NORTHWEST FOREST PRODUCTS ASSOCIATION

AND

WOODWORKERS DISTRICT LODGE 1

IAM, AFL-CIO

HEALTH AND WELFARE PLAN AND TRUST

OTHERWISE KNOWN AS

The Nelson Trust

Active Employee Plan

January 1, 2009

The Nelson Trust

www.nelsonbenefits.org

Administered by BeneSys
PMB #116
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IMPORTANT NOTICE

THE TRUSTEES ESTABLISHED THIS PLAN BY UTILIZING MONEY NEGOTIATED THROUGH COLLECTIVE BARGAINING. THE BENEFITS DESCRIBED IN THE DOCUMENT, WHILE INTENDED TO REMAIN IN EFFECT INDEFINITELY, CANNOT BE GUARANTEED FOR ANY DEFINITE PERIOD OF TIME. THE PLAN WILL CONTINUE FOR PRESENT AND FUTURE ACTIVE PLAN PARTICIPANTS FOR THE PERIOD OF TIME THAT THE PARTIES AGREE TO CONTINUE TO REQUIRE CONTRIBUTIONS INTO THE PLAN SUFFICIENT TO UNDERWRITE THE COST OF BENEFITS. THE PLAN WILL TERMINATE IF CONTRIBUTIONS SHOULD CEASE AND THE RESERVES ARE EXPENDED. THE BENEFITS ARE DETERMINED BY THE TRUSTEES. THE BENEFITS ARE NOT GUARANTEED LIFETIME BENEFITS.

THE TRUSTEES RESERVE THE RIGHT TO MAKE ANY CHANGES IN THE PLAN THAT THEY DEEM NECESSARY INCLUDING BENEFIT AND ELIGIBILITY CHANGES, TERMINATION OF ALL, OR A PORTION OF, THE COVERAGES OR TO REQUIRE OR CHANGE MONTHLY EMPLOYEE CONTRIBUTIONS.

This document is the Summary Plan Description for all benefits. The document is also the Plan Document for vision, ODS dental, medical-surgical-hospital, prescription drug and accident and sickness benefits, which are all self-funded. Any services or supplies not specifically authorized by the Plan are not covered benefits. Life insurance and Willamette Dental benefits are insured benefits. The terms and provisions of the group insurance contracts control if there is a question of whether or not a benefit is covered. All benefits are subject to future amendments adopted by the Board of Trustees increasing or decreasing benefits.

NO PARTICPATING EMPLOYER, EMPLOYER ASSOCIATION OR LABOR ORGANIZATION, NOR ANY INDIVIDUAL EMPLOYED THEREBY, HAS AUTHORITY TO ANSWER QUESTIONS CONCERNING THE TRUST FUND AND THE PLAN.

PLEASE REFER INQUIRIES TO THE OFFICE OF THE TRUST ADMINISTRATOR AND INSERT THE EMPLOYEE'S IDENTIFICATION NUMBER ON ALL CORRESPONDENCE.

TO: PARTICIPATING EMPLOYEES

This document describes in general terms the comprehensive health and welfare plan developed by the Board of Trustees and financed through collective bargaining between your Union and your Employer.

Employer contributions will ordinarily pay all of the premium for employees and dependents.

It is the continuing objective of your Board of Trustees that this Plan be maintained on a basis that will provide effective protection for you and your dependents.

We urge that you read this document carefully so you will be thoroughly familiar with your benefits. Any questions you may have should be directed to the Trust Administrator's office.

EMPLOYER TRUSTEES	UNION TRUSTEES
Cliff Slade	Steve Wilson
Hank Snow	Leon Blocker
Tony Ventresco	Mick Burnell
Brooks Burton	Mike Heuer
Jack McGuill (alternate)	Eric Dobson
Michelle Payne (alternate)	Chuck Macrae (term ended February 1, 2009)
	Steve Fluke (term began February 1, 2009)

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Eligibility Rules for Employees and Dependents

This section of your document describes who is eligible for coverage. The Nelson Trust has the discretionary authority to determine your eligibility for benefits.

Initial Eligibility – Full Trust Benefits

You and your eligible dependents will be covered for full Trust-paid benefits on the first day of the second calendar month following two consecutive months in which you are credited with 100 or more compensable hours per month. For example, if you are credited with 100 or more hours per month in the months of February and March, you and your dependents will be covered for full benefits for the month of May.

Immediate Life Insurance Benefit – Employee Only

Newly hired employees are provided with the $20,000 life insurance death benefit paid for by the Trust, which becomes effective immediately upon active full-time employment. Although benefits are payable in the event of death from any cause, benefits under this section apply only to life insurance coverage and do not include accidental death and dismemberment benefits.

Should your active employment terminate before you become eligible for all Trust paid benefits, this death benefit will terminate as of 12:01 a.m. of the day following the date of your termination of active employment. (If you are laid off or on leave of absence, you are not considered to be actively employed.)

During this initial period before you are eligible for full Trust benefits, there is no extension of the $20,000 death benefit beyond the day you terminate active employment and there is no conversion privilege. However, if you become totally disabled during this initial period, while actually employed, the $20,000 death benefit will remain in effect during continuance of disability for a maximum period of 90 days from the date you last worked.

Should you return to active full-time employment following a period in which you did not initially qualify for full Trust benefits or if you are a former eligible employee who, because of termination of employment, is required to satisfy the requirements of a new employee, you will again be eligible for this immediate $20,000 death benefit.

Eligibility of Employees of New Participating Employers

When an employer becomes a participating employer under this Plan and by reason of such participation an existing employee insurance coverage plan is, has been, or will be terminated, each employee of the employer eligible to participate in the Plan may secure available coverage for the employee or for the employee and dependents under this Plan from and after the effective date of the employer's participation by making self-payments as provided under Item 3 on page 8 of these Employee Eligibility Rules. You and your eligible dependents will be initially eligible for full Trust-paid benefits on the first day of the second calendar month following the month in which you were credited with 100 or more compensable hours if you were employed by your employer in the month your employer became a participating employer.

Dependent Eligibility

Your spouse will be eligible for dependent benefits while eligible as an employee, subject to maintenance of benefit rules; however, your children will not be eligible for dependent coverage if eligible as an employee.

Qualified Dependents are:

- Your wife or husband and you must be recognized as being married in the state in which you live; and
- Unmarried dependent children from birth and less than 19 years of age. The Plan will continue to cover the child up to age 25 if the child is enrolled full time in an accredited institution of higher learning. Coverage will cease at the end of the month in which the 25th birthday occurs.
- The Plan will also cover unmarried dependent children up to any age provided they are mentally or physically incapacitated and incapable of self-support continuously since their 19th birthday.
- The term "children" includes your natural children, step-children; adopted children, children placed for adoption, other children dependent upon you for support or children who are alternate recipients under a Qualified Medical Child Support Order.

Enrollment Procedure

Enrollment forms and address change forms may be obtained from your employer or Local Lodge office.

Prepare and forward to the Trust Administrator’s office a complete enrollment form listing all qualified dependents, their birthdates and Social Security numbers.

File a new enrollment form immediately to record any changes in your beneficiary designation, or to add or delete dependents.

If you acquire a dependent after your coverage has become effective, your new dependent must be enrolled within 31 days.

Upon retirement a new enrollment form should be completed to update dependent and beneficiary information.

Continuance of Coverage

After you and your dependents become covered, your full Trust benefits will be continued when you meet one of the following requirements:

1. Credit for 100 or more compensable hours in a month provides coverage for the second following month.

   Example:

If you are credited with 100 or more hours in the month of:	You and your dependents are covered for the month of:
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February
January	March
February	April
March	May

2. If you are credited with less than 100 hours in a month, but you are credited with at least one hour during that month and your total credited hours that month plus the immediately preceding two months total at least 300 hours, then coverage will be provided for the second following calendar month.

   Example:

If you had a total of 300 hours in these 3 months with at least one hour in the month of: ↓			You and your dependents are covered for the month of:
February	March	**April**	June
March	April	**May**	July
April	May	**June**	August
May	June	**July**	September
June	July	**August**	October
July	August	**September**	November
August	September	**October**	December
September	October	**November**	January
October	November	**December**	February
November	December	**January**	March
December	January	**February**	April
January	February	**March**	May

Loss of Coverage

Unless coverage is otherwise extended under the provisions of this Plan, you and your dependents will lose eligibility for coverage on the first day of the SECOND calendar month following the month in which you fail to have credited:

1. 100 or more compensable hours with one or more participating employers
2. At least one hour in that month and an accumulation of at least 300 hours during that month and the immediately preceding two months, as shown above
3. **Certificate of Creditable Coverage**

   If your coverage under this Plan ends and you become eligible for a new health plan, the length of time you were covered under this Plan may be used to reduce the length of any preexisting condition exclusion period in your new plan.

   When your coverage ends, either as an active employee (or dependent) or under COBRA, you will receive a certificate of creditable coverage. This certificate provides information your new plan may need. You have the right to request from your employer or Trust Administrator a misplaced certificate.

   You should check with your new plan's administrator to verify whether the new plan limits coverage for preexisting conditions and how creditable coverage is applied under that plan. If your new plan has a preexisting condition limitation, you should present your certificate to your new plan so your new plan's administrator will know to apply your creditable coverage under this Plan to the preexisting limitation period under your new plan.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75 mile radius, the law requires your employer to continue contributions for your (and your dependents') coverage under the active plan for up to 12 weeks during a 12-month period you are on leave due to:

- Your care for a newborn child or the placement for adoption or foster care of a child;
- Your care for a child, spouse or parent because of a serious health condition;
- Your inability to perform the functions of your position because of your own serious health condition. If you are disabled while hourly eligible, you will be entitled to disability coverage;
- Your spouse child or parent is on active duty (or has been notified of an impending call or order to active duty) in support of a qualifying exigency as determined by regulations issued by the Secretary of Labor; or
- Your care for your spouse, child, parent or next of kin who is a covered service member of qualified exigency. This leave is for 26 work weeks during a 12 month period.

Contact your employer as soon as you think you are eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other obligations under FMLA.

When your coverage under FMLA ends, you and your dependents will be able to elect COBRA self-pay coverage.

Coverage During Disability

1. **Disability**

   If you become disabled while eligible by hours worked, your coverage and your dependent's coverage will be continued based on hours reported on your behalf prior to the onset of your disability. Upon return to active employment, the Plan will provide Trust-paid coverage for you and your dependents during the month in which you return to work and the following two months, provided your employer-employee relationship has not been severed.

2. **Self-Payment Disability Extension**

   If your disability extends beyond the period described in 1. above, your coverage and your dependents' coverage may be continued up to a maximum of 18 consecutive calendar months, provided you pay the appropriate subsidized self-pay amount.

   If you become eligible to receive disability benefits under Social Security and provide the Trust Administrator’s office with a copy of your award, your subsidized self-pay rights may be continued beyond the 18 consecutive months during such disability until you qualify for Parts A and B (the voluntary portion) of Medicare. Under present Social Security regulations, a disabled employee will become eligible for Part A and Part B of Medicare when disability benefits have been received for not less than 24 months in a row.

   Once you become eligible for Medicare and qualify for a disability pension benefit under a Woodworker's District Lodge 1, IAM, AFL-CIO negotiated Pension Plan, then please refer to Eligibility Rules for Retirees and Dependents in the retiree document in order to continue coverage under the Retiree Plan.

   However, if you become eligible for Medicare and DO NOT qualify for a disability pension benefit under Woodworkers District Lodge 1, IAM, AFL-CIO negotiated Pension Plan, then you have the option to convert to an individual policy to supplement Medicare benefits.

American Recovery and Reinvestment Act of 2009 (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) became law on February 17, 2009. ARRA includes provisions that change the way The Nelson Trust administers COBRA.

The major change is a 65 percent COBRA subsidy for up to nine months for individuals who were involuntarily terminated from employment between September 1, 2008 and December 31, 2009, and who were covered by The Nelson Trust. If you become eligible for COBRA for reasons other than involuntary termination, such as divorce, or for gross misconduct, you are not eligible for the subsidy.

If you paid the full COBRA premium when you were eligible for the subsidy, the Plan may either reimburse the amount of the subsidy or apply the premiums as a credit toward later months. Note that the subsidy does not extend your normal maximum COBRA coverage period of 18 months for employment termination. The subsidy ends if you become eligible for other group medical coverage or Medicare. Be sure to notify the Trust Administrator’s office immediately when this happens, since you will be subject to a penalty equal to 110 percent of any subsidy that is provided when you are not eligible.

If you would otherwise qualify for the COBRA subsidy but you did not have COBRA, for whatever reason, on February 17, 2009, you will be offered a second election period of 60 days beginning after a new election notice is sent to you. If you then elect COBRA, you become eligible for the subsidy and your coverage will date back to March 1, 2009, not to your original loss of coverage date.

The subsidy is taxable income for federal income tax purposes for a tax year for those who receive the subsidy and have a modified adjusted gross income of more than $125,000, if single, or $250,000, if married filing jointly, for each tax year in which the subsidy is received.

Self-Payment Privileges and Procedures (Including COBRA)

1. Self-Payment Procedures

When you lose active employee coverage because of a reduction of hours, layoff, leave of absence, disability, termination or retirement, you will be provided the option to continue health coverage for yourself and/or your dependents under the Active Employee Plan or the Retiree Plan if you pay the applicable cost of the coverage. If you are retired, then please refer to the retiree document for more details.

A dependent who becomes ineligible under this Plan because of the death of the Plan Participant, divorce or a child losing dependent status, may also be eligible to continue coverage by self-payment. If you elect not to continue coverage by self-payment, your qualified dependent(s) may be eligible to continue coverage by self-payment. The dependent must apply for and pay the applicable cost of the coverage.

Continuation coverage includes COBRA. When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require The Nelson Trust to offer qualified Plan Participants an election to continue their group coverage for a limited time. Under COBRA, a qualified Plan Participant must apply for COBRA coverage within a certain time period.

The Plan will provide qualified Plan Participants with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this Plan.

Under the self-payment coverage you have the right to choose one of the following options:

Active Employee Plan

Option #1:

First 6 months

Employee Life, Accidental Death & Dismemberment, Dependent Life, Medical, Dental and Vision

7th through 18th month

Medical, Dental and Vision

There is no Life Insurance

Option #2:

First 6 months

Employee Life, Accidental Death & Dismemberment, Dependent Life, and Medical

7th through 18th month

Medical

There is no Life Insurance

Retiree Plan: Unlimited

Medical and Prescription (Includes Life Insurance) or Prescription only if covered under a Medicare Advantage Plan (Includes Life Insurance)

Under the Active Employee Plan a higher level of coverage cannot be chosen once a lower level has been selected. For example, if you initially select Option #2, you cannot select Option #1 at a later date during that period of self-payment.

If you choose self-pay coverage under the Active Employee Plan the coverage will be the same as outlined in this document.

If the Trust changes its health coverage for regular Plan Participants, self-payment coverage will be changed in the same way.

Procedure for Continuing Coverage

Your Employer has the responsibility to notify the Trust Administrator if any of the following happens to you:

- Reduction of hours
- Layoff
- Leave of absence
- Termination
- Retirement
- Date of disability
- Date of return to work

You or a family member has the responsibility to inform the Trust Administrator in writing of a death, divorce or a child losing dependent status within 60 days of the event. If you do not provide notice to the Trust Administrator within this time frame, you may lose eligibility for continuation coverage.

Within 14 days of the Trust Administrator being notified that one of these events has occurred, the Trust Administrator will notify you that you have the right to choose to maintain self-payment coverage. You will have 60 days to complete and return the application to continue coverage. The first self-payment will not be due until 45 days after you have made the election and must include payment for all past months. Thereafter, self-payments will be due on the first day of each month for that month's coverage. You have a 30-day grace period to mail or deliver your self-payment; if it is not received by the 30th day of the month, then further self-payments will not be accepted.

You are urged to complete the form the Trust Administrator's office sends to you and return your check with the form to the Trust Administrator's office as soon as possible so that timely eligibility can be provided. Upon receipt of your application and first self-payment, the Trust Administrator's office will forward a monthly notice to your home address as indicated on the enrollment form on file with the Trust Administrator's office. **IT IS THE RESPONSIBILITY OF THE INDIVIDUAL TO REMIT THE SELF-PAYMENT IN A TIMELY MANNER. THE MONTHLY NOTICE IS PROVIDED BY THE TRUST ADMINISTRATOR'S OFFICE ONLY AS A CONVENIENCE TO THE INDIVIDUAL**.

If your address changes, be sure to report it to the Trust Administrator's office. You can obtain an address change form online at **www.nelson.aibpa.com** or from your employer or local Lodge office.

To maintain eligibility under the self-pay program, there must be no gap between regular Trust coverage and self-pay coverage. Payments must be made in a timely manner and must be continuous for each individual. Once self-pay coverage lapses for a person for any reason it cannot be reinstated for that person prior to reinstatement of self-pay rights. Further, if coverage for your qualified dependents is not continued, then you cannot reinstate their coverage during this period of self-payment.

Please Note: Always include your identification number on all checks or money orders. This will assist the Trust Administrator's office in processing your payment in a timely manner.

The schedule of self-payment rates is on file at the employer and local Lodge offices. The self-payment rates are also set forth on the initial notice you receive from the Trust Administrator's office and the applicable rate for your category of coverage will be set forth on your self-payment billing form after you have made your election.

2. Self-Payment – Short Hours, Layoff, Leave of Absence or Plant Closure

If you and your qualified dependents are not entitled to Trust-paid coverage because of short hours, layoff, leave of absence or plant closure, you may continue to cover yourself and at your option your qualified dependents by making the appropriate self-payment for a maximum of 18 consecutive months as follows:

1st – 6th month – subsidized self-payment
7th – 18th month – full self-payment

If you return to active employment and have not been terminated, then you and your qualified dependents will be entitled to Trust-paid coverage under this Plan for the month of return and the following month. This Trust-paid coverage reinstates the self-pay privilege as outlined in this section.

If you return to active employment after a prior termination, you will be required to requalify as a new employee.

3. Subsidized Self-Payment – Employees of New Participating Employers

If you are an employee of a new employer participating under this Plan and because of the participation your existing employee insurance coverage is, has been, or will be terminated, you may obtain medical only coverage under this Plan for yourself and your qualified dependents from and after the effective date of your employer's participation by making subsidized self-payments for a maximum of six consecutive months.

4. Full Self-Payment – Labor Dispute

If you lose eligibility as a result of a labor dispute, you may continue to cover yourself and at your option your qualified dependents by making full self-payment for a maximum of 18 consecutive months.

If you return to active employment with a participating employer, you and your dependent will be entitled to Trust-paid coverage under this Plan for the month of return and the following month.

5. Full Self-Payment – Termination of Employment

If you lose eligibility as a result of termination of employment, you may continue to cover yourself and at your option your qualified dependents by making full self-payment for a maximum of 18 consecutive months.

Reinstatement after Loss of Coverage

1. **Layoff, Approved Leave of Absence, Labor Dispute or Plant Closure**

   If you lose coverage because of layoff, approved leave of absence, labor dispute, or plant closure, upon return to active employment with a participating employer you will be entitled to Trust-paid employee and family coverage for the month of return and the following month.

2. **Disability**

   If you lose coverage during a period of disability due to the non-remittance of self-payment, then you and your qualified dependents will be entitled to Trust-paid coverage under this Plan during the month in which you return to work and the following two months.

3. **Military Service**

   The Plan will provide Trust-paid coverage for you and your qualified dependents during the month in which you return to work and the following two months after you return to your prior participating employer from service in the armed forces of the United States within 90 days of your release from your initial enlistment for ACTIVE DUTY. At that time, if you have not established hourly eligibility, you may make self-payments.

   Please see below for continuation coverage while you are in the military service.

   Contact your employer for information on continuation rights and requirements if you are called for military service. You may also contact the U.S. Department of Labor at 866-4-USA-DOL or visit its Web site at **www.dol.gov/vets**. An online guide to USERRA can be viewed at **www.dol.gov/elaws/userra.htm**.

4. **Termination of Employment**

   If you lose coverage as a result of termination of employment and later are re-employed by a participating employer you will be required to requalify as a new employee.

California Employees

If you are employed by a participating employer located in California and are under the California Unemployment Compensation Disability Act (UCD), you and your qualified dependents will be entitled to receive all benefits of this Plan, less any benefits paid to you on your behalf by reason of the California Unemployment Compensation Disability Act.

Coverage for Salaried Employees

Coverage is available for salaried employees of a participating employer or a local Lodge provided that all salaried employees within the same classification are reported on a non-selective basis.

Salaried employees and their qualified dependents will be covered for full Trust-paid benefits on the first day of the second calendar month following the month for which the participating employer remits the flat rate contribution on behalf of the salaried employee. This flat rate contribution amount is determined by the Board of Trustees.

All salaried employees and their qualified dependents are eligible for the same benefits, self-payment rights and retiree coverages as that of the hourly employee.

Coverage for Hourly Employees of Contractor/Subcontractor Employers

Coverage is available for hourly employees of a participating contractor/subcontractor employer on the basis that the flat rate contributions will be made if the employee works 100 or more hours during the month. This flat rate contribution amount is determined by the Board of Trustees.

These hourly employees and their eligible dependents will be covered for full Trust-paid benefits on the first day of the second calendar month following the month in which the 100 hours were worked. If the employee does not work 100 hours, then the employer will not be permitted to contribute on that employee's behalf and no coverage will be given unless a self-payment is made.

All employees of a participating contractor/subcontractor and their qualified dependents are eligible for the same benefits and self-payment rights as that of the hourly employee.

Coverage for Employees of Participating Employer not in Lumber or Forest Products Industry

Coverage is available for employees of a participating employer not in the lumber or forest products industry on the basis that the flat rate contribution will be made if the employee has one or more compensable hours in a month. The flat rate contribution amount is determined by the Board of Trustees.

These employees and their eligible dependents will be covered for full Trust-paid benefits on the first day of the second calendar month following the month in which the hours were worked. If the employee does not work at least one hour then the employer will not be permitted to contribute on that employee's behalf and no coverage will be given unless a self-payment is made.

All employees of a participating employer not in the lumber or forest products industry and their qualified dependents are eligible for the same benefits and self-payment rights as that of the hourly employee.

Benefits for Widows/Widowers, Divorced Spouses and Dependent Children of Employees

Your spouse and qualified dependent children have the right to continue self-pay coverage under this Plan if coverage is lost for any of the following reasons:

- Your death
- Reduction in hours, layoff, leave of absence, disability, termination or retirement
- Divorce
- A qualified dependent child no longer meets the Plan's definition of a qualified dependent

The employee or family member has the responsibility to inform the Trust Administrator of a death, divorce or a child losing dependent status within 60 days of the event.

Benefits under this section are limited to Medical, Dental, and Vision.

1. Spouses

Dissolution of Marriage

If your marriage is dissolved while you and your spouse are covered, your former spouse may continue coverage by making full self-payments. Full self-payment coverage for your children may also be continued if they would lose coverage under this Plan because of the divorce.

If the divorce occurs during a period of self-payment and the maximum period of self-payment on account of the employee's divorce is 36 months, the 36-month period will be reduced by the number of months of self-payments already made. The maximum period of self-payment is determined as follows:

Spouse

Self-payments may be made for a maximum of 36 months.

Children

The maximum period for eligible children is 36 months if your former spouse does not continue coverage. The maximum period for eligible children is also 36 months if your former spouse continues coverage for less than 36 months.

Please Note: Always include your former spouse's identification number on all checks or money orders. This will assist the Trust Administrator's office in processing the payment in a timely manner.

2. Death of Employee

If you die while you are covered, your spouse and qualified dependent children may continue coverage by making the appropriate self-payment for a maximum of 36 consecutive months. The Plan provides four months of Trust-paid coverage for your surviving spouse and qualified dependent children following expiration of hourly eligibility earned by the employee. This Trust-paid coverage includes Medical, Dental and Vision benefits. After expiration of the four months of Trust-paid coverage, your spouse and qualified dependent children can continue coverage for an additional 32 months by making the appropriate self-payment as follows:

1st – 4th month – Trust-paid coverage
5th – 16th month – Subsidized self-payment
17th – 36th month – Full self-payment

If you and your family are covered by self-payment and you die during the first six months of self-payment, the four months of Trust-paid coverage will provide those benefits for which self-payment is being made; i.e. if the family was self-paying for Medical only, the four months Trust-paid coverage would only provide Medical benefits (excluding Dental and Vision.) Moreover, the 32-month period will be reduced by the number of months of full family self-payments already paid to the Plan.

If you die after the sixth month of family self-payment, the four months of Trust-paid coverage will not be provided and your family will be entitled to self-pay for the number of months remaining under the 36-month provision.

If at the time of your death you are under 55 years of age:

If your spouse is under 55 years of age, then your spouse has the right to continue coverage by self-payment for a maximum of 36 consecutive months. This self-payment privilege will terminate prior to the end of the 36-month provision if your spouse does not make timely

self-payment, remarries and is eligible for other group coverage, or becomes covered under any other group plan.

If your spouse is 55 years of age or over, then your spouse will be allowed to continue coverage by self-payment until one of the following events takes place:

A. The self-payment is not made within 31 days of the due date

B. Your spouse becomes covered under any other group plan

C. Your spouse remarries

D. Your spouse becomes eligible for Medicare

or

E. The Trust no longer provides group health coverage to any employees

If at the time of your death you are age 55 years or older:

If at the time of your death you are age 55 years or older and you are eligible for retirement under a Woodworkers District Lodge 1, IAM, AFL-CIO negotiated pension plan, then your surviving spouse may continue coverage as the surviving spouse for 16 months (four months of Trust-paid coverage and 12 months of subsidized self-pay). Your surviving spouse may then continue coverage as the surviving spouse of a retiree as outlined in the retiree benefit document. There is no age restriction on your surviving spouse. Your surviving spouse's right to self-pay terminates if your surviving spouse remarries and is eligible for other group coverage.

If at the time of your death you are age 55 years or older and not eligible for retirement under a Woodworkers District Lodge 1, IAM, AFL-CIO negotiated pension plan, your surviving spouse is governed by the general death provisions on page 11.

3. Dependent Children

If your qualified dependent children are covered under the Active Employee Plan, they can continue those benefits for 36 months by making the appropriate payment if coverage is lost for any of the following reasons:

A. Your death

B. Divorce of you and your spouse

C. The dependent child no longer meets the Plan's definition of a qualified dependent

Please Note: The qualified dependent's identification number should be included on the self-payment check or money order. This will assist the Trust Administrator's office in processing the payment in a timely manner.

Addition of New Dependents

Individuals on self-payment coverage under the Active Employee Plan may add their own dependents acquired on or after the date self-payment coverage begins by enrolling dependents within 31 days of acquisition; however, after acquired dependents do not qualify for their own self-payment coverage at a later date.

Coverage for Active Employees Age 65 or Over or a Spouse Age 65 or Over of an Active Employee

You are covered first by the Plan and second by Medicare. Plan coverage is the same as for all

active employees and dependents and the Plan will pay to the extent of its benefits and Medicare will pay second subject to its provisions. You should contact a Social Security office for a description of Medicare coverage.

You should contact your local Social Security office at least 45 days prior to attaining age 65 for details regarding enrollment in Medicare. It is IMPORTANT that this be done in order that you may enroll in Medicare when you first become eligible. If you delay enrolling, Medicare coverage may not begin immediately.

Coverage for Active Employees or their Dependents who are Disabled and Eligible for Medicare

You are covered first by the Plan and second by Medicare. Plan coverage is the same as for all active employees and dependents and the Plan will pay to the extent of its benefits and Medicare will pay second subject to its provisions.

Termination of Coverage

See COBRA below.

Retiree Benefits

Please refer to the retiree document if you wish to continue coverage under the retiree program of this Plan. The retiree document states the necessary rules and regulations that must be met in order to continue coverage under the retiree program.

When you retire you have the choice of either electing COBRA or the Retiree Plan. If you or one of your qualified dependents elects COBRA, then you or your dependent will not be permitted to switch, at a later date, to the Retiree Plan except in two cases. First, if you are on COBRA because of lack of hours and you ultimately retire while you are on COBRA, you will have the option of (a) continuing on COBRA for the maximum number of months or (b) going immediately into the Retiree Plan. You cannot switch to the Retiree Plan if you continue on COBRA for the maximum number of months. Second, if you obtain a Social Security Disability Award while you are on COBRA, you may remain on COBRA and switch to the Retiree Plan after you obtain Medicare coverage whether or not you receive a pension while on COBRA and before you obtain Medicare coverage.

Changes in Coverage

No rights are vested under this Plan. The Nelson Trust may change its terms, benefits and limitations at any time. Changes to this Plan will apply as of the date the change becomes effective to all Plan Participants and to eligible employees and dependents who become covered under this Plan after the date the change becomes effective.

The exception is inpatient confinements described in "Extended Benefits"; please see the "How Do I Continue Coverage?" section. Changes to this Plan won't apply to inpatient stays that are covered under that provision.

Certificate of Health Coverage

When your coverage under this Plan terminates, you'll receive a "Certificate of Health Coverage." The certificate will provide information about your coverage period under this Plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward any waiting period for preexisting conditions. You'll need a certificate each time you leave a health plan and enroll in a plan that has a waiting period for preexisting conditions.

Therefore, it's important for you to keep the certificate in a safe place.

If you haven't received a certificate, or have misplaced it, you have the right to request one from the Trust Administrator or your former employer within 24 months of the date coverage terminated.

When you receive your Certificate of Health Coverage, make sure the information is correct. Contact the Trust Administrator or your former employer if any of the information listed isn't accurate.

Documents that may establish creditable coverage in the absence of a certificate include explanations of benefit claims or correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

Plan Termination

No rights are vested under this Plan. The Nelson Trust is not required to keep the Plan in force for any length of time. The Nelson Trust reserves the right to change or terminate this Plan, in whole or in part, at any time with no liability. Plan changes are made as described in "Plan Changes" in this document. If the Plan were to be terminated, you would only have a right to benefits for covered care you receive before the Plan's end date.

COBRA and USERRA Continuation Coverage

What is continuation coverage?

Federal law requires that this Plan give you and your dependents covered by the Plan the opportunity to continue health care coverage when you go into the uniformed service or there is a "qualifying event" that would result in a loss of coverage under this Plan. Depending on the type of qualifying event, "qualified beneficiaries" includes the employee-participant covered under the Plan, the covered participant's spouse, and the dependent children of the covered participant.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

How long will continuation coverage last?

USERRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because you will be serving in the uniformed service for more than 31 days. Uniformed service includes the armed forces, the National Guard when engaged in training or full time duty, the Public Health Service, and any other category of individuals designated by the President in time of war or national emergency. When you go into the uniformed service, you are required to give notice to your employer of this fact. However, you are excused from giving this notice if military necessity or circumstances make giving the notice impossible or unreasonable. Your employer will then notify the Plan of your eligibility for USERRA continuation coverage. You will be eligible for USERRA continuation coverage at the end of the later of either (a) coverage earned by employment or (b) any special military leave plan provided by your employer.

Once you are eligible for USERRA continuation coverage, you may either (a) elect continuation coverage for you and/or your spouse and your dependents or (b) not elect continuation coverage. If you do not elect continuation coverage, your spouse and/or dependents may elect COBRA continuation coverage. If you elect continuation coverage you must pay for the coverage but you do not have to choose between USERRA and COBRA continuation coverage. Your coverage will terminate if any required premium is not paid in full and on time. The rules for election, payment and termination are the same for both USERRA and COBRA. For The Nelson Trust, the period of coverage for USERRA is the greater of the period of time, under the facts, of either law. You are eligible for immediate reinstatement of Plan coverage when you return to employment and you have complied with all of the USERRA rules. Reinstatement occurs whether or not you elected and maintained continuation coverage while you were in the uniformed service.

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for a maximum of 18 months. Generally, coverage may be continued for a maximum of 36 months in the case of losses of coverage due to a participant's death, divorce, the participant's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan. When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries, other than the employee, lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full and on time
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage

Continuation coverage may also be terminated for any reason that the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage such as fraud.

The Plan has a special rule for a surviving spouse if the spouse is age 55 or older and is covered by the Plan at the time of the death. This spouse, whose coverage would otherwise terminate under the Plan because of the employee-participant's death, is entitled to coverage until the earliest of the:

- Failure to pay the premium
- Date the spouse is covered under another group health plan
- Date the spouse remarries and is covered under another plan
- Date the spouse becomes eligible for federal Medicare

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify, in writing, the Trust Administrator, A & I Benefit Plan Administrators, Inc., 1220 S.W. Morrison Street, Suite 300, Portland, Oregon 97205-2222, of a disability or a second qualifying

event in order to extend the period of continuation coverage. Failure to provide written notice of a disability or a second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. Each qualified beneficiary, who has elected continuation coverage, will be entitled to the 11-month disability extension if one of them qualifies for Social Security disability. The disability must have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The written notice must be given within 60 days after the latest of (a) the Social Security determination of disability; (b) the date of the qualifying event; (c) the date on which the qualifying beneficiary loses coverage or would lose coverage; or (d) the date the qualified beneficiary is informed of the obligation to give the notice of disability. You or your qualified beneficiaries are eligible for this extension of COBRA coverage if you or any of your qualified beneficiaries becomes disabled. In addition, the disability may precede the qualifying event.

However, if there is a final determination of **nondisability**, the qualified beneficiary must notify the Trust Administrator within 30 days of the determination. Moreover, if the qualified beneficiary is determined by SSA to be **no longer disabled**, you must notify the Trust Administrator of that fact within 30 days after SSA's determination. The extended continuation will end the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled.

Second Qualifying Event

An 18-month extension of coverage is available to a spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is a total of 36 months. The second qualifying events may include the death of a covered employee, divorce, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Trust Administrator in writing within 60 days after a second qualifying event occurs if you elect to extend your continuation coverage.

How can you elect COBRA or USERRA continuation coverage?

Once the Trust Administrator receives notice that you are eligible for USERRA continuation coverage, you will be offered the right to elect USERRA continuation coverage only for yourself or for yourself and dependents. If you do not elect coverage for your spouse and/or dependents, they have the right to elect COBRA continuation coverage.

To elect continuation coverage under either COBRA or USERRA, you must complete an election form according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee-participant's spouse may elect continuation coverage even if the participant does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The participant or the

participant's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose preexisting condition exclusions if you do not have continuation coverage for the maximum time available to you. Third, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you have continuation coverage for the maximum time available to you.

How much does COBRA or USERRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay is on the COBRA/USERRA notice. The monthly cost may change once a calendar year as permitted by law. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA or USERRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed, or the date you hand deliver the notice.) You will lose all continuation coverage rights under the Plan if you do not make your first payment for continuation coverage in full within 45 days after the date of your election. You are responsible for making sure to determine that the amount of your first payment is correct. You may contact the Trust Administrator's office, A & I Benefit Plan Administrators, Inc., 1220 S.W. Morrison Street, Suite 300, Portland, Oregon 97205-2222, 503-222-7696 to confirm the correct amount of your first payment.

Subsequent payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make subsequent payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is provided to you when coverage ends. The subsequent payments can be made on a monthly basis. Under the Plan, each of these subsequent payments for continuation coverage is due on the first day of each month for that coverage period. If you make a subsequent payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Trust Administrator will send subsequent notices of payments due for these coverage periods.

Grace periods for subsequent payments

Subsequent payments are due on the first day of each month for coverage for that month. You will be given a grace period of 30 days after the first day of the coverage period to make each subsequent payment. For example, your COBRA or USERRA payment is due February 1 for coverage as of February 1. The grace period ends 30 days from February 1. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is received before the end of the grace period for that payment.

You will lose all rights to continuation coverage under the Plan if you fail to make a subsequent payment before the end of the grace period for that coverage period.

Your first payment and all subsequent payments need to be payable to The Nelson Trust and should be sent to the Trust Administrator's office at:

A & I Benefit Plan Administrators, Inc.
1220 S.W. Morrison Street, Suite 300
Portland, Oregon 97205-2222

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in the "COBRA and USERRA Continuation Coverage" section of this document or from the Trust Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your Plan, you should contact the Trust Administrator, A & I Benefit Plan Administrators, Inc., 1220 S.W. Morrison Street, Suite 300, Portland, Oregon 97205-2222, 503-222-7696.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, which is listed below, or visit the EBSA Web site at **www.dol.gov/ebsa**.

Seattle District Office
1111 Third Avenue, Suite 860
Seattle, WA 98101-3212
Telephone 206-553-4244
Fax 206-553-0913

Keep Your Plan Informed of Address Changes

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

Adding Family Members

A child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's

initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage.

Extended Benefits

Under the following circumstances, certain benefits of this Plan may be extended after your coverage ends for reasons other than rescission.

Extended Inpatient Benefits

The inpatient benefits of this Plan will continue to be available after coverage ends if:

- Your coverage didn't end because of fraud or an intentional misrepresentation of material fact under the terms of the coverage
- You were admitted to a medical facility prior to the date coverage ended
- You remained continuously confined in a medical facility because of the same medical condition for which you were admitted

Please Note: Newborns are eligible for Extended Inpatient Benefits only if they are enrolled beyond the 31-day period specified in the Newborn Care benefit.

Such continued inpatient coverage will end when the first of the following occurs:

- You're covered under a health plan or contract that provides benefits for your confinement or would provide benefits for your confinement if coverage under this Plan did not exist.
- You're discharged from that facility or from any other facility to which you were transferred.
- Inpatient care is no longer medically necessary.
- The maximum benefit for inpatient care in the medical facility has been provided. If the calendar year ends before a calendar year maximum has been reached, the balance is still available for covered inpatient care you receive in the next year. Once it's used up, however, a calendar year maximum benefit will not be renewed.
- This Plan's lifetime maximum has been provided.

Continuation under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing health plan coverage for you and your dependents. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in the health plan when you are re-employed, generally without any waiting periods or exclusions (e.g., preexisting condition exclusions) except for service-connected illnesses or injuries.

Your USERRA and COBRA rights are similar in The Nelson Trust. See COBRA Continuation.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 866-4-USA-DOL or visit its Web site at **www.dol.gov/vets**. An online guide to USERRA can be viewed at **www.dol.gov/elaws/userra.htm**.

Converting to a Non-Group Plan

You may be entitled to coverage under one of Premera Blue Cross's Conversion plans when your coverage under this Plan ends. Conversion plans are individual plans insured by Premera

Blue Cross, and they differ from this Plan. You pay the monthly payment. You must apply and send the first subscription charge payment to Premera Blue Cross within 31 days of the date your coverage ends under this Plan.

You can apply for a Conversion plan if you live in Washington State and you're not eligible for Medicare coverage, and one of two things is true:

- You're not entitled to services or benefits for medical and hospital care under another group plan.
- You're entitled to other coverage, but that coverage contains exclusions or waiting periods for any preexisting conditions you have.

For more information about Premera Blue Cross Conversion plans, contact the Premera Blue Cross Customer Service department.

Please Note: The rates, coverage and eligibility requirements of the Premera Blue Cross Conversion plans differ from those of your current group plan. In addition, enrollment in a Conversion plan may limit your ability to later purchase an individual plan without a preexisting condition waiting period.

Medicare Advantage Plans

If you're enrolled in Parts A and B of Medicare, you may be eligible for guaranteed-issue coverage under certain Medicare Advantage Plans. You must apply within 63 days of losing coverage under this Plan.

Medical

Introduction

This Plan is self-funded by The Nelson Trust, which means that The Nelson Trust is financially responsible for the payment of plan benefits. The Nelson Trust has the final discretionary authority to determine eligibility for benefits and construe the terms of the Plan.

The Nelson Trust has contracted with Premera Blue Cross, an Independent Licensee of the Blue Cross and Blue Shield Association, to perform administrative duties under the Plan, including the processing of claims. The Nelson Trust has delegated to Premera Blue Cross the discretionary authority to determine eligibility for benefits and to construe the terms used in the Plan to the extent needed to perform its duties. Premera Blue Cross doesn't insure this Plan. In the Medical section of this document, Premera Blue Cross is called the "Claims Administrator." This document replaces any other benefit document you may have.

How to Use this Document

This document will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **How Does Selecting a Provider Affect My Benefits?** – how using network providers will cut your costs
- **What Types of Expenses Am I Responsible for Paying?**
- **What Are My Benefits?** – what's covered and what you need to pay for covered services
- **What's Not Covered?** – services that are either limited or not covered under this Plan
- **Eligibility Rules for Employees and Dependents** – eligibility requirements for this Plan
- **How Do I File a Claim?** – step-by-step instructions for claims submissions
- **What if I Have a Question or an Appeal?** – processes to follow if you want to file a complaint or an appeal
- **Definitions** – terms that have specific meanings under this Plan. Example: In the Medical section of this document, "you" and "your" refer to Plan Participants under this Plan. "We," "us" and "our" refer to Premera Blue Cross.

For More Information

You'll find our contact information on the back cover of this document. Please call or write Customer Service for help with:

- Questions about benefits or claims
- Questions or complaints about care you receive
- Changes of address or other personal information

You can also get benefit, eligibility and claim information through our Interactive Voice Response system when you call.

Online information about your plan is at your fingertips whenever you need it

You can use our Web site to:

- Locate a health care provider near you
- Get details about the types of expenses you're responsible for and this Plan's benefit maximums
- Check the status of your claims

Medical

- Visit our health information resource to learn about diseases, medications, and more

Group Name:	The Nelson Trust
Effective Date:	January 1, 2009
Group Number:	1035171
Plan:	Your Choice
Certificate Form Number:	TNT2008

Medical

Summary of Benefits

MEDICAL PLAN	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	$300 $600	Shared with in-network deductible
Coinsurance (plan pays this percentage of costs after deductible based on allowable charges)	80%	70%
Calendar Year Stop Loss Limit Individual Family	$5,000 in allowable charges $10,000 in allowable charges	$5,000 in allowable charges $10,000 in allowable charges
Calendar Year Out-of-Pocket Maximum Individual Family	$1,300 $2,600	$1,800 $3,600
Lifetime Benefit Maximum	$2,000,000	
Preventive Care and Health Education		
Preventive Office Visit (up to $300 per calendar year; does not include annual women's exam or immunizations)	100%; deductible waived	70% after deductible
Immunizations	100%; deductible waived	100%; deductible waived
Annual Women's Exam	100%; deductible waived	70% after deductible
Diabetes Health Education	100%; deductible waived	100%; deductible waived
Professional Care		
Professional Office Visit (including urgent care)	80%	70%
Preventive Diagnostic Imaging and Laboratory Services – Including PAP/PSA	100%; deductible waived	70%
Outpatient Diagnostic Imaging and Laboratory	80%	70%
Outpatient Mammography (diagnostic)	100%; deductible waived	70%
Inpatient Professional Services	80%	70%
Contraceptive Management	80%	70%
Facility Care		
Inpatient Facility	80%	70%
Skilled Nursing Facility (up to 14 days; additional benefits may be extended if approved by the Trust)	80%	70%
Outpatient Surgery Facility	80%	70%
Emergency Care		
Emergency Care (copay waived if admitted or accidental injury)	$150 copay, then 80%	$150 copay, then 80%
Ambulance Transportation	80%	80%
Air Ambulance	80%	80%

Medical

MEDICAL PLAN	In-Network	Out-of-Network
Other Services		
Transplants		
Facility Services	100%; deductible waived	70%
Professional Services	80%	70%
Chemical Dependency ($14,000 per 24 months)	80%	70%
Mental Health Inpatient Facility Care (7 days per calendar year)	80%	70%
Mental Health Outpatient Professional Care (15 visits per calendar year)	80%	70%
Hospice (12 days inpatient, 240 hours respite, up to 6 months)	100%; deductible waived	70%
Home Health Care (130 visits per calendar year)	100%; deductible waived	70%
Medical Supplies, Equipment, Prosthetics and Orthotics	80%	70%
Chiropractic and Other Manipulations	100% up to $16 per day	100% up to $16 per day
Rehabilitation Inpatient Facility (massage therapy and massage therapist not covered)	80%	70%
Rehabilitation Outpatient Care Including Physical, Occupational & Speech Therapy; Cardiac & Pulmonary Rehabilitation; and Chronic Pain (massage therapy and massage therapist not covered)	80%	70%

Please Note: Balance billing may apply if a provider is not contracted with Premera Blue Cross. Plan participants are responsible for amounts in excess of the allowable charge.

How Does Selecting a Provider Affect My Benefits?

To help you manage the cost of health care, The Nelson Trust has made use of our provider networks and our provider network arrangements with Blue Cross and/or Blue Shield Licensees throughout the country to furnish covered services to you through their provider networks. These networks consist of hospitals and other health care facilities, physicians and professionals. Throughout this section of your document, you will find important information on how to manage your health care costs and out-of-pocket expenses through your choice of providers.

This Plan's benefits are designed to provide lower out-of-pocket expenses when you receive care from network providers. (There are some exceptions explained in "In-Network Benefits for Non-Network Providers" later in this section.) The provider networks are different depending upon the state in which you receive care.

Throughout the Medical section of this document, the term "network" refers to the following provider networks:

State	Provider Type
Washington	The Premera Blue Cross Heritage network. In Clark County, Washington, you also have access to providers through the BlueCard® Program. See "All Other States" later in this list.
Alaska	Providers who have contracts with Premera Blue Cross Blue Shield of Alaska.
Wyoming	The local Blue Cross and/or Blue Shield Licensee's Traditional (Participating) network.
All Other States	The local Blue Cross and/or Blue Shield Licensee's PPO (preferred) network.

Throughout the Medical section of this document, "non-network provider" refers to a provider who is not in the applicable network shown above.

This document refers to the benefits payable to network providers as "in-network" benefits and the benefits payable to non-network providers as "non-network" benefits.

Important Note: You access network providers in Clark County, Washington and in states other than Washington and Alaska through the BlueCard Program. See "The BlueCard Program" later in this document for more information about how BlueCard works.

You're entitled to receive a provider directory automatically, without charge.

For the most current information on network providers in Washington or Alaska, please refer to our Web site or contact Customer Service. You can call the BlueCard provider line to locate a network provider. You'll find our Web address and these phone numbers listed on the back cover of this document.

How Selecting a Provider Affects your Out-of-Pocket Expenses

You'll always get the highest level of benefits and lowest out-of-pocket costs when you get covered services from a network provider. If the provider you choose is a network provider (as defined above), the provider agrees to accept the allowable charge as payment in full. (Please see "Definitions" in the Medical section of this document for an explanation of the allowable charge.) You're responsible only for applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

If the provider you choose is a non-network provider, you'll get the lowest level of benefits under this Plan for covered services and supplies, except as stated below. You'll also be responsible for amounts above the allowable charge, in addition to applicable copays, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered

services and supplies. Amounts in excess of the allowable charge do not count toward the calendar year deductible, if any, or as coinsurance.

In-Network Benefits for Non-Network Providers

The following covered services and supplies provided by non-network providers will always be covered at the in-network level of benefits.

- Emergency care. If you have a "medical emergency" (please see "Definitions" in the Medical section of this document) this Plan provides worldwide coverage.
- Services from certain categories of providers (such as Alcohol Treatment Facilities, blood banks and ambulance companies located in Washington State) to which provider contracts are not offered. These types of providers are not listed in the provider directory.
- Services associated with admission by a network provider to a network hospital that are provided by hospital-based providers.
- Facility and hospital-based provider services received in Washington or Alaska from a hospital that has a provider contract with Premera Blue Cross, if you were admitted to that hospital by a network provider who doesn't have admitting privileges at a Washington or Alaska network hospital.
- Covered services received from providers located outside the United States, Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

Please Note: Although benefits to non-network providers in these circumstances are paid at the in-network rate, benefits are only paid up to the allowable charge. Any balance above the allowable charge may be billed as the patient's responsibility.

Please see the "Benefit Level Exceptions for Non-Emergent Care" section for more information on how to request in-network benefits for services other than those listed above from non-network providers.

Benefit Level Exceptions for Non-Emergent Care

A "benefit level exception" is the Plan's decision to provide in-network benefits for covered services from a non-network provider.

You, your provider, or the medical facility may ask us for the benefit level exception. However, the request may be made before you get the service or supply. If the request is approved, benefits for covered services and supplies will be provided at the in-network benefit level. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You'll be responsible for amounts applied toward applicable deductibles, copays, coinsurance, amounts that exceed benefit maximums, amounts above the allowable charge, and charges for non-covered services. If the request is denied, in-network benefits won't be provided.

Please call Customer Service at the phone numbers shown on the back cover of this document to request a benefit level exception.

What Types of Expenses Am I Responsible for Paying?

This section of your document explains the types of expenses you must pay for covered services before the benefits of this Plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for. You'll find the dollar amounts for these expenses and when they apply in the "What Are My Benefits?" section.

Medical

Copayments

Copayments (hereafter referred to as "copays") are fixed up-front dollar amounts that you're required to pay for certain covered services. Your provider of care may ask that you pay the copay at the time of service.

The copays applicable to the "Medical Services" portion of this Plan are located under the "What are My Copays?" provision in the "What are My Benefits?" section later in this booklet. Any benefits that are subject to different copays will state those amounts in the benefit.

After your copay, other than Emergency Room services, benefits subject to a copay aren't subject to your deductible, coinsurance, or out-of-pocket maximum.

Please refer to the Emergency Room Services benefit under the "What Are My Benefits?" section for more details.

Calendar Year Deductible

A calendar year deductible is the amount of expense you must incur in each calendar year for covered services and supplies before this Plan provides certain benefits. The amount credited toward the calendar year deductible for any covered service or supply won't exceed the "allowable charge" (please see "Definitions" in the Medical section of this document).

Individual Deductible

An "Individual Deductible" is the amount each Plan Participant must incur and satisfy before certain benefits of this Plan are provided.

Family Deductible

We also keep track of the expenses applied to the individual deductible that are incurred by all enrolled family members combined. When the total equals a set maximum, called the "Family Deductible," we will consider the individual deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible.

The calendar year deductible amounts applicable to the "Medical Services" portion of this Plan are located under the "What Are My Benefits?" section.

What doesn't apply to the calendar year deductible?

Amounts that don't accrue toward this Plan's calendar year deductible are:

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays

Coinsurance

"Coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. It's the percentage you're responsible for, not including copays and the calendar year deductible, when the Plan provides benefits at less than 100% of the allowable charge.

The coinsurance percentage applicable to the "Medical Services" portion of this Plan is located under "What's My Coinsurance?" in the "What Are My Benefits?" section. Any benefits that are subject to a different coinsurance percentage will state that percentage in the benefit.

Out-of-Pocket Maximum

The "individual out-of-pocket maximum" is the maximum amount, made up of the calendar year deductible and coinsurance that each individual could pay each calendar year for certain covered services and supplies. This Plan has separate out-of-pocket maximum limits for network providers and non-network providers.

Once the family deductible is met, your individual deductible will be satisfied. However, you must still pay coinsurance until your individual out-of-pocket maximum is reached.

We keep track of the total deductible and coinsurance amounts applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals a set maximum, called the "Family Out-of-Pocket Maximum," we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. Only the amounts used to satisfy each enrolled family member's individual out-of-pocket maximum will count toward the family out-of-pocket maximum. This Plan has separate family out-of-pocket maximum limits for network providers and non-network providers.

Please refer to "What's My Out-of-Pocket Maximum?" in the "What Are My Benefits?" section for the amount of any out-of-pocket maximums you're responsible for.

Once the network provider out-of-pocket maximum has been satisfied, benefits subject to that maximum will be provided at 100% of allowable charges for covered services of network providers for the remainder of that calendar year.

Once the out-of-pocket maximum for non-network providers has been satisfied, benefits subject to that maximum will be provided at 100% of allowable charges for covered services of non-network providers for the remainder of that calendar year; balances above allowable charges may be billed as the patient's responsibility, and are in addition to the stated out-of-pocket maximum.

What Are My Benefits?

This section of your document describes the specific benefits available for covered services and supplies. Benefits are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or injury.
- It must be, in our judgment, medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must not be excluded from coverage under this Plan.
- The expense for it must be incurred while you're covered under this Plan and after any applicable waiting period required under this Plan is satisfied.
- It must be furnished by a "provider" (please see "Definitions" in the Medical section of this document) who's performing services within the scope of his or her license or certification.

Benefits for some types of services and supplies may be limited or excluded under this Plan. Please refer to the actual benefit provisions throughout this section and the "What's Not Covered?" section for a complete description of covered services and supplies, limitations and exclusions.

Medical

What Are My Copays?

Emergency Room Copay

For each emergency room visit, you pay $150. Emergency room visits are also subject to any applicable calendar year deductible and coinsurance. The emergency room copay will be waived if related to an accidental injury or you're admitted directly to the hospital from the emergency room.

What's My Calendar Year Deductible?

Individual Calendar Year Deductible

For each Plan Participant, this amount is $300.

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowable charges that apply to your individual calendar year deductible toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to your individual calendar year deductible toward that maximum.

Please Note: The calendar year deductible accrues toward the out-of-pocket maximum.

Family Deductible

The maximum calendar year deductible for your family is $600.

What's My Coinsurance?

When you choose network providers, your coinsurance is 20% of allowable charges.

When you choose non-network providers, your coinsurance is 30% of allowable charges.

However, there are a few exceptions to the above coinsurance percentages. Please see the benefits listed below for details:

- The Ambulance Services benefit
- The Emergency Room Services benefit
- The Transplants benefit
- The Diabetes Health Education benefit
- The Diagnostic Services benefit
- The Diagnostic and Screening Mammography benefit
- The Preventive Medical Care benefit

What's My Out-of-Pocket Maximum?

Individual Maximum

For care from network providers, your out-of-pocket maximum amount is $1,300 each calendar year.

For care from non-network providers, your out-of-pocket maximum is $1,800 (plus any charges above allowable charges) each calendar year.

However, services that always apply in-network benefits, like Ambulance Services or Emergency Room Services, apply toward the in-network out-of-pocket maximum limit.

Medical

Family Maximum

For each family, this amount is $2,600 per calendar year, for care from network providers.

For care from non-network providers, this amount is $3,600 (plus any charges above allowable charges) for each family per calendar year.

Does My Plan Have a Lifetime Maximum?

The lifetime maximum amount of benefits for services described in this document that are available to any one Plan Participant is $2,000,000.

Annual Restoration – Each January 1 of your continuous coverage, we will restore up to $25,000 of your lifetime maximum that has been paid by the Plan and not previously restored. This restoration occurs regardless of the state of your health.

It's important to note that certain benefits of this Plan are also subject to separate lifetime benefit maximums.

Medical Services

Ambulance Services

Benefits for the following services are subject to your calendar year deductible and coinsurance.

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the Plan Participant who requires transportation.

Ambulatory Surgical Center Services

The following services are subject to your calendar year deductible and applicable coinsurance.

Benefits are provided for services and supplies furnished by an ambulatory surgical center.

Blood Products and Services

Benefits are provided for blood and blood derivatives, subject to your calendar year deductible and coinsurance.

Chemical Dependency Treatment

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Facility Services

Benefits for the following services are subject to your calendar year deductible and applicable coinsurance.

Medical

Outpatient Professional Visits

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Benefits are provided for inpatient and outpatient chemical dependency treatment and supporting services provided to a Plan Participant up to a maximum benefit of $14,000 per Plan Participant, in any 24-consecutive-month period. This period begins on the first day of covered treatment. Covered services must be furnished by a state-approved treatment program.

The current edition of the **Patient Placement Criteria for the Treatment of Substance Related Disorders** as published by the American Society of Addiction Medicine is used to determine whether services for chemical dependency treatment are medically necessary.

Please Note: Benefits for medically necessary detoxification services are provided under the Emergency Room Services and Hospital Inpatient Care benefits and don't accrue toward the chemical dependency treatment benefit maximum above.

This benefit doesn't cover:

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, except as deemed medically necessary by us
- Family and marital counseling, and family and marital psychotherapy, as distinguished from counseling, except when medically necessary to treat the diagnosed substance use disorder or disorders of a Plan Participant

Chiropractic and Other Manipulations

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition when received from any covered provider.

Benefits are provided for medically necessary spinal and other manipulations to treat a covered illness, injury or condition.

Benefits for spinal and other manipulations are provided up to $16 for each date of service.

For outpatient diagnostic services, please see the "Diagnostic Service" benefit.

Non-manipulation services are covered as any other medical service.

Available benefits for covered physical therapy services are provided under the Rehabilitation Therapy and Chronic Pain Care and Neurodevelopmental Therapy benefits.

Contraceptive Management and Sterilization Services

Contraceptive Management and Sterilization Procedures

Consultations

These services are subject to your calendar year deductible and applicable coinsurance.

Sterilization Procedures

Outpatient Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Medical

Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Injectable, Implantable and Emergency Contraceptives

The services shown below are subject to your calendar year deductible and applicable coinsurance:

- Injectable contraceptives
- Implantable contraceptives (including hormonal implants)
- Emergency contraception methods (oral or injectable) when furnished by your health care provider

This benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs
- Contraceptive drugs, supplies or devices dispensed by a licensed pharmacy

Dental Services

This benefit will only be provided for the dental services listed below.

Care for Injuries

Professional Visits

Professional visits are subject to your calendar year deductible and applicable coinsurance to examine the damage done by a dental injury and recommend treatment.

Dental Treatment

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

When services are related to an injury, benefits are provided for the preparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when they're:

- Necessary as a result of an injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
  - Extensive restoration, veneers, crowns or splints
  - Periodontal disease or other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets the Plan's extension criteria. We must receive extension requests within 12 months of the injury date.

When Your Condition Requires Hospital or Ambulatory Surgical Center Care

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Ambulatory Surgical Center Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Anesthesiologist Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

General anesthesia and related facility services for dental procedures are covered when medically necessary for one of 2 reasons:

- The Plan Participant is under the age of 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office
- The Plan Participant has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center

Please Note: This benefit will not cover the dentist's services unless the services are to treat a dental injury and meet the requirements described above.

Diabetes Health Education

The benefits of this Plan provide for outpatient health education and training services to manage the condition of diabetes. These services aren't subject to your calendar year deductible, coinsurance or a calendar year benefit limit.

Diagnostic Services

Benefits for preventive diagnostic services aren't subject to your calendar year deductible and coinsurance when you use a network provider. Preventive diagnostic services are laboratory and imaging services done for preventive or screening purposes. (A list of these services is available on our Web site or by contacting us.)

When you use a network provider, benefits for all other diagnostic services are subject to your calendar year deductible and coinsurance.

If you see a non-network provider, benefits for all diagnostic services are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this document.

The Diagnostic Services benefit covers diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Screening tests for prostate, colorectal and cervical cancer

Medical

- Diagnostic imaging and scans (such as x-rays and EKGs)
- Laboratory services, including routine and preventive
- Pathology tests

Please Note:

- Diagnostic surgeries, including scope insertion procedures, such as endoscopies or colonoscopies, can only be covered under the Surgical Services benefit.
- Allergy testing is covered only under the Professional Visits and Services benefit.
- When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.
- When outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

For mammography services, please see the Diagnostic and Screening Mammography benefit.

Diagnostic and Screening Mammography

Benefits for these services aren't subject to your calendar year deductible or coinsurance when furnished by a network provider.

Please Note: If you see a non-network provider, benefits for diagnostic and screening mammography are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this document.

The Diagnostic and Screening Mammography benefit covers diagnostic and screening mammography recommended by your physician, advanced registered nurse practitioner or physician's assistant.

Emergency Room Services

You pay a $150 copay per visit to the emergency room. Benefits for these services are also subject to your calendar year deductible and coinsurance.

Please Note: The emergency room copay will be waived if related to an accidental injury or you're admitted directly to the hospital from the emergency room.

This benefit is provided for emergency room services, including related services and supplies, such as surgical dressings and drugs, furnished by and used while in the emergency room. Also covered under this benefit are medically necessary detoxification services; these services don't accrue toward the Chemical Dependency Treatment benefit maximum. This benefit covers outpatient diagnostic services when they are billed by the emergency room and are received in combination with other hospital or emergency room services.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

Home and Hospice Care

To be covered, home health and hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.). In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without home health or hospice services.

Medical

Benefits are provided, up to the maximums shown below, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work. Also included in this benefit are medical equipment and supplies provided as part of home health care. (Such equipment and supplies are not subject to the benefit maximums stated in the Medical Equipment and Supplies benefit.)

Home Health Care

Benefits for the following services aren't subject to your calendar year deductible and coinsurance when services are provided by network providers.

Please Note: If you see a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this document.

This benefit provides up to 130 intermittent home visits per Plan Participant each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy, phototherapy and private duty nursing when received in conjunction with home health care services, are also covered under this benefit. Home health care provided as an alternative to inpatient hospitalization is not subject to this limit.

Hospice Care

Benefits for a terminally ill Plan Participant shall not exceed 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the Plan Participant is facing imminent death or is entering remission. The initial 6-month period starts on the first day of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under Home Health Care. You pay the same share of the allowable charge for in-home hospice care as you do for home health care.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill Plan Participant.
- **Inpatient hospice care** up to a maximum of 12 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.

  Inpatient hospice care is not subject to your calendar year deductible and coinsurance when you use a network facility.

Please Note: If services and supplies are furnished by a non-network medical facility, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this document.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Prescription drugs and insulin are subject to your calendar year deductible and coinsurance when provided by a network provider.

Please Note: If prescription drugs and insulin are furnished and billed by a non-network provider, benefits are subject to your calendar year deductible and coinsurance. For an explanation of the amount you'll pay for services and supplies from non-network providers, please see the "What Are My Benefits?" section of this document.

Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

This benefit doesn't cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured Plan Participant
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

Hospital Inpatient Care

The following services are subject to your calendar year deductible and applicable coinsurance.

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets.
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards.
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen.
- Facility charges for diagnostic and therapeutic services. Facility charges include any services received by a hospital-employed provider and billed by the hospital.
- Blood, blood derivatives and their administration.
- Medically necessary detoxification services. These services don't accrue toward the Chemical Dependency Treatment benefit maximum.

For inpatient hospital chemical dependency treatment, except as stated above for medically necessary detoxification services, please see the Chemical Dependency Treatment benefit.

For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

For benefit information on professional diagnostic services done while at the hospital, see the Diagnostic Services benefit.

Medical

This benefit doesn't cover:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is, in our judgment, medically necessary to treat your condition

Hospital Outpatient Care

Outpatient Surgery Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Other Outpatient Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. This benefit covers outpatient diagnostic services only when they are billed by the hospital and received in combination with other outpatient hospital services.

Infusion Therapy

Benefits for the following services are subject to your calendar year deductible and applicable coinsurance.

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Plan participants who are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for Plan Participants with gastrointestinal dysfunction

This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements.

Mastectomy and Breast Reconstruction Services

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Inpatient Professional and Surgical Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Medical

Outpatient Surgical Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Professional Visits

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Other Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any Plan Participant electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses (not subject to the benefit maximum stated in the Medical Equipment and Supplies benefit)
- Physical complications of all stages of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending physician and the patient.

Medical Equipment and Supplies

Benefits for the following services are subject to your calendar year deductible and applicable coinsurance.

Covered medical equipment, prosthetics and supplies include:

Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. The Plan may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the Plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Benefits for medical and respiratory equipment are not subject to a benefit maximum.

Medical Supplies, Orthotics (Other than Foot Orthotics), and Orthopedic Appliances

Covered services include, but aren’t limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

Benefits for medical supplies, orthotics (other than foot orthotics), and orthopedic appliances are not subject to a benefit maximum.

Medical

Please Note: This benefit does not include medical equipment or supplies provided as part of home health care. See the Home and Hospice Care benefit for coverage information.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) as stated below, are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

Please Note: This benefit does not include prosthetics prescribed or purchased as part of a mastectomy or breast reconstruction. Please see the Mastectomy and Breast Reconstruction Services benefit for coverage information.

Benefits for prosthetics are not subject to a benefit maximum.

Foot Orthotics and Therapeutic Shoes

Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses.

This benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use.
- Special or extra-cost convenience features.
- Items such as exercise equipment and weights.
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices.
- Over bed tables, elevators, vision aids, and telephone alert systems.
- Structural modifications to your home or personal vehicle.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities.
- Penile prostheses.
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications.

Mental Health Care

Benefits for mental health services, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided as stated below. Benefits are subject to the same calendar year deductible, coinsurance or copays as you would pay for inpatient services and outpatient visits for other covered medical conditions.

Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice as determined by us.

Medical

Covered services must be furnished by one of the following types of providers:

- Hospital
- State-licensed community mental health agency
- Licensed Physician (M.D. or D.O.)
- Licensed Psychologist (Ph.D.)
- Any other provider listed under the definition of "provider" (please see "Definitions" in the Medical section of this document) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license

Covered services may also be furnished by a state hospital operated and maintained by the state of Washington for the care of the mentally ill.

Benefits are provided up to the following maximums:

Inpatient Care

Up to seven days per Plan Participant each calendar year for facility and professional care. As an alternative to inpatient care, this Plan covers “psychiatric partial days.” Two psychiatric partial days will count as one inpatient day.

Outpatient Therapeutic Visits

Up to 15 office or home therapeutic visits per Plan Participant each calendar year. Also covered under this benefit are biofeedback services for generalized anxiety disorder when provided by a qualified provider.

“Outpatient therapeutic visit” (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the *Physician’s Current Procedural Terminology*, published by the American Medical Association.

Residential Care

Up to seven days per Plan Participant each calendar year for facility and professional care.

For psychological and neuropsychological testing and evaluation benefit information, please see the Psychological and Neuropsychological Testing benefit.

For chemical dependency treatment benefit information, please see the Chemical Dependency Treatment benefit.

This benefit doesn’t cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a Plan Participant

Neurodevelopmental Therapy

Benefits are provided for the treatment of neurodevelopmental disabilities for Plan Participants under the age of seven. The following inpatient and outpatient neurodevelopmental therapy services must be medically necessary to restore and improve function, or to maintain function

where, in our judgment, significant physical deterioration would occur without the therapy. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

Inpatient Care

Benefits for inpatient facility and professional care are not subject to a benefit limit. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Care

Benefits for outpatient care are subject to all of the following provisions:

- The Plan Participant must not be confined in a hospital or other medical facility
- Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, physical, occupational or speech therapist, chiropractor, or naturopath

When the above criteria are met, benefits will be provided for physical, speech and occupational services.

Outpatient Facility Care

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

A "visit" is a session of treatment for each type of therapy.

The Plan won't provide this benefit and the Rehabilitation Therapy and Chronic Pain Care benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

This benefit doesn't cover:

- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired Plan Participant
- Gym or swim therapy
- Custodial care

Newborn Care

Newborn children of a Plan Participant are covered automatically for the first 31 days from birth.

To continue benefits beyond the 31-day period, please see the dependent eligibility and enrollment guidelines outlined in the "Eligibility Rules for Employees and Dependents" section.

For newborn enrollment information, please see the "Eligibility Rules for Employees and Dependents" section.

Plan benefits and provisions will apply, subject to the child's own applicable copay, calendar year deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital Care

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

The Newborn Care benefit covers hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Professional Care

Benefits for services received in a provider's office are subject to the terms of the Professional Visit benefit. Well-baby exams in the provider's office are covered under the Preventive Medical Care benefit. This benefit covers:

- Inpatient newborn care, including newborn exams.
- Follow-up care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision.

Inpatient Professional Care

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Professional Visits

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

This benefit doesn't cover immunizations and outpatient well-baby exams. See the Preventive Medical Care benefit for coverage of immunizations and outpatient well-baby exams.

Nutritional Therapy

Benefits for the following services are subject to your calendar year deductible and applicable coinsurance.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. Nutritional therapy for conditions other than diabetes is limited to 4 visits per Plan Participant each calendar year. Nutritional therapy for the condition of diabetes isn't subject to a calendar year benefit limit.

Obstetrical Care

Benefits for obstetrical care are provided on the same basis as any other condition for the subscriber or enrolled spouse. Obstetrical care benefits aren't covered for dependent children. However, complications of pregnancy are covered on the same basis as any other illness for the subscriber, enrolled spouse, or enrolled dependent child.

The Obstetrical Care benefit includes coverage for voluntary termination of pregnancy.

Facility Care

Inpatient Hospital Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Birthing Center and Short-Stay Hospital Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

This benefit covers inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction doesn't apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Plan benefits are also provided for medically necessary supplies related to home births.

Professional Care

Benefits for the following obstetrical care services are subject to your calendar year deductible and applicable coinsurance.

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus.
- Delivery, including cesarean section, in a medical facility, or delivery in the home.
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced

registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this Plan will cover those services as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

Orthognathic Surgery (Jaw Augmentation or Reduction)

These services are only covered if the Plan Participant has been covered by the Trust since birth or services are due to an accidental injury.

Inpatient Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Surgical Facility Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Professional Visits

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Other Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

When medical necessity criteria are met, benefits for procedures to lengthen or shorten the jaw (orthognathic and/or maxillofacial surgery) are provided. Covered services include repair of a dependent child's congenital anomaly. Orthognathic surgery isn't subject to a calendar year benefit limit. These procedures are not covered under other benefits of this Plan.

Phenylketonuria (PKU) Dietary Formula

Benefits for PKU dietary formula are subject to your calendar year deductible and coinsurance.

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU).

Preventive Medical Care

Benefits for routine and preventive services performed on an outpatient basis are subject to a combined maximum of $300 per Plan Participant per calendar year. Annual women's exams or immunizations do not apply to this $300 maximum.

Routine or Preventive Exams

Benefits for exams **aren't** subject to your calendar year deductible and coinsurance when you use a network provider.

Medical

Benefits for exams **are** subject to your calendar year deductible and coinsurance when you use a non-network provider.

Covered exam services include:

- Routine physical exams
- Well-baby and well-child exams
- Physical exams related to school, sports and employment

For outpatient routine or preventive diagnostic services (including x-ray), screening and diagnostic mammography, and laboratory services benefit information, please see the Diagnostic Services benefit and the Diagnostic and Screening Mammography benefit.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive medical benefits of this Plan.

This benefit doesn't cover:

- Services not named above as covered.
- Charges for preventive medical services that exceed what's covered under this benefit.
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Routine or other dental care.
- Routine vision and hearing exams.
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the Plan Participant.
- Physical exams for basic life or disability insurance.
- Work-related disability evaluations or medical disability evaluations.

Annual Women's Exam

Benefits for one annual women's exam per calendar year when services are received from a network provider aren't subject to your calendar year deductible and coinsurance. These services are not subject to the $300 preventive maximum specified above.

For preventive diagnostic service, including pap smear, please see the Diagnostic Services benefit.

For mammography services, please see the Diagnostic and Screening Mammography benefit.

Immunizations

Benefits for immunizations, including travel immunizations, are paid at 100% of allowable charges and not subject to your calendar year deductible and coinsurance. These services are not subject to the $300 preventive maximum specified above.

Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home.

Outpatient Professional Exams and Visits

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Medical

Other Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Benefits are also provided for the following professional services when provided by a qualified provider:

- Second opinions for any covered medical diagnosis or treatment plan
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions" in the Medical section of this document)
- Diabetic foot care
- Repair of a dependent child's congenital anomaly

Therapeutic Injections and Allergy Tests

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Benefits are available for the following:

- Therapeutic injections, including allergy injections
- Allergy testing

For surgical procedures performed in a provider's office, surgical suite or other facility benefit information, please see the Surgical Services benefit.

For professional diagnostic services benefit information, please see the Diagnostic Services benefit.

For home health or hospice care benefit information, please see the Home and Hospice Care benefit.

For benefit information on contraceptive injections or implantable contraceptives, please see the Contraceptive Management and Sterilization Services benefit.

For diagnosis and treatment of psychiatric conditions benefit information, please see the Mental Health Care benefit.

This benefit doesn't cover:

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services

Psychological and Neuropsychological Testing

The following services are subject to your calendar year deductible and applicable coinsurance.

Benefits are provided up to a maximum benefit of 12 hours per Plan Participant each calendar year for all services combined. Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

See the Neurodevelopmental Therapy benefit for physical, speech or occupational therapy assessments and evaluations related to neurodevelopmental disabilities.

Medical

Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies. Please see the Neurodevelopmental Therapy benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

Inpatient Care

Benefits are provided for inpatient facility and professional care. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

Inpatient Facility Care

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Inpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Care

Benefits for outpatient care are subject to all of the following provisions:

- You must not be confined in a hospital or other medical facility.
- Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, physical, occupational, or speech therapist, chiropractor, or naturopath.

When the above criteria are met, benefits will be provided for physical, speech and occupational services, including cardiac and pulmonary rehabilitation. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

Outpatient Facility Care

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

Outpatient Professional Services

Benefits for these services are subject to your calendar year deductible and applicable coinsurance.

A "visit" is a session of treatment for each type of therapy. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. All benefit maximums apply. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

The Rehabilitation Therapy and Chronic Pain Care Benefit doesn't cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired Plan Participant
- Gym or swim therapy
- Massage Therapy; Services by a Massage Therapist
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the Plan Participant's injury or illness or from the date of the Plan Participant's surgery that made the rehabilitation necessary

The Plan won't provide the Rehabilitation Therapy and Chronic Pain Care benefit and the Neurodevelopmental Therapy benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available.

Skilled Nursing Facility Services

Benefits for the following services are subject to your calendar year deductible and applicable coinsurance.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must admit you directly from the hospital to the skilled nursing facility and actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 14 days per Plan Participant each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a Medicare-approved skilled nursing facility.

Please Note: Additional skilled nursing benefits may be extended if approved by the Trust. Please call the Premera Customer Service department at 800-722-1471 to obtain Trust approval for any additional days needed.

This benefit doesn't cover:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

Surgical Services

Benefits for the following services are subject to your calendar year deductible and applicable coinsurance.

This benefit covers surgical services (including injections) that are not named as covered under other benefits, when performed on an inpatient or outpatient basis, in such locations as a

hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts, repair of a dependent child's congenital anomaly, surgical procedures required as a result of temporomandibular joint disorder (TMJ) and the transfusion of blood or blood derivatives.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit.

Transplants

Waiting Period

This Plan doesn't provide benefits for an organ, bone marrow or stem cell transplant, including any procedure associated with the transplant (for example, testing, blood typing, chemotherapy, radiation or hospitalization), unless you've been covered by The Nelson Trust for 24 consecutive months or since birth. The 24 months includes the period of time that a recipient or self-donor is covered by a company sponsored health and welfare plan, which is established and maintained pursuant to an IAM collective bargaining agreement. However, this waiting period doesn't apply if the transplant is needed as a direct result of:

- An injury that occurs on or after your effective date of coverage under this Plan
- A congenital anomaly of a child who's been covered by a medical plan provided by The Nelson Trust since birth
- A congenital anomaly of a child who's been covered by a medical plan provided by The Nelson Trust since placement for adoption with the Plan Participant

Covered Transplants

This benefit covers medical services only if provided by network providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Inpatient Facility Services

Benefits for services in a network facility or an approved transplant center are covered in full. When you use a non-network provider, benefits are subject to your calendar year deductible and coinsurance.

Inpatient Professional and Surgical Services

Benefits are subject to your calendar year deductible and coinsurance.

Outpatient Surgical Facility Services

Benefits for a network facility or an approved transplant center are covered in full. When you use a non-network provider, benefits are subject to your calendar year deductible and coinsurance.

Outpatient Professional Visits

Benefits are subject to your calendar year deductible and coinsurance.

Other Outpatient Professional Services

Benefits are subject to your in-network calendar year deductible and coinsurance.

Transport and Lodging

The transport and lodging benefits are subject to your calendar year deductible, but aren't subject to your coinsurance. Benefits are provided up to the benefit limit of $7,500 per transplant.

Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see "Definitions" in the Medical section of this document for the definition of "experimental/ investigational services.") We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet the Plan's criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

  The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the Plan's criteria for coverage are:

  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous)

  Please Note: For the purposes of this Plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services benefit).
- You've satisfied your waiting period.
- Your medical condition must meet the Plan's written standards.
- The transplant or reinfusion must be furnished in an approved transplant center. (An "approved transplant center" is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

  Of course, if none of our centers or the approved transplant centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

Recipient Costs

Benefits are provided for transplant or reinfusion related expenses 30 days before the date of a solid organ transplant, or in the case of bone marrow or stem cell procedures, 30 days before the date of reinfusion. Benefits stop 180 days from the date of the transplant or reinfusion. Inpatient stays for episodes of rejection related to a solid organ transplant or bone marrow or

stem cell reinfusion beyond the 180-day period will also be provided. However, the time limits above don't apply to this benefit's coverage for transportation and lodging.

This benefit also provides coverage for anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

Procurement expenses are limited to $75,000 per transplant. Covered services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center.
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and two companions will be provided up to a maximum of $125 per day.
- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided up to a maximum of $80 per day.
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companions are limited to $7,500 per transplant.

This benefit doesn't cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a Plan Participant.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (please see "Definitions" in the Medical section of this document).
- Personal care items.

What Do I Do if I'm Outside Washington and Alaska?

The BlueCard Program

Premera Blue Cross, like all Blue Cross and/or Blue Shield Licensees, participates in a program called "BlueCard." Plan participants can take advantage of BlueCard when they receive covered services in Clark County, Washington or outside Washington and Alaska from hospitals, doctors, and other medical care providers who have contracted with the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. The national BlueCard Program is

available throughout the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands.

Your identification card tells contracting providers which independent Blue Cross and/or Blue Shield Licensee covers you. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this Plan. When you use your identification card, you will receive many of the conveniences you're accustomed to from Premera Blue Cross. In most cases, there are no claim forms to submit because contracting providers will handle claim submission for you. In addition, your out-of-pocket costs may be less, as explained below.

Here's How BlueCard Helps Keep Costs Down

When you obtain health care services in Clark County, Washington or outside Washington and Alaska through BlueCard (excluding BlueCard Worldwide; see below), the amount you pay for covered services is calculated on the **lower** of:

- The billed charges for your covered services, or
- The "negotiated price" that the Host Blue passes on to Premera Blue Cross for your covered services

The methods used to determine the negotiated price will vary among Host Blues according to the terms of their provider contracts. Often, the negotiated price will consist of a simple discount, which reflects the actual price allowed as payable by the Host Blue. But, sometimes, it's an estimated price that factors in aggregate payments expected to result from the Host Blue's settlements, withholds, other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects an **average** expected savings with your health care provider or a specified group of providers. The price that reflects average savings may result in greater variation above or below the actual price than will the estimated price. In accordance with national BlueCard policy, these estimated or average prices will also be adjusted from time to time to correct for overestimation or underestimation of past prices. However, the amount on which your payment is based remains the final price for the covered services billed on your claim.

Some states may mandate a surcharge or a method of calculating what you must pay on a claim that differs from BlueCard's usual method noted above. If such a mandate is in force on the date you received care in that state, the amount you must pay for any covered services will be calculated using the methods required by that mandate. Such methods might not reflect the entire savings expected on a particular claim.

Clark County Providers

Some providers in Clark County, Washington do have contracts with Premera Blue Cross. These providers will submit claims directly to us and benefits will be based on our allowable charge for the service or supply.

Non-BlueCard Claim Submission

If a hospital, doctor, or other medical care provider does not contract with the Host Blue, that claim might not be filed on your behalf. For instructions on how to file a claim in this situation, refer to "How do I File a Claim?" in the Medical section of this document.

BlueCard Worldwide®

If you're outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British

and U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide. BlueCard Worldwide is unlike the national BlueCard Program in certain ways. For instance, although BlueCard Worldwide provides a network of contracting hospitals, it offers only referrals to doctors. When you receive care from doctors, you will have to submit claim forms on your own behalf to obtain reimbursement for the services provided through BlueCard Worldwide.

To access health care services through BlueCard Worldwide and to obtain additional information about providers' charges, please call 800-810-BLUE (2583).

Further Questions?

If you have questions or need additional information about using your identification card in Clark County, Washington or outside Washington and Alaska, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, call 800-810-BLUE (2583).

Care Management

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important, as explained below.

The benefits of this Plan don't require preauthorization for coverage. You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions that might benefit from case management.

Case Management

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this Plan's benefits. The decision to provide benefits for these alternatives is within the Plan's sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

Case Management is subject to the terms set forth in the signed written agreements. Your Plan benefits may be utilized as specified in the signed agreements, but the agreements are not to be construed as a waiver of the right to administer the Plan in strict accordance with its terms in other situations. All parties have the right to re-evaluate or terminate the Case Management agreement at any time, at their sole discretion. Case Management termination must be provided in writing to all parties. Your remaining benefits under this Plan would be available to you at that time.

What's Not Covered?

This section of your document explains circumstances in which all the benefits of this Plan are either limited or no benefits are provided. Benefits can also be affected by our "Care Management" provisions and your eligibility. In addition, some benefits have their own specific limitations.

Waiting Period for Transplants

Organ, bone marrow and stem cell transplants are subject to a benefit specific 24-month waiting period. Please see the Transplant benefit for details.

Medical

Limited and Non-Covered Services

In addition to the specific limitations stated elsewhere in this Plan, the Plan won't provide benefits for the following:

Acupuncture

Services and supplies for acupuncture; or services of an acupuncturist

Benefits from Other Sources

Benefits aren't available under this Plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Boat coverage
- Commercial liability coverage
- Homeowner policy
- School or athletic policy
- Other type of liability or insurance coverage
- Worker's Compensation or similar coverage
- Any excess insurance coverage

Benefits that Have Been Exhausted

Amounts that exceed the allowable charge or maximum benefit for a covered service

Biofeedback Services

- Biofeedback for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback and neurofeedback services

Caffeine or Nicotine Dependency

Treatment of caffeine or nicotine dependency

Charges for Records or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review

Chemical Dependency Coverage Exceptions

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous

Cosmetic Services

Services and supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance or shape of a body structure, including any direct or indirect complications and aftereffects thereof

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury

- Repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy as specified under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders upon our review and approval

Counseling, Educational or Training Services

- Counseling, education or training services, except as stated under the Chemical Dependency Treatment, Nutritional Therapy, Diabetes Health Education and Mental Health Care benefits. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy, except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of a Plan Participant.
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children under the age of seven as stated under the Neurodevelopmental Therapy benefit.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling.
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs.
- Social or cultural therapy.
- Gym or swim therapy.

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed medically necessary by us

Custodial Care

Custodial care, except when provided for hospice care (please see the Home and Hospice Care benefit)

Dental Care

Dental services or supplies, except as specified under Dental Services (please see the "Medical Services" section under "What Are My Benefits?")

Drugs and Food Supplements

Prescription drugs dispensed and billed by a pharmacy, including contraceptive drugs, supplies and devices; over-the-counter drugs, solutions, supplies and food and nutritional supplements; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins

Environmental Therapy

Therapy designed to provide a changed or controlled environment

Experimental or Investigational Services

Any service or supply that Premera Blue Cross determines is experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the definition of "experimental/investigational services" (please see "Definitions" in the Medical section of this document).

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please see “What if I Have a Question or an Appeal?” in the Medical section of this document for an explanation of the appeals process.

Please Note: This exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of “Oncology Clinical Trials” in “Definitions” in the Medical section of this document.

Family Members or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit.

Gender Transformations

Treatment or surgery to change gender, including any direct or indirect complications and after effects thereof

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- We approve your request for a benefit level exception for non-emergent care to the facility (please see the "Benefit Level Exceptions for Non-Emergent Care" provision in the Medical section of this document).
- You’re receiving care for a "medical emergency" (please see “Definitions” in the Medical section of this document).
- The Plan must provide available benefits for covered services as required by law or regulation.

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth
- Hair prostheses, such as wigs or hair weaves, transplants, and implants

Hearing Exams and Testing

Routine hearing exams and testing

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness

Human Growth Hormone

Benefits are not provided for human growth hormone

Infertility and Sterilization Reversal

- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs

- Any assisted fertilization techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof
- Reversal of surgical sterilization, including any direct or indirect complications thereof

Massage Therapy and Massage Therapist

Services and supplies provided for Massage Therapy or services provided by a Massage Therapist

Medical Equipment and Supplies

- Supplies or equipment not primarily intended for medical use.
- Special or extra-cost convenience features.
- Items such as exercise equipment and weights.
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices.
- Over bed tables, elevators, vision aids, and telephone alert systems.
- Structural modifications to your home or personal vehicle.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities.
- Penile prostheses.
- Prosthetics, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit.
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications.

Military and War-Related Conditions, Including Illegal Acts

- Acts of war, declared or undeclared, including acts of armed invasion.
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto. However, this exclusion does not apply to U.S. military personnel (active or retired) or their dependents enrolled in the TRICARE program. The benefits of this Plan will be provided on a primary basis to TRICARE beneficiaries consistent with federal law.
- A Plan Participant's commission of an act of riot or insurrection.
- A Plan Participant's commission of a felony or act of terrorism.

No Charge or You Don't Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this Plan weren't in effect
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services

Not Covered

- Services or supplies ordered when this Plan isn't in effect, or when the person isn't covered under this Plan, except as stated under specific benefits and under "Extended Benefits"
- Services or supplies provided to someone other than the ill or injured Plan Participant, other than outpatient health education services to manage the condition of diabetes covered under the Diabetes Health Education benefit

- Services and supplies that aren't listed as covered under this Plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn't covered under this Plan

Not in the Written Plan of Care

Services, supplies or providers not in the written plan of care or treatment plan, or not named as covered in the Home and Hospice Benefit, Neurodevelopmental Therapy and Rehabilitation Therapy and Chronic Pain Care benefits.

Not Medically Necessary

- Services or supplies that aren't medically necessary, in our judgment, even if they're court-ordered. This also includes places of service, such as inpatient hospital care.
- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary.
- Any days of inpatient care that exceed the length of stay that is, in our judgment, medically necessary to treat your condition.

Obesity Services

Treatment of obesity or morbid obesity, including surgery, and any direct or indirect complications and aftereffects thereof; services and supplies connected with weight loss or weight control except for services to treat diabetes covered under the Diabetes Health Education and Nutritional Therapy benefits. This exclusion applies even if you also have an illness or injury that might be helped by weight loss.

Online Consultations

Electronic, online or Internet medical consultations or evaluations

Orthognathic/Maxillofacial Care

Services or supplies for orthognathic/maxillofacial care

Orthodontia Services

Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers

Outside the Scope of a Provider's License or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received

Personal Comfort or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services
- Dietary assistance, such as "Meals on Wheels"

Medical

Pregnancy of Dependent Children

Any care connected with a dependent child's pregnancy, except care furnished for the treatment of a complication of pregnancy

Private Duty Nursing Services

Private duty nursing, except when billed in conjunction with Home Health care

Rehabilitation Services

Inpatient rehabilitation received more than 24 months from the date of onset of the Plan Participant's injury or illness or from the date of the Plan Participant's surgery that made the rehabilitation necessary

Routine or Preventive Care

- Routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof, except as stated under the Professional Visits and Services benefit; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. This includes foot-support supplies, devices and shoes, except as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability.
- Services and supplies that aren't directly related to your illness, injury or distinct physical symptoms. Examples are routine physical examinations and diagnostic surgery. However, this exclusion doesn't apply to services and supplies specified as covered under the following benefits:
  - Diagnostic Services
  - Diagnostic and Screening Mammography
  - Newborn Care
  - Preventive Medical Care
  - Diabetic Health Education

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof

Skilled Nursing Facility Coverage Exceptions

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of chemical dependency

Temporomandibular Joint (TMJ) Disorders

Any services or supplies, including office visits and evaluations, connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications thereof. The exception are surgical procedures and associated diagnostic imaging required as a result of TMJ disorder, which is covered on the same basis as any other surgical service. See the Surgical Services benefit.

Transplant Coverage Exceptions

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Transplants benefit
- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers
- Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental/investigational services" (Please see "Definitions" in the Medical section of this document.)

Vision Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware

Vision Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies. Also not covered are non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

Work-Related Conditions

- Any illness, condition or injury arising out of or in the course of employment, for which the Plan Participant is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
  - Occupational coverage required of, or voluntarily obtained by, the employer
  - State or federal workers' compensation acts
  - Any legislative act providing compensation for work-related illness or injury

  However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of The Nelson Trust if they're exempt from the above laws and if The Nelson Trust doesn't furnish them with workers' compensation coverage. They'll be covered under this Plan for conditions arising solely from their occupations with The Nelson Trust. Coverage is subject to the other terms and limitations of this Plan.

What if I Have Other Coverage?

Please Note: If you participate in a Health Savings Account (HSA) and have other health care coverage that is not a high deductible health plan as defined by IRS regulations, the tax deductibility of the Health Savings Account contributions may not be allowed. Contact your tax advisor or HSA plan administrator for more information.

Coordinating Benefits with Other Health Care Plans

This plan coordinates benefits with other health care coverage you may have. Coordination of benefits is done based on a provision called "Maintenance of Benefits" as described below.

All of the benefits of this plan are subject to coordination of benefits, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.

- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

Other Types of Health Coverage Subject to Coordination

The following types of coverages are included in this plan's coordination provisions:

- Group or individual health insurance plans, including student health care coverage sponsored by a school, college, or university
- Labor organization plans, trusteed and association plans, and employee benefit organization plans
- Health insurance plans provided to federal, state or local government employees
- Other government-sponsored coverage such as Medicare, but not including worker's compensation coverage

Primary versus Secondary Plan

Certain governmental plans, such as Medicaid and TRICARE, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

A plan that doesn't have a COB provision that complies with this plan's rules is primary to this plan unless the rules of both plans make this plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

Non-Dependent or Dependent The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

Dependent Children Unless a court decree states otherwise, the rules below apply:

- **Birthday Rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child’s health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.

- If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
- If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
  - The plan covering the custodial parent, first.
  - The plan covering the spouse of the custodial parent, second.
  - The plan covering the non-custodial parent, third.
  - The plan covering the spouse of the non-custodial parent, last.
  - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

Please Note: The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

Retired or Laid-Off Employee The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

Continuation Coverage If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that isn't through COBRA or other continuation law.

Please Note: The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

Length of Coverage The plan that covered you longer is primary to the plan that didn't cover you as long.

If none of the rules above apply, the plans must share the allowable expenses equally.

Maintenance of Benefits

When this plan is secondary, coordination is based on a process called "maintenance of benefits." This is a three-step process where we:

1. Calculate what this plan would have paid if it were primary
2. Calculate this plan's secondary payment by subtracting what the primary plan paid from what this plan would have paid if it had been primary, and
3. Determine the amount you are responsible for. This amount will depend on how much your primary plan paid, this plan's allowable charge, and whether you received services from a network or non-network provider.

When the primary plan pays an amount equal to or greater than what this plan would have paid if it had been primary, this plan will pay nothing.

Medical

The following examples show how maintenance of benefits works for both network and non-network providers. These examples assume deductibles are met, and this plan pays 80% of allowable charges for network providers, and 70% for non-network providers. In the examples, the following amounts are used:

Provider's billed charge: $200.00

This plan's allowable charge:.....$180.00

Amount primary plan paid:.....$125.00

Example #1 - Network Provider

Step #1: Calculate what this plan would have paid if it had been the primary plan:

80% of $180.00 (allowable charge) = $144.00.

Step #2: Calculate the amount this plan pays as the secondary plan by subtracting the primary plan's payment from what this plan would have paid if it had been primary.

$144.00 (amount this plan would pay if primary) - $125.00 (other plan payment) = $19.00.

Step #3: Calculate the amount that is your responsibility. Because in this example a network was used, the amount you are responsible for is this plan's allowable charge minus what the primary and secondary plans have paid. The difference between the provider's billed charge and the allowable charge is written off by the network provider.

$180.00 Premera Blue Cross's allowable charge

-$125.00 Primary plan's payment

-$ 19.00 Secondary (this plan's) payment

$ 36.00 Amount you are responsible for (our allowable charge minus payments from both plans.)

Example 2 - Non-Network Provider

Step #1: Calculate what this plan would have paid if it had been the primary plan:

70% of $180.00 allowable charge = $126.00

Step #2: Calculate this plan's secondary payment by subtracting the primary plan's payment from what this plan would have paid if it had been primary:

$126.00 - $125.00 = $1.00

Step #3: Calculate the amount that is your responsibility. Because in this example a non-network provider was used, you are responsible for any amounts not paid by the primary and secondary plans:

$ 200.00 Provider's billed charge *

- $ 125.00 Primary plan's payment

- $ 1.00 Secondary (this plan's) payment

$ 74.00 Amount you are responsible for (provider's billed charge minus payments from both plans.) *

*Actual amount may be less if provider has a network agreement with primary plan.

Subrogation and Reimbursement

If the Plan makes claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP)

insurance exists, the Plan is entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the “third party” because it’s a party other than you or the Plan. This party includes a UIM carrier because it stands in the shoes of a third party tortfeasor and because the Plan excludes coverage for such benefits.

Definitions

The following terms have specific meanings in this section:

- **Subrogation** means we may collect, on behalf of the Plan, directly from third parties to the extent the Plan has paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated to repay any monies advanced by the Plan from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that the Plan has to the monies advanced under your plan. Because the Plan has paid for your illness or injuries, the Plan is entitled to recover those expenses.

The Plan is entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits the Plan paid for the condition, whether or not you have been made whole prior to the Plan's recovery. The Plan's right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. This right allows the Plan to pursue any claim against any third party or insurer, whether or not you choose to pursue that claim. The Plan's rights and priority are limited to the extent the Plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights.

The Plan’s first priority right of reimbursement will not be reduced due to a Plan Participant’s own negligence; or due to a Plan Participant not being made whole; or due to attorney’s fees and costs.

In recovering benefits provided on behalf of the Plan, we may at The Nelson Trust's election hire an attorney or have the Plan be represented by your attorney. The Nelson Trust will pay reasonable for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by the Plan or The Nelson Trust or on their behalf. If you retain an attorney or other agent to represent you in the matter, you must require that legal representative to reimburse the Plan directly from the settlement or recovery. Before accepting any settlement on your claim against a third party, you or your legal representative must notify us in writing of any terms or conditions offered in a settlement, and you or your legal representative must notify the third party of the Plan's interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by the Plan on your behalf. If you or your legal representative fail to cooperate fully with us in the recovery of benefits the Plan has paid as described above, you are responsible for reimbursing the Plan for such benefits.

You or your legal representative must, within 14 business days of receiving a request from the Plan, provide all information and sign and return all documents necessary to exercise the Plan’s right under this provision.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until the Plan's subrogation and reimbursement rights are fully determined.

If you incur claim expenses for treatment of illness or injury arising out of a motor vehicle accident after receiving a recovery from the third party, primary medical payment insurance, uninsured motorist or underinsured motor vehicle coverage, the Plan will not pay benefits for otherwise covered expenses until the total amount of health care expense incurred both before

and after recover plus the reasonable expenses of recovery such as attorney's fees and court costs exceed the amount of recovery.

Agreement to Arbitrate

Any disputes that arise as part of this provision will be resolved by arbitration. Both you and the Plan will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in King County, Washington or another location as agreed upon by all parties.

This agreement to arbitrate will begin on the effective date of the contract, and will continue until any dispute regarding this Plan's subrogation or reimbursement is resolved.

Uninsured and Underinsured Motorist/Personal Injury Protection Coverage

The Plan has the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

How Do I File a Claim?

Claims Other than Prescription Drug Claims

Many providers will submit their bills to us directly. However, if you need to submit a claim, follow these simple steps:

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. You can order extra Subscriber Claim Forms by calling Customer Service.

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the Plan Participant who incurred the expense
- Identification numbers for both the subscriber and The Nelson Trust (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis or ICD-9 code
- Procedure codes (CPT-4, HCPCS, ADA or UB-92) or descriptive English nomenclature for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an injury, the date, time, location and a brief description of the event

Medical

Step 3

If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the "Explanation of Medicare Benefits."

Step 4

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail your claims to us at the mailing address shown on the back cover of this document.

Timely Filing

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 15 months of discharge for hospital or other medical facility expenses, or within 15 months of the date the expenses were incurred for any other services or supplies; or
- For Plan Participants who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits or within 90 days of the start of service or within 30 days after the service is completed, whichever is greatest.

We won't provide benefits for claims we receive after the later of these 2 dates, nor will we provide benefits for claims that were denied by Medicare because they were received past Medicare's submission deadline.

Special Notice about Claims Procedure

We'll make every effort to process your claims as quickly as possible. We'll tell you if this Plan won't cover all or part of the claim no later than 30 days after we first receive it. This notice will be in writing. We can extend the time limit by up to 15 days if it's decided that more time is needed due to matters beyond our control. We'll let you know before the 30-day time limit ends if we need more time. If we need more information from you or your provider in order to decide your claim, we'll ask for that information in our notice and allow you or your provider at least 45 days to send us the information. In such cases, the time it takes to get the information to us doesn't count toward the decision deadline. Once we receive the information we need, we have 15 days to give you our decision.

If your claim was denied, in whole or in part, our written notice will include:

- The reasons for the denial and a reference to the provisions of this Plan on which it's based
- A description of any additional information needed to reconsider the claim and why that information is needed
- A statement that you have the right to appeal our decision
- A description of the Plan's complaint and appeal processes

If there were clinical reasons for the denial, you'll receive a letter stating these reasons.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You must notify us in writing and give us the name, address and telephone number where your appointee can be reached.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in this Plan, you may file suit in a state or federal court.

What if I Have a Question or an Appeal?

When You Have Questions

Call your provider of care when you have questions about the health care services you receive. Please call our Customer Service department with any other questions regarding the Plan.

When You Have a Complaint

A **complaint** is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you're not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, a representative will tell you.

When you have a complaint, call or write our Customer Service department. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We'll let you know when we've received your complaint. We also may request more information when needed. When we receive all needed information, we'll review your complaint and respond as soon as possible, but never more than 30 calendar days.

When You Have an Appeal

You will be given notice if a claim is wholly or partially denied including the termination of a benefit. The notice will set forth the following:

- The specific reason or reasons for the benefit denial;
- Reference to the specific Plan provision on which the denial was based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- Appropriate information as to the steps to be taken if you wish to appeal the determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim;
- An explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the circumstances or a statement that the explanation will be provided free of charge on request if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion; and
- A description of the expedited review process applicable to urgent care if the adverse benefit determination is for an urgent care claim.

Unless your appeal is deemed urgent, we will mail you a notice of our Level I and Level II decisions within 5 calendar days after the review is complete.

Medical

An **appeal** is an oral or written request to reconsider:

1. A decision on a complaint, or
2. A decision to deny, modify, reduce, or end payment, coverage or authorization of coverage. There is an appeal process to Premera Blue Cross and an appeal process to The Nelson Trust. An appeal must be made within 180 calendar days of the date of our decision.

Although we'll accept an appeal made by phone to our Customer Service department except for an urgent care claim, it's a better idea to put appeals in writing so you can keep copies for your records. Please send all written appeals to:

Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

We'll let you know when we receive your appeal.

You have the right to give us comments, documents or other information to support your appeal. You can also request to review documents relevant to your claim.

You may mail appeals to our Appeals Coordinator at the Appeals address shown on the back cover of this document.

Premera Blue Cross Appeals Process

Our standard appeal process has two levels of review:

Level I: The Level I Appeal panel will decide most appeals within 30 calendar days except for an urgent care claim. This panel will include health care providers who were not involved in the initial decision. We can extend our review time up to 15 more calendar days if we need more information. You will be notified if a delay occurs. There are three exceptions to the 30-day time limit:

- **Urgent Care Claim Appeal**

  An urgent care claim is a claim which (a) could seriously jeopardize your life or health; (b) could affect your ability to regain maximum function; or (c) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that could not be managed without the care or treatment which is the subject of the claim. An urgent care claim may be submitted either orally or in writing by either you or your representative. An urgent care claim will be decided as soon as possible but not later than 72 hours after receipt of the claim. The administrator will notify you as soon as possible but not later than 24 hours after the receipt of the claim, if specific information is necessary to complete the claim to determine the extent of coverage. You will have a reasonable period of time to provide the specified information but not less than 48 hours. Notification of an adverse benefit determination will be made as soon as possible but not later than 48 hours after the earlier of: (a) the receipt of the specified information; or (b) the end of the period afforded you to provide the specified information. Notification of the benefit determination may be oral but a written or electronic notification will be given not later than 3 days after the oral notification.

- **A decision to change, reduce or end an ongoing service**

  We will mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than 30 calendar days from the day we receive your appeal, unless you agree to a longer one.

Medical

- **Denial of an experimental or investigational service**

  We will mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended with your informed written consent.

Level II: Your appeal will be reviewed by a Premera Blue Cross panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. Unless your appeal is deemed urgent (see "Urgent Appeals" below), the panel will evaluate all the information within 30 days for an appeal of ongoing care from the date Premera Blue Cross receives your Level II request.

- **Urgent Care Appeal**

  You may appeal an adverse benefit determination within 180 days following receipt of the notice. An appeal of an urgent care claim may be submitted orally or in writing to Premera Blue Cross by either you or your representative. You may request an expedited review. You will be notified of the determination as soon as possible, considering the medical urgency, but not later than 72 hours after receipt of the request for an expedited review. A decision on a non-expedited review will be made within 60 days of your request for review. All information between you and Premera Blue Cross may be submitted by telephone, facsimile or other available similar expeditious method.

- **Appeals of Ongoing Care**

  While you are appealing a decision to change, reduce or end coverage because the service or level of service is no longer medically necessary or appropriate, we will suspend our denial. Our coverage for services received during the appeal period does not and should not be construed to reverse our denial. **If our initial decision is upheld, you must repay all amounts that The Nelson Trust has paid for such services. You will also have to pay providers any difference between the allowable charge and the provider's billed charge.**

The Nelson Trust Claim Appeal Process

If you do not agree with a claim denial made by Premera Blue Cross, you may submit a further appeal to the Claims Review Committee. Please send your appeal to:

The Nelson Trust
ATTN: Appeal
1220 SW Morrison Street, #300
Portland, OR 97205-2222

The Nelson Trust Board of Trustees or its appointed Claims Review Committee has the authority to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided.

- **Appeal of Urgent Care**

  You may appeal an adverse urgent care claim to The Nelson Trust's Claims Review Committee within 180 days of an adverse decision. You may request an expedited review; otherwise a claim will be given a non-expedited review. An expedited review may be submitted orally or in writing. All necessary information, including the benefit determination, will be transmitted between you and the Plan by telephone, facsimile or other expedited method. The decision on review will be made as soon as possible but no later than 72 hours after receipt of the request for an expedited review. A non-expedited review will be decided within 60 days of your request for review. If special circumstances are required, the Claims Review Committee may delay a decision provided you are given notice. You or your representative may review pertinent documents and submit written issues and comments for

review. The Claims Review committee may elect to voluntarily obtain an independent evaluation of the claim by an independent Review Organization, which by law, is required to be independent and unbiased.

- **Appeals of Ongoing Care**

  You may appeal an Ongoing Care claim to The Nelson Trust's Claims Review Committee within 180 days of an adverse decision. A decision will be made within 60 days of your request for review. If special circumstances require, the Claims Review Committee may delay a decision provided you are given notice. You or your representative may review pertinent documents and submit written issues and comments for this review. The Claims Review Committee may elect to voluntarily obtain an independent evaluation of the claim by an Independent Review Organization, which by law, is required to be independent and unbiased.

- **Voluntary Appeal to Board of Trustees**

  You may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal must be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, you or your representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees will decide the appeal within 60 days of your request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that you are given notice. The notice will be given prior to commencement of the extension; will state the special circumstances which require the extension; and will state the expected date of the decision. The Board of Trustees will notify you in writing as soon as possible of its decision but not later than 5 days after the decision.

  If you submit the claim to The Nelson Trust Board of Trustees, The Nelson Trust agrees that: (a) the voluntary appeal will not have any effect on your rights to any other benefit under The Nelson Trust; (b) any statute of limitations is tolled during the voluntary review process; and (c) no fees or costs are imposed on you as part of this appeal process. The Nelson Trust waives any right to assert that you did not exhaust your administrative remedies if you do not submit a claim to the Claims Review Committee or to The Nelson Trust Board of Trustees.

Other Information about this Plan

This section tells you how this Plan is administered. It also includes information about legal requirements we and The Nelson Trust must follow and other information that must be provided.

Conformity with the Law

If any provision of the Plan or any amendment thereto is deemed to be in conflict with applicable laws or regulations, upon discovery of such conflict the Plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Plan Participant Cooperation

You're under a duty to cooperate with us and The Nelson Trust in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and The Nelson Trust in the event of a lawsuit.

Evidence of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before benefits under this Plan are provided. This proof may be submitted by you, or on your behalf by your health care providers. No benefits will be available if the proof isn't provided or acceptable to the Plan.

Medical

Intentionally False or Misleading Statements

If this Plan's benefits are paid in error due to a Plan Participant's or provider's commission of fraud or providing any intentionally false or misleading statements, the Plan is entitled to recover these amounts. Please see the "Right of Recovery" provision later in this section.

And, if a Plan Participant commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the Plan Participant's acceptability for coverage, we may, as directed by The Nelson Trust:

- Deny the Plan Participant's claim
- Reduce the amount of benefits provided for the Plan Participant's claim
- Rescind the Plan Participant's coverage under this Plan (rescind means to cancel coverage back to its effective date, as if it had never existed at all)

Notice of Information Use and Disclosure

We may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Plan and our administrative service contract with The Nelson Trust

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our Customer Service department and ask a representative to mail a request form to you.

Notice of Other Coverage

As a condition of receiving benefits under this Plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which the Plan provides benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

Medical

Notices

Any notice we're required to submit to The Nelson Trust or Plan Participant will be considered to be delivered if it's mailed to The Nelson Trust or Plan Participant at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

Right of Recovery

On behalf of the Plan, we have the right to recover amounts the Plan paid that exceed the amount for which the Plan is liable. Such amounts may be recovered from the Plan Participant or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the Plan Participant or any of his or her dependents (even if the original payment wasn't made on that Plan Participant's behalf) when the future benefits would otherwise have been paid directly to the Plan Participant or to a provider that does not have a contract with us.

Right to and Payment of Benefits

Benefits of this Plan are available only to Plan Participants. Except as required by law, the Plan won't honor any attempted assignment, garnishment or attachment of any right of this Plan. In addition, Plan Participants may not assign a payee for claims, payments or any other rights of this Plan.

At our option only, we have the right to direct the benefits of this Plan to:

- You
- A provider
- Another health insurance carrier
- The Plan Participant
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the Plan's obligation as to payment of benefits.

Venue

All suits or legal proceedings brought against us, the Plan, or The Nelson Trust by you or anyone claiming any right under this Plan must be filed:

- Within 3 years of the date the rights or benefits claimed under this Plan were denied in writing, or of the completion date of the independent review process if applicable; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal or arbitration proceedings brought by the Plan will be filed within the appropriate statutory period of limitation, and you agree that venue, at the Plan's option, will be in King County, the state of Washington.

Medical

Definitions

The terms listed throughout the Medical section of this document have specific meanings under this Plan.

Allowable Charge

The allowable charge shall mean one of the following:

- **Providers in Washington and Alaska Who have Agreements with Us**

  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this Plan.

  Your liability for any applicable calendar year deductibles, coinsurance, copays and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

- **Providers Outside Washington and Alaska Who have Agreements with Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Washington and Alaska, or in Clark County, Washington, allowable charges are determined as stated in "What do I do if I'm Outside Washington and Alaska?" ("The BlueCard Program") in the Medical section of this document.

- **Providers Who Don't have Agreements with Us or Another Blue Cross Blue Shield Licensee**

  The allowable charge will be no greater than the maximum allowance that would have been allowed had the medically necessary covered services been furnished by a provider that has an agreement in effect with the local Blue Cross and/or Blue Shield Licensee (when applicable) or with us (when the provider is in Washington or Alaska or no local Blue Cross and/or Blue Shield allowable charge applies).

  When you seek services from providers that **don't** have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowable charge, for your normal share of the claims costs (see the "What Are My Benefits?" section for further detail).

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in The Nelson Trust's administrative services agreement with us.

Ambulatory Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Chemical Dependency

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use.
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued.
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted.

Community Mental Health Agency

An agency that's licensed as such by the state of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Complication of Pregnancy

A condition which falls into one of the 3 categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix requiring treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma uterine rupture before onset or during labor
  - Ante- or postpartum hemorrhage requiring medical/surgical treatment
  - Placental conditions which require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention

Congenital Anomaly of a Dependent Child

A marked difference from the normal structure of an infant's body part, that's present from birth and manifests during infancy.

Medical

Custodial Care

Any portion of a service, procedure or supply that, in our judgment, is provided primarily:

- For ongoing maintenance of the Plan Participant's health and not for its therapeutic value in the treatment of an illness or injury.
- To assist the Plan Participant in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Dental Care Provider

A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this Plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of his or her license or certification, as allowed by law. This Plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

Dentally Necessary

Those covered services which are, in our judgment, determined to meet all of the following requirements. They must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the Plan Participant's dental health, unless provided for preventive services when specified as covered under this Plan
- Appropriate and consistent with authoritative dental or scientific literature
- Not primarily for the convenience of the Plan Participant, the Plan Participant's family, the Plan Participant's dental care provider or another provider
- The least costly of the alternative levels of services which can safely be provided to the Plan Participant
- Not primarily for research or data accumulation

The fact that the covered services were furnished, prescribed, or approved by a dental care provider does not in itself mean that the services were dentally necessary.

Effective Date

The date when your coverage under this Plan begins. If you re-enroll in this Plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.

Medical

- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards set in the definition of "Oncology Clinical Trials" below in this section will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center (TEC).

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians.
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses.

A “hospital” will never be an institution that’s run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition or pregnancy.

Injury

Physical harm caused by a sudden event at a specific time and place. It’s independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility as an overnight bed patient.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It’s of no use in the absence of illness or injury.

Medical

Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples of a medical emergency are severe pain, suspected heart attacks and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved chemical dependency treatment program or hospice.

Medically Necessary

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Network Provider

A provider that is in one of the networks stated in the "How Does Selecting a Provider Affect My Benefits?" section.

Non-Network Provider

A provider that is not in one of the provider networks stated in the "How Does Selecting a Provider Affect My Benefits?" section.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Voluntary termination of pregnancy is included as part of obstetrical care.

Medical

Oncology Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An “oncology clinical trial” does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial)
- Any drug or device provided as part of a phase I oncology clinical trial
- Services, supplies or pharmaceuticals that would not be charged to the Plan Participant, were there no coverage
- Services provided in a clinical trial that are fully funded by another source

The Plan Participant for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage **before** you enroll in the clinical trial.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be covered under this Plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this Plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)

- Psychologist (Ph.D.)
- Nurse (R.N.) licensed by a state

Plan (also called "This Plan")

The Nelson Trust's self-funded plan described in the Medical section of this document.

Plan Participant (also called "You" and "Your")

A person covered under this Plan as an employee or dependent.

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this Plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - **The American Hospital Formulary Service-Drug Information**
  - **The American Medical Association Drug Evaluation**
  - **The United States Pharmacopoeia-Drug Information**
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that’s other than that stated in its FDA-approved labeling.

Benefits aren’t available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Provider

A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this Plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the state of Washington and other such facilities are included as required by state and federal law.

In states other than Washington, "provider" means health care practitioners and facilities licensed or certified consistent with the laws and regulations of the state in which they operate, and provide health care services consistent with applicable state requirements.

Psychiatric Condition

A condition listed in the **Diagnostic and Statistical Manual (DSM) IV** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

Skilled Care

Care that's ordered by a physician and, in our judgment, requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Subscriber

An enrolled employee of The Nelson Trust. Coverage under this Plan is established in the subscriber's name.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

The Nelson Trust

The entity that sponsors this self-funded plan.

We, Us and Our

Means Premera Blue Cross in the Medical section of this document.

Prescription Drug

Summary of Benefits

Benefit	Retail Pharmacy	Medco By Mail
How much medication can I order?	Up to a **30-day** supply	Up to a **90-day** supply
What is my **payment** for medications?	**$5** for generics **30%** for preferred brands, with a minimum of **$30** and a maximum of **$60** **50%** for nonpreferred brands, with a minimum of **$50** and a maximum of **$100** **10%** copay for diabetic	**$10** for generics **30%** for preferred brands, with a minimum of **$75** and a maximum of **$150** **50%** for nonpreferred brands, with a minimum of **$125** and a maximum of **$250** **10%** copay for diabetic
Are there any **other costs?**	No.	No. Standard shipping is free.

Please Note: This information is an overview of The Nelson Trust prescription drug benefit. Benefits, coinsurance amounts, and copayments are subject to change by your health Plan.

Your Pharmacy Options

Retail Pharmacies

You may want to use a **participating retail pharmacy** for short-term prescriptions (such as antibiotics to treat infections). Be sure to show your prescription benefit card to the pharmacist and pay your retail payment for each prescription.

To find a participating retail pharmacy near you:

Visit **www.medco.com** and click "Locate a pharmacy."

Ask at your retail pharmacy whether it participates in the Medco network.

If you use a nonparticipating retail pharmacy, you must pay the entire cost of the prescription and then submit a reimbursement claim to Medco.

Plans that allow members to use nonparticipating retail pharmacies generally reimburse the amount the drug would have cost at a participating retail pharmacy minus your retail payment.

Medco By Mail Pharmacies

Over 6 million members enjoy the convenience and savings of having their long-term medications (those taken for 3 months or more) delivered to their home or office. Medications are dispensed by **Medco By Mail** pharmacists through our network of mail-order pharmacies.

Medco By Mail Advantages

- Get up to a 90-day supply (compared with a typical 30-day supply at retail) of each covered medication for just one mail-order payment.
- Registered pharmacists are available 24 hours a day, 7 days a week.
- Order refills online, by mail, or by phone—anytime day or night. To order online, register at **www.medco.com**. Refills are usually delivered within 3 to 5 days after we receive your order.
- Choose a convenient payment option—Medco offers a safe, convenient method of paying for prescription orders. E-check is an electronic funds transfer system that automatically deducts payments from your checking account. You can also pay by money order, personal check, credit card, or through our automatic payment program. For more information, visit **www.medco.com** or call Member Services.
- Standard shipping is free.

Using Medco By Mail

1. When using Medco By Mail, be sure to ask your doctor to write a prescription for up to a **90-day supply** of each medication (plus refills for up to one year, if appropriate).
2. Fill out the Medco By Mail order form.
3. Send the completed form, your prescription, and your payment option in the Medco By Mail envelope.

Your medication usually will be delivered within 8 days after we receive your initial order. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering. If you don't have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail-order prescription is being processed.

You may also have your doctor fax your prescriptions. Ask your doctor to call 888-327-9791 for faxing instructions.

Specialty Care Pharmacy

Some conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis, are treated with specialty medications. If you use specialty medications, you'll appreciate **Accredo Health Group** extras, including:

- Up to a 90-day supply of your specialty medication for just one payment
- Access to nurses who are trained in specialty medications
- Answers to your questions about specialty medications from a pharmacist 24 hours a day, 7 days a week
- Coordination of home care and other health care services

For more information, call Accredo at 800 309-7139.

Online Services

If you have Internet access, you can take advantage of Medco's award-winning, consumer-friendly Web site. More than 4 million active registered users visit **www.medco.com** to:

- Compare the cost of brand-name and generic drugs at retail and via mail order.

- Access plan highlights, as well as health and wellness information.
- Obtain order forms, claim forms, and envelopes.
- Submit mail-order refills.
- Check the status of Medco By Mail orders.

General information

To Contact Member Services

Member Services is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas) by calling toll-free 800-309-7139. Our Member Services representatives can:

- Help you find a participating retail pharmacy
- Send you order forms, claim forms, and envelopes
- Answer questions about your prescriptions or plan coverage

To Access Medco by TTY

TTY is available for hearing-impaired Plan Participants. Call 800-759-1089.

To Order Prescription Labels Printed in Braille

Braille labels are available for mail-order prescriptions. Call 800-309-7139.

Other Things You Should Know

Medco Protects Your Safety

The risks associated with drug-to-drug interactions and drug allergies can be very serious. To protect your safety—whether you use Medco By Mail or **medco.com**®—Medco checks for potential interactions and allergies. We also send information electronically to participating retail pharmacies.

Medco May Contact Your Doctor about Your Prescription

If you are prescribed a drug that is not on your plan's preferred list, yet an alternative plan-preferred drug exists, we may contact your doctor to ask whether that drug would be appropriate for you. If your doctor and you agree to use a plan-preferred drug, you will never pay more and will usually pay less.

Medco Protects Your Privacy

Because your privacy is important to us, Medco complies with federal privacy regulations. Medco uses health and prescription information about you and your dependents to administer your plan and to fill your mail-order prescriptions.

Your Plan May Have Coverage Limits

Your plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use Medco By Mail, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. We will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Controlled Substances

Federal law prohibits the return of dispensed controlled substances.

Vision

Evidence of Coverage & Disclosure Form

Provided by: Vision Service Plan

This evidence of coverage and disclosure form discloses the terms and conditions of coverage. Please read the form completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them. All applicants have a right to review the evidence of coverage and disclosure form prior to enrollment.

This evidence of coverage and disclosure form constitutes only a summary of the terms and conditions of coverage. The provisions of the contract control in the event of a conflict. The Plan contract itself should be consulted to determine governing terms and conditions of coverage.

Definitions

Anisometropia

A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

Benefit Authorization

Authorization issued by VSP identifying the individual named as a Plan Participant of VSP, and identifying those Plan Benefits to which a Plan Participant is entitled.

Copayments

Any amounts required to be paid by or on behalf of a Plan Participant for Plan Benefits which are not fully covered.

Eligible Dependent

Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group as specified under the “Eligibility Rules for Employees and Dependents” section of this document.

Emergency Condition

A condition, with sudden onset and acute symptoms, that requires the Plan Participant to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

Enrollee

An employee or member of Group who meets the criteria for eligibility specified under the “Eligibility Rules for Employees and Dependents” section of this document.

Experimental Nature

Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

Group

An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

Keratoconus

A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

Member Doctor

An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Plan Participants of VSP.

Non-Member Provider

Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Plan Participants of VSP.

Plan Benefits

The vision care services and vision care materials which a Plan Participant is entitled to receive by virtue of coverage under this plan, as defined in the Schedule of Benefits.

Plan Participant

An Enrollee or Eligible Dependent who meets the eligibility criteria and who is covered under this plan.

Renewal Date

The date on which this plan shall renew or terminate if proper notice is given.

Schedule of Benefits

The document that lists the vision care services and vision care materials which a Plan Participant is entitled to receive by virtue of this plan.

Visually Necessary or Appropriate

Services and materials medically or visually necessary to restore or maintain a patient’s visual acuity and health and for which there is no less expensive professionally acceptable alternative.

Procedures for Using this Plan

Please read the following information so you will know from whom or what group of providers health care may be obtained.

1. When you desire to obtain Plan Benefits from a Member Doctor, you should contact a Member Doctor or VSP. A list of names, addresses, and phone numbers of Member Doctors in your geographic location can be obtained from your Group, Trust Administrator, or VSP. If this list does not cover the geographic area in which you desire to seek services, you may call or write the VSP office nearest you to obtain one which does.
2. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain Benefit Authorization from VSP.
3. When such Benefit Authorization is provided by VSP and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against this plan in spite of your termination of coverage or the termination of this plan. Should you receive services from a Member Doctor without such Benefit Authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.
4. You pay only the Copayment to the Member Doctor for the services covered by this plan. VSP will pay the Member Doctor directly according to their agreement with the doctor. VSP reimburses its Member Doctors on a fee-for-service basis. There are no incentives or financial bonuses paid to Member Doctors for services covered under this plan.

   Please Note: If you are eligible for and obtain Plan Benefits from a Non-Member Provider, you should pay the provider his full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown on the Schedule of Benefits, less any applicable Copayments.
5. In emergency conditions, when immediate vision care of a medical nature such as for bodily trauma or disease is necessary, Plan Participant can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider if the Schedule of Benefits indicates Plan Participant’s Plan includes such coverage). No prior approval from VSP is required for Plan Participant to obtain vision care for Emergency Conditions of a medical nature.
6. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.
7. In the event of termination of a Member Doctor’s membership in VSP, VSP will remain liable to the Member Doctor for services rendered to you at the time of termination and permit Member Doctor to continue to provide you with Plan Benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

Benefit Authorization Process

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by the Trust Administrator and the level of coverage (i.e., service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Plan Participant by Group under this Plan. When Plan Participant requests services under this plan, Plan Participant's prior utilization of Plan Benefits will be reviewed by VSP to determine if Plan Participant is eligible for new services based upon Plan Participant's Plan’s level of coverage. Please refer to

the Vision Care Plan Disclosure Form and Evidence of Coverage for a summary of the level of coverage provided to Plan Participant by Group.

Prior Authorization

Certain Plan Benefits require VSP's prior authorization before such Plan Benefits are covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

1. Initial Determination: VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the Plan Participant's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
2. Appeals: If VSP denies the doctor's request for prior authorization, the doctor, Plan Participant or the Plan Participant's authorized representative may request an appeal of the denial. Please refer to the section on Claim Appeals, below, for details on how to request an appeal. VSP shall provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within thirty (30) calendar days. Plan participant may designate any person, including the provider, as Plan Participant's authorized representative.

   For more information regarding VSP's criteria for authorizing or denying Plan Benefits, please contact VSP's Customer Service Department.

Benefits and Coverages

Through its Member Doctors, VSP provides Plan Benefits to Plan Participants as may be Visually Necessary or Appropriate, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

IMPORTANT: The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

1. **Eye Examination:** A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated. Each Plan Participant is entitled to an Eye Examination as indicated on the Vision Care Plan Disclosure Form and Evidence of Coverage.
2. **Lenses:** The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses. Each Plan Participant is entitled to new lenses as indicated on the Vision Care Plan Disclosure Form and Evidence of Coverage.
3. **Frames:** The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. Each Plan Participant is entitled to new frames as indicated on the Schedule of Benefits.

4. **Contact Lenses:** Unless otherwise indicated on the Vision Care Plan Disclosure Form and Evidence of Coverage, contact lenses are available under this plan in lieu of all other lens and frame benefits described herein.

   When you obtain Visually Necessary contact lenses from a Member Doctor, professional fees and materials will be covered as indicated on the Schedule of Benefits with prior authorization from VSP. Coverage for Visually Necessary contact lenses regardless of whether they are obtained from a Member Doctor or Non-Member Provider is subject to review and authorization from VSP's optometric consultants.

   If you select contact lenses for other than Visually Necessary circumstances, they will be considered Elective contact lenses. When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

5. If you elect to receive vision care services from one of the Member Doctors, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his full fee. VSP will reimburse you in accordance with the reimbursement schedule shown on the Schedule of Benefits, less any applicable Copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.

6. **Additional Discount:** Each Plan Participant shall be entitled to receive a 20%* discount toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Plan Participants shall be entitled to receive a discount of 15% off of contact lens examination services from any Member Doctor.**

   Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

   Limitations:
   - Discounts do not apply to vision care benefits obtained from Non-Member Providers.
   - 20% discount applies to complete pairs of glasses only.
   - Discounts do not apply is prohibited by the manufacturer.
   - Discounts do not apply to sundry items; e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

   *Note: The 20% discount applies to the frame on the off year.

   **Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

7. **Low Vision Services and Materials**: The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Plan Participant falls within this category, he or she will be entitled to professional services as well as ophthalmic materials including but not limited to supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the

frequency and benefit limitations as outlined on the Vision Care Plan Disclosure Form and Evidence of Coverage. Consult your Member Doctor for details.

Exclusions and Limitations of Benefits

This plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, this Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional costs for the options, unless the extra is defined as a Plan Benefit in the Schedule of Benefits.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

Not Covered

There is no benefit under this Plan for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an Experimental Nature
- Costs for services and/or materials above Plan Benefit allowances indicated on the Schedule of Benefits
- Services/materials not indicated as covered Plan Benefits on the Schedule of Benefits

Liability in Event of Non-Payment

In the event VSP fails to pay the provider, you shall not be liable for any sums owed by VSP other than those not covered by the Plan.

Complaints and Grievances

If Plan Participant ever has a question or problem, Plan Participant's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Plan Participant's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Plan Participant, the Plan Participant may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Plan participants also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt.

Claim Payments and Denials

1. **Initial Determination:** VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Plan Participant or Plan Participant's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
2. **Request for Appeals:** If a Plan Participant's claim for benefits is denied by VSP in whole or in part, VSP will notify the Plan Participant in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Plan Participant may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Plan Participant for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Plan Participant's name and date of birth, the name of the provider of services and the claim number. The Plan Participant may state the reasons the Plan Participant believes that the claim denial was in error. The Plan Participant may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Plan Participant the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Plan participant or Plan Participant's authorized representative should submit all requests for appeals to:

   VSP
   Member Appeals
   3333 Quality Drive
   Rancho Cordova, CA 95670
   (800) 877-7195

   VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Plan Participant within thirty (30) calendar days after receipt of a request for appeal from the Plan Participant or Plan Participant's authorized representative.

   - **Urgent Care Claims**

     A claimant shall be given notice if a claim for urgent care shall be wholly or partially denied no later than 48 hours after the earlier of the Plan's receipt of requested specified information or the end of the period of time to provide the requested specified information. The denial and information to appeal may be given orally but written notice must be furnished within 3 days after the oral notification. If the claimant shall not be satisfied with the decision, the claimant may submit the claim to the Claims Review Committee for a determination within 60 days of the denial. The Claims Review Committee shall review

the issue and the claimant shall be given written notice of the decision 72 hours after submission of the claim.

The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal shall be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees shall decide the appeal within 45 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that the claimant shall be given notice. The notice shall be given prior to commencement of the extension; shall state the special circumstances which require the extension; and shall state the expected date of the decision. The Board of Trustees shall notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

A claimant shall not undertake any legal action for a claim until all rights under the claims appeal procedure shall have been exhausted."

- **Pre-service Claims**

  A claimant shall be given notice if a claim shall be wholly or partially denied. If the claimant shall not be satisfied with the decision, the claimant may submit the claim to the Claims Review Committee for a determination within 60 days of the denial. The Claims Review Committee shall review the issue and the claimant shall be given written notice of the decision 15 days after submission of the claim.

  The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal shall be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees shall decide the appeal within 45 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that the claimant shall be given notice. The notice shall be given prior to commencement of the extension; shall state the special circumstances which require the extension; and shall state the expected date of the decision. The Board of Trustees shall notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

  A claimant shall not undertake any legal action for a claim until all rights under the claims appeal procedure shall have been exhausted."

- **Other Claims**

  A claimant shall be given notice if a claim shall be wholly or partially denied. If the claimant shall not be satisfied with the decision, the claimant may submit the claim to the Claims Review Committee for a determination within 60 days of the denial. The Claims Review Committee shall review the issue and the claimant shall be given written notice of the decision 30 days after submission of the claim. However, the Claims Review Committee may obtain a 15 day extension of time to make the decision if the Claims Review Committee shall not be able to make a decision for reasons beyond its control. To obtain the extension, the Claims Review Committee shall:

  a. give the claimant written notice of the extension prior to the expiration of the 30 days;

  b. advise the claimant of the circumstances requiring the extension of time;

c. advise the claimant of the expected date of the decision; and

d. state the additional information, if any, that the claimant failed to submit and permit the claimant at least 45 days to provide the information.

The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal shall be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees shall decide the appeal within 45 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that the claimant shall be given notice. The notice shall be given prior to commencement of the extension; shall state the special circumstances which require the extension; and shall state the expected date of the decision. The Board of Trustees shall notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

A claimant shall not undertake any legal action for a claim until all rights under the claims appeal procedure shall have been exhausted.

3. **Review by the Department of Managed Health Care:** The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 877-7195 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (888-HMO-2219) and a TDD line (877-688-9891) for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Arbitration

Any dispute or question arising between VSP and Group or any Plan Participant involving the application, interpretation, or performance under this plan shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration. The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

Vision

Second Opinions

All requests for a second opinion shall be directed, in writing, to:

Vision Service Plan
Clinical Consultant
Health Care Services Division
3333 Quality Drive
Rancho Cordova, CA 95670

The Clinical Consultant will review each request and respond within twenty (20) days of receipt of the written request.

The requesting patient shall provide all evidence supporting the request for a second opinion when requested by the Clinical Consultant.

A request for a second opinion shall be granted when it is determined by the Clinical Consultant, based on information provided by the Enrollee and the original examining Member Doctor, that the initial examination was insufficient to ascertain the visual health problems of the patient.

In no circumstance will a second opinion be granted if the patient's initial vision examination was performed by a Non-Member Provider.

Termination of Benefits

Terms and cancellation conditions of this plan are shown on the Vision Care Plan Disclosure Form and Evidence of Coverage. Plan Benefits will cease on the date of cancellation of this plan whether the cancellation is by Group or by VSP due to non-payment of administrative fees. If service is being rendered to you as of the termination date of this plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of this plan.

Individual Continuation of Benefits

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees of the Group who may desire to retain their coverage.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. Refer to the "Eligibility Rules for Employees and Dependents" in this document for details on COBRA provisions.

Vision Care Plan Disclosure Form and Evidence of Coverage

ELIGIBILITY: Enrollees & Eligible Dependents: Refer to the “Eligibility Rules for Employees and Dependents” section of this document for details.

PLAN AND SCHEDULE:

PLAN B

Examination:	once every 12 months
Lenses:	once every 12 months
Frames:	once every 24 months

TYPE OF ADMINISTRATION: VSP will provide administrative services of the following nature: claim and billing administration. Benefits provided under this plan are self-insured by the Trust.

VSP'S ADDRESS IS:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Vision

Schedule of Benefits

General

This Schedule lists the vision care services and vision care materials to which Plan Participants of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

PLAN BENEFITS	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Vision Examination	Covered in Full	Up to $ 45.00
VISION CARE MATERIALS		
Lenses		
Single Vision	Covered in Full*	Up to $ 45.00*
Bifocal	Covered in Full*	Up to $ 65.00*
Trifocal	Covered in Full*	Up to $ 85.00*
Lenticular	Covered in Full*	Up to $125.00*
Frames	$120 allowance for frame of your choice.* 20% off the amount over your allowance.	Up to $ 47.00*
CONTACT LENSES		
Visually Necessary		
Professional Fees and Materials	Covered in Full*	Up to $250.00*
Elective		
Professional Fees** and Materials	Up to $ 120.00	Up to $105.00

*Subject to a $25.00 copay.

**Additional discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Vision

Copayment
There shall be no Copayment for the examination. If materials (lenses and frames) are provided, there shall be a Copayment of $ 25.00 payable by the Plan Participant to the Member Doctor at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Low Vision
Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

PLAN BENEFITS	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Covered in Full	Up to $125.00
Supplemental Aids	75% of cost	75% of cost

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

Additional Discount
Each Plan Participant shall be entitled to receive a discount of twenty percent (20%)* toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Plan Participants shall be entitled to receive a discount of fifteen percent (15%) off contact lens examination services from any Member Doctor.**

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

Limitations:

- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

*Note: The 20% discount applies to the frame on the off year.

**Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

Dental

The Nelson Trust offers a choice of two dental plans for you and your eligible family members. You may elect either plan when you first become eligible and you may change your plan each year during the open enrollment period.

Option 1 – Oregon Dental Services (ODS), including the Delta Dental network of over 100,000 providers nationwide

Option 2 – Willamette Dental Insurance, Inc., a managed dental care program with over 60 offices in Oregon, Washington and Idaho

Each plan covers most necessary dental services and supplies, including diagnostic and preventive care (such as exams, cleanings, and X-rays), basic and major restorative services (such as fillings, crowns, and dentures).

Oregon Dental Service (ODS)

The ODS Companies
601 S.W. Second Avenue
Portland, Oregon 97204

Telephone Numbers

Enrollee Inquiries

Portland	503-265-5680
Toll-Free	877-277-7280
TDD/TTY (for the hearing and speech impaired)	800-433-6313

Spanish Dental Customer Service (Servicio al Cliente Area Dental)

Portland	503-265-2963
Toll-Free (Llamado Gratis)	877-299-9063

Dental Office Inquiries

Portland	503-243-4494
Toll-Free	800-452-1058

ODS reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by ODS. The monitoring is to ensure the quality and accuracy of the service provided by employees of ODS to their customers.

Welcome

Welcome to Oregon Dental Service (ODS).

The Plan is self-funded and The Nelson Trust has contracted with Oregon Dental Service to provide claims and other administrative services.

In the ODS section of this document, the terms, "you" and "your" refer to the enrolled employee and/or enrolled dependents. "We", "us", and "our", refer to Oregon Dental Service (ODS), the Claims Administrator of the Plan.

Created in 1955, ODS was the first company in America to provide prepaid dental coverage. Today we are Oregon's largest, covering over 500,000 people from more than 1,400 groups.

Using Your Program

Our dental plans are easy to use and cost effective. If you choose a participating dentist from the ODS Premier Dental Directory (which is available on the ODS Web site at **www.odscompanies.com** under "Provider Search"), all of the paperwork takes place between our office and your dentist's office. More than 90% of all licensed dentists in Oregon are ODS participating dentists. For travelers and employees outside Oregon, our national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

Dental – Oregon Dental Service (ODS)

When you need dental care you may use any dental provider. However, **there are differences in reimbursement by ODS for participating dentists and non-participating dental providers.** An example is provided on page 114. While an Enrollee may choose the services of any dentist, ODS does not guarantee the availability of any particular dentist.

During your first appointment, tell your dental provider that you have dental benefits through ODS. You will need to provide your subscriber identification number and ODS Group number to the dentist. These numbers are located on your ODS I.D. card.

For expensive treatment plans, ODS provides a predetermination service. Your dentist may submit a predetermination request to get an estimate of what your coverage would pay. The predetermination will be processed according to the Plan's current contract and returned to your dental provider. You and your dental provider should review the information before beginning treatment.

All predetermination forms and claims should be submitted to:

Oregon Dental Service
601 S.W. Second Avenue
Portland, Oregon 97204
503-265-5680 in Portland Area
877-277-7280 Toll-Free

If you have questions about your Plan, contact the ODS Customer Service Department in Portland at 503-265-5680 or toll-free at 877-277-7280, TDD 800-433-6313.

Review this document carefully. It describes the benefits of your plan. It is the responsibility of the Enrollee to review his or her Plan and to be aware of its limitations and exclusions.

Please Note: This document is a description of your dental care program. All plan provisions are governed by The Nelson Trust's agreement with ODS. This document may not contain every plan provision. All provisions or terms of the policy not described in this document still apply.

Definitions

For the purpose of this Policy, the following definitions shall apply:

Abutment

A tooth used to support a prosthetic device (implant crowns, bridges, partial dentures or overdentures).

Accepted Fee

The filed fee approved by ODS for a specific dental procedure performed by a participating dentist submitting that fee and performing that dental service. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to our Dental Consultant who determines a comparable code to the one billed. ODS will use the Maximum Plan Allowance for the comparable code to price the claim.

Alveolar Structures

The upper and lower jaw bones.

Alveoloplasty

The surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

Amalgam

A silver-colored material used in restoring teeth.

Anterior

Refers to teeth located at the front of the mouth (see Tooth Chart).

Benefit Year

A calendar year or portion thereof (see Claim Determination Period).

Benefits

Those dental services which are available under the terms of this Policy.

Bicuspid

A premolar tooth, between the front and back teeth (see Tooth Chart).

Bridge

Also called a fixed partial denture. A bridge replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Abutment crowns (crowns placed on adjacent teeth) are considered part of the bridge.

Broken

A tooth is considered broken when a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.

Cast Restoration

Includes crowns, inlays, onlays, and any other restoration to fit a specific patient's tooth that is made at a laboratory and cemented into the tooth.

Claim Determination Period

A calendar year (January 1 through December 31) or portion thereof.

Composite

A tooth-colored material used in restoring teeth.

Copayment (Copay)

The relative percentages (coinsurance) to be paid by the Enrollee.

Covered Employee

An employee for whom the Policyholder has made contributions to provide dental benefits.

Covered Employment

Employment for which an employer has made contributions to provide dental care benefits.

Debridement

The removal of excess plaque. A periodontal “pre-cleaning” procedure is done when there is too much plaque for the dentist to perform an exam.

Deductible

The amount of covered expenses that are paid by the Enrollee before benefits are payable by the Plan.

Dental Provider

A duly licensed dentist, certified denturist or registered hygienist, legally entitled to practice dentistry at the time and in the place services are performed; to the extent that he or she is operating within the scope of his or her license, certificate, or registration as required under law within the state of practice.

Dentally Necessary

- Services that are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan,
- Services that are appropriate with regard to standards of good dental practice in the service area,
- Services that have a good prognosis, and/or
- Services that are the least costly of the alternative supplies or levels of service that can be safely provided to you. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

Please Note: The fact that a dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Eligibility Date

The date an employee’s or dependent’s eligibility for benefits becomes effective under the terms of this Policy.

Eligible Dependent

Any of the dependents of an employee who are eligible for benefits in accordance with the conditions of eligibility as stated in the “Eligibility Rules for Employees and Dependents” section of this document.

Eligible Employee

Any employee who meets the conditions of eligibility as stated in the “Eligibility Rules for Employees and Dependents” section of this document.

Eligible Person

Any employee or dependent who meets the conditions of eligibility as stated in the "Eligibility Rules for Employees and Dependents" section of this document. For the purposes of the Policy, an eligible person includes an individual who has made premium payments to continue coverage under the Policy.

Group Eligibility Waiting Period

The period of employment or membership with the Group that a prospective Enrollee must complete before coverage begins.

Group Health Plan

Any plan, fund or program established and maintained by an employer or an employee organization, or both, for the purpose of providing health care for its participants or their beneficiaries through insurance, reimbursement or otherwise. This dental Plan is a group health plan.

Maximum Payment Limit

The amount payable by the Plan for covered services received each calendar year, or portion thereof, for each eligible patient.

Maximum Plan Allowance

For a participating dental provider, the maximum amount is based on a fee filed with ODS. For non-participating dental providers, the maximum amount is based on a per service average allowance of the participating dentists' filed fees. *The non-participating dentist has the right to bill the difference between the ODS Maximum Plan Allowance and the actual charge. This difference will be a patient responsibility.*

Mental Incapacity

Intellectual competence usually characterized by an IQ of less than 70.

Non-Participating Dental Providers

Those dental providers who are not participating.

Non-Participating Dentist

A licensed dentist who is not a participating dentist.

ODS

Oregon Dental Service, a not-for-profit dental health care service contractor. References to ODS as paying claims or issuing benefits mean that ODS processes a claim and the Plan Sponsor reimburses ODS any benefit issued.

Palliative Treatment

Treatment performed only to control pain, swelling, or bleeding in or around the teeth and gums. Palliative treatment does not include follow-up care or definitive restorations such as, but not limited to, crowns, extractions, or root canal treatment.

Participating Dental Provider

A licensed dental provider who has agreed to render services in accordance with terms and conditions established by ODS and has satisfied ODS that he or she is in compliance with such terms and conditions.

Participating Dentist

A licensed dentist who has agreed to render services in accordance with terms and conditions established by ODS and has satisfied ODS that he or she is in compliance with such terms and conditions.

Periodic Exam

A routine exam (check-up) commonly performed every six months.

Periodontal Maintenance

A periodontal procedure for patients who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (prophylaxis).

Physical Incapacity

The inability to pursue an occupation or education because of a physical impairment.

Plan Participant

An employee, dependent of the employee or an individual otherwise eligible who has enrolled for coverage under the terms of the Policy.

Plan Sponsor

The Nelson Trust, which has contracted with Oregon Dental Service to provide claims and other administrative services.

Policy

The agreement between ODS and the Policyholder including the application of the Policyholder for the Policy and the appendices, amendments, endorsements and riders, if any. The Policy constitutes the entire policy between the parties.

Policyholder

The group or employer for whose Plan Participants dental benefits are being provided.

Policy Term

The period commencing on the effective date hereof and continuing until the termination date as herein provided.

Policy Year

The 12-month period commencing on the effective date and each 12-month period thereafter.

Pontic

An artificial tooth that replaces a missing tooth, and is part of a bridge.

Posterior

Refers to teeth located toward the back of the mouth (see Tooth Chart).

Prophylaxis

Cleaning and polishing of all teeth.

Reline

The process of resurfacing the tissue side of a denture with new base material.

Restoration

The treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, fillings and crowns.

The Plan

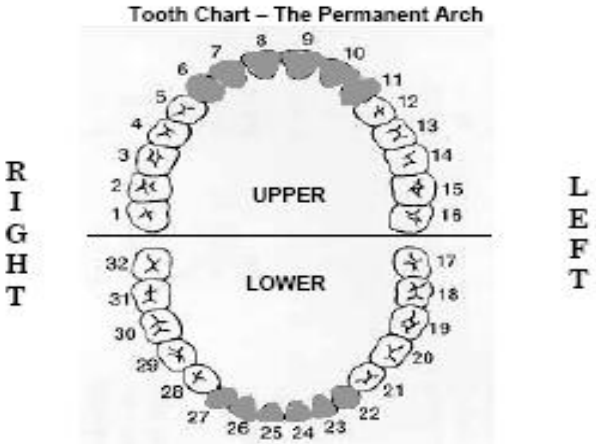
The employee dental benefit plan funded and provided by the Plan Sponsor.

Veneer (Chairside and Laboratory)

A layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration that is created (cast) at a laboratory. Chairside and laboratory veneers may be paid at different benefit levels.

ViziLite

A non-excisional soft tissue screening to detect oral cellular abnormalities.



Please Note: Anterior teeth are shaded gray.

The Permanent Arch		
Tooth #		Description of Tooth
Upper	Lower	
1	17	3rd Molar (wisdom tooth)
2	18	2nd Molar (12-yr molar)
3	19	1st Molar (6-yr molar)
4	20	2nd Bicuspid (2nd premolar)
5	21	1st Bicuspid (1st premolar)
6	22	Cuspid (canine/eye tooth)
7	23	Lateral Incisor
8	24	Central Incisor
9	25	Central Incisor
10	26	Lateral Incisor
11	27	Cuspid (canine/eye tooth)
12	28	1st Bicuspid (1st premolar)
13	29	2nd Bicuspid (2nd premolar)
14	30	1st Molar (6-yr molar)
15	31	2nd Molar (12-yr molar)
16	32	3rd Molar (wisdom tooth)

Eligibility and Enrollment

Eligibility and coverage rules for this dental plan are governed by general Trust eligibility rules for active employees. Please refer to the “Eligibility Rules for Employees and Dependents” section of this document for an explanation of eligibility and self-payment rules and regulations for employees and qualified dependents.

Benefits and Limitations

Below is a general list of services the Plan covers when performed by a dental provider (licensed dentist, certified denturist or registered hygienist). These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures.

Limitations may apply to these services, so please see below. Also, see “Exclusions” in the ODS section of this document for exclusions.

Deductible: $50.00

Per patient (not to exceed $100.00 per family) per calendar year, or portion thereof

Deductible applies to covered Class II and Class III services

Maximum Payment Limit: $2,000.00

Per eligible patient per calendar year, or portion thereof

All covered services (Class I, II, III) apply to Maximum Payment Limit

1. Class I: 100% is provided toward covered Class I services

A. Diagnostic

Examination

Intra-oral x-rays to assist in determining required dental treatment.

Diagnostic Limitations:

1) Periodic (routine) or comprehensive examinations or consultations are covered only once in any six (6)-month period*.
2) Complete series x-rays or a panoramic film is covered only once in any three (3) year period*.
3) Supplementary bitewing x-rays are covered only once in any six (6)-month period*.
4) Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
5) Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
6) ViziLite is covered once in any six (6)-month period*.

B. Preventive

Prophylaxis (cleanings)
Topical application of fluoride
Space maintainers
Sealants

Preventive Limitations:

1) Prophylaxis (cleaning) or periodontal maintenance is covered only once in any six (6)-month period*.
2) *Additional cleaning benefit is available for Plan Participants with diabetes and female Plan Participants in their third trimester of pregnancy. To be eligible for this additional benefit, Plan Participants must be enrolled in the ODS Oral Health, Total Health program. See the "ODS Oral Health, Total Health Program" section of this document for more details.
3) Periodontal maintenance is covered only once in any three (3)-month period*.
4) Topical application of fluoride is covered only once in any six (6)-month period* for all ages.
5) Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth, during any five (5) year period.

*__Please Note:__ These time periods are calculated from the previous date of service.

2. Class II: 80% is provided toward covered Class II services

A. Restorative

Provides amalgam (silver) fillings on posterior (back) teeth and composite (tooth colored) fillings on anterior (front) teeth for the treatment of carious lesions (decay).

Restorative Limitations:

1) Composite, resin, or similar (tooth colored) restorations in posterior (back) teeth are considered optional services. Coverage shall be made for a corresponding amalgam (silver) restoration. **If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.**
2) Inlays are considered an optional service; an alternate benefit of an amalgam will be provided.
3) Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
4) Refer to Class III Limitations for further limitations when teeth are restored with crowns or cast restorations.
5) A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

B. Oral Surgery

Extractions (including surgical), other minor surgical procedures, general anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).

Oral Surgery Limitations:

1) A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
2) General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.
3) Surgery on larger lesions or malignant lesions is not considered minor surgery.
4) Brush biopsy is covered once in any six (6)-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

C. Endodontic

Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Endodontic Limitations:

1) A separate charge for cultures is not covered.
2) Pulp capping is covered only when there is exposure of the pulp.
3) Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

D. Periodontic

Treatment of diseases of the gums and supporting structures of the teeth.

Periodontic Limitations:

1) Periodontal scaling and root planing is limited to once per quadrant in any six (6)-month period.
2) Periodontal maintenance is limited to once in any three (3)-month period*.
3) A separate charge for post-operative care done within six (6) months following periodontal surgery is not covered.
4) Full mouth debridement is limited to once in a three (3) year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within twenty-four (24) months.

3. Class III: 65% is provided toward covered Class III services.

A. Restorative

Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

Restorative Limitations:

1) Cast restorations (including pontics) are covered once in a five (5) year period on any tooth. See Class II for limitations on buildups.
2) Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and you are responsible for paying the difference.

3) If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

B. Prosthodontic

Bridges, partial dentures, and complete dentures; includes denture relines and repair of an existing prosthetic device.

Prosthodontic Limitations:

1) A bridge or denture (full or partial denture) will be covered only once in a five (5) year period and only if the tooth, toothsite, or teeth involved have not received a cast restoration benefit in the past five (5) years.
2) *Full, immediate and overdentures:* If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
3) *Partial dentures:* A temporary (interim) partial denture is only a benefit when placed within two (2) months of a recently extracted anterior tooth or for missing anterior permanent teeth of patients age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
4) *Denture adjustments and relines:* A separate, additional charge for denture adjustments, repairs, and relines done within six (6) months after the initial placement is not covered. Subsequent relines will be covered only once per denture in a twelve (12)-month period.
5) Surgical placement, removal of implants, or related services are not covered. We will benefit:
   - The final crown and abutment over a single implant. This benefit is limited to once per tooth in any five-year period; or
   - Provide an alternate benefit per arch of a full or partial denture for the final prosthetic when the implant is placed to support a prosthetic device. The alternate benefit will apply to the frequency limitation (only once in any five-year period) for prosthetic devices.
   - This benefit or alternate benefit is not provided if the tooth received a cast restoration or prosthodontic benefit within the previous five (5) years.
6) Fixed bridges or removable cast partial dentures are not covered for patients under age sixteen (16).
7) Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. You are responsible for paying the difference.

4. General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, ODS will pay the applicable percentage of the Maximum Plan Allowance for the least costly treatment. The Plan Participant will then be responsible for the remainder of the dental provider's fee.

5. Non-Participating Dental Providers

The program requires that amounts payable for services of a non-participating dental provider be limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's non-participating dentist allowance.

ODS Oral Health, Total Health

Did you know that visiting your dentist on a regular basis and keeping your mouth healthy is critical to keeping the rest of your body healthy?

Recent studies have indicated a relationship between periodontal disease and bacteria in the mouth with various health problems. These problems can include pre-term, low birth weight babies and diabetes. Research also confirms that regular visits to the dentist may help in the diagnosis and management of diabetes. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Oral Health, Total Health Benefits

We care about your overall health and have developed a program for ODS Plan Participants based on this new evidence.

Diabetes

If you have diabetes, elevated blood sugar levels can have a negative effect on your oral health. Diabetes increases your risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make your diabetes more difficult to manage. Infections may cause your blood sugar to rise and require more insulin to keep it under control.

Diabetic enrollees covered under this Plan are eligible for a total of four prophylaxes (cleanings) or periodontal maintenance sessions per calendar year. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Plan.

Pregnancy

Keeping your mouth healthy during your pregnancy is important for you and your baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby.

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during your third trimester of pregnancy. By enrolling in the ODS Oral Health, Total Health program, you are eligible for a prophylaxis (cleaning) or periodontal maintenance in the third trimester of pregnancy regardless of normal plan frequency limits. Please note this benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Plan.

Enrollment

Enrolling in the ODS Oral Health, Total Health Program is easy.

Please complete and return the Oral Health, Total Health enrollment form found on our Web site or call ODS dental customer service at 503-265-5680 or toll-free at 877-277-7280 to enroll. For Plan Participants with diabetes, proof of diagnosis is required.

Exclusions

1. Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.
2. The Plan does not cover:
   - Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan;
   - Services that are inappropriate with regard to standards of good dental practice;
   - Services with poor prognosis.
3. The following are not covered:
   - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
   - Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
   - Services which are provided, without cost to the Enrollee, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Plan;
   - Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto.
4. A separate charge for periodontal charting is not covered.
5. Services or supplies caused by or provided to correct congenital or developmental malformations, including, but not limited to cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth), are excluded.
6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guards).
7. Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ) are excluded.
8. Gnathologic recordings or similar procedures are excluded.

9. Dental services started prior to the date the individual became eligible for such services under the Plan are excluded.
10. Hypnosis, premedications, analgesics (e.g., nitrous oxide), local anesthetics or any other prescribed drugs are excluded.
11. Hospital or facility charges for services or supplies, or additional fees charged by the dental provider for hospital, extended care facility or home care treatment are excluded.
12. Charges for missed or broken appointments are excluded.
13. Experimental procedures or supplies are excluded.
14. Orthodontic services (treatment of malalignment of teeth and/or jaws) are excluded.
15. This Plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III services which were ordered and fitted while still eligible, and then only if such items are cemented within thirty-one (31) days after individual eligibility ends. This provision is not applicable if the Policyholder transfers the Plan to another claims administrator.
16. This Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.
17. Surgical placement or removal of implants or attachments to implants is not covered. See Limitations.
18. Plaque control and oral hygiene or dietary instruction are not covered.
19. Claims submitted more than 15 months after the date of service are not covered, except as stated in the Claims Administration and Payment section in this document.
20. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.
21. Services performed on the tongue, lip or cheeks are not covered.
22. Precision attachments are not covered.
23. Taxes are not covered.
24. Exclusions include all other services or supplies not specifically included in this Plan as covered dental services.

Example of How the Plan Pays

Please note the payments on specific claims will be based on the individual agreement between ODS and the dentist. **If you see a Non-Participating Dentist, some disallowed charges that are provider discounts for Participating Dentists will be patient responsibility**. For purposes of this example, it is assumed any deductible has been met and the benefit is 80% of the allowed charge. Allowed charge is based on the Maximum Plan Allowance.

Participating Dentist									
CDT/Category	**Tooth**	**Total Charges**	**Disallowed/ Reason**	**Deduct**	**Provider Discount**	**Allowed**	**Copay**	**Paid**	**Pt. Resp.**
D2150 Amalgam Filling	30	$120.00	$20.00**	$0.00	$20.00	$100.00	$20.00	$80.00	$20.00
D9215 Local Anesthesia	--	$50.00	$50.00*	$0.00	$50.00	$0.00	$0.00	$0.00	$0.00
Totals		$170.00	$70.00	$0.00	$70.00	$100.00	$20.00	$80.00	$20.00

Total Out of Pocket Expense

Reason Code: * A separate, additional payment is not provided for local anesthesia.

** The fee charged exceeds the maximum allowance.

Non-Participating Dentist									
CDT/Category	**Tooth**	**Total Charges**	**Disallowed/ Reason**	**Deduct**	**Provider Discount**	**Allowed**	**Copay**	**Paid**	**Pt. Resp.**
D2150 Amalgam Filling	30	$120.00	$20.00**	$0.00	$0.00	$100.00	$20.00	$80.00	$40.00
D9215 Local Anesthesia	--	$50.00	$50.00*	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00
Totals		$170.00	$70.00	$0.00	$0.00	$100.00	$20.00	$80.00	$90.00

Total Out of Pocket Expense

Reason Code: * A separate, additional payment is not provided for local anesthesia.

** The fee charged exceeds the maximum allowance.

The additional amount you would pay for using a Non-Participating Dentist is $70.00.

Coordination of Benefits

Coordination of Benefits (COB) occurs when you have health care coverage under more than one Plan.

Definitions

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan

Any of the following coverages, including Plan coverages, which provide benefit payments or services to a Plan Participant for hospital, medical, surgical or dental care:

- Group, blanket or franchise insurance (except student accident insurance);
- Prepayment coverage on a group basis, including HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits that exceeds $100 a day.

Each contract or other arrangement for coverage described above is a separate Plan.

Claimant

The covered person for whom the claim is made.

Claim Period

See “Definitions” in the ODS section of this document, paragraph entitled "Claim Determination Period."

Allowable Expense

Any expense which is covered by at least one Plan during a Claim Period. Where a Plan provides benefits in the form of a service rather than cash payments, the cash value of the service during a Claim Period will also be considered an Allowable Expense.

If a Plan benefit has a visit, day or dollars paid limitation and the limitation has been met, services in excess of the limitation will not be considered covered expenses for the purpose of this provision.

This Plan

The part of this Group contract that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans.

How COB Works

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

The Primary Plan (the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of total Covered Expense; or
- The amount of benefits it would have paid had it been the Primary Plan.

Which Plan Pays First?

When another Plan does not have a COB provision, that Plan is primary, and therefore determines and pays its benefits first. When another Plan does have a COB provision, the first of the following rules that applies will govern:

- **Non-Dependent/Dependent**

  If a Plan covers the claimant as an employee, member or non-dependent, then that Plan will determine its benefits before a Plan which covers the person as a dependent.

- **Dependent Child/Parents Not Separated or Divorced**
  - If the claimant is a dependent child whose parents are not divorced or separated and the claimant is eligible for benefits under both parents' plans, then the Plan of the parent whose birthday falls earlier in the calendar year will determine its benefits before the Plan of the parent whose birthday falls later in that year.
  - If both parents' birthdays are on the same day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.

- **Dependent Child/Separated or Divorced Parents**

  If two or more plans cover the claimant as a dependent child of divorced or separated parents, then the following rules apply:
  - First the Plan of the parent with custody of the child, then the Plan of the spouse of the parent with custody of the child, and finally the Plan of the parent without custody.
  - However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Active/Inactive Employee**

  The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other

Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule is ignored.

- **Longer/Shorter Length of Coverage**

  If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or non-dependent longer are determined before those of the plan that covered that person for the shorter time.

Where part of a Plan coordinates benefits and a part does not, each part will be treated as a separate Plan.

This COB provision will not apply to a claim when the Allowable Expense for a Claim Period is $50 or less. However, if additional expense is incurred during the Claim Period and the total Allowable Expense exceeds $50, then this COB provision will apply to the total amount of the claim.

Credit Savings

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Allowable Expense during the Claim Period.

COB and Plan Limits

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

The Plan's Right to Collect and Release Needed Information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits available under this Plan and other plans. The Plan may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the claimant. The Plan need not tell, or get consent of, any person to do this. Each Enrollee claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

If benefits that this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are policy benefits and are treated like other policy benefits in satisfying policy liability.

Right of Recovery

If this Plan pays more for an Allowable Expense than is required by this provision, the excess payment may be recovered from:

- The claimant,
- Any person to whom the payment was made, or
- Any insurance company, service plan or any other organization which should have made payment.

Correction of Payments

If another plan makes payments this Plan should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them.

If the Plan makes payments that should have been made by another plan, we will have the right to recover them from the person to or for whom they were made, or from insurance companies or other organizations. The person involved must sign any documents that are necessary to enforce our rights under this provision.

Continuation of Coverage

The eligibility for Continuation of Coverage and the terms under which you may continue dental coverage are set forth in the "Eligibility Rules for Employees and Dependents" section of this document. You may continue dental coverage only if you continue medical benefits.

Claims Administration and Payment

The following section explains how claims are administered.

Submission and Payment of Claims

1. Claim Submission

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity, or in the case of a Medicaid claim, is a claim valid if submitted later than one year from the date submission is otherwise required. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expenses were incurred.

A claim for which additional information is received will not be reprocessed after the Plan's claim submission period, as described in the previous paragraph.

2. Explanation of Benefits (EOB)

Soon after you make a claim, ODS will report to you on the action ODS has taken by sending you a document called an Explanation of Benefits. The Explanation of Benefits (EOB) will indicate if a claim has been paid, denied, or accumulated toward satisfying the deductible. If all or part of a claim is denied, the reason for the action will be stated in the Explanation of Benefits.

If you do not receive an Explanation of Benefits within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained under Submission and Payment of Claims.

3. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at 503-265-5680 or toll-free at 877-277-7280 or write to our Dental Customer Service Department. We will respond to your inquiry within 30 days of receipt.

4. Plan Time Frames for Processing Claims

If your claim is denied, we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30

days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information to complete our processing of your claim, our notice of delay will describe the information needed, and the party responsible for providing the additional information will have at least 45 days to submit the additional information. Once we receive the additional information, we will complete our processing of the claim within 15 days.

Submission of information necessary to process a claim is subject to the Plan's claim submission period explained under Submission and Payment of Claims.

Appeals

1. Definitions
For purposes of this section, the following definitions apply:

Adverse Benefit Determination

Means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Plan Participant's or beneficiary's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or accidental injury.

An adverse determination is a written notice from the Plan, in the form of a letter or an Explanation of Benefits (EOB), which has set forth the following:

- The specific reason or reasons for the benefit denial,
- Reference to the specific Plan provision on which the denial was based,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Group's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim;
- An explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the circumstances or a statement that the explanation will be provided free of charge on request if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion; and
- A description of the expedited review process applicable to the urgent care if the adverse benefit determination is for an urgent care claim.

Post-Service Claim
Any claim for a benefit under a group health plan that is not a pre-service claim.

Pre-Service Claim

Any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

Claim Involving Urgent Care
Any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the Plan Participant or the ability of the Plan Participant to regain maximum function, or
- In the opinion of a dentist with knowledge of the Plan Participant's dental condition, would subject the Plan Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Time Limit for Submitting Appeals
You have **180 days** from the date of an adverse benefit determination to submit a written appeal regarding an adverse determination. If a written appeal is not submitted within the appropriate time frames as outlined in this section, you will lose your rights to the appeals process. If you do not submit your written appeal on time, you may lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

3. The Review Process

ODS has a two-level review process. The first level of review is called a First Level Appeal. The second level of review is a Second Level Appeal.

Please Note: The timelines addressed in the paragraphs below do not apply when:

- The time period is too long to accommodate the clinical urgency of the situation,
- The Plan Participant does not reasonably cooperate, or
- Circumstances beyond the control of either party prevents that party from complying with the standards set, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

4. First Level Appeals

You may request that ODS review an adverse benefit determination. Your request, called an appeal, must be in writing except for an urgent care claim. If you need assistance on filing an appeal, contact ODS Dental Customer Service Department at 503-265-5680 or toll-free at 877-277-7280 to discuss the issue, as it may be possible to resolve your situation with a phone call. You may submit written comments, documents, records, and other information relating to the claim for benefits. Upon request, and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. ODS' response time to your appeal is based on the nature of the claim. The appeal will receive a full investigation by persons who were not involved in the initial determination.

An appeal related to an **urgent care claim** will be entitled to expedited review upon request. The request may be made orally or in writing. An appeal related to an **urgent care claim** will be responded to not later than 72 hours after receipt of the appeal, unless the Plan Participant fails to provide sufficient information for ODS to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, ODS shall notify the Plan

Participant as soon as possible, but no later than 24 hours after receipt of the appeal by the Plan, of the specific information necessary to complete the claim. The Plan Participant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. ODS shall notify the Plan Participant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (a) ODS's receipt of the specified information, or (b) the end of the period afforded the Plan Participant to provide the specified additional information.

The investigation of an appeal of a **pre-service claim** will be completed within 15 days of receipt of the appeal.

The investigation of an appeal of a **post-service claim** will be completed within 30 days of receipt of the appeal.

When an investigation has been completed, you will receive a written notice of the disposition of your appeal, including the basis for the decision, along with information on your right to a Second Level Appeal.

5. Second Level Appeal

If you disagree with our decision made in response to a First Level Appeal, you may request a review of the decision. Your second appeal must be made within 180 days of the date of our action on your First Level Appeal.

An appeal of an urgent care claim may be submitted orally or in writing to ODS by either the claimant or the claimant's representative. The appeal may request an expedited review. The claimant will be notified of the determination as soon as possible, considering the medical urgency, but not later than 72 hours after receipt of the request for an expedited review. A decision on a non-expedited review will be made within 60 days of the claimant's request for review. Information between the claimant and ODS may be submitted be telephone, facsimile or other available similar expeditious method.

If you request a Second Level Appeal, you must submit your appeal in writing, except for an urgent care claim. Your Second Level Appeal will be reviewed by persons who were not previously involved in the review of your case. You will have the option to submit written comments, documents, records and other information related to your case that was not previously submitted. We will notify you in writing of the decision, including the basis for the decision, and applicable information to appeal to The Nelson Trust.

8. The Nelson Trust Claim Appeal Process

If you do not agree with a claim denial made by ODS, you may submit a further appeal to the Claims Review Committee. The Nelson Trust Board of Trustees or its appointed Claims Review Committee has the authority to reconsider claims for benefits which have been denied in whole or part by ODS and to determine if additional benefits should be provided. This review provides for a means for benefits to be reconsidered and additional benefits provided.

The claimant may appeal an adverse urgent care claim to the Nelson Trust Claims Review Committee within 180 days of the adverse decision. A claimant may request expedited review otherwise a claim will be given a non-expedited review. An expedited review may be submitted orally or in writing. All necessary information including the benefit determination will be transmitted between the claimant and the plan by telephone, facsimile or other expedited method. The decision on review will be made as soon as possible no later than 72 hours after the receipt of the request for an expedited review. A non-expedited review will be decided within 60 days of the claimant's request for review. If special circumstances require the Claims Review Committee may delay a decision provided the claimant is given notice.

The claimant or the claimant's representative may review pertinent documents and submit written issues and comments for this review. The Claims Review Committee may elect to voluntarily obtain an independent evaluation of the claim by an Independent Review Organization, which by law, is required to be independent and unbiased.

Voluntary Appeal to Board of Trustees

The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal must be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees will decide the appeal within 60 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that the claimant is given notice. The notice will be given prior to commencement of the extension; will state the special circumstances which require the extension; and will state the expected date of the decision. The Board of Trustees will notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

If the claimant submits the claim to the Nelson Trust Board of Trustees, the Nelson Trust agrees that: (a) the voluntary appeal will not have any effect on the claimant's rights to any other benefit under the Nelson Trust; (b) any statute of limitations is tolled during the voluntary review process; and (c) no fees or costs are imposed on the claimant as part of this appeal process. The Nelson Trust waives any right to assert that the claimant did not exhaust the claimant's administrative remedies if the claimant does not submit a claim to the Claims Review Committee or to the Nelson Trust Board of Trustees.

Benefits Available from Other Sources

Situations may arise in which your health care expenses may be the responsibility of someone other than this Plan. Here are descriptions of the situations that may arise.

1. Coordination of Benefits (COB)

This provision applies to this Plan when you or your covered dependent have health care coverage under more than one plan. For a complete explanation of COB see the section titled "Coordination of Benefits."

2. Third-Party Liability

An individual covered by the Plan may have a legal right to recover benefits or health care costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or health care costs were paid by the Plan. For example, an individual who is injured may be able to recover the benefits or health care costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for health care expenses connected with the illness or injury. Should the Plan make an advance payment of Benefits, as described below, the Plan is entitled to be reimbursed for any benefits paid by the Plan that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by the Plan through these recoveries help reduce the cost of premiums and providing benefits.

Because recovery from a Third Party may be difficult and take a long time, and payment of benefits where a Third Party may be legally liable is excluded under the terms of this Plan, as

a service to you, the Plan will pay a Covered Individuals' expenses based on the understanding and agreement that the Covered Individual is required to honor the Plan's rights of subrogation as discussed below, and, if requested by us, to reimburse the Plan in full from any recovery the Covered Individual may receive, no matter how the recovery is characterized.

Upon claiming or accepting Benefits, or the provision of Benefits, under the terms of this Plan, the member agrees that the Plan shall have the remedies and rights as stated in this Section. We may elect to seek recovery under one or more of the procedures outlined in this Section. The Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

Definitions

For purposes of this Section relating to Third Party Liability, the following definitions apply:

Covered Individual
An individual covered by the Plan, including a dependent of a Member. "Covered Individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by the Plan, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or dental expenses of such individual.

Benefits
Any amount paid by the Plan, or submitted to the Plan for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of "Benefits" by the Covered Individual.

Third Party Claim
Any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of dental expenses from the Plan, may file a Third Party claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, the Plan is still entitled to recover Benefits as described herein.)

Third Party
Any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the Covered Individual. "Third Party" includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.

Recovery Funds
Any amount recovered from a Third Party.

Subrogation

Upon payment by the Plan, it shall be subrogated to all of the Covered Individual's rights of recoveries therefore, and the Covered Individual shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this sub-section, we may pursue the Third Party in the Plan's name, or in the name of the member. The Plan is entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan.

Right of Recovery

In addition to the Plan's subrogation rights, we may, at our sole discretion and option, ask that the Covered Individual, and his or her attorney, if any, protect the Plan's reimbursement rights. If we elect to proceed under this sub-section, the following rules apply:

1. The Covered Individual holds any rights of recovery against the Third Party in trust for the Plan, but only for the amount of Benefits we paid for that illness or injury.
2. The Plan is entitled to receive the amount of Benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, the Plan disentitled to receive the amount of Benefits it has paid whether the health care expenses are itemized or expressly excluded in the Third Party recovery.
3. If, and only if, we ask the Covered Individual, and his or her attorney, to protect our reimbursement rights under this sub-section, then the Covered Individual may subtract from the money to be paid back to the Plan, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.
4. We may ask the Covered Individual to sign an agreement to abide by the terms of this Right of Recovery sub-section. If we elect to proceed under this sub-section the Plan will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.
5. This right of recovery includes the full amount of the Benefits paid, or pending payment by the Plan, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or dental expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. The Plan's recovery rights will not be reduced due to the Covered Individual's own negligence.
6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by the Plan, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

Motor Vehicle Accidents

Any expense for injury or illness which results from a motor vehicle accident, and which is payable under a motor vehicle insurance policy is not a covered Benefit under this Plan and will not be paid by the Plan.

If a claim for health care expenses arising out of a motor vehicle accident is filed with the Plan, and if motor vehicle insurance has not yet paid, then the Plan may advance Benefits, subject to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, and subject to the next paragraph.

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, in Third Party claims involving the use or operation of a motor vehicle, the Plan, at our sole discretion and option, is entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538.

Additional Third Party Liability Section Provisions

In connection with the Plan's rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sub-sections, Covered Individuals shall do one or more of the following and agrees that we may do one or more of the following, at our discretion:

1. If the Covered Individual seeks payment by the Plan of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to the Plan by a Provider to the Covered Individual.
2. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by us from the Third Party.
3. In order to receive an advance payment of Benefits pursuant to this Section, the Plan requires that any Covered Individual seeking payment of Benefits by the Plan, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Person's parent or guardian, must fill out, sign and return to our office a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential Third-Party claim. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.
4. The Covered Individual shall cooperate with us to protect the Plan's recovery rights under this Section, and in addition, but not by way of limitation, shall:
    a. Sign and deliver such documents as we reasonably require to protect the Plan's rights;
    b. Provide any information to us relevant to the application of the provisions of this Section, including dental information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
    c. Take such actions as we may reasonably request to assist us in enforcing the Plan's rights to be reimbursed from Third Party recoveries.
5. By accepting the payment of benefits by the Plan, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party.

6. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of the Plan's recovery rights set forth herein.
7. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of this Section.
8. This Section applies to any Covered Individual for whom advance payment of Benefits is made by the Plan whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by the Plan.
9. If the Covered Individual continues to receive dental treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, the Plan will provide Benefits for the continuing treatment of that illness or injury only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing dental treatment have been exhausted for that purpose.
10. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then the Plan has the right to not advance payment of Benefits or to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or dental condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, the Plan may notify dental providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.
11. Coordination of Benefits (where the Covered Individual has health care coverage under more than one Plan or health insurance policy) is not considered a Third Party Claim.
12. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

General Plan Information

The following describes other procedures and policies in effect when processing your claims.

Request for Information

When necessary to process claims, we may require that you submit information concerning benefits to which you or your dependent is entitled. We may also require that you authorize your provider to provide us with information about a condition for which you claim benefits.

Disclosure of Benefit Reduction

The Plan will provide notification of material reductions in covered services or benefits to the Group no later than 60 days after the adoption of the change.

Confidentiality of Member Information

The confidentiality of your protected health information is of extreme importance to the Plan Sponsor and to ODS. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. Your information is used internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell your information. For

more complete detail about how your Plan Sponsor uses your information, please refer to the "HIPAA" section of this document. ODS, as the third party administrator, is required to adhere to these same practices. If you have additional questions about the privacy of your information beyond that provided in the "HIPAA" section of this document, please contact your Plan Sponsor.

Transfer of Benefits

Only you and your covered dependents are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on the Plan.

Recovery of Benefits Paid by Mistake

If we make a payment for you or a covered dependent to which you are not entitled, or if we pay a person who is not eligible for payments at all, the Plan has the right to recover the payment from the person we paid or anyone else who benefited from it, including a physician or provider of services. Our right to recovery includes the right to deduct the amount paid from future benefits we would provide for you or any covered dependent even if the payment was not made on that person's behalf. Once a mistake has been identified in any of the provisions of the Plan, it can be rectified immediately. Any prior mistake does not permanently change the Plan.

Warranties

All statements made by the applicant, Policyholder, or a Plan Participant, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting coverage will avoid the coverage or reduce benefits unless contained in a written form and signed by the Policyholder or the Plan Participant, a copy of which has been given to the Policyholder or to the person or the beneficiary of the person.

Limitation of Liability

ODS shall incur no liability whatsoever to any eligible person concerning the selection of dentists to render services hereunder. In performing or contracting to perform dental service, such dentists shall be solely responsible and, in no case, shall ODS be liable for the negligence of any dentist rendering such services. Nothing contained in the Policy between ODS and the Group shall be construed as obligating ODS to render dental services.

Provider Reimbursements

Providers contracting with ODS to provide services to Plan Participants agree to look only to ODS for payment of the part of the expense which is covered by the Plan and may not bill the Plan Participant in the event the Plan fails to pay the provider for whatever reason. The provider may bill the covered person for applicable coinsurance, copayments and deductibles or non-covered expenses except as may be restricted in the provider contract.

Independent Contractor Disclaimer

Oregon Dental Service (ODS) and Participating Dentists are independent contractors. ODS and Participating Dentists do NOT have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a Participating Dentist's provision of dental care to ODS Enrollees may be deemed to exist or be construed to exist between ODS and Participating

Dentists. A Participating Dentist is solely responsible for the dental care provided to any patient, and ODS does not control the detail, manner or methods by which a Participating Dentist provides care.

No Waiver

Any waiver of any provision of the Policy, or any performance under the Policy, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. No delay or omission on the part of ODS in exercising any right, power or remedy provided in this Plan, including, without limitation, our delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

Group is the Agent

The Group is your and your enrolled dependents' agent for all purposes under the Policy. The Group is not the agent of Oregon Dental Service.

Governing Law

To the extent the Policy is governed by state law, it shall be governed by and construed in accordance with the laws of the State of Oregon.

Where any Legal Action Must Be Filed

Any legal action arising out of the Policy must be filed in either a state or federal court in the State of Oregon.

Time Limits for Filing a Lawsuit

Any legal action arising out of, or related to, the Policy and filed against the Plan by you, any of your dependents, any Plan Participant or any third party, must be filed in court within three years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

Willamette Dental Insurance, Inc.

Group Dental Certificate of Coverage

A Contract has been issued to the Policyholder. Willamette Dental Insurance, Inc. certifies that the Member of any Participating Employer Group in good standing with the Policyholder will be covered as provided by the terms of this Certificate. If the Plan Participant's coverage is changed by an amendment to the Contract, Willamette Dental Insurance, Inc. will provide the Policyholder with a revised Certificate or other notice to be given to Plan Participants.

Possession of this Certificate does not necessarily mean the Plan Participant is covered. A Plan Participant is covered only if the requirements set out in this Certificate are met.

This Certificate is a summary of the Benefits available under the Group Contract between Willamette Dental Insurance, Inc. and the Policyholder. For complete details on Benefits and other Contract provisions including, but not limited to, the exclusions and limitations, please refer to the Contract on file with your Participating Employer Group. To the extent any information in this Certificate is inconsistent with the terms and provisions of the Contract, the terms and provisions of the Contract shall control.

Definitions

The following defined terms are used throughout this Certificate in the Willamette Dental Insurance, Inc., section of this document:

Benefits

Services performed by a provider that are covered under the Contract, and any payments by the Company for a Plan Participant for services or supplies covered under the Contract.

Calendar Year

January 1 through December 31.

Company

Willamette Dental Insurance, Inc.

Copay and Copayment

The dollar amount that will be the Plan Participant's responsibility to pay for certain services to be provided under the Contract.

Dependent

A person listed on the Plan Participant's enrollment application as a Dependent of the Plan Participant, who is eligible for Dependent coverage:

- As stated in Article 2 of the Contract, and as stated in the "Eligibility Rules for Employees and Dependents" section of this document,
- Whose enrollment application for coverage has been accepted by the Company, and
- For whom the applicable Premium for coverage has been paid.

Dental Emergency

The sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring necessary care to control pain, swelling, or bleeding in or around the teeth and gums. Such emergency care must be provided within forty-eight (48) hours following the onset of the emergency, and includes treatment for acute infection, pain, swelling, bleeding, or injury to natural teeth and oral structures. The emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy, or prosthetic Benefits. For the purpose of Benefit determination, consideration will be given by the Company to the symptoms of the condition, and the actions that would have been taken by a prudent person under such circumstances.

Investigational Service or Supply

A service or supply (including, but not limited to, equipment, drugs, devices, and other items) that is determined by the Company to meet any one of the following:

- Any service or supply classified by the Company as experimental or investigational. The terms experimental and investigational shall mean the following: (1) services or supplies which are under continued scientific testing and research because they have not yet been proven to show a demonstrable benefit for a particular illness, (2) disease or condition, or (3) to be safe and efficacious. The Company in its sole discretion shall make all determinations of which services and supplies will be considered to be experimental or investigational. In determining whether services or supplies are experimental or investigational, the Company will consider the following: (4) whether the services or supplies are in general use in the dental community in which services were obtained, (5) whether the services or supplies are under continued scientific testing and research, (6) whether the services or supplies show a demonstrable benefit for a particular illness, disease or condition, and (7) whether the services or supplies are proven to be safe and efficacious. Upon written request, the Company shall provide to a Plan Participant all documentation in the Company's possession, and used by the Company in connection with determining whether a service or supply is experimental or investigational.
- Any service or supply that is on an investigational protocol, unless approved in writing in advance by the Company.

Licensed Dentist

A licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.).

Necessary Service or Supply

The service or supply meets all of the following criteria as determined by the Participating Dentist:

- It is required to diagnose or treat the Plan Participant’s condition.
- It is consistent with the symptoms or diagnosis and treatment of the condition.
- It is the most appropriate level of service that is essential to the Plan Participant's needs.
- It is not an Investigational Service or Supply.
- It is not primarily for the convenience of the Plan Participant or the Participating Provider.

Participating Dentist

Licensed Dentist who is employed by or is under contract with Willamette Dental Group, P.C., or any of its affiliates, to provide dental services.

Participating Employer Group

Any employer that meets the following conditions:

- is subject to the terms of the in force collective bargaining agreements;
- is a member in good standing of the Policyholder; and
- whose participation under the Contract has been approved in writing by the Policyholder.

Participating Provider

A dental services provider that has contracted in writing with the Company to accept payment from Plan Participants. To look solely to the Company according to the terms of the Contract, for any dental services rendered to a Plan Participant who has previously paid, or on whose behalf prepayment has been made to the Company for such dental services.

Plan Administrator

The Policyholder, or a person who has been designated by the Policyholder to act as its agent. The agent will remit the Premium to the Company, as well as, give and receive any notices under this Contract.

Plan Participant

An individual employee of the Participating Employer Group who is eligible for coverage:

- as stated in Article 2 of the Contract and as stated in the “Eligibility Rules for Employees and Dependents” section of this document;
- whose enrollment application for coverage has been accepted by the Company; and
- for whom the applicable Premium for coverage has been paid.

Policyholder

Trustees, The Nelson Health and Welfare Trust Fund.

Premium

The total money to be paid to the Company each month as consideration for the Benefits offered by the Contract.

Specialist

A Licensed Dentist who has completed additional training in one or more areas of dental treatment, and who provides services to the Plan Participant upon referral by the Participating Dentist.

Dental – Willamette Dental Insurance, Inc.

Willamette Dental Group, P.C.

The Oregon corporation that has signed a dental services provider agreement with the Company, to act as a Participating Provider for the Company, for purposes of providing dental services on behalf of the Company, to Plan Participants according to the terms of the Contract.

Plan Participant Eligibility for Coverage

To be eligible for coverage under this Contract, the Plan Participant must be and remain an active employee of a Participating Employer Group that is a member in good standing with the Policyholder. A Plan Participant becomes eligible as stated in the "Eligibility Rules for Employees and Dependents" section of this document (see such section regarding specific requirements for initial and continued eligibility).

Dependent Eligibility for Coverage

To be eligible for coverage under this Contract, the Dependent becomes eligible as stated in the "Eligibility Rules for Employees and Dependents" section of this document (see such section regarding specific requirements for initial and continued eligibility).

Exclusions

No Benefits will be provided for the following:

- Conscious sedation/general anesthesia.
- Any condition resulting from military service or declared or undeclared war.
- Any injuries sustained while practicing for, or competing in a professional or semiprofessional athletic contest. Semiprofessional athletics means an athletic activity for gain or pay that requires an unusually high level of skill and substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.
- Bleaching of a tooth.
- Cast dowel post.
- Endodontics, bridges, crowns, or other service or prosthetic devices requiring multiple treatment dates or fittings, if treatment was started or ordered prior to the Plan Participant's effective date under the Contract, or if the item was installed or delivered more than sixty (60) days after the Plan Participant's coverage under the Contract has terminated. Root canal treatment will be covered, if the tooth canal was opened prior to termination, and treatment is completed within sixty (60) days after termination.
- Charges by any person other than a Licensed Dentist, licensed denturist, or licensed hygienist.
- Charges that would not have been made, or that the Plan Participant would have had no obligation to pay in the absence of the Contract.
- Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements.
- Full-mouth reconstruction.
- Cosmetic dentistry or surgery.

- Dental implants, or implant supported prosthetics, unless specifically provided in a rider to this Certificate. The following implant procedures are excluded from coverage:
  - Endosseous
  - Subperiosteal dental implants
  - Transosseous dental implants
  - Tomograms
  - CT Scans
- Excision of a tumor, biopsy of soft or hard tissue, removal of a cyst, nonodentogenic, or exostosis.
- Dental services started prior to the date the Plan Participant became eligible for services under the Contract.
- Extraction of permanent teeth for tooth guidance procedures, procedures for tooth movement, regardless of purpose, correction of malocclusion, preventive orthodontic procedures, or other orthodontic treatment, unless specifically provided in a rider to this Certificate in the Willamette Dental Insurance, Inc., section of this document.
- Habit-breaking or stress-breaking appliances.
- Hospital or other facility care for dental treatment, including physician services for hospital treatment. Services of a Licensed Dentist will be provided in a hospital, or other facility only when all of the following requirements are met, subject to the hospital visit Copayment specified in Exhibit A to this Certificate in the Willamette Dental Insurance, Inc., section of this document:
  - A hospital setting must be medically necessary.
  - The services must be authorized, in writing, in advance by a Participating Dentist.
- Intentionally self-inflicted injuries. The fact that a person may be under the influence of any chemical substance shall not be considered as a limitation on the ability to form the intent specified in this Section.
- Investigational Services or Supplies, as defined in “Definitions” in the Willamette Dental Insurance, Inc., section of this document.
- Materials not approved by the American Dental Association.
- For occupational injury or disease (including any arising out of self-employment).
- Occlusal guards.
- Personalized restoration, precision attachments, and special techniques.
- Prescription drugs, medications, or supplies, unless specifically listed as covered in Exhibit A to this Certificate in the Willamette Dental Insurance, Inc., section of this document.
- Services for accidental injury to natural teeth that are provided more than twelve (12) months after the date of the accident.
- Repair, or replacement of lost, stolen or broken items.

- Replacement of an existing denture, crown, or bridge less than five (5) years after the date of the most recent placement.
- Replacement of implants and superstructures are covered only after five (5) years have elapsed from any prior provision of the implant.
- Replacement of sound restorations.
- Services or supplies that are not listed as covered in Exhibit A to this Certificate in the Willamette Dental Insurance, Inc., section of this document.
- Services to the extent that they are not necessary for treatment of a dental injury, or disease, or are not recommended and approved by the Licensed Dentist attending the Patient.
- To the extent that coverage is available under any federal, state, or other governmental program, if application is duly made therefore, except where required by law, such as cases of emergency or for coverage provided by Medicaid.
- Transseptal fiberotomy.
- Veneers, composite surfaces on posterior teeth.
- Splints, night guards, and other appliances used to increase vertical dimension and restore bite.
- Orthognathic surgery.
- Services or supplies provided to correct congenital or developmental malformations, including, but not limited to, cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, ectodental displasia, and fluorosis (discoloration of teeth).
- Services for temporomandibular joint disorders.

Coordination of Benefits

Coordination of Benefits (COB) applies when a Plan Participant is covered by more than one Plan that includes a COB provision. When this occurs, benefits from one Plan will be coordinated with the benefits from another Plan, so that the total payment does not exceed 100% of the dentist's charges. Having two or more Plans does not entitle a Plan Participant to Benefits under the Contract for services otherwise limited or excluded under the Contract. The limitations and exclusions contained in the Contract still apply, including restrictions on frequency of services.

1. Plan means coverage under the Contract, and any of the following dental plans providing benefits for dental services or supplies:
   a. Any group or blanket insurance policy.
   b. Any group prepayment arrangement.
   c. Any labor/management trustee plan labor organization plan, employer organization plan, or employee organization plan, whether on an insured or uninsured basis.
   d. Any coverage under a governmental plan that allows Coordination of Benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are in excess to those of any private insurance program or other non-governmental program.

e. Any other group-type coverage that is not available to the public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

Each contract or other arrangement for coverage under items 1.a through 1.e above is a separate Plan. In addition, if an arrangement has two parts and the Coordination of Benefits rules apply only to one of the two, each of the parts is a separate Plan.

2. Plan does not include the following:

a. Individual or family benefits provided through insurance contracts, member contracts, coverage through individual Health Maintenance Organizations, or other prepayment service, or group practice plans.

b. Benefits covering grammar school, high school, and college students for accidents only, including athletic injuries.

3. Allowable expense means any necessary, reasonable and customary item of expense for dental care when the item of expense is covered at least, or in part, by one or more plans covering the Plan Participant for whom the claim is made. However, if the Contract contains more than one Plan, an expense covered by one of the Plans, and not by the others, will be an allowable expense for the Plan that covers it and not for the others.

4. Claim determination period means a calendar year. However, a claim determination period does not include any time before, or after the period when the Plan Participant was insured under the Contract.

5. If payment under the Contract must be made first, that payment will not be reduced because of this section.

If a Plan does not have a Coordination of Benefits provision, that Plan must provide benefits first.

If a Plan also has Coordination of Benefits, 5.a through 5.g below will apply:

a. The benefits of the Plan that covers an individual as a Plan Participant will be determined before the benefits of a Plan which covers an individual as a Dependent.

b. If a Dependent child is covered by different parents under separate plans, the order of benefits will be determined by the “Birthday Rule,” pursuant to which the parent whose month and day of birth occurs earlier in the Calendar Year, will be considered primary before the benefits of the Plan of the parent whose month and day of birth occurs later in the Calendar Year. If the parents have the same birthday, the benefits of the Plan that covered the parent longer are determined first.

If the other Plan has a gender rule, the other Plan will determine the order of benefits.

c. If a Dependent child is covered under two or more Plans of parents who are separated or divorced, then the benefits are determined in the following order:

1) The Plan of the parent with custody.

2) The Plan of the spouse of the parent with custody.

3) The Plan of the parent without custody.

4) The Plan of the spouse of the parent without custody.

d. If the court decrees financial responsibility for the child's dental care, and the entity obligated to pay or provide the benefits of that parent has actual knowledge of those terms, the benefits of that Plan are determined first.

e. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired, (or covers a Dependent of such person), are determined before those of a Plan that covers that person as a laid-off or retired employee, (or covers a Dependent of such person). If the other Plan does not have this rule, this rule will be ignored.

f. If the above rules regarding determination of the order of benefits do not establish the primary Plan, then the Plan that has covered the Plan Participant for the longest period of time is the primary Plan.

g. If applicable, and both husband and wife are employees of the same company, and both enroll in this Plan, all Copayment and visit charges are waived.

6. Right to Receive and Release Necessary Information—As a condition of receiving Benefits under the Contract, and subject to the restrictions on the use or disclosure of protected health information, and non-public personal information as required by law, the Plan Participant agrees to 6.a through 6.f below:

   a. The Plan Participant authorizes any dentist, physician, hospital, dental clinic, or other provider of services, or party having knowledge to disclose to the Company, any pertinent or relevant dental, or medical information it requires.

   b. The Plan Participant authorizes the Company to examine any pertinent, or relevant dental or medical records of the Plan Participant at the offices of any dentist, physician, hospital, dental clinic, or other provider of services for the purpose of verifying services or supplies.

   c. The Plan Participant authorizes the Company, in the exercise of its subrogation rights described in the Contract, and persons acting on behalf of the Company, to release any information about the accident, the Plan Participant's Injuries, and the Benefits and medical, or dental services received by the Plan Participant, to any person who may be liable to the Plan Participant, or to the Company, and to such person's insurer.

   d. The Plan Participant authorizes the Company to examine the employment, and payroll records of the Plan Participant, for verifying eligibility, and proper enrollment under the Contract.

   e. The Company will keep information about the Plan Participant confidential whenever possible, but such information may be disclosed to other parties without authorization, if such disclosure serves a legitimate purpose of this Company for purposes of administration of Coordination of Benefits (COB).

   f. Subject to the Company's obligation in item d. above, the Plan Participant waives any claim of privilege, or Confidentiality that might be asserted in any action by, or against the Company, or the party furnishing such information.

7. Facility of Payment – Whenever payments that should have been made by the Company, according to the Contract, have been made under another Plan, the Company may pay the other Plan, the amount the Company should have paid the Plan Participant. Any such payment, will be a Benefit, and the Company will be fully discharged from liability to the extent of that payment.

8. Right of Recovery – If the amount of the payments made by the Company is more than it should have paid under the Contract, the Company may recover the excess from one or more of:

   a. the Plan Participant it has paid or for whom it has paid,

   b. insurance companies, or

   c. other organizations.

   The amount paid includes the reasonable cash value of any benefits provided in the form of services. A secondary Plan that provides benefits in the form of services, may recover the reasonable cash value of providing 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 the primary Plan. Nothing in the Contract shall be interpreted to require a Plan to reimburse a covered Patient in cash for the value of services provided by the Plan which provides benefits in the form of services.

Dental Coverage

1. The Plan Participant must receive services from a Participating Dentist for services to be covered under the Contract, except as otherwise specifically provided in the Contract. The Participating Dentists who are providing the services covered under the Contract agree that they will accept fees in the amount established by the Company, as full payment for their services, except for the Plan Participant's Copayment responsibility, as provided in the Contract. The Participating Dentists agree that their charges to the Plan Participant will not exceed the Copayment amounts specified in Exhibit A to this Certificate in the Willamette Dental Insurance, Inc., section of this document.
2. The Company will make available to the Plan Administrator, a list of the Participating Provider offices at which the Participating Dentists offer services. The Company reserves the right to change the list without notice, but a current list shall be maintained at the principal office of the Company, for the Plan Participant's review during regular business hours.
3. The services of a Specialist will only be covered upon referral by a Participating Dentist. The Plan Participant will be responsible for charges by the Specialist, for procedures other than those specifically authorized by the Participating Dentist.

Emergency Care

1. Coverage for a Dental Emergency will be provided twenty-four (24) hours a day, three hundred sixty-five (365) days a year. When emergency services are received during office hours by a Participating Dentist at a Participating Provider office, the Plan Participant will be responsible for the standard office visit Copayment as specified in Exhibit A to this Certificate. When emergency services are received after hours by a Participating Dentist at a Participating Provider office, the Plan Participant will be responsible for the standard office visit Copayment, and an additional emergency treatment after hours Copayment, as specified in Exhibit A to this Certificate. Office hours shall mean 7:00 a.m. to 6:00 p.m., Monday through Saturday (excluding all nationally recognized holidays), and after hours shall mean all other hours and days in a calendar week.
2. In the event of a Dental Emergency that requires the services of a non-Participating Dentist located outside of a fifty (50) mile radius of any Participating Provider office, the Company will reimburse to the Plan Participant up to $100 for the cost of the services provided by the non-participating dentist, less any copay amount, to the extent that such services would

have been available under the Contract, if the Plan Participant had used a Participating Dentist. If, in the event of a Dental Emergency, the Plan Participant uses a non-participating dentist, claims for Benefits under the Contract must be presented to the Company in writing. When a claim form is submitted, it must be completely filled out, and signed by the Plan Participant and the non-participating dentist, and must be accompanied by an itemized statement from the dentist for his or her services. The Company shall have the right to request additional information from the dentist needed to process the claim, including X-rays. No Benefits or reimbursement will be provided unless the requested information is received. All claims must be submitted within six (6) months of the date of service.

Claims Review Procedures

If a Plan Participant has a complaint against the Company, or the Company has notified the Plan Participant in writing that a claim has been denied, the following will occur:

1. The Company will review the Plan Participant's claim, and will notify the Plan Participant, in writing, of the decision within thirty (30) days, unless special circumstances result in a delay.
2. If the Company is unable to make a decision within thirty (30) days due to circumstances beyond its control, the Company will provide notice to the Plan Participant indicating that an extension of up to fifteen (15) additional days is necessary to complete the review process.
3. If the Company requests additional information, the Plan Participant will have forty-five (45) days to provide the information. If the Plan Participant fails to provide the information within forty-five (45) days, the Company may decide the claim based on the information the Company has already received.
4. The Company shall provide written notification of an adverse determination, and the right to appeal, to the Plan Participant or authorized representative. If all or part of a Plan Participant's claim is denied, the Plan Participant will receive a written notice of denial containing:
   a. The reason for the decision.
   b. Reference to the parts of the Contract on which the decision is based.
   c. Reference to any internal rule, or guideline relied upon in making the decision, along with the Plan Participant's right to receive a copy of these guidelines, free of charge, upon request.
   d. A statement that the Plan Participant may request an explanation of the scientific, or clinical judgment the Company relied upon to exclude expenses that are experimental or investigational, or are necessary or accepted according to accepted standards of dental practice.
   e. The Plan Participant or authorized representative may review pertinent documents, records and other information relevant to the claim.
5. The Plan Participant, or authorized representative, may request an appeal of the adverse determination, and submit issues and comments to the Company's Member Relations Department within one hundred eighty (180) days after receiving notice of the adverse determination.
6. The Plan Participant should state the reason for the appeal, and may submit written comments, documents, records or any other information related to the claim.

7. The person conducting the appeal review will be someone other than the person who denied the claim, and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole, or in part, on a clinical judgment, including determinations with regard to whether the service was considered experimental, investigational, and/or not dentally necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment, and will not be subordinate to that person. The appeal review will include any written comments, or other items the Plan Participant submits to support their claim.
8. If the Company denies any part of the Plan Participant's appeal on review, the Plan Participant will receive a written notice of denial containing:
   a. The reason for the decision
   b. Reference to the parts of the Contract on which the decision is based
   c. Reference to any internal rule or guideline, free of charge, upon request
   d. Information containing the Plan Participant's right to receive, free of charge, copies of non-privileged documents and records relevant to the Plan Participant's claim
   e. A statement that the Plan Participant may request an explanation of the scientific or clinical judgment the Company relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental practice

Urgent Care Claims

A claimant shall be given notice if a claim for urgent care shall be wholly or partially denied no later than 48 hours after the earlier of the Plan's receipt of requested specified information or the end of the period of time to provide the requested specified information. The denial and information to appeal may be given orally but written notice must be furnished within 3 days after the oral notification. If the claimant shall not be satisfied with the decision, the claimant may submit the claim to the Claims Review Committee for a determination within 60 days of the denial. The Claims Review Committee shall review the issue and the claimant shall be given written notice of the decision 72 hours after submission of the claim.

The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal shall be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees shall decide the appeal within 45 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that the claimant shall be given notice. The notice shall be given prior to commencement of the extension; shall state the special circumstances that require the extension; and shall state the expected date of the decision. The Board of Trustees shall notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

A claimant shall not undertake any legal action for a claim until all rights under the claims appeal procedure shall have been exhausted.

Dental – Willamette Dental Insurance, Inc.

Pre-service Claims

A claimant shall be given notice if a claim shall be wholly or partially denied. If the claimant shall not be satisfied with the decision, the claimant may submit the claim to the Claims Review Committee for a determination within 60 days of the denial. The Claims Review Committee shall review the issue and the claimant shall be given written notice of the decision 15 days after submission of the claim.

The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal shall be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees shall decide the appeal within 45 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay a decision for 60 days provided that the claimant shall be given notice. The notice shall be given prior to commencement of the extension; shall state the special circumstances that require the extension; and shall state the expected date of the decision. The Board of Trustees shall notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

If you submit the claim to The Nelson Trust Board of Trustees, The Nelson Trust agrees that: (a) the voluntary appeal will not have any effect on your rights to any other benefit under The Nelson Trust; (b) any statute of limitations is tolled during the voluntary review process; and (c) no fees or costs are imposed on you as part of this appeal process. The Nelson Trust waives any right to assert that you did not exhaust your administrative remedies if you do not submit a claim to the Claims Review Committee or to The Nelson Trust Board of Trustees.

A claimant shall not undertake any legal action for a claim until all rights under the claims appeal procedure shall have been exhausted.

Other Claims

A claimant shall be given notice if a claim shall be wholly or partially denied. If the claimant shall not be satisfied with the decision, the claimant may submit the claim to the Claims Review Committee for a determination within 60 days of the denial. The Claims Review Committee shall review the issue and the claimant shall be given written notice of the decision 30 days after submission of the claim. However, the Claims Review Committee may obtain a 15-day extension of time to make the decision if the Claims Review Committee shall not be able to make a decision for reasons beyond its control. To obtain the extension, the Claims Review Committee shall:

1. give the claimant written notice of the extension prior to the extension of the 30 days;
2. advise the claimant of the circumstances requiring the extension of time;
3. advise the claimant of the expected date of the decision; and
4. state the additional information, if any, that the claimant failed to submit and permit the claimant at least 45 days to provide the information.

The claimant may appeal to the Board of Trustees the decision of the Claims Review Committee. The appeal shall be written and made within 180 days after the receipt of the decision of the Claims Review Committee. For the appeal, the claimant or the claimant's representative may review and copy pertinent documents and may submit issues and comments in writing. The Board of Trustees shall decide the appeal within 45 days of the claimant's request for review. If special circumstances require, the Board of Trustees may delay

a decision for 60 days provided that the claimant shall be given notice. The notice shall be given prior to commencement of the extension; shall state the special circumstances that require the extension; and shall state the expected date of the decision. The Board of Trustees shall notify the claimant, in writing, as soon as possible of its decision but not later than 5 days after the decision.

If you submit the claim to The Nelson Trust Board of Trustees, The Nelson Trust agrees that: (a) the voluntary appeal will not have any effect on your rights to any other benefit under The Nelson Trust; (b) any statute of limitations is tolled during the voluntary review process; and (c) no fees or costs are imposed on you as part of this appeal process. The Nelson Trust waives any right to assert that you did not exhaust your administrative remedies if you do not submit a claim to the Claims Review Committee or to The Nelson Trust Board of Trustees.

A claimant shall not undertake any legal action for a claim until all rights under the claims appeal procedure shall have been exhausted.

Allocation of Authority

Except for those functions that the Contract specifically reserves to the Policyholder, the Company will have full and exclusive authority to control and manage the Contract, to administer claims, and to interpret the Contract and resolve all questions arising in the administration, interpretation, and application of the Contract. The Company's authority includes but is not limited to:

1. The right to resolve all matters when a review has been requested
2. The right to establish, and enforce rules, and procedures for the administration of the Contract and any claim under it
3. The right to determine eligibility for insurance, entitlements to Benefits, and amount of Benefits payable
4. Sufficiency, and the amount of information the Company may reasonably require to determine 1, 2, or 3 above

Subject to the review procedures of the Contract, any decision made by the Company in the exercise of the Company's authority is conclusive and binding.

Subrogation

1. The Benefits of the Contract, as determined by the Company, will be available to a Plan Participant who suffers a work-related injury, or injury for which another party may be liable, subject to the exclusions and limitations of the Contract. Subject to the limitations, if the Company provides Benefits for the treatment of an injury, whether or not caused by another party, the Company shall:
   a. Be subrogated to the right of the Plan Participant or the Plan Participant's representative to recover compensation for the injury, and
   b. Have a subrogation lien in any recoveries to the extent of the reasonable value of Benefits made by the Company.
2. The Plan Participant or the Plan Participant's representative shall:
   a. Give the Company, in writing, the name and address of the party who caused the injury or is responsible for treatment, the facts surrounding the occurrence of the injury, and any other information reasonably necessary to protect the Company's subrogation rights, and

b. Assist the Company in the process of submitting bills relating to the injury, to the responsible insurer when the Plan Participant knows, or can reasonably determine, that the responsible party has liability insurance or other coverage.

The Plan Participant or the Plan Participant's representative shall cooperate fully with the Company in recovering the amount the Company has paid, including giving prior written notice to the Company of any intended settlement. Subject to the limitations specified in the Contract, the Plan Participant shall reimburse the Company for its subrogated interest, without reduction for any attorney's fees or costs incurred, except that where the services of a Plan Participant's attorney are necessary and beneficial to the Company, the Company's subrogation interest shall be reduced by a proportionate share of the attorney's fees.

Collection by Plan Participant or Plan Participant's Representative

If a claim is paid, a settlement is made, or a judgment is recovered in connection with the injury, the Company's subrogation rights shall be limited to the excess over the amount necessary to fully compensate the Plan Participant for the loss sustained.

Worker's Compensation

The Contract does not replace or affect the requirement that an employer provide worker's compensation insurance. Benefits for treatment of a condition arising out of, or in the course of employment, or self-employment for wages or profit are excluded under the Contract, to the extent the Plan Participant has claimed, or is entitled to claim workers' compensation insurance coverage for the treatment of such condition.

Termination of Benefits

Coverage for the Plan Participant and his or her enrolled Dependents will terminate, if the Plan Participant ceases to be eligible as previously defined, or if the Contract is terminated. A Dependent's coverage will terminate at the end of the month in which the Dependent is no longer eligible as previously defined.

Spouse Continuation of Coverage

According to Oregon law (ORS 743.600), a legally separated, divorced, or surviving spouse age 55 or over, may elect to continue coverage under the Contract. Dependent children of the spouse may remain covered, provided the dependent children are otherwise eligible under the Contract.

Continuation of coverage will terminate on the earliest of any of the following:

1. Failure to make premium payments when due, including any grace period allowed by the Contract
2. The date the Contract terminates
3. The date the legally separated, divorced, or surviving spouse becomes covered under another group dental plan, and not subject to any preexisting condition limitation under such other group dental plan
4. The date on which the legally separated, divorced, or surviving spouse becomes eligible for federal Medicare coverage

COBRA Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), gives qualified beneficiaries the right to elect COBRA continuation after group coverage ends, because of a qualifying event. The following provision apply only to groups that normally employ twenty (20) or more employees on a typical business day, during the previous Calendar Year, and are required by federal law to comply with COBRA.

1. Continuation coverage under the Contract, will be provided to a Plan Participant entitled to such coverage under COBRA, when all requirements of COBRA, such as timely notices, have been met.
2. The Participating Employer Group must notify the Company of an individual's election to COBRA continuation coverage, within sixty (60) days after the election, if all notice requirements of COBRA have been met in a timely manner. Failure by the Plan Participant to make timely election, or by the Participating Employer Group to provide timely notification to the Company, will constitute a waiver of the individual's right to continuation coverage under the Contract. Failure to provide timely notices may not, in all cases, terminate an employer's obligation to provide continuation coverage; however, such failure will eliminate any obligation of the Company to provide continuation coverage under the Contract.

Any continuation of coverage provided pursuant to this COBRA paragraph will be concurrent with any other continuation or extension of coverage available to the Plan Participant under the Contract, unless specified otherwise. COBRA continuation coverage under the Contract will cease, if the Contract with the entire Policyholder terminates, or when the Plan Participant, after the date of the COBRA election, becomes entitled to Medicare or covered under another group health care plan that does not contain a specific limitation or exclusion for a preexisting condition.

Exhibit A—Schedule of Covered Services and Copayments

1. Office Visit Charge $10

2. Diagnostic and Preventive Services

D0120	Periodic oral evaluation	None
D0140	Limited oral evaluation – emergency	None
D0150	Comprehensive oral evaluation	None
D0160	Detailed & extensive oral evaluation	None
D0170	Re-evaluation – limited	None
D0210	Complete series x-rays	None
D0220	Periapical – first film	None
D0230	Intraoral – each additional film	None
D0240	Intraoral – occlusal film	None
D0250	Extraoral – first film	None
D0260	Extraoral – each additional	None
D0270	Bitewings – single film	None
D0272	Bitewings – two films	None
D0274	Bitewings – four films	None
D0330	Panoramic x-rays	None
D1110	Teeth cleaning (prophylaxis) adult	None
D1120	Teeth cleaning (prophylaxis) child	None
D1203	Topical fluoride – child	None
D1204	Topical fluoride – adult	None
D1310	Diet modification – nutritional counseling	None
D1320	Tobacco counseling	None
D1330	Oral Hygiene Instruction	None
D0340	Cephalometric film	None
D0350	Oral / facial images	None
D1351	Sealant/tooth	None
D0415	Bateriologic Studies	None
D0425	Caries Susceptibility Tests	None
D0460	Pulp vitality test	None
D0470	Diagnostic casts	None

Dental – Willamette Dental Insurance, Inc.

3. Space Maintainers

D1510	Space Maintainer – unilateral fixed	None
D1515	Space Maintainer – bilateral fixed	None
D1520	Space Maintainer – unilateral removable	None
D1525	Space Maintainer – bilateral removable	None
D1550	Space Maintainer – recement	None

4. Restorative Dentistry

a. Amalgam Restorations – Primary Teeth

D2110	Fillings – 1 surface	None
D2120	Fillings – 2 surfaces	None
D2130	Fillings – 3 surfaces	None
D2131	Fillings – 4 or more surfaces	None

b. Amalgam Restorations – Permanent Teeth

D2140	Filings – 1 surface	None
D2150	Fillings – 2 surfaces	None
D2160	Fillings – 3 surfaces	None
D2161	Fillings – 4 or more surfaces	None
D2951	Pin retention – per tooth, in addition to restoration	None
D2940	Sedative filling – temporary	None

c. Resin Restorations

D2330	Resin – 1 surface (anterior only)	None
D2331	Resin – 2 surfaces (anterior only)	None
D2332	Resin – 3 surfaces (anterior only)	None
D2335	Resin – 4 surfaces (anterior only)	None
D2336	Crown – resin primary anterior	None
D2337	Crown – resin permanent	None
D2950	Core buildup, including any pins	None
D2380	Resin – one surface (primary posterior only)	None
D2381	Resin – two surfaces (primary posterior only)	None
D2382	Resin – three surfaces (primary posterior only)	None

d. Inlay/Onlay (cast restorations)

D2510	Inlay – gold 1 surface	$210
D2520	Inlay – gold 2 surfaces	$210
D2530	Inlay – gold 3 or more surfaces	$210
D2542	Onlay – gold 2 surfaces	$210
D2543	Onlay – gold 3 surfaces	$210
D2544	Onlay – gold 4 or more surfaces	$210
D2610	Inlay – porcelain/ceramic 1 surface	$210
D2620	Inlay – porcelain/ceramic 2 surfaces	$210
D2630	Inlay – porcelain/ceramic 3 surfaces	$210
D2642	Onlay – porcelain/ceramic 2 surfaces	$210
D2643	Onlay – porcelain/ceramic 3 surfaces	$210
D2644	Onlay – porcelain 4 or more surfaces	$210
D2910	Recement inlay	None

5. Crowns

D2710	Crown – resin laboratory	$210
D2740	Crown – porcelain/ceramic (anterior only)	$210
D2750	Crown – porcelain/metal	$210
D2780	¾ crown – gold	$210
D2790	Full cast crown – gold	$210
D2920	Recement crown	None
D2970	Temporary crown for fractured tooth	None
D2930	Stainless Steel crown – primary	None
D2931	Stainless Steel crown – permanent	None
D2932	Crown – prefabricated resin	None
D2933	Crown – prefabricated stainless steel w/resin window	None
D2954	Prefabricated dowel post & core	None
D2955	Post removal (no endo therapy)	None
D2957	Each additional prefabricated post – same tooth	None
D2970	Temporary crown (fractured tooth)	None
D2980	Repair crown	None

6. Endodontics

D3110	Pulp cap – direct excluding final restoration	None
D3120	Pulp cap – indirect	None
D3220	Pulpotomy	None
D3221	Gross pulpal debridement – primary & permanent teeth	None
D3230	Pulpal therapy – primary anterior	None
D3240	Pulpal therapy – primary posterior	None
D3310	Root canal therapy – anterior	$75
D3320	Root canal therapy – bicuspid	$150
D3330	Root canal therapy – molar	$225
D3331	Treatment of root canal obstruction – non-surgical access	None
D3332	Incomplete endodontic therapy – inoperable or fractured tooth	None
D3333	Internal repair of perforation defects	None
D3346	Retreatment – anterior	$75
D3347	Retreatment – bicuspid	$150
D3348	Retreatment – molar	$225
D3351	Apexification – initial visit	$225
D3352	Apexification – interim visit	None
D3353	Apexification – final visit	None
D3410	Apicoectomy – anterior	$75
D3421	Apicoectomy – bicuspid 1st root	$150
D3425	Apicoectomy – molar 1st root	$225
D3426	Apicoectomy – each additional root	None
D3430	Retrograde filling – per root	None
D3450	Root amputation per tooth	$225
D3920	Hemisection	$225
D3950	Canal prep – preform dowel/post	None

7. Periodontics

D4210	Gingivectomy or gingivoplasty – per quadrant	$210
D4211	Gingivectomy – per tooth	$55
D4220	Gingival curettage – per quadrant	$55
D4240	Gingival flap inclusion – per quadrant	$210
D4249	Crown lengthening hard tissue	$210
D4260	Osseous surgery – per quadrant	$210
D4263	Bone replacement graft – 1st site in quadrant	None

D4264	Bone graft – each additional site in guardant	None
D4270	Pedicle soft tissue graft procedure	$210
D4271	Free soft tissue graft procedure	$210
D4273	Subepithelial connective graft	$210
D4274	Distal wedge procedure	$210
D4341	Periodontic scale & root plane – per quadrant	$55
D4355	Preliminary full-mouth debridement	None
D4381	Antimicrobial irrigation	None
D4910	Periodontic maintenance following therapy	None

8. Prosthodontics - Removable

D5110	Complete (upper denture)	$210
D5120	Complete (lower denture)	$210
D5130	Immediate (upper denture)	$210
D5140	Immediate (lower denture)	$210
D5213	Partial (upper denture)	$210
D5281	Partial-removable unilateral	$210
D5410	Adjustment – complete denture, upper	None
D5411	Adjustment – complete denture, lower	None
D5421	Adjustment – partial denture, upper	None
D5422	Adjustment – partial denture, lower	None
D5510	Repair broken denture no teeth damaged	None
D5520	Repair denture replace missing or broken teeth (each tooth)	None
D5620	Repair partial cast framework	None
D5630	Repair or replace partial clasp	None
D5640	Replace teeth – partial per tooth	None
D5650	Add tooth to existing partial	None
D5660	Add clasp to existing partial	None
D5710	Rebase complete upper denture	None
D5711	Rebase complete lower denture	None
D5720	Rebase upper partial	None
D5721	Rebase lower partial	None
D5730	Reline complete upper denture (chairside)	None
D5731	Reline complete lower denture (chairside)	None
D5740	Reline upper partial (chairside)	None
D5741	Reline lower partial (chairside)	None

D5750	Reline upper denture – lab	None
D5751	Reline lower denture – lab	None
D5760	Reline upper partial – lab	None
D5761	Reline lower partial – lab	None
D5810	Interim denture – upper	$105
D5811	Interim denture – lower	$105
D5820	Interim partial – upper	$105
D5821	Interim partial – lower	$105
D5850	Tissue conditioning – upper	None
D5851	Tissue conditioning – lower	None
D5860	Overdenture – complete	$210
D5861	Overdenture – partial	$210
D5986	Fluoride gel custom trays	None

9. Prosthondontics - Fixed

D6210	Pontic, cast (per tooth)	$210
D6240	Pontic (per tooth), porcelain/metal	$210
D6241	Pontic (per tooth) maryland bridge	$210
D6545	Cast metal retainer	$210
D6720	Crown – resin/metal abutment	$210
D6750	Crown – porcelain metal abutment	$210
D6780	Crown – ¾ cast metal abutment	$210
D6790	Crown – full gold abutment	$210
D6930	Recement bridge	None
D6972	Prefabricated post/core in addition to bridge	None
D6973	Core build-up w/wo pins	None
D6975	Coping – metal	None
D6980	Bridge repair	None

10. Oral Surgery

D7110	Routine extraction – single tooth	None
D7120	Each additional tooth – routine extraction	None
D7130	Root removal	None
D7210	Surgical extraction – erupted	$100
D7220	Removal of impacted tooth – soft tissue	$100
D7230	Removal of impacted tooth – partial bony	$100

D7240	Removal of impacted tooth – complete bony	$100
D7241	Removal of impacted tooth – complete bony with complications	$100
D7250	Surgical removal residual root	$100
D7260	Oroantral fistula closure	$100
D7270	Tooth re-implantation	$100
D7280	Surgical exposure for orthodontic reasons	$100
D7291	Transseptal fiberotomy	$100
D7310	Alveoloplasty w/extractions-per quadrant	None
D7320	Alveoloplasty w/o extractions-per quadrant	None
D7340	Vestibuloplasty	$100
D7350	Vestibuloplasty – more complex	$100
D7470	Removal of exostosis – per site	$100
D7480	Remove non-vital bone segment	$100
D7960	Frenectomy	$100
D7281	Surgical exposure to aid eruption	$100
D7510	I & D intraoral soft tissue	None
D7520	I & D extraoral soft tissue	None
D7530	Remove foreign body – soft tissue	None
D7540	Remove foreign body – hard tissue	None
D7670	Stabilization splint-alveolus	None
D7910	Suture small wound up to 5 cm	None
D7911	Complicated suture up to 5 cm	None
D7940	Osteoplasty	$100
D7970	Excision hyperplastic tissue	$100
D7971	Excision of pericoronal flap	$100
D7980	Sialolithotomy	$100

11. Anesthesia

D9110	Palliative (emergency) minor	None
D9230	Nitrous Oxide (per visit)	$20
D9220	General Anesthesia – 1st 30 minutes	Not covered
D9221	General Anesthesia – Each Additional 15	Not covered

12. Miscellaneous

D9310	Consultation – per session	None
D9911	Application of desensitizing medicaments	None

D9430	Observation visit	None
D9440	Emergency treatment – after office hours	$20
D9951	Occlusal adjustment – simple	None
D9952	Occlusal adjustment – complete	None
D9970	Enamel microabrasion	None
D9420	Hospital Visit – exam (service copays still apply)	$125
	Cancellation of appointment without 24 hours notice	$20
	Out of area emergency reimbursement	$100

13. Exclusions

See "Exclusions" in the Willamette Dental Insurance, Inc., section of this document.

Orthodontic Services Rider

To be eligible for orthodontic coverage the Plan Participant and his or her Dependents must be covered under the Contract. Orthodontic treatment started prior to enrolling for coverage under the Contract will be prorated according to the extent of Orthodontic Services provided by the Company to complete the treatment plan. Orthodontic Services as described below will be provided by a Participating Dentist or a Specialist when a treatment plan is prepared by a Participating Dentist prior to rendering services. The treatment plan is based on an examination that must take place while the Plan Participant is covered under the Contract and the examination must show a diagnosis of an abnormal occlusion that can be corrected by orthodontic care. Services connected with orthodontic treatment will be provided subject to the service Copays listed below and the applicable service Copays listed in Exhibit A to this certificate. There are no limitations to the length of orthodontic treatment provided the Plan Participant remains covered under the Contract. Once active treatment ends, there will be no additional orthodontic service Copays for three (3) years provided that the post-treatment plan is followed and appointments are kept. No Benefits will be provided for appliances being replaced (such as headgear and retainers) or for Benefits provided prior to rendering such treatment. If coverage under the Contract terminates prior to completion of orthodontic treatment, there may be additional charges for Orthodontic Services rendered if treatment continues after the termination or change in the Plan Participant's dental coverage. Continuing orthodontic treatment will be prorated based on fee-for-service rates. If orthodontic treatment Benefits terminate before the end of the prescribed treatment period, Benefits will continue through the end of the month in which the orthodontic coverage was terminated.

Pre-Orthodontic Service Copay

The Plan Participant will be responsible to pay the Copays listed below for Pre-Orthodontic Services provided:

- Initial orthodontic exam $ 25
- Study models and x-rays $125
- Case presentation $ 0

The Pre-Orthodontic Copays will be deducted from the Orthodontic Service Copay listed below.

Dental – Willamette Dental Insurance, Inc.

Orthodontic Service Copay

The Plan Participant will be responsible to pay the Copay listed below for Orthodontic Services provided:

- Copayment for all levels of comprehensive Orthodontic Services: $2,300
- Copayment for limited Orthodontic Services will be prorated based on the treatment rendered, provided that such Copayment shall not exceed the Copayment for comprehensive Orthodontic Services shown above.

Orthodontic Services Provided

The following are the Orthodontic Services provided pursuant to this Orthodontic Services Rider:

ADA Code	Procedure
D8020	Limited Orthodontic Treatment Transitional (Mixed dentition)
D8030	Limited Orthodontic Treatment Adolescent (Permanent Dentition & Growing)
D8040	Limited Orthodontic Treatment Adult (Permanent Dentition – not growing)
D8060	Interceptive Orthodontic Treatment/Transitional
D8070	Comprehensive Orthodontic Treatment Transitional (Mixed Dentition)
D8080	Comprehensive Orthodontic Treatment Adolescent (Permanent Dentition & Growing)
D8090	Comprehensive Orthodontic Treatment Adult (Permanent Dentition – not growing)
D8691	Repair of Orthodontic Appliance

Questions and Answers

Can I sign up for the Willamette Dental plan and still go to my own dentist?

Your dental care will only be covered when provided by a dentist or specialist at a Willamette Dental office. Your coverage also extends if it is referred to an outside dentist or specialist by your Willamette Dental dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in Exhibit A.

Can I choose one primary care dentist?

Yes, we encourage you to establish a long-term relationship with a primary Willamette Dental dentist. Once you select your dentist, you may schedule all future appointments with them. You are also free to change Willamette Dental dentists or locations at anytime.

Where are your offices?

Office locations are noted on the following table. With more than 50 dental office locations throughout Oregon, Washington and Idaho, there is probably a Willamette Dental office convenient to most Plan Participants. Most offices are open Monday through Saturday from 7:00 a.m. to 6:00 p.m. Maps and driving directions are available at **www.WillametteDental.com**.

Dental – Willamette Dental Insurance, Inc.

How do I schedule an appointment?

Simply call our Appointment Center:

Portland Metro Area 503-952-2100

Toll-Free 800-461-8994

How long will it take to get an appointment?

Willamette Dental's scheduling goals are as follows:

Emergencies: Within approximately 24 hours

First Appointment: 30 days

Regular Hygiene: (Cleanings) 45 days

Non-Emergency Operative Appointment: 60 days

With the exception of emergencies, the number of days shown above are averages. The length of wait-time for an appointment may vary based on your choice of provider, dental office location, and your desired day or time of appointment.

60 Offices in Oregon, Washington and Idaho		
Oregon	**Idaho**	*Tacoma/Olympia*
Portland Metro	Boise	Lakewood
13 Offices	Coeur d'Alene	Olympia
	Idaho Falls	West Tacoma
Salem	Meridian	Tumwater
2 Offices	Nampa	Puyallap
	Pocatello	
Southern Oregon	Twin Falls	*Eastern Washington*
Albany		Kennewick
Corvallis	**Washington**	Northpointe
Grants Pass	*Seattle/King County*	Pullman
Eugene	4 Offices	Richland
Medford		Spokane
Roseburg	*Puget Sound*	Wenatchee
Springfield	Bellevue	Yakima
	Bellingham	
Central Oregon	Everett	*Southwest Washington*
Bend	Federal Way	Vancouver-East
	Kent	Hazel Dell
Oregon Coast	Lynnwood	Longview
Lincoln City	Renton	
Tillamook	Silverdale	
Maps and driving directions for dental offices are available at **www.WillametteDental.com**		

What can I expect at my first visit?

At your first visit to a Willamette Dental office, you will receive a thorough examination that includes x-rays. Your dentist will develop a ***Personal Dental Care Plan*** based on your immediate needs, current dental health and long term oral health goals. This individual plan will include recommendations for cleanings, restorations, and preventive treatments.

Will I receive two cleanings per year?

Your Willamette Dental dentist will make a recommendation for your teeth cleaning and examination frequency that fits your risk factors. A Plan Participant with periodontal disease could need four or more therapeutic cleanings per year, whereas a Plan Participant with healthy teeth and gums may only need one cleaning every 12 months.

What if I have an emergency?

In Oregon, Washington or Idaho: If you're traveling in our service area, then call the Appointment Center toll-free at 800-461-8994 or in the Portland Metro area at 503-952-2100 to make an appointment at a Willamette Dental office.

Outside Our Service Area: If you cannot get to a Willamette Dental office, or if you are traveling outside our service area, then you may go to any licensed dentist to obtain emergency treatment. Willamette Dental will reimburse up to $100 for any treatment rendered by a licensed dentist. Upon arriving home, contact our Patient Relations Department for reimbursement. You will need to schedule follow-up care with your Willamette Dental primary care dentist.

What if I need to reschedule an appointment?

If you need to reschedule or cancel an appointment, please call our Appointment Center at 800-461-8994 as soon as possible. A missed appointment fee is applied to your account for any missed appointment that you miss without a 24-hour notice.

Can I get major work done right away?

Our practice philosophy is to first diagnose and treat urgent conditions that pose an immediate threat to your oral health. The next priority is prevention: controlling the disease process and motivating you to be active in maintaining good oral health. This assists in preventing future deterioration of oral and dental tissues due to progressive decay or periodontal disease. Major restorative work is normally performed once you have achieved a satisfactory state of oral health where your teeth and supporting structures are stabilized and when you have demonstrated a commitment to maintaining your oral health. This is the best way to ensure the long-term success of whatever major restorative work you may need.

Is orthodontia available in every office?

Specialty services, including orthodontia for children and adults, are generally available on a regional basis. To find where specialty service is available in your area, simply contact our Appointment Center toll-free at 800-461-8994 or in the Portland Metro area at 503-952-2100.

Whom do I call if I need more information?

Questions about dental plan or service should be directed to our Patient Relations Department. You can reach us:

Available Monday - Friday	8 a.m. to 5 p.m. PST
Telephone:	800-460-7644
Email:	relations@willamettedental.com

Life and Accidental Death and Dismemberment (AD&D) Insurance

Regence Life and Health Insurance Company
100 S.W. Market Street
Portland, Oregon 97201

Certificate Schedule for Policyholder:
The Nelson Trust
Group Policy Number: OR 013171
Revised Effective Date: 12/01/2007

Benefit Provisions

LIFE	AD&D	DEPENDENT LIFE
$20,000**	$20,000**	$2,000 - Spouse
		$ 200 - Children 14 days, but less than 6 months
		$ 400 - Children 6 months, but less than 2 years
		$ 800 - Children 2 years, but less than 3 years
		$1,200 - Children 3 years, but less than 4 years
		$1,600 - Children 4 years, but less than 5 years
		$2,000 - Children 5 years, but less than 19 years*
		$2,000 - Incapacitated Children over 19 years

*or to age 25 if the Child is enrolled full-time in an accredited institution of higher learning.

**Benefits and amounts differ for Retired Employees, Disabled Employees, and newly hired Employees who have not satisfied the qualifying period to be eligible for full Trust-paid benefits. Please see your Trust Administrator for more information.

Eligibility

Eligibility is determined by the Trust. Please see your Trust Administrator for more information.

Certificate

This is your certificate, which:
1. is a summary of your insurance under the group policy,
2. is not a contract of insurance,
3. is subject to the terms of the group policy, and
4. voids and replaces any prior certificates issued under the group policy number shown above.

Policy

We have issued the group policy to the policyholder. This policy is a contract of insurance:

1. Between your policyholder and us, and
2. Through which you are insured.

Signed for Regence Life and Health Insurance Company on the insured's effective date.

SECRETARY PRESIDENT

Definitions

Age

The age at your last birthday.

Amount

The amount of insurance.

Beneficiary

The person(s) to whom we will pay the proceeds.

Certificate

A document given to you outlining your coverage under the policy. It is not part of the entire contract of insurance.

Children

A live birth recorded by a valid birth certificate in the jurisdiction where the birth occurred, and includes your unmarried:
1. natural children;
2. step-children;
3. adopted children;
4. other children dependent upon the insured for support.

Coverage will commence on the 14th day following birth and may continue up to nineteen (19) years of age. Insurance will continue to cover the child up to age twenty-five (25), if the child is enrolled full-time in an accredited institution of higher learning.

Insurance will also cover unmarried dependent children up to any age, provided:
1. They are mentally or physically incapacitated; and
2. Incapable of self support continuously since their nineteenth (19th) birthday.

Class

A grouping of insureds:
1. based on their job positions; and
2. determined by the Trust.

Contributory insurance

You must pay a part of the premiums. All such payments are:
1. made directly to the Trust; and
2. forwarded to us as part of the total premium.

Conversion

You may exchange your rights under the policy for an individual policy. This only applies to:
1. Term Life Insurance; or
2. Dependent's Life Insurance.

Coverage

All terms and provisions appearing under one of the following captions of the policy, if provided:
1. Term Life Insurance; or
2. Accidental Death and Dismemberment; or
3. Dependents' Life Insurance; or
4. other benefit riders.

Covered

You are insured under the policy.

Date of Death

The date of the insured's death.

Dependent

Your spouse and children who are not insured employees themselves under the policy.

Effective Date

The date the policy is put in force.

Eligibility Rules

The eligibility provisions formulated by the Board of Trustees of Nelson Trust are hereby incorporated by reference.

Eligible Employee

A person who:
1. Is a member of the eligible classes shown in the policy schedule; and
2. Is within the age requirements shown in the policy schedule.

He, his, and him

Refer to both genders.

Illness

A disease process that:
1. causes the abnormal function of:
   - an organ;
   - a system of the body; or
   - the whole body; and
2. Is caused by a:
   - pathogenic change; or
   - a psychological disturbance.

In Force

The policy is in effect. Premiums are paid and all insuring conditions are met.

Injury

Bodily injury which:
1. results directly and independently of all other causes from an accident;
2. has fulfilled all conditions under the policy to become insured; and
3. results in:
   - disability;
   - death; or
   - dismemberment.

Insured

A person who:
1. is included under an eligible class;
2. has fulfilled all conditions under the policy to become insured; and
3. has insurance in force under the policy.

Insured's Application

His enrollment card.

Insured's Effective Date

The date you become covered under the policy.

Noncontributory Insurance

You are not required to pay any part of the premiums.

Notice

Written notice in a form satisfactory to us for that purpose.

Person

Used in the singular. There may be more than one person—natural or legal.

Physician

A licensed physician practicing within the scope of his license.

Policyholder

Herein referred to as the “Nelson Trust” or Trust; a Taft Hartley arrangement between the Northwest Forest Products Association and Woodworkers District Lodge 1, IAM, AFL-CIO.

Pregnancy

Includes:
1. childbirth;
2. normal miscarriage;
3. elective abortion;
4. Caesarean section; and
5. complications from these.

Proceeds

The amount of insurance we will pay as a benefit. This amount is:
1. shown in the certificate schedule; and
2. subject to the amount that you are eligible for as shown in the policy schedule for your class.

Proof

A properly completed claim form, plus:
1. for **life insurance –**
   - a certified copy of the death certificate; or
   - death decreed by a court order;

   or
2. for **accidental death and dismemberment insurance –** written proof acceptable to us.

Spouse

Your legal husband or wife.

We, Us, and Our

Regence Life and Health Insurance Company.

You and Your

Insured employee.

Benefit and Beneficiary Provisions

Benefit

We will pay the proceeds:
1. when we receive proof of your loss;
2. if coverage insuring the type of loss has been selected:
   - in the policy; and
   - for your class;
3. if the premiums have been paid for that coverage; and
4. subject to all policy provisions.

Beneficiary

Your enrollment card lists your choice of beneficiary. If your spouse is your designated beneficiary and you and your spouse divorce, the designation of your former spouse as beneficiary is automatically void at the time of the divorce. If you elect to retain your former spouse as your beneficiary, you must complete a new designation of beneficiary and name your former spouse. Such new designation will be valid if it is completed after the date of the divorce. If you do not designate, in writing, a new beneficiary, the Facility of Payment provision of the policy will govern.

Proceeds will be paid:
1. To you—for proceeds paid as a result of:
   - accidental dismemberment;
   - accidental loss of sight; or
   - the death of a dependent.
2. To the beneficiary as defined on your enrollment card in the event of loss of life. If the beneficiary is not indicated on your enrollment card, to the following:
   - to your wife or husband; or
   - to your dependent children in equal shares, or all to the survivor thereof; or
   - to your father and mother, in equal shares, or all to the survivor thereof; or
   - to your brothers and sisters in equal shares, or all to the survivor thereof; or
   - to your estate—if no beneficiaries survive you.

Change of Beneficiary

During your lifetime, you may change the beneficiary. Notice of the change must be dated and signed by you and sent to the Trust Administrator. The change takes effect on the date it is signed. We are not liable for any action we take before we receive the notice at our home office.

Insuring Provisions

Eligibility

See definition of "Eligible employee."

Insured's Effective Date

See definition of “Insured’s effective date.”

Termination of Employee's Insurance

Your coverage ends when:
1. the policy terminates; or
2. the Trust does not remit premiums; or
3. you cease to be in an eligible class; or
4. you enter active duty in the military.

Changes to the Policy

No agent can:
1. change the policy; or
2. waive any of its terms.

Changes can be made only:
1. if the Trust and we agree; and
2. by a written endorsement executed by us.

In performing any duties in connection with the policy, the Trust is:
1. your agent; and
2. not our agent.

Incontestability: No statement made by you about your or your dependents' insurability will be used to contest the validity of this insurance, unless:
1. the coverage has been in force prior to the contest for less than two years during:
   - for the **insured's coverage**—your lifetime; or
   - for the **dependents' coverage**—your dependent's lifetime;
2. it is in the insured's application signed by you; and
3. a copy of the insured's application is or has been given to:
   - you; or
   - the beneficiary.

Except in the case of fraud, all statements made by you are deemed to be:
1. representations; and
2. not warranties.

The policy or your coverage may be contested at any time for nonpayment of premiums.

Misstatement of Age or Class

We will pay based on the amount of insurance:
1. **if your age or class is misstated**—that you are entitled to at your true age or class; or
2. **if your dependent's age is misstated**—that your dependent is entitled to at his true age.

Physical Exams and Autopsy

(This provision also applies to dependents.)

We will have the right and opportunity to examine you:
1. by a physician of our choice;
2. at our own expense;
3. while a claim is pending or being paid; and
4. as often as we may reasonably require.

We also have the right to make an autopsy:
1. in the case of death;
2. where it is allowed by law; and
3. at our expense.

Time of Payment of Claims

We will pay the proceeds for insured losses as soon as we receive proof.

Other Insurance

This insurance is not in lieu of worker's compensation, it does not affect any requirement for worker's compensation coverage.

Assignment

You may assign any of your rights. We are not liable for the assignment's:
1. validity; or
2. sufficiency.

We are not bound by an assignment until we receive it.

Coverage 1 - Term Life Insurance

(only available to employees)

Term Life Benefit

We will pay the proceeds to the beneficiary:
1. If this coverage has been selected:
   - in the policy;
   - for your class; and
   - as shown in the policy schedule;
2. if the premiums have been paid for this coverage;
3. subject to all policy provisions; and
4. when we receive proof of your death.

Term Life Proceeds

The proceeds we will pay is the amount that your life is insured at the date of death.

Facility of Payment

We have the option to pay the proceeds to any one or more of your surviving relatives instead of paying your estate. These relatives include your:
1. spouse; or
2. children; or
3. parents; or
4. brothers and sisters.

We have the option to pay up to $2,000 of the proceeds:
1. if allowed by law; and
2. to any person who appears to us as having incurred costs from your:
   - last illness;
   - death; or
   - funeral.

If a beneficiary is a minor or not competent, we have the right to pay up to $2,000 to the person or institution who appears to us to have assumed the beneficiary's custody and principal support. We will take this action until or unless a formal complaint is made by a legal representative of the beneficiary.

Our liability for the payment ends if we make it in good faith.

Other Modes of Settlement

Other modes of settlement may be arranged if you and we agree. We will furnish data on these other modes upon request.

Extension of Employee Life Insurance During Total Disability

(Accidental death and dismemberment and dependent's life benefits are not included.)

Definitions

(**for this provision only)**

Totally Disabled or Total Disability

You are unable to work at any employment or occupation for which you are or become qualified by reason of education, training or experience and are not in fact engaged in any employment or occupation for wage or profit because of disability:
1. caused by injury or illness; and
2. that started while your life is insured under this coverage.

If you become totally and permanently disabled while insured under the policy and before age 60 (or if you are otherwise qualified under the previous policy held by the Trust), and if you remain disabled after nine (9) months, you and your doctor should complete the proof form and return it to the Trust Administrator.

The proof of disability form must be submitted to us no later than 12 months from your last reported month of eligibility. Subsequent proof of disability may be required each year thereafter. If so, a form will be mailed to you to be completed by you and your doctor. If required, the subsequent proof of continuous disability will be requested during the last three (3) months of each one (1) year term after the first. If proof cannot be given within this time, it must be given as soon as reasonable possible within three (3) months after the time it is otherwise required.

When we are satisfied with the proof of disability, life insurance will be extended while your total disability continues and while the required premium payments are made by the Trust.

If you die before the twelfth (12^{th}) month of disability and proof of disability has not been filed, your beneficiary must file proof of death, together with any required proof of continuous disability, within one (1) year of the date of your death. We are not liable for a death claim unless we receive proof of your death within one (1) year after the date of your death.

The amount of life insurance extended will be the lesser of:
1. the amount shown in the policy schedule; or
2. the amount of life insurance in force on your last day of active work.

Extended life insurance will end on the sooner of the date:
1. you are no longer totally disabled;
2. you fail to furnish the required proof of continuous total disability;
3. you refuse to be examined as required;

4. the required premium payment is not made by the Trust; or
5. the policy terminates.

Conversion

You may convert all or part of the insurance under this coverage without evidence of insurability to an individual life policy:
1. if insurance ends because:
   a. of termination of your:
      1) employment; or
      2) membership in an eligible class; or
   b. of your retirement; or
   c. you reach a specified age; or
   d. of a policy change affecting your class; or
   e. the policy or the employer's participation ends or is amended; and
2. if within 31 days after termination you:
   a. give us a written request to convert; and
   b. pay the first premium on the new policy.

The new policy may be on any individual plan of life insurance, except term, issued by us:
1. at the age and for the amount applied for; and
2. without disability or other supplemental benefits.

The new policy:
1. face amount may not exceed:
   a. the amount of insurance in force on the conversion date; or
   b. **for "1.e." above**—the lesser of:
      1) the amount that terminated—less the amount of any life insurance for which you are or become eligible under any group policy issued or reinstated:
         a) by us or any company; and
         b) within 31 days after the termination of your coverage; or
      2) $10,000.00;
2. premium rate will be based on:
   a. your age on its effective date;
   b. the rates then in use by us; and
3. effective date will begin at the end of the 31 day conversion period after termination.

If you die during the 31 day conversion period, the amount we will pay:
1. will be paid under the group policy; and
2. will be the maximum amount that could have been converted, whether or not:
   a. the application to convert was made; or
   b. the first premium was paid.

Any life conversion policy must be surrendered without claim. We will refund any premium paid for it. Conversion to an individual policy will not stop any right under extended insurance if:
1. all conditions of that provision are met within the time required; and
2. the individual policy is given to us:
   a. for cancellation; and
   b. without a claim under it—except for a refund of premiums paid.

Coverage 2 - Accidental Death, Dismemberment, Paralysis and Loss of Sight

(only available to employees)

Definitions

(for this coverage only)

Loss

Means with regard to:
1. **life**—death;
2. **hands and feet**—complete severance through or above the wrist or ankle joint;
3. **sight**—loss of sight, which is:
   a. entire; and
   b. irrecoverable.

Benefit

We will pay the proceeds to the beneficiary for accidental loss of life and to you for accidental dismemberment or accidental loss of sight:
1. if this coverage has been selected:
   a. in the policy;
   b. for your class; and
   c. as shown in the policy schedule;
2. if the premiums have been paid for this coverage;
3. subject to all policy provisions;
4. when we receive proof of your loss shown below:
   a. that was caused by injury while you were insured under this coverage; and
   b. that occurs within 365 days from the date of the injury; and
5. if the loss is not excluded below.

The principal sum that applies to the insured is shown in the policy schedule for loss of:

Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
Sight of one eye	One-half of the Principal Sum
One hand or one foot	One-half of the Principal Sum

Exclusions

We will not pay the proceeds for any loss resulting from:

- Intentionally self-inflicted injury—or any attempt to injure oneself while sane or insane
- Medical or surgical treatment
- Any war or act of war—declared or undeclared

- Military service
- Bodily or mental infirmity or disease from bacterial infections (except accidental ingestion of contaminated foods)—other than infection caused from an injury covered under this coverage

Coverage 3 - Dependent Life Insurance

Definitions

(for this coverage only)

Dependent's Effective Date

The date the dependent becomes insured under the policy.

Dependent Life Benefit

We will pay the proceeds to the beneficiary:
1. if this coverage has been selected:
   a. in the policy;
   b. for your class; and
   c. as shown in the policy schedule;
2. if the premiums have been paid for this coverage;
3. subject to all policy provisions; and
4. when we receive proof of the dependent's death.

Dependent Life Proceeds

We will pay the amount:
1. that your dependent's life is insured for at the date of death; and
2. shown in the policy schedule for dependents in your class on the date of death.

Beneficiary
We will pay the proceeds to:
1. you—if you are living; otherwise
2. your estate; or (at our option)
3. your spouse—if living.

Termination of Employee's Dependent Insurance

A dependent's coverage ends on the sooner of the date:
1. the person ceases to be a dependent; or
2. you stop paying premiums—if premiums are required; or
3. your coverage ceases under the policy; or
4. all dependent coverage ceases under the policy; or
5. the dependent child becomes an insured employee; or
6. the day you are eligible for extended insurance; or
7. the day a final decree of divorce is rendered; or
8. the day the dependent enters active duty in the military.

Conversion

Your dependent spouse may convert his insurance if:
1. it ends because:
   a. the policy terminated; or
   b. the policy was amended; or
   c. you die—the surviving dependent may convert only the insurance under the policy that would end because of your death; or
   d. he ceases to be a qualified spouse; and
2. if within 31 days after termination he:
   a. gives us a written request to convert; and
   b. pays the first premium on the new policy.

The new converted individual life policy:
1. may be on any form issued by us except for term insurance:
   a. that has a level:
      1) premium; and
      2) amount of insurance; and
   b. that he selects from among those forms we then issue for:
      1) his age; and
      2) the amount applied for;
2. premium rate will be based on:
   a. his age on its effective date; and
   b. the rates then in use by us;
3. effective date will begin at the end of the 31-day term to convert; and
4. amount may not exceed the amount of his insurance being terminated—less any amount that he is or becomes eligible for under any group policy issued or reinstated:
   a. by us or any company; and
   b. within 31 days after his insurance terminates.

If the spouse dies during the 31-day conversion period, the proceeds we will pay:
1. will be paid under this group policy; and
2. will be the maximum amount which could have been converted, whether or not:
   a. the application to convert was made; or
   b. the first premium was paid.

Any life conversion policy must be surrendered without claim. We will refund any premium paid for it.

How to File a Claim

1. Notice for claims for life insurance and accidental death and dismemberment insurance benefits should be filed directly with the Trust Administrator's office at:

   A&I Benefit Plan Administrators, Inc.
   1220 S.W. Morrison Street, Suite 300
   Portland, OR 97205-2222

2. You may request a claim form from us or from the Trust Administrator's office.
3. Claims must be filed within one year of the date of death.

Employee Accident and Sickness Weekly Indemnity Benefits

Amount of Coverage

Accident and Sickness Weekly Indemnity (Non-Occupational) .....Up to $350*

* $40 if disability commences after termination of employment but before eligibility for benefits terminates.

Please Note: Weekly Indemnity Benefits for California employees will be $350 less the amount of weekly disability benefits payable under California U.C.D.

1. The amount of the Accident & Sickness Weekly Indemnity Benefit will be calculated based upon 60% of the employee's current straight time hourly rate times normal scheduled hours (usually 40 hours per week), with a maximum benefit of $350.00 per week.
2. If you are unable to work because of a disability caused by an accident, which is not due to bodily injury arising out of or in the course of employment of any kind, or a disability caused by a sickness not covered by the Worker's Compensation Act, you will be paid a weekly benefit referred to in item 1. above. This benefit will only be paid to those having hourly/flat rate eligibility at the time of the disability. A "disability" means that for medical reasons you are unable to perform the essential duties of your regular occupation or any other work for wages or profit.

The determination of your entitlement to the weekly benefit will be made by the Claims Administrator with medical advice, where appropriate.

If you terminate employment due to a quit, discharge, or retirement, the amount of weekly indemnity will be $40 for disabilities which commence after termination of employment but before eligibility for benefits terminates.

Weekly indemnity benefits for California employees will be $350 less the amount of weekly disability benefit payable under California U.C.D.

If covered employee is a donor and is disabled as a result of a transplant to any person of a natural organ or tissue requiring surgical removal, the same benefit will be payable that would have been payable had the employee been disabled by a non-occupational disease.

In no event will accident and sickness weekly benefits be payable under this plan for any disability which commenced before your month of coverage, or during a month in which you are eligible by self-payment.

Weekly benefits are not payable for any period which you are not under the care of a doctor licensed to practice medicine.

Benefits are payable from the first day for a disability due to an accident and from the fourth day for a disability due to sickness. Payment will continue as long as you are disabled, up to a maximum of twenty-six weeks for each period of disability.

Periods of disability due to the same cause will be considered different periods of disability if they are separated by a return to full-time work for a period of 90 consecutive days. You will not be disqualified for additional coverage if return to work is prevented by shut-down, plant closure, or similar work-related cause, provided you are listed on the payroll of a participating employer, and throughout which period you are medically certified as available for work.

Your waiting period will be based on a seven-day week, Monday through Sunday, and you will be paid on a normal five-day work week, Monday through Friday.

Weekly benefits will not be paid for any period of disability during which you are qualified for accident and sickness benefits under a plan of a non-participating employer.

All accident and sickness claims must be received by the Trust Administrator's office within 90 days of the disability.

How to File a Claim

1. Obtain a claim form from your employer or local Lodge.
2. Fill out your part of the form and have the doctor and employer fill out the remainder.
3. Have the completed form sent to the Trust Administrator's office at:

   A&I Benefit Plan Administrators, Inc.
   1220 S.W. Morrison Street, Suite 300
   Portland, OR 97205-2222

4. **File your claim immediately.** Benefits cannot be paid until your completed claim form is received. Claims not filed within 90 days of disability are subject to denial.

Questions and Answers Pertaining to the Plan

The purpose of the following questions and answers section is intended to clarify many of the eligibility provisions of The Nelson Trust. Please remember that this document is furnished for the purpose of giving a brief and clear summary of benefits available under the Plan. In the event questions arise concerning eligibility or the payment of benefits, then the content of the formal Plan eligibility rules and insurance contracts will control in all instances.

1. Q. **How is The Nelson Trust administered?**

   A. The Nelson Trust and its operations are administered by a Board of Trustees composed of fourteen representatives from the Northwest Forest Products Association, and the Woodworkers District Lodge 1, IAM, AFL, CIO.

2. Q. **How can a Plan Participant appeal a decision if the Plan Participant feels that a mistake has been made in the determination of eligibility or in the amount of benefits payable under the Plan?**

   A. For Medical, see the “What if I Have a Question or an Appeal?” section of this document.

   For Vision, see the “Complaints and Grievances” section of this document.

   For ODS Dental, see the “Appeals” section of this document.

   For Willamette Dental, see the “Claims Review Procedures” section of this document.

3. Q. **How is The Nelson Trust financed?**

   A. The Nelson Trust is financed by employer contributions according to the provisions of the working agreement. The Plan Participants may also be required to make contributions upon terms set by the Board of Trustees. Assets of The Nelson Trust can only be used for providing benefits and the cost of administration.

4. Q. **Can an employee working for a participating contractor/subcontractor or employer not in the lumber or forest products industry qualify for coverage under the 300-hour eligibility rule?**

   A. No, employees working for a contractor/subcontractor or employer not in the lumber or forest products industry have eligibility based on a flat rate contribution. Therefore eligibility cannot be determined based on the 300-hour eligibility rule.

5. Q. **Are new employees of new participating employers allowed to self-pay before attaining normal eligibility?**

   A. Yes, but only in cases where the employees of a new participating employer will be losing coverage under that employer's prior plan, then those employees may self-pay under the self-pay rules. This self-pay right applies only to the employees of a new participating employer and not to newly hired employees of an existing employer.

6. Q. **Will The Nelson Trust accept advance self-payments for future months of coverage?**

   A. Yes, but The Nelson Trust urges the dependent(s) to take advantage of the self-payment billing procedure in that The Nelson Trust has found that it assists the family of the deceased employee in knowing for which month(s) eligibility has been purchased. If self-payments are made without using the billing form, then the covered dependent's identification number should be written on the face of the check or money order. This will assist the Trust Administrator’s office in processing the payment in a timely manner.

HIPAA

The Nelson Trust complies with a federal law that protects the privacy of health information for you and all other Plan Participants and beneficiaries of The Nelson Trust. This protected health information is called PHI and includes:

1. your mental or physical condition,
2. the provisions of your health care, and
3. the payment for your health care.

The Nelson Trust has a Privacy Policy which is an explanation of The Nelson Trust's use of your PHI and your rights under the law.

The Nelson Trust was amended to comply with the law. It now provides that the Trustees will:

- Not use or disclose your PHI other than as permitted by the Plan documents or as required by law
- Ensure that any person to whom The Nelson Trust provides your PHI agrees to the same restrictions and conditions that apply to The Nelson Trust
- Not use or disclose your PHI for employment-related actions or in connection with any other employee benefit plan
- Report to The Nelson Trust's Privacy Official any use or disclosure of your PHI that is inconsistent with the permitted uses or disclosures
- Make your PHI available to you, consider your requested amendments to your PHI and, upon your request, provide you with an accounting of disclosures of your PHI
- Make The Nelson Trust's internal practices and records relating to the use and disclosure of your PHI available to DHHS upon request
- Require, if feasible, any person who receives your PHI to return or destroy all your PHI received from The Nelson Trust that the person maintains in any form and retain no copies of your PHI when no longer needed for the purpose for which disclosures were made, except that, if the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction for the information not feasible

Ms. Lee Centrone was appointed as the contact person for any questions about The Nelson Trust Privacy Policy or about your PHI. Please contact Ms. Lee Centrone in writing at 1220 S.W. Morrison Street, Suite 300, Portland, Oregon 97205-2222, if you have any questions or wish a copy of The Nelson Trust's Privacy Policy.

ERISA Information

Please Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each Plan Participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either the:

Office of the Employee Benefits Security Administration
U.S. Department of Labor
1111 Third Ave. Suite 860
MIDCOM Tower
Seattle, WA 98101-3212

or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. N.W.
Washington, D.C. 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 at 866-444-3272.

Name of Plan

Northwest Forest Products Association-Woodworkers District 1, IAM, AFL-CIO Health and Welfare Plan (The Nelson Trust)

Plan Number

501

Plan Administrator

The Nelson Trust is a health and welfare benefit plan, which is jointly administered by 14 Trustees who are responsible for the administration of the Plan. Seven Trustees are appointed by each party to The Nelson Trust. The names and addresses of the Trustees are as follows:

Trustees Representing the Employer	Trustees Representing the Union
Cliff Slade Simpson Investment Co. 917 East 11th St. Tacoma, WA 98421-3039	Steve Wilson IAM Woodworkers Dist. Lodge W1 25 Cornell Ave Gladstone, OR 97027-2547
Hank Snow Roseburg Forest Products Co. PO Box 1088 Roseburg, OR 97470	Leon Blocker IAM Woodworkers Dist. Lodge W2 1962 Madison Ave Memphis, TN 38104
Tony Ventresco Potlatch Forest Products Corp. 805 Mill Rd. PO Box 1388 Lewiston, ID 83501	Mick Burnell IAM Woodworkers Dist. Lodge W3 718 Grand Ave Schofield, WI 54476
Brooks Burton Weyerhaeuser Company P.O. Box 1060 Hot Springs, AR 71902-1060	Mike Heuer IAM Woodworkers Dist. Lodge W536 536 Oregon Way Longview, WA 98632
Management Alternates	Eric Dobson IAM Woodworkers Local Lodge W38 PO Box 98 Shelton, WA 98584
Jack McGuill Simpson Investment Co. PO Box 460 Shelton, WA 98584-0460	Chuck Macrae (term ended February 1, 2009) IAM Woodworkers Dist. Lodge W1 25 Cornell Ave Gladstone, OR 97027-2547
Michelle Payne Weyerhaeuser Company P.O. Box 907 Albany, OR 97321	Steve Fluke (term began February 1, 2009) IAM Woodworkers Dist. Lodge W1 25 Cornell Ave Gladstone, OR 97027-2547

Employer Identification Number "EIN"

93-6041903

Date of the End of the Plan Year

Plan year ends on each December 31.

Type of Plan

The plan is an employee welfare benefit plan. The benefits provided by The Nelson Trust as specified in other sections of this document are provided by contracts with Premera Blue Cross, Medco, Regence Life and Health Insurance Company, ODS Health Plan, Vision Service Plan and Willamette Dental Insurance. The medical-surgical hospital benefits, prescription drug benefits, vision benefits, ODS dental benefits, and accident & sickness benefits are self-funded.

Eligibility for Participation

In general, an individual is initially eligible to participate and receive all benefits on and after the first day of the second calendar month following two consecutive months in which the individual is credited with 100 or more compensable hours per month. The specific provision relative to initial eligibility, continued eligibility and loss of eligibility are contained in "Eligibility Rules for Employees and Dependents."

Source of Contributions

Employers contribute to The Plan at a specified rate per compensable hour. Plan participants may also be required to make contributions upon terms set by the Board of Trustees. All contributions are made to a trust fund. Plan participants or beneficiaries may receive from the Trust Administrator upon written request, information whether a particular employer is a sponsor of the Plan.

Agent for Service

The agent for service of process on The Nelson Trust is the Trust Administrator.

Claims Appeal Procedures

The Claims Appeal Procedures are contained in the following sections of this document:

- For Medical— “What if I Have a Question or an Appeal?”
- For Vision— “Complaints and Grievances”
- For ODS Dental— “Appeals”
- For Willamette Dental— “Claims Review Procedures”

Correspondence relative to Claims Appeal Procedures should be addressed to the Trust Administrator.

Collective Bargaining Agreements

The Nelson Trust is the subject matter of collective bargaining agreements. The provisions of the collective bargaining agreements relate to the health and welfare benefits. The parties to the collective bargaining agreements are:

- Woodworkers District Lodge 1, IAM, AFL-CIO
- Local Lodges chartered by or affiliated with the IAM, AFL-CIO
- Northwest Forest Products Association and Individual Employers

Request for Information and Documents

All requests for information, a copy of a collective bargaining agreement, or correspondence relative to coverage, benefits and interpretation of The Nelson Trust should be in writing and addressed to the Trust Administrator.

What Are My Rights under ERISA?

This Plan is an employee welfare benefit plan that's subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the "ERISA Plan" in this section.

When used in this section, the term "ERISA Plan" refers to The Nelson Trust's employee welfare benefit plan. The "ERISA Plan administrator" is The Nelson Trust or an administrator named by The Nelson Trust. Premera Blue Cross and the other administrators or carriers are **not** the ERISA Plan administrator.

- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. The Nelson Trust is required to file an annual report with the U.S. Department of Labor; Plan Participants are entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report. The Nelson Trust is required by law to furnish each Plan Participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under The Nelson Trust as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing The Nelson Trust on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, (if The Nelson Trust has such an exclusionary period) when you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under The Nelson Trust, if you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of The Nelson Trust, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. (The Nelson Trust has delegated to the carriers and claims administrators the discretionary authority to construe the terms used in The Nelson Trust to the extent stated in our administrative services contract or insurance policy with The Nelson Trust). 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.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay a fine until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA 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 ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you 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.

If you have any questions about your Plan, you should contact the Trust Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

Note: No participating employer, employer association or labor organization, or any of their employees, are authorized to answer questions concerning the trust fund and the Plan. Please direct all inquiries to the office of the Trust Administrator and insert the employee's identification number on all correspondence.

This document is a summary of the benefits and provisions available through The Nelson Trust health and welfare plans. If there is a discrepancy between this document and the official plan documents or insurance policies, the Plan documents or insurance policies will govern plan provisions and how benefits are paid. The Trustees reserve the right to make any changes in the Plan that they deem necessary, including benefit and eligibility changes, termination of all, or a portion of, the coverages, or to require or change monthly employee contributions.

Important Contact Information

For questions about . . .	Contact . . .	Web Sites and Phone Numbers
Trust Administration Life and Accidental Death and Dismemberment (AD&D) Insurance Accident and Sickness Weekly Indemnity (A&S)	**A&I Benefit Plan Administrators, Inc.** 1220 S.W. Morrison Street, Suite 300 Portland, OR 97205-2222	**www.nelson.aibpa.com** 503-222-7696 800-811-8853 Fax: 503-228-0149
Medical	**Premera Blue Cross** **Mail Your Claims to** P.O. Box 91059 Seattle, WA 98111-9159 **Physical Address** 7001 220th St. S.W. Mountlake Terrace, WA 98043-2124 **Send Your Appeals to** Attn: Appeals Coordinator P.O. Box 91102 Seattle, WA 98111-9202	**www.premera.com** Local and toll-free number: 800-722-1471 Local and toll-free TDD number for the hearing impaired: 800-842-5357 **BlueCard** Nationwide toll-free number: 800-810-BLUE(2583) Outside the United States call collect: 804-673-1177
Prescription Drug **Specialty Care Pharmacy**	**Medco Health Solutions, Inc.** Member Services **Medco by Mail** Medco Health Solutions of Fort Worth P.O. Box 650022 Dallas, TX 75265-0022 **Accredo Health Group**	**www.medco.com** 800-309-7139 TTY: 800-759-1089 800-309-7139 800-309-7139
Dental	**Oregon Dental Services (ODS)** 601 S.W. Second Avenue Portland, OR 97204-3156 Group #5933 Spanish Dental Customer Service (Servicio al Cliente Area Dental) Dental Office Inquiries **Willamette Dental Insurance, Inc.** Patient Relations Department Appointment Center	**www.odscompanies.com/members** 503-265-5680 Portland 877-277-7280 Toll-Free TDD/TTY: 800-433-6313 503-265-2963 877-299-9063 (Llamado Gratis) 503-243-4494 Portland 800-452-1058 Toll-Free **www.willamettedental.com** 800-460-7644, Option 4 relations@willamettedental.com 503-952-2100 Portland Metro Area 800-461-8994 Toll-Free
Vision	**Vision Service Plan (VSP)** P.O. Box 997100 Sacramento, CA 95899-7100 **Physical Address** **Send Your Appeals to** 3333 Quality Drive Rancho Cordova, CA 95670 **Send Second Opinion Requests to** Clinical Consultant Health Care Services Division 3333 Quality Drive Rancho Cordova, CA 95670	**www.vsp.com** 916-851-5000 800-877-7195
California State Disability Insurance (SDI) Benefits (for California employees)	**EDD, Disability Insurance** P. O. Box 13140 Sacramento, CA 95813-3140	**www.edd.ca.gov/direp/dirq2501.htm** 800-480-3287 (English) 800-658-8846 (Spanish) TTY (teletypewriter for deaf, hearing-impaired and speech-impaired persons only) 800-563-2441