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

Primary Plan means the plan that must determine its benefits for Your health care before the benefits of an Other Plan and without taking the existence of that Other Plan into consideration. (This is also referred

to as that plan being "primary" to that Other Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

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

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

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

Order of Benefit Determination

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

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

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

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

If a court decree awards joint custody of You without specifying that one of Your parents is responsible for Your health care expenses or health care coverage, a plan that covers You as the child of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the child of Your parent whose Birthday occurs later in the Year. If both parents have the same Birthday, the plan of the parent who has been covered by his or her plan longer shall be primary to the plan of the other parent. If the Other Plan does not contain this child rule, the Other Plan's dependent rule will govern.

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

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

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

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

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

If this Plan is the Secondary Health Plan according to the order of benefit determination and any Other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

Appeal Process

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

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: Appeals, Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator at 1 (866) 240-9580.

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

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

Appeals

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

CIVIL ACTION

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

LEGAL ACTION

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

EXPEDITED APPEALS

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

- the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or
- according to a physician with knowledge of Your medical or dental condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

First-Level Expedited Appeal

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

Further Appeals

If You have exhausted all possible levels of Appeal described here, You may contact Your Plan Administrator for possible continuation of the appeals process.

INFORMATION

If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at: 1 (866) 240-9580 or You can write to the Claims Administrator's Customer Service department at the following address: Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

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

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

Representative means someone who represents You for the purpose of the Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purpose of the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is an unmarried and dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical or dental condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You or Your treating Provider only.

Who Is Eligible, How to Enroll and When Coverage Begins

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

To enroll and remain eligible under the Plan, You must meet all of the following requirements in effect with the Plan Sponsor on a continuous basis:

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

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

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

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

Employees

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

Dependents

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

- The person to whom You are legally married (spouse).
- Your child who is under age 26, who is not offered health insurance through their employer and who meets any of the following criteria:
 - Your natural child, step child, adopted child or child legally placed with You for adoption;
 - a child for whom You have court-appointed legal guardianship; and
 - a child for whom You are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
 - he or she is a Beneficiary immediately before his or her 26th birthday; or
 - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site at www.Regence.com, or by calling their Customer Service department at: 1 (866) 240-9580.

NEWLY ELIGIBLE DEPENDENTS

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

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

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

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

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.

When Coverage Ends

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

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

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

AGREEMENT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the earliest occurrence of the following dates:

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

NONPAYMENT

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

FAMILY AND MEDICAL LEAVE

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

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:

- in order to care for Your newly born child;
- in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
- the placement of a child with You for adoption or foster care; or
- You suffer a serious physical or Mental Health Condition.

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

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

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

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Plan Sponsor must keep the Claims Administrator advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

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

COVERAGE DURING ABSENCE FROM WORK DUE TO TOTAL DISABILITY

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

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

If You Die

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

Loss of Dependent Status

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

- the date on which termination of the Plan occurs:
 - if Your employment is terminated on the 1st – 7th day of the month, dependent coverage under such Participant will terminate at midnight, on the 15th day of the month, in which termination occurs;
 - if Your employment is terminated on the 8th – 22nd day of the month, dependent coverage under such Participant will terminate at midnight, on the last day of the month, in which termination occurs; and
 - if Your employment is terminated on the 23rd through the last day of the month, dependent coverage under such Participant will terminate at midnight, on the 15th day, of the following of the month;
- the date the dependent enters the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
- the last day of the month in which the dependent fails to meet the Plan's definition of an eligible dependent;
- the first day of the month for which there is failure to make any required contributions; or
- the last day of the month in which the Participant becomes ineligible.

OTHER CAUSES OF TERMINATION

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

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

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

CERTIFICATES OF CREDITABLE COVERAGE

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

COBRA Continuation of Coverage

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

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

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

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

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

General Rules

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

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

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

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

If You or Your Beneficiaries do not elect COBRA continuation coverage, coverage under the Plan will end according to the terms described in the Summary Plan Description and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice

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

General Provisions

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

CHOICE OF FORUM

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

GOVERNING LAW AND DISCRETIONARY LANGUAGE

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

PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Oregon. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Summary Plan Description. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER

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

NOTICES

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

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 Regence to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and in Clark County in the state of Washington and that Regence is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor or the Claimants for any of Regence's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

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

WHEN BENEFITS ARE AVAILABLE

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

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

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

Definitions

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

Affiliate means a company with which the Claims Administrator has a relationship that allows access to providers in the state in which the Affiliate serves and includes 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:

- With respect to Participating Dentists, the amount Participating Dentists have contractually agreed to accept as full payment for Covered Services.
- With respect to Nonparticipating Dentists, Reasonable Charges for Covered Services as determined by the Claims Administrator.

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

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

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

Claimant means a Participant or a Beneficiary.

Covered Service means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other provider, who has personally evaluated the patient, and determined by the Claims Administrator (or their designee) to be all of the following:

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

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE UNDER THE PLAN.

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

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

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

Family means a Participant and his or her Beneficiaries.

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

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

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

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of illness or any other cause.

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

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, injury or illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is 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.

Nonparticipating Dentist means a Dentist who does not have an effective participating contract with the Claims Administrator to provide services and supplies to Claimants.

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

Participating Dentist means a Dentist who has an effective participating contract with the Claims Administrator to provide services and supplies to Claimants in accordance with the provisions of the Plan.

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.

Regence refers to Regence BlueCross BlueShield of Oregon.

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

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

Summary Plan Description

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

PLAN NAME

BRIGHT WOOD CORPORATION HEALTH AND WELLNESS PLAN

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR

Bright Wood Corporation
P.O. Drawer 828
Madras, OR 97741
(541) 475-2234

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS

93-0720678

PLAN NUMBER

501

TYPE OF PLAN

Welfare Benefit Plan: dental benefits.

TYPE OF ADMINISTRATION

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

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS

Bright Wood Corporation
Attn: Director of Personnel
P.O. Drawer 828
Madras, OR 97741
(541) 475-2234

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

SOURCES OF CONTRIBUTIONS TO THE PLAN

Contributions for plan expenses are obtained from Plan Sponsor and Participants.

FUNDING MEDIUM

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

All funds and earnings received by the Plan Sponsor will be applied toward payment of Plan benefits and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan documents. The Plan Sponsor may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

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

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

PLAN FISCAL YEAR ENDS ON

April 30

PLAN TERMINATION PROVISIONS

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

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

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

NOTICE OF ERISA RIGHTS

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

Receive Information About Your Plan And Benefits

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

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

Continue Employer Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

Procedures For Filing Claims

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

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

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

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**For more information contact the Claims Administrator at
1 (866) 240-9580 or 100 SW Market Street, Portland, OR 97201**

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