Appendix 1

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible Preferred Provider $300 ~~$500~~ (Per Insured Person, Per Policy Year)
Deductible Out-of-Network $300 ~~$1,000~~ (per Insured Person, Per Policy Year) **Coinsurance**
Preferred Provider 95% ~~80%~~ except as noted below
Coinsurance Out-of-Network 95% ~~60%~~ except as noted below
Out-of-Pocket Maximum $1,000 ~~$5,000~~ (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum $2,000 ~~$10,000~~ (For all Insureds in a Family, Per Policy Year)

The Coinsurance amount is the percentage of Covered Medical Expenses that the Company pays. For the Covered Medical Expenses listed in the Schedule of Benefits, benefits will be paid at the Coinsurance amount stated above, unless otherwise specifically stated.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The provider network for this plan is Choice.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits:
Benefits will be paid as specified below for services not covered by the student health fee when treatment is rendered at Cougar Health Services (CHS) on the Pullman campus, Multicare Rockwood Clinic for students attending the Spokane campus, and Community Health of Central Washington for students attending the Yakima campus. Multicare Rockwood Clinic in Spokane, Community Health of Central Washington in Yakima and CHS Vancouver Clinic in Vancouver serve as the CHS for students attending these campuses.

- All CHS locations: The Deductible and Copays will be waived for Covered Medical Expenses incurred when treatment is rendered at CHS.
- At CHS Pullman Campus, Multicare Rockwood Clinic, Community Health of Central Washington and CHS Vancouver Clinic locations: ~~location only:~~ Benefits will be paid at 100% for Covered Medical Expenses, chlamydia and gonorrhea tests, and vision exams subject to any benefit maximums, except as follows: 1) Outpatient Physiotherapy will be paid at 95% ~~80%~~ for Covered Medical Expenses~~; and 2) Prescription Drugs will be paid 80% for generic drugs and 70% for brand-name drugs up to a 90- day supply. Self-administrable injectable medications are limited to a 31-day supply, other than insulin.~~
- ~~At Multicare Rockwood Clinic, Community Health of Central Washington and CHS Vancouver Clinic locations: Benefits will be paid at the Coinsurance and benefit maximums applicable to all other providers, except Outpatient Physiotherapy will be paid at 80% for Covered Medical Expenses incurred.~~
- ~~Vision exams performed at CHS Pullman Campus will be covered at 100%.~~
- ~~Chlamydia and Gonorrhea tests rendered at CHS Pullman Campus are covered at 100%, unless covered under the Preventive Care Services benefit.~~

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Room and Board Expense	95% ~~80%~~ of Preferred Allowance after Deductible	95%~~ 60%~~ of Usual and Customary Charges after Deductible

Intensive Care	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Hospital Miscellaneous Expenses	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Routine Newborn Care	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Assistant Surgeon Fees	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Anesthetist Services	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Registered Nurse's Services	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Physician's Visits	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible

Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Day Surgery Miscellaneous	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Assistant Surgeon Fees	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Anesthetist Services	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Physician's Visits	~~$25 Copay per visit~~ 95% ~~80%~~ of Preferred Allowance after Deductible	~~$25 Copay per visit~~ 95% ~~60%~~ of Usual and Customary Charges after Deductible

Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$200 Copay per visit 100% of Preferred Allowance after Deductible	$200 Copay per visit 100% of billed charges after Deductible
Diagnostic X-ray Services	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible

COL-17-WA (PY21) SOB (312-1) 2

Radiation Therapy	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Laboratory Procedures Lab work billed or referred by CHS Pullman Campus, Multicare Rockwood Clinic, Community Health of Central Washington and CHS Vancouver Clinic will be covered at 100%.	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Tests & Procedures	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Injections	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Chemotherapy	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible

Prescription Drugs The Policy does not include a pharmacy network for Prescription Drugs. All Prescription Drug benefits are payable under the Out of-Network Provider benefits. The Insured Person will be responsible for paying the lowest of either the applicable Coinsurance as provided in this benefit or the amount the Insured Person would pay for the Prescription Drug when purchased without using benefits provided under the Policy. No Deductible, Copays, or Coinsurance will be applied to contraceptives covered under the Preventive Care Services benefit. The total amount an Insured is required to pay for a covered insulin Prescription Drug will not exceed $50 ~~$100~~ per 30-day supply. Insulin Prescription Drugs will be covered without being subject to a Deductible and any Copay and/or Coinsurance paid by the Insured will be applied toward the Insured's Deductible.	Prescription deductible - Not applicable Generic - $10 ~~$20~~ copay Preferred - $25 ~~$40~~ copay Non-preferred - $35 ~~$80~~ copay Prescription out-of-pocket - Not Applicable	Prescription deductible - Not applicable 80% Coinsurance per prescription generic drug 80% ~~70%~~ Coinsurance per prescription preferred drug 70% Coinsurance per prescription non-preferred drug Prescription out-of-pocket - Not Applicable

Ambulance Services	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Durable Medical Equipment	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Consultant Physician Fees	~~$25 Copay per visit~~ 95% ~~80%~~ of Preferred Allowance after Deductible	~~$25 Copay per visit~~ 95% ~~60%~~ of Usual and Customary Charges after Deductible
Dental Injury $900 ~~$300~~ maximum per Policy Year for each Injury	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~of Usual and Customary Charges after Deductible
Dental Treatment	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~of Usual and Customary Charges after Deductible

Mental Illness Treatment See Benefits for Mental Disorders and Substance Use Disorders	**Inpatient:** 100% ~~80%~~ of Preferred Allowance after Deductible **Outpatient office visits:** ~~$25 Copay per visit~~ 100% ~~80%~~ of Preferred Allowance after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 100% ~~80%~~ of Preferred Allowance after Deductible	**Inpatient:** 100% ~~60%~~ of Usual and Customary Charges after Deductible **Outpatient office visits:** ~~$25 Copay per visit~~ 100% ~~60%~~ of Usual and Customary Charges after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 100% ~~60%~~ of Usual and Customary Charges after Deductible
Substance Use Disorder Treatment See Benefits for Mental Disorders and Substance Use Disorders	**Inpatient:** 95% ~~80%~~ of Preferred Allowance after Deductible **Outpatient office visits:** ~~$25 Copay per visit~~ 95% ~~80%~~ of Preferred Allowance after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:**95% ~~80%~~ of Preferred Allowance after Deductible	**Inpatient:** 95% ~~60%~~ of Usual and Customary Charges after Deductible **Outpatient office visits:** ~~$25 Copay per visit~~ 95%~~60%~~ of Usual and Customary Charges after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 95% ~~60%~~ of Usual and Customary Charges after Deductible
Maternity	95% ~~80%~~ of Preferred Allowance ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~80%~~ of Preferred Allowance for other covered services after Deductible	95% ~~60%~~ of Usual and Customary Charges ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~60%~~ of Usual and Customary Charges for other covered services after Deductible
Complications of Pregnancy	95% ~~80%~~ of Preferred Allowance ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~80%~~ of Preferred Allowance for other covered services after Deductible	95% ~~60%~~ of Usual and Customary Charges ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~60%~~ of Usual and Customary Charges for other covered services after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	100% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible

COL-17-WA (PY21) SOB (312-1) 4

Diabetes Services **See Benefits for Diabetes**	95% ~~80%~~ of Preferred Allowance ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~80%~~ of Preferred Allowance for other covered services after Deductible	95% ~~60%~~ of Usual and Customary Charges ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~60%~~ of Usual and Customary Charges for other covered services after Deductible
Home Health Care	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Hospice Care	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Inpatient Rehabilitation Facility	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~of Usual and Customary Charges after Deductible
Skilled Nursing Facility 60 days maximum per Policy Year	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~of Usual and Customary Charges after Deductible
Urgent Care Center	~~$25 Copay per visit~~ 95% ~~80%~~ of Preferred Allowance after Deductible	~~$25 Copay per visit~~ 95% ~~60%~~ of Usual and Customary Charges after Deductible
Hospital Outpatient Facility or Clinic	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~of Usual and Customary Charges after Deductible
Approved Clinical Trials	95% ~~80%~~ of Preferred Allowance ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~80%~~ of Preferred Allowance for other covered services after Deductible	95% ~~60%~~ of Usual and Customary Charges ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~60%~~ of Usual and Customary Charges for other covered services after Deductible
Transplantation Services	95% ~~80%~~ of Preferred Allowance ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~80%~~ of Preferred Allowance for other covered services after Deductible	95% ~~60%~~ of Usual and Customary Charges ~~$25 Copay per visit for Outpatient Physician's Visits~~ ~~after Deductible~~ 95% ~~60%~~ of Usual and Customary Charges for other covered services after Deductible
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Acupuncture Services	~~$25 Copay per visit~~ 95% ~~80%~~ of Preferred Allowance after Deductible	~~$25 Copay per visit~~ 95% ~~60%~~ of Usual and Customary Charges after Deductible
Genetic Testing	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~of Usual and Customary Charges after Deductible

Infertility	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Medical Foods See also Benefits for Phenylketonuria Treatment and Eosinophilic Gastrointestinal Associated Disorder	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Neurodevelopmental Therapy	95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible
Nutritional Counseling	~~$25 Copay per visit~~ 95% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible

COL-17-WA (PY21) SOB (312-1) 5

Pre-exposure Inoculations Rabies series pre-exposure inoculations and rabies titer test, Veterinary Students Only. Up to $100 each, lifetime maximum of $300.	100% ~~80%~~ of Preferred Allowance not subject to Deductible	95% ~~60%~~ of Usual and Customary Charges not subject to Deductible
Wellness Benefit $150 maximum per Policy Year. Includes Physician's office visits, physical examinations, and laboratory tests not otherwise covered under Preventive Care.	100% of Preferred Allowance not subject to Deductible	100% of Usual and Customary Charges not subject to Deductible
Routine Eye Exam Covered Students age 19 and older only. Limited to one per Policy Year.~~; up to a $100 maximum. The maximum does not apply when services are rendered at the CHS.~~	100% of Preferred Allowance not subject to Deductible	100% of billed charges not subject to Deductible
Vision Care Supplies Covered Students age 19 and older only. There is a combined maximum of $350 for Lenses and Frames, including contact lenses.	100% of Preferred Allowance not subject to Deductible	100% of billed charges not subject to Deductible
STD Screening Not otherwise covered under Preventive Care, the physician office visit and laboratory tests are covered including a urinalysis and the comprehensive metabolic panel.	100% ~~80%~~ of Preferred Allowance after Deductible	95% ~~60%~~ of Usual and Customary Charges after Deductible

Gender Affirming Care • Office visits • Inpatient Facility Fees • Other Professional Services	100% of Preferred Allowance after Deductible	95% of Usual and Customary Charges after Deductible

The following are examples of covered services: • Breast/chest affirmation surgery • Genital affirmation surgery • Rhinoplasty or nose implants • Face-lifts • Lip enhancement or reduction • Facial bone reduction or enhancement • Blepharoplasty • Breast augmentation to any size • Liposuction of the waist (body contouring) • Reduction thyroid chondroplasty • Hair removal • Voice modification surgery (laryngoplasty or shortening of the vocal cords) • Skin resurfacing		
Allergy Testing and Treatment	95% of Preferred Allowance after Deductible	95%- of Usual and Customary Charges after Deductible
Foot Care • Foot care for members with impaired blood flow to the legs and feet when it puts the member at risk • Treatment of corns, calluses and toenails	95% of Preferred Allowance after Deductible	95%- of Usual and Customary Charges after Deductible
Hearing Care Non-preventive, medically necessary hearing care supplies and procedures	95% of Preferred Allowance after Deductible	95%- of Usual and Customary Charges after Deductible
Cellular Immunotherapy And Gene Therapy Medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy.	95% of Preferred Allowance after Deductible	95%- of Usual and Customary Charges after Deductible

Delta Dental PPO℠ Plan - Benefit Summary

Effective Date	August 16, 2022
Benefit Period	August 16, 2022 – December 31, 2022
Benefit Period Maximum (Per Person)	$1,500 ~~$1,000~~

Dental Network

	Delta Dental PPO℠ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
Benefit Period Deductible			
Does Not Apply to Class I (Per Person/Per Family)	$0	$25/$75 ~~$50~~	$50
Class I – Diagnostic & Preventive			
Exams	100% ~~90%~~	90%	90%
Cleaning			
X-Rays			
Class II – Restorative			
Fillings	80% ~~60%~~	80% ~~60%~~	80% ~~60%~~
Endodontics (Root Canal)			
Periodontics			
Oral Surgery			

Class III – Major Restorative			
Prosthodontics	80%	80%	80%
Crowns			
Dentures			
Fixed Partial Dentures			