IT'S ABOUT *you!*

2025 BENEFITS GUIDE

Bath&BodyWorks®

U.S. BENEFITS ELIGIBLE ASSOCIATES

Bath&BodyWorks

Here's where to find ...

Welcome

Bath & Body Works invests in **you** by providing benefits and programs that are inclusive and support the diverse needs of you and your family. Our goal is to continually look for ways to make our benefits and programs **better for you.**

Throughout this Benefits Book you will find details about your 2025 benefits, so you can get the most out of them all year long.

Stay Connected with Your Benefits

Connect with your benefits all year long at **mybbwbenefits.com**.

To access your personal benefits information during the year, visit HR Access at **HRAccess.bbwcorp.com**. Log on from your computer, smart phone or tablet to:

- Update personal information
- Search for open, internal positions
- Access benefits information
- Access your W-2
- Enroll in benefits, if benefits-eligible, within 30 days of your hire or promotion date. Just click on **Benefits** and follow the instructions to enroll. **Note:** Enrollment elections become effective on your date of hire or the date you become eligible for benefits.

Questions? Call Associate Connect at 866.473.4728.

Connect With Your Benefits

Here are the carriers you can contact with questions about your 2025 benefits:

GENERAL		
Associate Connect	1.866.473.4728	■ The single resource for all your Bath & Body Works benefits & payroll information. Associate Connect representatives will assist you Monday - Friday between 9 a.m. and 8:00 p.m. EST.
HR Access	**HRAccess.bbwcorp.com**	■ Enroll in benefits (web only). ■ Reference, update and access all personal and benefits information. ■ Home address ■ Benefits information ■ PTO (paid time off) ■ Access online W-2 ■ Tax withholding ■ Add/update life insurance beneficiaries ■ And more! It's your responsibility to ensure that your personal information on file is accurate and up- to-date.
Benefits Information	**HRAccess.bbwcorp.com** > Benefits > Benefits Information	Watch videos and find information about all of your benefits.
Employment Verification: The Work Number©	**theworknumber.com** 1.800.996.7566 1.800.367.5690 (OUTSIDE VERIFIERS)	Access instant employment and income verification when applying for a mortgage or loan, reference checking, leasing an apartment or other instances where proof of employment or income is needed
HEALTH BENEFITS		
Health Advocate	866.695.8622 **healthadvocate.com/members** (Company name: Bath & Body Works)	For help resolving health care and insurance-related issues.
WINFertility	844.343.0667 WINFertility Companion app Employer Code: BBW23	Access to a comprehensive and inclusive family-building benefit toward fertility treatment and related medications, adoption and surrogacy. WIN will help you better understand your options, so you can maximize your benefit and choose the best course of treatment.
Pharmacy: Optum Rx	optumrx.com 855-896-9779 Download OptumRx App	Manage your prescriptions and home delivery drug orders.
PROGRAMS OFFERED THROUGH ANTHEM		
Medical: Anthem	**anthem.com** 855.839.4533 Download Sydney Health app	Log on or contact Anthem customer service to manage your health care benefits. Download the Sydney Health app for fast, convenient access to your medical plan. From the app, you can find a doctor, view claims, see your benefits, view your ID card and more!
ANTHEM'S WELLNESS SERVICES AND CONDITION MANAGEMENT PROGRAMS		
Telemedicine: LiveHealth Online	**livehealthonline.com** Livehealth online app	Interact with a doctor live online through your android or IOS computer, tablet and mobile device. ■ Available real-time, 24/7/365 in most states ■ Doctors are in-network, U.S. board-certified and can ePrescribe to local pharmacies (where applicable)
Nurseline	800.700.9184	A 24-hour hotline answered by registered nurses to answer your Health-related questions
MyHealth Advantage	866.408.7197	A service that helps keep you and your bank account healthier when it comes to managing your health care

Bath&BodyWorks

ANTHEM'S WELLNESS SERVICES AND CONDITION MANAGEMENT PROGRAMS (CONT.)		
Hinge Health	855.902.2777 hinge.health/bathandbodyworks	Provides virtual physical therapy at no cost to help you better manage your musculoskeletal conditions.
Virta	virtahealth.com/individuals	Provides access to a virtual care team and personalized nutrition program to help you sustainably lose weight and support you on your weight loss journey.
ComplexCare	866.330.2543	A service that helps you manage more than one health issue or a condition that could mean frequent or high levels of health care.
ConditionCare	800.638.4814	A service that helps you manage the symptoms of asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease.
Behavioral Health Resource	866.621.0554	A total-health solution that can help you or your loved ones deal with anxiety, depression, drug or alcohol abuse, eating disorders, autism and other personal issues.
Building Healthy Families	833.812.1776	The comprehensive program, at no cost, offers support throughout every phase of the journey, from preconception to parenthood. This modern solution has been shaped by the voices of our customers and consumers and reflects the diversity and inclusion strategies of employers. Building Healthy Families is a program that truly meets the needs of today's families.
ADDITIONAL HEALTH BENEFITS		
Dental: Delta Dental	**deltadentaloh.com** 800.524.0149 Download Delta Dental	Delta Dental representatives will respond to your questions about dental health care and help you find dentists and orthodontists in the dental network. Download the Delta Dental mobile app to search for dentists, view ID cards and more!
Vision: VSP	**vsp.com** 800.877.7195 VSP app	Access information about your vision plan or vision discount.
Leaves Of Absence: Lincoln Financial Group (LFG)	**mylincolnportal.com** (Company code: BBWI) 844.869.3454	When you need to be off work for family, medical, maternity or parental leave, contact LFG to report your claim.
Employee Assistance Program (EAP)	Available 24 hours a day, 7 days a week **guidanceresources.com** (Organization Web ID: BBW) 866.483.1481 Download GuidanceNow app	Our EAP provides you eight counseling visits per person per issue each year to support your emotional wellbeing. You can connect to care by face-to-face, video, text, chat, phone, web or app. The EAP provides a lot of other ways to help you balance your work life and your personal life: From referrals and resources to help with just about anything — like hiring movers or finding a home contractor — to financial guidance. The EAP is available at no cost to you, your dependents and housemates (partner, roommate or anyone living under your roof).
SAVINGS AND FINANCES		
Associate Stock Purchase Plan (ASPP): Morgan Stanley	866.722.7310 Shareworks app	The ASPP gives you the opportunity to purchase Bath & Body Works, Inc. stock at a 15% discount. Offering periods happen twice a year.
401(k) Savings And Retirement Plan: Alight	**https://upointhr.com/bbw** 888.445.4567 Alight Mobile app	Enroll, designate your pre-tax and post-tax Roth savings contributions, name your beneficiary, make your investment choices, and obtain other general account information.
Life Insurance: Lincoln Financial Group (LFG)	**mylincolnportal.com** (Company code: BBWI) 844.869.3454	Provides financial protection for your loved ones if you die.
Flexible Spending Account (FSA): HealthEquity®	**healthequity.com** (Select Login > WageWorks) 877.924.3967 Ez Receipts® app	Manage your dependent care and health care accounts. Update your profile information, including your email and home address.
Commuter Benefit: HealthEquity®	**healthequity.com** (Select login > Wageworks) 877.924.3967 Ez Receipts® app	Manage your commuter account.

SAVINGS AND FINANCES (CONT.)		
Tuition Assistance Associate Connect	1.866.473.4728	Discuss tuition assistance for work-related undergraduate or graduate course work.
Guild Education	**bbw.guildeducation.com** 800.985.4027 9 a.m. - 9 p.m. ET	Guild brings together eligible Bath & Body Works associates and trusted learning partners to provide access to education. Eligible associates include those who work in the DC's and stores.
Product & Service Discounts: Lifemart	**https://bbw.lifecare.com** Lifemart app	Lifemart gives you access to exclusive discounts for you and your family. Save everyday on items, like flat-screen TVs, movie tickets and travel to gym memberships and child care.
Auto & Home Insurance: Farmers GroupSelect℠	**myautohome.farmers.com** (Company name: Bath & Body Works) 800.438.6381	Get special group rates to cover your auto and home.
Pet Insurance: Metlife	**metlife.com/mybenefits** (Company name: Bath & Body Works) 800.438.6388	Get special group discounts to cover your pet.
Group Legal Plan ARAG	**ARAGLegalCenter.com** (Access Code: 15661bbw) 800.247.4184	Get quality, affordable legal help to address everyday situations, like dealing with traffic tickets, resolving warranty issues or buying a home.
LIFESTYLE AND FAMILY		
Care.com Membership and Backup Child & Adult Care	**bbw.care.com** 855.781.1303	Get guidance and support during major life events or help with life's day-to-day challenges, such as child and senior care to daily tasks, including home maintenance or leisure planning.
Adoption/Surrogacy Assistance: WINFertility	**www.managed.winfertility.com/** bathandbodyworks 844.343.0667	Support, coaching, and reimbursement for expenses related to adoption and/or surrogacy.

About this Benefits Book

Thorough attention to detail was taken to ensure accuracy in this book. However, the wide range of situations that could possibly be included make it almost impossible to ensure that absolutely everything is covered. The constantly changing environment in which we do business, the growth of our company and the desire to always improve are some of the factors that bring about change.

For these and other reasons, the company, from time-to-time, may change various provisions contained in this book.

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

No Contract of Employment

The provisions in this book do not constitute an employment contract with you or anyone else and may be changed unilaterally by the company, at any time. Nothing in this book is written or intended to guarantee employment to any Associate, guarantee the terms or conditions of employment, or restrict in any way the right of the company or any Associate to terminate the employment relationship at any time. Employment with the company is at will in all U.S. locations and in locations outside of the U.S. where permissible by law. This means that at any time, with or without prior notice, an Associate is free to resign. Associates can make that decision for any reason they choose, and at the time of termination, all benefits of employment with the company will no longer apply. In addition, at any time, with or without cause and with or without prior notice, it also will be the option of the company to exercise the same decision in terminating an Associate's employment in accordance with applicable law. Unless modified by written agreement, signed by both the Associate and the Vice President of Human Resources or the Office of the General Counsel, no manager or other representative of the company has the authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the provisions of this book or other policies or practices of the company.

Health Benefits Book "Speak"

The use of the words "you" and "your" refer at all times to active Associates of Bath & Body Works (BBW). "You" and "your" also refer to you and your Covered Dependents as members of our benefits Plans. The use of the words "the company," "our," and "we," refer at all times to the business in which you work.

Capitalized Terms

Throughout this book you will notice capitalized words embedded within certain sentences. Capitalized terms may indicate those words that are defined in the medical and dental glossary in the back of this book.

Eligibility

There are several ways Associates become eligible for benefits. See the definition of benefits-eligible associate on page 64.

When You Have Questions

This book is the place to go first when you have questions. You may find it necessary to get specific interpretations to fully answer some questions—or to determine exactly how a benefit applies to your particular situation. When this happens, your manager, Associate Connect or the benefits administrator (Anthem, Delta Dental, etc.) will be glad to assist you. Do not hesitate to call on them. Refer to the Connect with Your Benefits section at the front of this book.

Consequences for Violations of Company Policies

All violations of our policies, or misuse of benefits whether contained in this book, The Code or elsewhere, no matter how trivial they may seem at the time, are harmful to the interests of the company. Associates who violate company policies or misuse benefits are subject to disciplinary action up to and including termination of employment.

Bath & Body Works invests in you by providing benefits and programs that inclusive and support the diverse needs of you and your family. It's up to you to learn about your options and take advantage of all the benefits Bath & Body Works offers, so you can choose the options that are right for you.

The Bath & Body Works Program is:

Comprehensive

We design our benefits to support the overall well-being of you and your family with a variety of plans and options, so you can choose coverage that bests meet your needs.

- Medical
- Pharmacy
- Dental
- Vision
- Legal insurance
- Health and Dependent Care Flexible Spending Accounts
- Optional life insurance for you and your dependents

Some benefits are provided at no cost to you even if you're not enrolled in any of the above plans.

- Disability
- Life insurance
- Mental Health and Well-Being Employee Assistance Program (EAP)
- Health Advocate

Cost effective

Bath & Body Works shares in the cost of health care with you by paying over 75 percent of health care costs.

Competitive

There's nothing like good competition. Throughout the year, we review our benefits plans to ensure we offer you cost-effective options while remaining competitive in the marketplace.

Coverage and Enrollment

Eligibility and Enrollment Deadlines

We want you to have the coverage you need when you become a full-time associate, which is why you are eligible for the benefits below on your hire or promotion date:

- Medical Plan
- Dental Plan
- Vision Plan
- Health and Dependent Care Flexible Spending Account
- Legal Insurance
- Optional Life Insurance

Make your enrollment elections during annual open enrollment (typically in October each year) or within 30 days of date of hire or becoming eligible for benefits. If you miss it, you'll have to wait until the next open enrollment period to enroll or make changes, unless you experience a "qualified life status change" (i.e. marriage or the birth of a child). See page 11 for more information about making changes during the year.

New Hires and Newly Eligible Associates

Consider enrolling as soon as possible. Since you're eligible for benefits immediately, the amount you owe for them is calculated as of your date of hire, or the date when you became eligible for benefits, regardless if you used them or when you enrolled. Once enrolled, any missed premiums will be deducted from your next paycheck, which may mean a one-time, temporary reduction in your net pay. And the sooner you enroll, the sooner you'll receive your medical and pharmacy ID card, your Health Care Flexible Spending Account card and any other related information needed to use your benefits.

Who is Eligible?

You are eligible to enroll in benefits if:

- You are a full-time Associate. A full-time associate is a non-seasonal associate who is classified as full-time (full-time associates are generally expected to work at least 30 hours per week).
- You are a legacy home office, distribution center or client contact center associate hired prior to January 1, 2004, or legacy store management.

In addition, if you are hired into a part-time or seasonal position, you may become benefits-eligible if you work an average of 30 or more hours per week over a 12-month measurement period. During your initial measurement period (a 12-month period ending 1 year from your date of hire), if you average 30 or more hours per week, you will be notified of your eligibility to enroll in benefits for a 12-month period.

After that, your hours will be measured for a 12-month period beginning in October and ending in September to determine benefits-eligibility during the following calendar year. If you are paid on a salaried basis, you will be credited with hours based on 52 weeks worked.

If you live in Hawaii, Puerto Rico or San Francisco, you have different medical plan options available to you. If you live in Puerto Rico, you also have a different dental plan available to you. You are eligible for all other benefits outlined in this Benefits Book. For details on your specific medical and dental plan options, refer to the medical and dental plan summaries on **mybbwbenefits.com**.

Family

We care about the wellbeing of your family too, which is why we offer coverage for your eligible dependents. Their coverage becomes effective the same day as yours. Eligible dependents include:

- Spouse
- Same or opposite-sex civil union or domestic partner
- Children under the age of 26 through:
  - Birth
  - Legal adoption or the verifiable process of legal adoption
  - Marriage, civil union or domestic partnership
  - Foster care
  - Legal guardianship

Covering a Child

Your child is eligible, regardless of whether they are a student, married, eligible for coverage through their own job, or your tax dependent. However, in the case of a child of your domestic partner or a child subject to guardianship, you may be taxed on the value of the child's benefits if they are not your tax dependent.

Before You Enroll

- **Document** your enrollment deadline based on your hire date, or the date you became eligible for benefits.
- **Read** this book and review our benefits website at **mybbwbenefits.com** to understand the benefits available to you
- **Compare** Bath & Body Works benefits with those of your Spouse or Domestic Partner to determine which options best suits your and your family's needs.
- **Gather** all information you need to enroll:
  - Dependent(s) date(s) of birth
  - Dependent(s) Social Security number(s)
- **Assign** beneficiary(ies) to your life insurance

Covering a Domestic Partner

A same or opposite-sex domestic partnership or civil union partnership must meet the following requirements:

- You have a legal civil union in a state that uses the civil union to formally recognize same-sex relationships or, if you don't have a civil union, you:
  - Are in a single dedicated relationship of at least 12 months and intend to remain in the relationship indefinitely; and
  - Share the same permanent residence and have done so for at least 12 months.
- Are not related by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside.
- Each are at least 18 years old.
- Each are mentally competent to consent to a contract.
- Neither you nor your domestic partner is married to another person under either statutory or common law.
- Are financially interdependent.
- Both would sign an affidavit of domestic partnership and provide evidence of the partnership if asked.

To receive appropriate tax treatment, be sure to properly designate your dependent during your benefits enrollment:

- Domestic partner: for same or opposite sex domestic partnerships, or for civil union partnerships
- Child of your domestic partner, or child subject to guardianship who is not your tax dependent

How to Enroll

Enroll online through HR Access 24/7 on any computer, smartphone, or tablet with an internet connection.

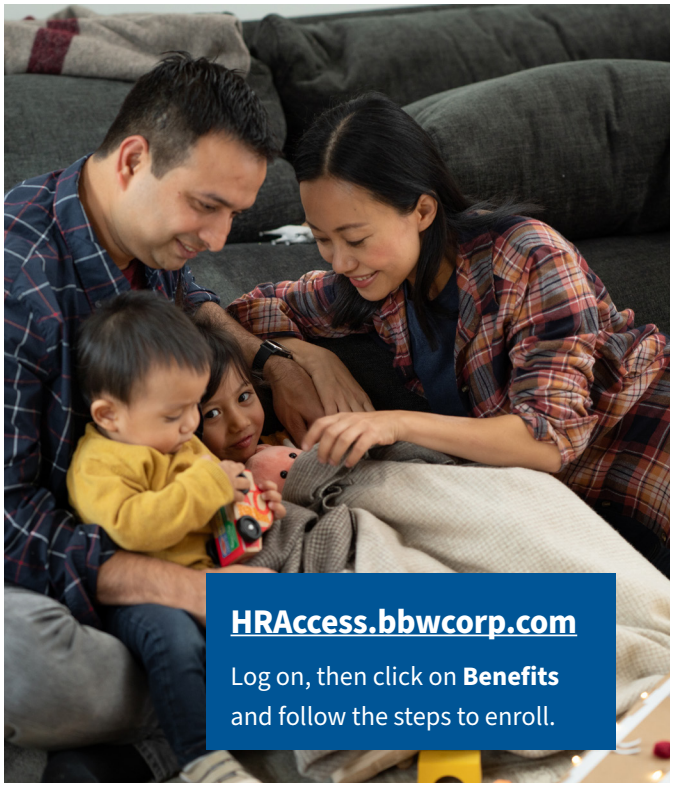
Make changes or edits to your benefits at any time during the open enrollment period.

Enrollment elections become effective on your date of hire, or the date you became eligible for benefits.

Be careful…don't miss it! If you miss this opportunity, you'll have to wait a year to enroll or make changes unless you experience a qualifying event, such as marriage or the birth of a child.

Dependent Verification

As the benefit plan sponsor, Bath & Body Works is obligated to ensure that only eligible dependents are enrolled in our benefit plans. You will receive information in the mail from Alight about the process to verify any dependents enrolled in the medical, dental and/or vision insurance plans. Please respond to these requests timely to avoid a disruption in coverage.



What Happens After You Enrolled

PAYROLL DEDUCTIONS: Payroll deductions for your benefits elections will be taken from your first paycheck (if enrolled) and will continue for each pay period throughout the year. If you're not enrolled right away, deductions will be taken as of your eligibility date.

CONFIRMATION STATEMENT: Following open enrollment, a confirmation statement will be mailed to your home confirming your enrollment elections. It is important that you review the confirmation statement and notify Associate Connect if it is not correct **as soon as possible**.

Newly hired or newly-eligible associates (enrolling outside of the open enrollment time frame), can view/print a confirmation statement after enrolling through HR Access.

MEDICAL AND PHARMACY ID CARDS: You'll receive a combined medical and pharmacy ID card after you enroll. Each enrolled Dependent will receive their own ID card; however, the account information will be the same for each Dependent. Show your ID card when you go to the doctor or pharmacy – that way they'll know you are covered under the medical and pharmacy plans.

If you require additional cards, visit **anthem.com** to request them.

DENTAL BENEFITS: You will not receive a dental ID card. Tell your Dentist you work for Bath & Body Works and have dental coverage through Delta Dental. Most Dentists will automatically submit your claim without the need for a claim form.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT: You will receive a Health Care Flexible Spending Account card from HealthEquity® after you enroll.

VISION BENEFITS: You will not receive a vision ID card for the Vision Plan. See page 43 for information about how to receive your benefits.

GROUP LEGAL PLAN: A membership kit will be sent to new Members from ARAG, our group legal plan partner, after you enroll.

Making Changes During the Year

You must experience a qualified life status change to change your elections after Open Enrollment ends. Changes must be made within 30 days of the event. Events include:

- Birth or adoption or placement for adoption of a child
- Marriage
- Divorce or legal separation
- Termination of same or opposite-sex domestic partnership, or civil union relationship
- Death of a spouse or dependent
- Dependent child reaches age 26*
- Termination of foster care placement or guardianship
- Change in employment status impacting your dependent's benefit eligibility
- National Medical Child Support Notice or Qualified Medical Child Support Order (not limited to 30 days but coverage won't be retroactive)
- Entitlement to Medicare or Medicaid
- Loss of other health insurance (for a reason other than failure to pay premium)
- Unpaid leave of absence
- Loss of Medicaid or SCHIP or becoming eligible for premium assistance under Medicaid or SCHIP (change must be made within 60 days for Medicaid and SCHIP events)
- Reduction in hours (full-time to part-time or part-time 30+ hours to under 30 hours). You may discontinue medical coverage for you and your enrolled dependents, if you certify that you and your enrolled dependents intend to enroll in other medical coverage within two months of discontinuing your Bath & Body Works medical coverage.

*Coverage will end on the last day of the month of the dependent's 26th birthday.

Connect with Your Benefits

To manage your benefits, see the Connect with Your Benefits section at the front of this book for details on how to connect with the various benefits carriers.

What Happens to Your Benefits If:

YOU AND YOUR SPOUSE/PARTNER WORK FOR BATH & BODY WORKS: If you and your spouse/partner work at Bath & Body Works, you can be covered together under any of our plans. You will not be charged the Spousal Surcharge for the medical plan.

YOU LEAVE THE COMPANY: Your benefits end on the date your employment with the company ends. Generally, this will be your last day worked. Payroll deductions for health benefits will be prorated based on the number of days you are covered in the pay period. To continue medical benefits, please see the Notice of COBRA Continuation Coverage Rights Under COBRA in the Resources section on **mybbwbenefits.com**.

YOU'RE REHIRED: You will be eligible for health benefits immediately upon rehire. (Enrollment information is located on page 10.) If you are rehired within 30 days you will be re-enrolled into the same benefits you had when you were previously employed. If you are rehired after 30 days, you will need to re-enroll in benefits. In either situation, you have 30 days from the date you were rehired to make changes to your elections.

YOU ARE ON AN APPROVED LEAVE OF ABSENCE: Please call Associate Connect at 866.473.4728 to learn how to continue your benefits. You'll find more information on Leaves of Absence in the Leaves of Absence section of this guide.

YOU DO NOT PAY THE COST OF COVERAGE: Your benefits will end if you fail to pay for your benefits coverage.

YOU NO LONGER MEET THE ELIGIBILITY REQUIREMENTS: Your health benefits end on the date you no longer meet the Plan's eligibility requirements.

Additional Information

See additional health benefits information in the Administrative Information section in this guide:

- Coordinating with other Plans
- Subrogation and reimbursement requirements
- How to File/Appeal a Claim

Bath & Body Works intends to maintain the health benefits programs indefinitely, but reserves the right to terminate, suspend, discontinue or amend any program at any time. If any health or welfare benefits program is terminated, your rights are limited to Covered Charges incurred before termination.

Bath&BodyWorks

Medical

We want to be sure you have choices when it comes to your health care, which is why we offer three medical plan options through Anthem, so you can choose the one that best meets your health care needs:

- Lower Premium Plan
- Lower Deductible Plan
- In-Network Only Plan

When choosing, consider whether you want to pay more out of your paycheck and less when you receive care or less out of your paycheck and more when you actually receive care.

If you live in Hawaii or San Francisco, you have different medical plan options available to you. Please refer to the medical plan summaries for your specific population on **mybbwbenefits.com**.

Understand the Medical Plan Options

Understand when to consider each medical plan option and how it works.

	Lower Premium	Lower Deductible	In-Network Only
Consider this plan if you are…	An infrequent user of health care because you are healthy. You want coverage if the unexpected happens and are okay with a higher out-of-pocket maximum. You want to pay less out of each paycheck knowing your out-of-pocket costs may be minimal due to your good health.	A more typical user of health care – you use health care about the same amount as other people you know. You prefer a lower out-of-pocket maximum	A more frequent user of health care. You are okay paying more on a biweekly basis and prefer a lower deductible and out-of-pocket maximum. You are comfortable using only in-network doctors.
How the plan works	Lowest biweekly premiums, but higher deductibles and out-of-pocket expenses when health care is needed. Instead of co-pays for medical services, pay a percentage of total cost once entire deductible is met. Option to use any in-network or out-of-network doctor (in-network will save money).	Higher biweekly premiums than the Lower Premium Plan, but less out-of-pocket exposure when health care is needed. Standard doctor and hospital visit co-pays. Option to use any in-network or out-of-network doctor (in-network will save money).	Highest biweekly premiums, but minimal out-of-pocket exposure when health care is needed. Standard doctor and hospital visit co-pays. Must use an in-network doctor/facility (NO COVERAGE out-of-network – you'll pay 100%

With the Lower Premium and Lower Deductible medical plan options, you can choose to receive care from a provider who is part of the Anthem network or a provider outside the network. You'll receive a higher level of benefits when you receive care from in-network providers because you pay discounted rates. To confirm your doctor is in the network, go to **anthem.com** and click on **Find a Doctor. Note:** When asked for the plan name, it's "Anthem National PPO (BlueCard PPO)" unless you live in the following states:

- In Florida, the network name is NetworkBlue
- In Georgia, the network name is Blue Open Access PPO
- In New Jersey, the network name is Horizon Managed Care Network

Medical Plan Benefits At a Glance

Medical	Lower Premium		Lower Deductible		In-Network Only	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible (Individual/Family)	$1,000 / $2,000	$2,000 / $4,000	$500 / $1,000	$1,000 / $2,000	$250 / $500	You pay 100% (except emergency – covered in-network)
Annual Out-of-Pocket Maximum (Individual/Family)	$4,500 / $9,000	$10,000 / $20,000	1,500 / $3,000	$3,000 / $6,000	$1,000 / $2,000	
Preventive Care ■ Annual Physical ■ Well Woman ■ Well Baby/Child ■ Immunizations	Covered 100%	You pay 50% after deductible	Covered 100%	You pay 40% after deductible	Covered 100%	
Telemedicine	You pay 20% after deductible	You pay 50% after deductible	$15	You pay 40% after deductible	$15	
Retail Clinics	You pay 20% after deductible	You pay 50% after deductible	$25	You pay 40% after deductible	$25	
Primary Care Doctor	You pay 20% after deductible	You pay 50% after deductible	$30	You pay 40% after deductible	$30	
Specialist	You pay 20% after deductible	You pay 50% after deductible	$40	You pay 40% after deductible	$40	
Urgent Care	You pay 20% after deductible	You pay 50% after deductible	$50	You pay 40% after deductible	$50	
Outpatient Care	You pay 20% after deductible	You pay 50% after deductible	$50	You pay 40% after deductible	$50	
Inpatient Care	You pay 20% after deductible	You pay 50% after deductible	$150	You pay 40% after deductible	$150	

Bath&Body Works

Medical Biweekly Premiums

Here's a look at your biweekly premiums based on the coverage level you choose

	Lower Premium	Lower Deductible	In-Network Only
Associate Only	$42.97	$72.81	$112.26
Associate + Spouse/ Domestic Partner	$117.32	$199.74	$307.46
Associate + Child(ren)	$97.60	$165.85	$255.87
Associate + Family	$140.08	$237.66	$366.09

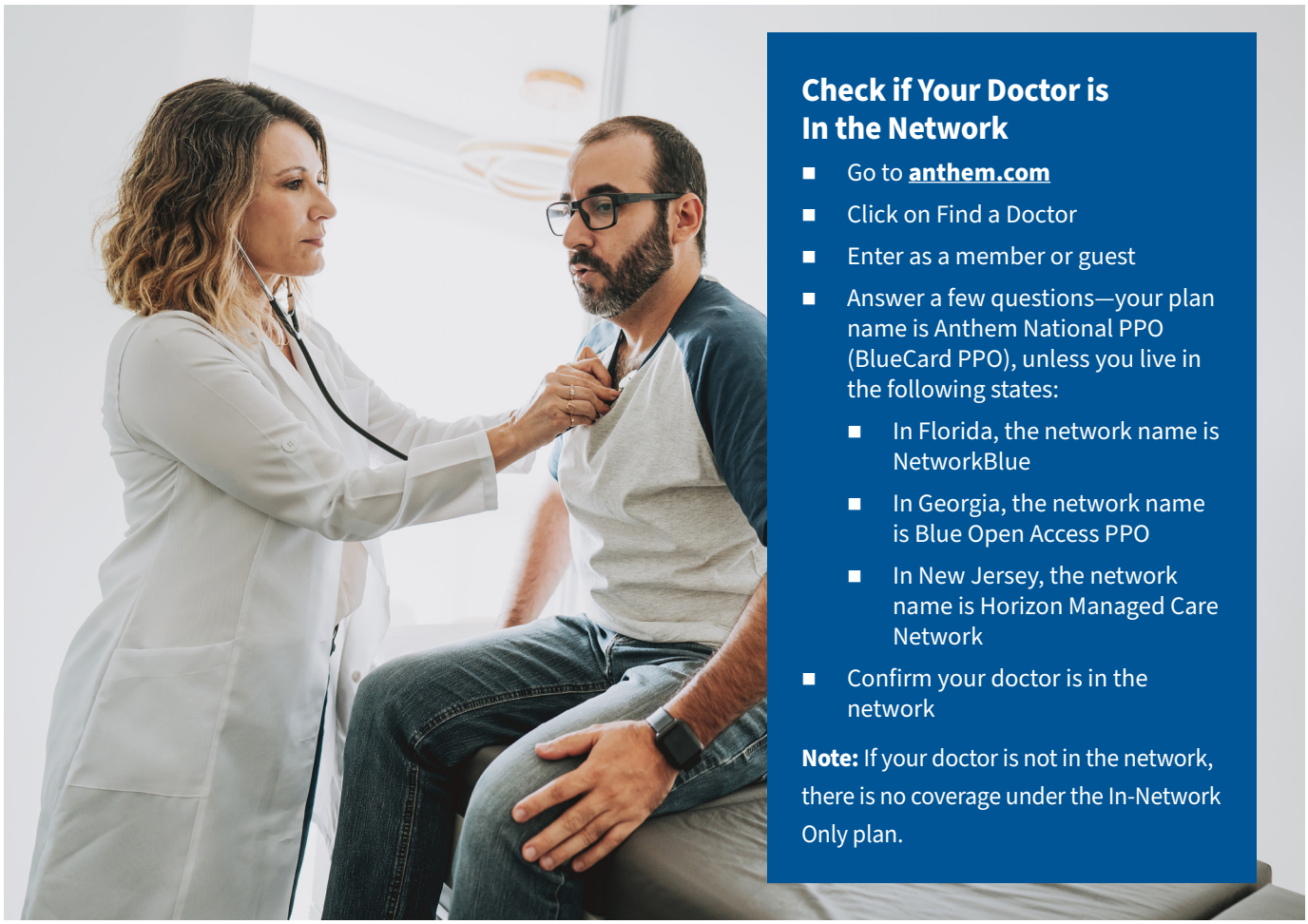
Additional contributions for working spouses

Bath & Body Works pays the majority of the cost of health care coverage for associates and their families. If your spouse or domestic partner has medical coverage available through their own employer, and you choose to enroll them in the Bath & Body Works Medical Plan, this shifts health care costs from their employer to Bath & Body Works.

We charge $55 biweekly if you choose to enroll your working spouse or domestic partner in our plan and they are eligible to participate in a medical plan through their own employer. This means you'll pay the biweekly premium for the medical plan of your choice, plus the $55 biweekly working spouse premium. You are responsible to indicate if your spouse or domestic partner has access to coverage through their own employer (during enrollment or status change).

Additional contributions for tobacco users

- Tobacco users will pay $25 more per pay period.
- Associates will indicate they or any covered dependents in the medical plan are tobacco users through HR Access during enrollment.
- A tobacco user is considered any associate or covered dependent who has used any tobacco products at least one time or more per week over the prior six months. Tobacco products include:
  - Cigarettes
  - Cigars
  - Vaping
  - e-cigarettes
  - Pipes
  - Chewing tobacco
  - Snuff
- If you use tobacco, we encourage you to enroll in Optum's Quit for Life Tobacco Cessation Program at no cost to you.
- If you, your spouse, and/or dependents over age 18 use tobacco, are enrolled in a Bath & Body Works medical plan, and you have not completed the Quit For Life Tobacco Cessation Program, you will be assessed an additional $25 per pay period surcharge. Upon successful completion of the program, the Bath & Body Works Benefits Team will be notified by Optum and you will no longer be required to pay the tobacco surcharge. The surcharge will be removed as soon as administratively feasible.



Check if Your Doctor is In the Network

- Go to **anthem.com**
- Click on Find a Doctor
- Enter as a member or guest
- Answer a few questions—your plan name is Anthem National PPO (BlueCard PPO), unless you live in the following states:
  - In Florida, the network name is NetworkBlue
  - In Georgia, the network name is Blue Open Access PPO
  - In New Jersey, the network name is Horizon Managed Care Network
- Confirm your doctor is in the network

Note: If your doctor is not in the network, there is no coverage under the In-Network Only plan.

Know Your Terms

Here are some important terms to know as you decide the medical plan to choose, as well as how to use it during the year:

- **CO-PAY** A flat fee for medical service. Your co-pays will count toward your out-of-pocket maximum.
- **DEDUCTIBLE** The amount you pay up front for covered medical services before coinsurance kicks in and then you're done with the deductible for the year. Your deductible will count toward your out-of-pocket maximum.
- **COINSURANCE** The percentage you pay for covered medical services once your deductible is paid – and then Bath & Body Works pays the balance.
- **OUT-OF-POCKET MAXIMUM** The most you'll pay for covered medical services in a plan year, so you're protected from high-cost claims. Once your share of medical expenses reaches the maximum, Bath & Body Works will pay 100% of your covered services for the balance of the year. These apply to your out-of-pocket maximum: Co-pays, deductibles and coinsurance (excluding pharmacy). Out-of-pocket maximums exclude balance billing by out-of-network providers.

Bath&Body Works

Use the Wellness Center at DC 3

We want you to have the health care services you need when you need them. That's why we provide the Bath & Body Works Wellness Center at DC 3. You don't have to be enrolled in a Bath & Body Works medical plan to use it! It's convenient, affordable and designed with you in mind.

Convenient Care

Visit a physician, fill your prescription and more—from the convenience of DC 3!

- Access health care for all associates and contractors
- Schedule in-person or virtual appointments online, by phone or by walk-in visit
- Use the MyPremiseHealth app or **mypremisehealth.com** for online scheduling, contacting providers, requesting refills and accessing test results
- Fill prescriptions at the Wellness Center Pharmacy
- Park in designated spaces when you're just coming in for a visit or picking up a prescription

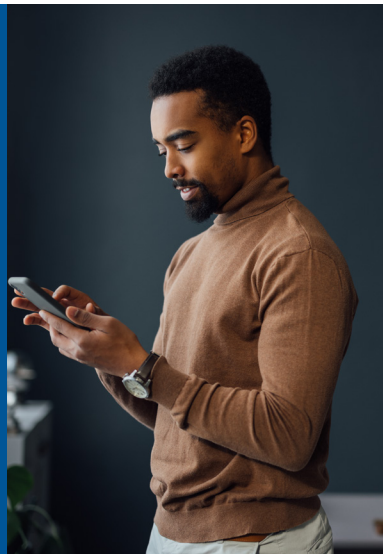
Get Affordable Care

If you're an associate who lives or works near DC 3, consider using the Wellness Center for these services:

- Primary care and urgent care ($25)
- Preventive medical services, including annual physical, biometric screening, well-woman care, immunizations, allergy shots, vaccinations (including free flu shots)
- Chronic disease management (obesity, COPD, hypertension, diabetes)
- Lab work and EKGs
- Gynecological care
- STI screening
- Travel medicine (work or personal)
- Physical therapy **($15 per session and no referral is needed!)**
- Behavioral health referrals and smoking cessation assistance
- Workplace injury/illness management and ergonomic assessments (occupational health care and rehabilitation)

Get started with the My Premise Health App

Scan the QR code to login or create your account on the My Premise Health app or mypremisehealth.com.



Fill Your Prescriptions

You have a full-service pharmacy to use to:

- Fill and transfer prescriptions (including dependents)
- Free FedEx delivery or curbside pickup
- Flu, shingles and pneumonia immunizations
- COVID-19 vaccinations and boosters
- Accepts most insurance plans
- Special prescription pricing and discounts on over-the-counter items
- Medication therapy and lifestyle consultation

Hours of Operation

	Wellness Center	Pharmacy
Hours	8 a.m. – 5 p.m. ET Monday – Thursday 8 a.m. – 12 p.m. ET Friday	8:30 a.m. – 5:00 p.m. ET Monday – Thursday 8:30 a.m. – 12:00 p.m. ET Friday
Phone	614.415.1200	380.529.4024
Fax	614.415.1201	380.529.4027

Save with the Wellness Center

You pay less when you receive care from the Wellness Center. Check out the difference in costs depending on the Anthem medical plan you enroll in:

Service Type	Cost Savings		
		If you use a provider outside of the Wellness Center	
	Wellness Center	Low Deductible/In-Network Plan	Lower Premium Plan
Office Visit	$25 primary care services	Copays: ■ $30 primary care provider ■ $50 urgent care ■ $40 specialist ■ ER visits are subject to deductible/coinsurance	Subject to deductible/coinsurance
Physical Therapy	$15 per session	$40 copay	Subject to deductible/coinsurance
Lab Work	Claims are subject to deductible/coinsurance	Generally the same	
Pharmacy Tier 1	Up to $8 copay for 30-day supply Up to $16 copay for 90-day supply	Up to $30 copay for 30-day supply Up to $90 copay for 90-day supply	
Pharmacy Tiers 2 & 3	Variable copay program	Tier 2: $40 or greater Tier 3: $55 or greater	

If you are enrolled in a Bath & Body Works medical plan, you will only pay the required copay that your plan allows for. In addition, the copay will accumulate toward your deductible. If you are not enrolled in a Bath & Body Works medical plan, you will pay the $25 or $15, and you can submit this directly to your insurance company for the copay to be applied to your plan deductible.

Understand the Ways to Save

If the Wellness Center isn't convenient for you, here are some other ways you can save on health care costs:

- **Consider Urgent Care or Minute Clinics for Non-Emergency Care**. If you need non-emergency care, consider going to an urgent care or minute clinic and pay what you'd pay for an office visit – a Co-pay or Coinsurance after the Deductible, depending on the plan you're enrolled in. When you visit the emergency room for non-emergency care, you'll be charged a $150 emergency room penalty in addition to the Deductible and Coinsurance.
- **Get In-Network Preventive Care.** In-network preventive care is covered 100%.
- **Save in the Health Care Flexible Spending Account (FSA).** With the Health Care FSA, you contribute pre-tax dollars to pay for eligible health care expenses. Pre-tax dollars are deducted from your pay before taxes are taken out, which reduces your taxable income, so you save on taxes.

Anthem's Wellness Services and Disease Management Programs

Take advantage of these wellness services and disease management programs Anthem provides to help you be more engaged in your health and make more informed health care decisions.

LiveHealth Online Telehealth

"FaceTime" with a doctor live with Anthem's LiveHealth Online through your computer, tablet or smartphone. It will save you time and money when you do! It's available real-time, 24/7/365 in most states. With LiveHealth Online:

- Doctors are in-network, U.S. board-certified and can ePrescribe to local pharmacies (where applicable)
- Lower Deductible and In-Network Only Plans: $15 Co-Pay (Visa, MasterCard and Discover)
- Lower Premium Plan: $49 applied to Deductible, once Deductible is met, 20% Coinsurance applies

To access LiveHealth Online, go to **livehealthonline.com**.

24/7 Nurseline

Contact Anthem's Nurse Coaches 24/7 to talk about your general health issues any time of the day or night. Can you treat the problem at home? Do you need to see your doctor? Or should you head straight to the emergency room? Making the right call can help you avoid needless worry and expense. And, most importantly, safeguard your health and the health of your family. Call 800.700.9184.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier.

Here's how it works: Anthem reviews your incoming health claims to see if they can save you any money. They can check to see what medications you're taking and alert your doctor if they spot a potential drug interaction. Anthem will also keep track of your routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Note, which summarizes your recent claims. From time to time, Anthem will offer tips to save you money on prescription drugs and other health care supplies. If you're eligible for this program you'll be contacted by Anthem.

Anthem will reach out to you when appropriate through digital alerts on **anthem.com** and the Sydney Health app.

Virtual Physical Therapy through Hinge Health

Hinge Health offers innovative digital programs for back, knee, hip, neck, shoulder, and other pain in easy-to-do 15-minute exercise therapy sessions. It's provided at no cost to Anthem medical plan participants.

Your Hinge Health benefit includes:

- Unlimited access to a personalized, expert-developed exercise therapy plan for lasting pain relief.
- Convenient exercise sessions you can do anytime, anywhere with the Hinge Health app.
- Dedicated one-on-one support from a physical therapist and qualified health coach who you can connect with via text, email, phone call or video chat to ask questions, set goals and more.

To learn more about Hinge Health and sign up, visit hinge.health/bathandbodyworks.

Weight Loss Management Program through Virta

Virta is your virtual care team and personalized nutrition program to help you sustainably lose weight and support your weight loss journey. Backed by research and trusted by thousands, Virta helps you discover the foods that are right for your health. It's provided at no cost to Anthem medical plan participants.

Virta's nutrition approach to weight loss is rooted in science, centered around your unique needs, and designed for lasting results. Together with your dedicated team of nutrition experts, you'll learn to better understand your body and the foods that fuel it.

Your Virta benefit includes

- Expert guidance from a health coach to keep you accountable.
- Exclusive nutrition resources and recipes for your lifestyle.
- A digital weight scale that syncs to your phone.

To learn more about Virta and to sign up, visit **virtahealth.com/individuals.**

Get Help with Multiple Conditions: ComplexCare

You may need ComplexCare if you have more than one health issue or a condition that could mean frequent or high levels of health care. This program can connect you, your family and your doctors with a ComplexCare nurse and other experts to help you reach your personal health goals and avoid costly hospital re-admissions.

You get 24-hour toll-free access to ComplexCare nurses for personal education, along with preventive care and self-management tips. The nurses give you personal attention and lifestyle coaching, help you make better decisions about your options, help you transition your care, and coordinate care between doctors and other health services. A nurse will contact you if you are eligible for the program.

To learn more, log on to **anthem.com** or call 888.249.3828.

Get Help with a Serious Condition: ConditionCare Core Programs

If you or someone you love suffers from a chronic health condition, let Anthem help you get more out of life. Anthem's ConditionCare nurses help people of all ages manage the symptoms of asthma and diabetes. And they work closely with adults who are dealing with chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease.

With ConditionCare, you'll get the information you need to feel your very best day after day. Anthem's ConditionCare nurses gather information from you and your doctor and then create a personalized plan for you. A nurse will contact you if you are eligible for the program.

To learn more or to enroll in ConditionCare, call 800.638.4814.

Get Help Managing a Condition: ConditionCare Support Programs

If you or a family member is diagnosed with certain types of cancer, vascular or musculoskeletal diseases, or low back pain, ConditionCare may be able to help. It's a no-extra-charge program that gives you toll-free, 24-hour access to Nurse Coaches registered nurses who can help you better manage your health and help you follow your doctor's care plan. And it's all backed by a clinical team of pharmacists, dietitians and exercise physiologists. ConditionCare also gives you the information and tools that can help you avoid unnecessary doctor's office visits, hospitalizations, and time away from your job.

To learn more or to enroll in ConditionCare, call 1.800.638.4814.

Autism Spectrum Disorder Program

Autism Spectrum Disorder (ASD) benefits, offered through Anthem, are designed for Bath & Body Works families with children or dependents who have ASD to help find heath care and applicable resources, provide coverage for care and lend support.

PROGRAM BENEFITS

- Coverage for Applied Behavior Analysis (ABA).
- Coverage is based on the plan you are enrolled in and where services are rendered (i.e., Low Deductible Plan: Co-pay for office visit or deductible and coinsurance at an outpatient facility).
- Pre-certification is required for coverage of ABA services.
  - If your family is currently using ABA services, please verify the provider's network status as this may impact your share of treatment costs under your plan benefits.
  - In-network ABA providers can be found at **anthem.com** or by calling the Member Services number on the back of your Anthem ID card.
  - Your ABA provider will need to call the pre-certification number on the back of your member ID card to initiate the pre-certification process.

ASD CASE MANAGEMENT

Anthem has a dedicated team of clinicians and board-certified behavioral therapists specializing in the unique challenges and needs of families impacted by ASD. The ASD Case Management program focuses on the entire family unit creating a strong system of care through engagement of community resources, medical services, behavioral health services and other supports. The program goal is better outcomes, more effective use of benefits, and healthier kids and families.

Behavioral Health Resources

The Behavioral Health Resource program is a total-health solution that can help you or your loved ones deal with anxiety, depression, drug or alcohol abuse, eating disorders, autism and other personal issues.

When you call the Behavioral Health Resource Center, you'll talk with someone who has experience helping others manage problems and finding the right treatment programs and care. They want to find out what's important to you and how they can help you cope with your situation before it takes a greater toll on your life and your health. The Behavioral Health Resource program is a comprehensive, single-source 24/7 Resource Line for access to:

- Crisis management and clinical triage, including emergency or urgent behavioral health guidance, support and information.
- Routine inquiries about behavioral health services, providers and hospitals.
- Coaching to help members make appropriate treatment decisions.
- Support in identifying providers with required behavioral health specialties.
- Information and tools to support member health activities.
- Help in coordinating behavioral health, EAP and medical services.
- Guidance for engaging members in other beneficial care programs and health care decisions can reduce time lost on the job and optimize costs of care.

There is no cost to use the program. To get the help you need, call the Behavioral Health Resource Center any time of day or night at 866.621.0554.

Note: Bath & Body Works also offers mental health and well-being resources through ComPsych's GuidanceResources EAP. See the Mental Wellbeing section of this guide to learn more.

Medical Plan Benefits: The Details

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
Acupuncture (stet)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $40 Specialist Co-Pay. Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $40 Specialist Co-Pay. Deductible does not apply.
Allergy ■ Office visit ■ Testing ■ Allergy injections	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP $40 Specialist Co-Pay. Deductible does not apply	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP $40 Specialist Co- Pay. Deductible does not apply.
Anesthesia Covered as In-Network and subject to Deductible and local Plan pricing when services rendered in a participating facility.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Autism Applied Behavior Analysis (ABA) Therapy (pre-certification required) Autism Case Management and Behavioral Health Services offered at no cost to plan members.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
BEHAVIORAL HEALTH/SUBSTANCE ABUSE CARE					
Hospital inpatient services ■ Inpatient Accommodations and Ancillaries ■ Detox ■ Residential Treatment	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Hospital Co-Pay, then 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Hospital Co-Pay, then 10% Coinsurance after satisfaction of Calendar Year Deductible.
Outpatient services Intensive Outpatient therapy (IOP) and Partial Hospitalization (PHP). Co-Pay applies to visits/consults only. Other services (including IOP and PHP) are subject to Deductible and Coinsurance. Applied Behavioral Analysis (ABA) Therapy is NOT covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100%. Deductible does not apply. Facility Outside of Doctor's Office covered at 100%.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/ $40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office covered at 100%
Doctor's services (Home and Office Visits)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/ $40 Specialist Co-Pay. Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/ $40 Specialist Co-Pay. Deductible does not apply.
ADD/ADHD Includes Autistic Disease, Mental Retardation, Developmental Delays and Learning Disabilities.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay. Facility Outside Doctor Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay. Facility Outside Doctor's Office10% Coinsurance after satisfaction of Calendar Year Deductible.
Biofeedback	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Blood Processing and Storage	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Clinic (Institutional) Co-Pay applies to professional office visit charge only.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% Deductible does not apply.
Clinical Trials	Clinical trials of any sort are not covered. However, effective 1/1/14, due to Health Care Reform, if a you are a part of a FDA approved clinical trial for a life threatening disease it will be covered under normal medical expenses that occur during the trial (i.e. lab work).				
DENTAL & ORAL SURGERY SERVICES					
Accidental Dental Accidental Injury to sound and natural teeth. Treatment must be started within three months of the accident and completed within 12 months of the accident.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay. Facility Outside Doctor's Office20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay. Facility Outside Doctor's Office10% Coinsurance after satisfaction of Calendar Year Deductible.
Oral Surgery Includes removal of impacted teeth. Dental Anesthesia is covered only if related to a payable Oral Surgery.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay Facility Outside Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay. Facility Outside Doctor's Office10% Coinsurance after satisfaction of Calendar Year Deductible.

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
DENTAL & ORAL SURGERY SERVICES (cont)					
Temporomandibular Joint Disease Treatment for Temporomandibular Joint Syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery or diagnostic services. Covered services do not include fixed or removable appliances which involve moveme *See dental section for coverage of appliances	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
LAB, X-RAY AND ULTRASOUND DIAGNOSTIC SERVICES (INCLUDING SECOND OPINION) BY A DOCTOR OR SPECIALIST					
Doctor's office, retail health clinic, onsite clinic or urgent care Applicable Co-Pay then covered at 100% if services are performed and billed in an office setting (except Lower Premium Plan). Outpatient facility and independent lab. Coinsurance and deducible apply if services are performed, processed and/or billed by a facility or lab other than by your doctor's office (independent lab, hospital, inpatient or outpatient facility, surgical center, etc.). Preventive: Covered at 100% at all service locations Diagnostic Mammogram: 10% Coinsurance/Deductible does not apply	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	$30 PCP/$40 Specialist Co-Pay then covered at 100% if services are performed and billed in an office setting. Facility Outside Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible if services are performed, processed and/or billed outside of a provider's office (independent lab, inpatient or outpatient facility, surgical center, etc.).	40% Coinsurance after satisfaction of Calendar Year Deductible.	$30 PCP/$40 Specialist Co-Pay then covered at 100% if services are performed and billed in an office setting. Facility Outside Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible if services are performed, processed and/or billed outside of a provider's office (independent lab, inpatient or outpatient facility, surgical center, etc.).
Dialysis/Hemodialysis	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
EMERGENCY ROOM, URGENT CARE, AND AMBULANCE SERVICES					
Emergency Room for an Emergency Medical Condition All other services Prudent Layperson guidelines apply all services will be paid at the In-Network level of benefit (Accidental Injury and medical emergency diagnoses pay as emergency).	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network Emergency Care or Urgent Care are covered at the In- Network level of benefits.
Emergency – Emergency Room Doctor Prudent Layperson guidelines apply (Accidental Injury and medical emergency diagnoses pay as emergency). Out-of-Network Emergency Care or Urgent Care are covered at the In-Network level of benefits.	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network Emergency Care or Urgent Care are covered at the In-Network level of benefits.
Emergency Room for non- Emergency Medical Conditions Emergency room visit (per visit) Co-Pay/ Coinsurance. All other services. Applies to non-Emergency Medical Condition diagnoses (as defined by Prudent Layperson guidelines).	$150 Emergency Room Penalty, then 20% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Emergency Room Penalty, then 50% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Emergency Room Penalty, then 20% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Emergency Room Penalty, then 40% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Emergency Room Penalty, then 10% Coinsurance after satisfaction of Calendar Year Deductible.
Non-Emergency Medical Condition - Emergency Room Doctor Applies to non-Emergency Medical Condition diagnoses (as defined by Prudent Layperson guidelines).	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay. Facility Outside Doctor Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Visit $30 PCP/$40 Specialist Co-Pay.Facility Outside Doctor's Office10% Coinsurance after satisfaction of Calendar Year Deductible.
Urgent Care clinic visit for an Emergency Medical Condition Clinic visit (per visit) Co-Pay/Coinsurance. All other services.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Ambulance Services (when Medically Necessary) Land/Air	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.	20% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at the In-Network benefit level.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network Emergency Care or Urgent Care are covered at the In- Network level of benefits

Note: Care received Out-of-Network for an Emergency Medical Condition will be approved at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in one of the following conditions: 1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount of the Out-of-Network Provider charges

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
EYE CARE					
Medical Vision Exam Office visit – medical eye care exams (treatment of disease or Injury to the eye). Doctor Co-Pay/ Coinsurance. Specialist Doctor Co-Pay/Coinsurance. Treatment other than office visit. Orthoptic training (eye-muscle exercise) is covered if services are rendered by a licensed Optometrist or an Orthoptic Technician.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.
Vision Hardware For glasses or contact lenses following cataract surgery, refer to P&O benefit.	Not covered				
HEARING CARE					
Office visit – Audiometric exam/ hearing evaluation test. Doctor Co-Pay/Coinsurance. Specialist Doctor Coinsurance. Cochlear Implants.Routine hearing exams are not covered under this medical Plan.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. 10% Coinsurance after satisfaction of Calendar Year Deductible.
Hearing Aid Services Hardware - Hearing Aids including exams and hearing aid fitting, testing and accessories. Limited to 1 hearing exam in a 24-month period payable at 100% after PCP/ Specialist Co-Pay. Maximum reimbursement is $1,500 per covered person every 24 months.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Home Health Care Services Private Duty Nursing is only covered in the Home and visits count toward the Home Health Care visit maximum. Includes Home Infusion Therapy (services do not count toward the visit maximum).	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Maximum days per lifetime	Maximum 120 visits per Calendar Year – combined In-Network and Out-of-Network.	120 visits per Calendar Year.	Maximum days per lifetime	Maximum 120 visits per Calendar Year – combined In-Network and Out-of-Network.	120 visits per Calendar Year.
Hospice Care Services	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Hospice Care Services	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.
HOSPITAL INPATIENT SERVICES – PRECERTIFICATION REQUIRED					
Room and Board (Semiprivate or ICU/CCU)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Hospital Inpatient Co-Pay, then 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Hospital services and supplies Precertification is required for hospital services. See Lab, X-Ray and Ultrasound for coverage details.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Inpatient Physical Medical Rehab Limited to 120 days per Calendar Year.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Skilled Nursing Facility Limited to 120 days per Calendar Year.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Pre-surgical/Pre-admission testing	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Doctor Services: ■ Surgeon ■ Anesthesiologist ■ Radiologist ■ Pathologist Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services at an In-Network facility. If an Out-of- Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Infusion Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
MATERNITY CARE & OTHER REPRODUCTIVE SERVICES					
Doctor's office: Global care (includes pre-and post-natal, delivery) Co-Pay (first visit): ■ Primary care Doctor (includes obstetrician and gynecologist) Co-Pay/Coinsurance. ■ Specialist Co-Pay/Coinsurance. ■ Midwife (Precertification required). ■ Includes Therapeutic and Elective Abortion. ■ Dependent Daughters are covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	First initial office visit is subject to $30/$40 Co- Pay then covered at 100%.	40% Coinsurance after satisfaction of Calendar Year Deductible.	First initial office visit is subject to $30/$40 Co-Pay then covered at 100%.
Hospital/Birthing Center Services (Precertification required) ■ Doctor's services ■ Newborn nursery services (wellbaby care) ■ Circumcision Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre- certified.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Inpatient Hospital Co-Pay, then 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	$150 Inpatient Hospital Co-Pay, then 10% Coinsurance after satisfaction of Calendar Year Deductible.
Fertility Services Includes coverage to diagnose and treat infertility; however, a diagnosis of infertility is not required to access fertility treatment services. There is a lifetime maximum coverage amount of $20,000 for medical services and supplies associated with the treatment of Infertility, and a lifetime maximum coverage amount of $10,000 for related pharmacy expenses. Covered services include, but are not limited to: Artificial Insemination (AI), Intrauterine Insemination (IUI), and Timed Intercourse (TI) cycles, Assisted Reproductive Technology (ART) services and supplies specific to ART (This does not include coverage for infertility treatment services as a result of voluntary sterilization), Pathology and Laboratory services. Fertility Preservation (elective and medically indicated), including egg and sperm freezing with one year of storage beginning from the initial date of cryopreservation.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible.
Sterilization - services that do not meet Women's Health Provision requirements Vasectomy. Precertification required for Inpatient procedures. Reversals are not covered. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Benefits for further details.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible. Facility Outside of Doctor's Office 40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible.
Contraceptives – services not included in Women's Health Provision Spermicide, vaginal ring, hormone patch. Depo - Estradiol Cypionate - up to 5 MG, and other covered contraceptives included in Women's Health provision but not meeting required Women's Health diagnosis restrictions. Covered for birth control as well as medical conditions.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible. Facility Outside of Doctor's Office 40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/ $40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible.
Contraceptives-covered under Women's Health Provision IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices (other than the ones listed above as not included in Women's Health). Covered based on the diagnosis restriction within the Women's Health provision.	See Preventive Care.	Not applicable	See Preventive Care.	Not applicable	See Preventive Care.

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
MEDICAL SUPPLIES AND EQUIPMENT					
Medical Supplies	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network is covered at the In-Network benefit level.
Durable Medical Equipment (Purchase & Rental)	20% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out of Network is covered at the In- Network benefit level, priced at the Non-participating provider level.
Prosthetics and Orthotics Wigs/Toupees limited to one per Benefit Period, subject to Medical Necessity. Foot Orthotics, based on Medical Necessity.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network is covered at the In-Network benefit level.
Diabetic Supply Diabetic Supplies covered by pharmacy Plan are not covered under medical - including lancets, syringes, insulin, etc. Diabetic supplies not covered under Pharmacy are covered by the medical Plan.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network is covered at the In- Network benefit level.	10% Coinsurance after satisfaction of Calendar Year Deductible. Out-of-Network is covered at the In-Network benefit level.
Nutritional Counseling When the diagnosis is for Diabetes, Eating Disorders, or for any other diagnosis if billed with specific Health Care Reform preventive care codes.	Covered at 100%. No Co-Pay or Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100%. No Co-Pay or Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100%. No Co-Pay or Deductible.
Nutritional Counseling All other nutritional counseling and falls outside of the Health Care Reform preventive care codes (see above).	Covered at 100% after $40 copay	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $40 copay	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $40 copay
OUTPATIENT HOSPITAL / FACILITY SERVICES					
Outpatient facility	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	$50 outpatient Copayment then 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	$50 outpatient Copayment then 10% Coinsurance after satisfaction of Calendar Year Deductible
Surgery - (Institutional) Includes Ambulatory surgery	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	$50 outpatient Copayment then 20% Coinsurance after satisfaction of Calendar Year Deductible	40% Coinsurance after satisfaction of Calendar Year Deductible.	$50 outpatient Copayment then 10% Coinsurance after satisfaction of Calendar Year Deductible.
Lab and x-ray services	See Lab, X-Ray and Ultrasound for details.	See Lab, X-Ray and Ultrasound for details.	See Lab, X-Ray and Ultrasound for details.	See Lab, X-Ray and Ultrasound for details.	See Lab, X-Ray and Ultrasound for details.
Outpatient Doctor services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible
Consultation, Second Opinion Outpatient/Office/ Clinic	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.
DOCTOR SERVICES (HOME AND OFFICE VISITS)					
Doctor or Specialist Visit	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.
Office Surgery	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply.
Prescription Injectables/ Prescription Drugs Dispensed in the Doctor's Office	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Preventive Services (regardless of Provider or setting where Preventive care is provided)	Covered at 100% Deductible does not apply.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% Deductible does not apply.
Retail Health Clinic-Professional Co-Pay applies to professional office visit charge only.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $25 Co-Pay Deductible does not apply.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $25 Co-Pay Deductible does not apply.
Skilled Nursing Facility	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Maximum days	120 days per Calendar Year				

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
SURGICAL SERVICES					
Surgery Cosmetic/Reconstructive Surgery (subject to Medical Necessity)	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Gastric Bypass/Obesity Surgery When Medically Necessary Precertification Required	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
THERAPY SERVICES - OUTPATIENT					
Doctor or Specialist office visit	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. 10% Coinsurance after satisfaction of Calendar Year Deductible.
Outpatient Services	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Physical Therapy (Maximum visits per Calendar Year) Occupational Therapy ■ Combined Institutional/Professional. ■ Maintenance therapy is not covered. ■ Outpatient services subject to Deductible and Coinsurance. Speech Therapy ■ Combined Institutional/Professional. ■ Outpatient services subject to Deductible and Coinsurance.	30 visit maximum per Calendar Year combined In and Out- of-Network (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.	30 visit maximum per Calendar Year combined In and Out- of-Network (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.	30 visit maximum per Calendar Year combined In and Out-of-Network (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.	30 visit maximum per Calendar Year combined In and Out-of-Network (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.	30 visit maximum per Calendar Year (not combined with any other therapy). Visits beyond 30 require ongoing documentation from your attending Doctor and are limited to maximum medical improvement.
Chiropractic Care (Maximum visits per Calendar Year)	Limited to a 20 visit maximum per Calendar Year combined In and Out-of-Network for manipulations regardless of provider specialty.	Limited to a 20 visit maximum per Calendar Year combined In and Out-of-Network for manipulations regardless of provider specialty.	Limited to a 20 visit maximum per Calendar Year combined In and Out-of-Network for manipulations regardless of provider specialty.	Limited to a 20 visit maximum per Calendar Year combined In and Out-of-Network for manipulations regardless of provider specialty.	Limited to a 20 visit maximum per Calendar Year for manipulations regardless of provider specialty.
Cardiac and Pulmonary Rehabilitation Maintenance therapy is not covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible.
Chemotherapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible.
Radiation Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible. Facility Outside of Doctor's Office 40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible.
Respiratory Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Infusion Therapy	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
Vision Therapy (Outpatient Hospital setting) Orthoptic training (eye-muscle exercise) is covered if services are rendered by a licensed Optometrist or an Orthoptic.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	20% Coinsurance after satisfaction of Calendar Year Deductible.	40% Coinsurance after satisfaction of Calendar Year Deductible.	10% Coinsurance after satisfaction of Calendar Year Deductible.
NOTE: Inpatient therapy services will be paid under the Inpatient Hospital benefit.					

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
THERAPY SERVICES - OUTPATIENT (CONT)					
Transgender Surgery Medically necessary surgical procedures The Plan follows WPATH standards of care, covered persons must meet all eligibility qualifications outlined under the Plan Services must be performed by a qualified provider at a facility with a history of treating individuals with gender changes. Prior to all treatment, services must be authorized by Anthem. Certain services are not covered.	20% Coinsurance after satisfaction of Calendar Year Deductible.	50% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 20% Coinsurance after satisfaction of Calendar Year Deductible and if applicable the $50 outpatient Co-Pay, or $150 Hospital Confinement Co-Pay.	40% Coinsurance after satisfaction of Calendar Year Deductible.	Doctor's Office Covered at 100% after $30 PCP/$40 Specialist Co-Pay. Deductible does not apply. Facility Outside of Doctor's Office 10% Coinsurance after satisfaction of Calendar Year Deductible and if applicable the $50 outpatient Co- Pay, or $150 Hospital Confinement Co-Pay.
Transplants Any Medically Necessary human organ and stem cell/ bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy. The Center of Excellence requirements do not apply to Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Coverage starts one day prior to a Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.) Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible
Covered Transplant Procedure during the Transplant Benefit Period Care coordinated through a Center of Excellence. You are responsible for any charges from the Out-of-Network Transplant Provider.	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient) Includes unrelated donor search up to $30,000 per transplant.	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement) Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible
All Other Covered Transplant Services	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible	Not Covered	Center of Excellence Covered at 100% Network Transplant Center 10% Coinsurance after satisfaction of Calendar Year Deductible

Covered Services & Supplies	Lower Premium		Lower Deductible		In-Network Only
	In-network	Out-of-network	In-network	Out-of-network	In-network
TRAVEL REIMBURSEMENTS					
Eligible Travel and Lodging The plan covers the following travel and lodging expenses for you to receive medical care when medical services are not available within 100 miles of your home: ■ U.S domestic travel and lodging expenses for you and one companion, to travel from your home to receive the covered services (coach class air fare, train or bus travel are examples of covered services) ■ Total maximum travel and lodging benefit is $4,000 per year limit except if travel is to receive a transplant which is covered at $10,000 per occurrence. ■ Lodging: $50 per night (per IRS guidelines) / $100 maximum per night if accompanied by a travel companion To receive reimbursement for travel and lodging: ■ Medical services must be covered by the plan with a related claim on file ■ Medical services must be performed by an in-network doctor/facility and permitted under state and local law ■ No prior authorization for the travel and lodging benefit is required. However, members are responsible for attesting there is no in-network provider within 100 miles of their home address unless the care is to receive a transplant in which you must asst to no in-network provider within 50 miles of their home address ■ Travel for transplants must be performed at Center of Excellence facility (see transplants) To obtain a travel and lodging claim form, or for detailed information about these covered services, including specific eligibility requirements are any limitations contact Member Services at: ■ Anthem: 1-855-839-4533	Travel reimbursements for medical services are covered at 100%	Not Covered	Travel reimbursements for medical services are covered at 100%	Not Covered	Travel reimbursements for medical services are covered at 100%

Health Care Management – Precertification

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher-cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization for you to receive benefits for certain services. Prior authorization criteria will be based on multiple sources, including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments, which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service telephone number on your Identification Card.

Types of Requests

PRECERTIFICATION A required review of a service, treatment or admission for a benefit coverage determination, which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Doctor must notify the Claims Administrator within two business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

PREDETERMINATION An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Claims Administrator will review your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

POST SERVICE CLINICAL CLAIMS REVIEW A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

General Exclusions and Limitations

The plan does not cover any expenses incurred for services, supplies, medical are or treatment relating to, arising out of, or given in connection with the following:

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Admissions for Non-Inpatient Services	Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
Administrative Charges	Charges for any of the following: ■ Failure to keep a scheduled visit; ■ Completion of claim forms or medical records or reports unless otherwise required by law; ■ For Doctor or Hospital's stand-by services; ■ For holiday or overtime rates. ■ Membership, administrative, or access fees charged by Doctors or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results. ■ Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
Allergy Services	Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto injections.
Alternative Therapies	Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to recreational, or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
Before Coverage Begins/ After Coverage Ends	Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends.
Biomicroscopy	Biomicroscopy, field charting or aniseikonic investigation.
Comfort and Convenience Items	Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
Complications	Complications of non-covered procedures are not covered.
Crime and Incarceration	Injuries received while committing a crime as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation. This Exclusion does not apply if you were the victim of a crime, including domestic violence.
Custodial Care and Rest Care	Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Doctor. Inpatient Room and Board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
Daily Room Charges	Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.
Dental Care	Dental care and treatment and Oral Surgery (by Doctors or Dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (Fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or Periodontal Disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this book.
Educational/Behavioral Services	Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems. Special education, including lessons in sign language to instruct a Member, whose ability to speak have been lost or impaired, to function without that ability, is not covered.
Excessive Expenses	Expenses in excess of the Plan's Maximum Allowed Amount.
Employer or Association Medical/Dental Department	Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
Experimental/Investigative Services	Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigative for the diagnosis for which the Member is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Member's Doctor to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
Family Members	Services rendered by a Provider who is a close relative or Member of your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
Foot Care	Foot care only to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
Free Services	Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
Government Programs	Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a Member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Health Spa	Expenses incurred at a health spa or similar facility.
Ineligible Hospital	Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
Ineligible Provider	Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
Inpatient Rehabilitation Programs	Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Doctor or; the treatment is for maintenance therapy; or ■ the Member has no restorative potential; or ■ the treatment is for congenital learning or neurological disability/disorder; or ■ the treatment is for communication training, educational training or vocational training.
Maintenance Care	Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.
Marital Counseling	Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
Medicare Benefits	Services paid under Medicare Benefits (in circumstances where Medicare is or would be primary to the Plan) or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. Renal disease (ESRD) after the coordination period, Medical Parts A and B shall be treated as the primary payor whether or not the Member has enrolled in Medicare Part B. For services provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Never Events	The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
Non-Covered Services	Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Book.
Not Medically Necessary Services	Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
Obesity Services	Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss, etc.).
Out of Network Providers	For any care, services, or supplies received from an Out-of-Network Provider; except for Emergency Care, Urgent Care, or allowed as an Authorized Service by the Claims Administrator.
Over the Counter Drug Equivalents	Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that the Plan must cover under federal law with a Prescription.
Prescription Drugs	Any Prescription Drugs purchased at a retail or Home Delivery (Mail Service) Pharmacy.
Private Duty Nursing	For Private Duty Nursing services except when provided through the "Home Care" benefit.
Private Rooms	Private room, except as specified as Covered Services.
Research Screenings	For examinations related to research screenings, unless required by law.
Reversal of Sterilization	Services related to or performed in conjunction with reverse sterilization.
Services Not Specified as Covered	No Benefits are available for services that are not specifically described as Covered Services in this book. This exclusion applies even if your Doctor orders the service.
Sexual Dysfunction	Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
Shoes	Shoe inserts, (except when prescribed by a Doctor for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
Smoking Cessation	Smoking Cessation programs and treatment of nicotine addiction including gum, patches and Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, unless otherwise required by law.
Spider Veins	Treatment of telangiectatic dermal veins (spider veins) by any method.
Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary	Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to: ■ Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards; ■ Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs; ■ The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment; ■ Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers; ■ Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Member's house or place of business and adjustments made to vehicles; ■ Air conditioners, humidifiers, dehumidifiers, or purifiers; ■ ental or purchase of equipment if you are in a facility which provides such equipment; ■ Other items of equipment that the Claims Administrator determines do not meet the listed criteria.

SERVICES NOT COVERED BY THE PLAN	ADDITIONAL INFORMATION
Therapy Services	Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in this book. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
Transplant Services	The following services and supplies rendered in connection with organ/tissue/bone marrow transplants: Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants; ■ Transportation, travel or lodging expenses for non-donor family Members; ■ Donation related services or supplies, including search, associated with organ acquisition and procurement; ■ Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.
Transportation	Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the "Ambulance Service" section. Ambulance transportation from the Hospital to the home is not covered.
Thermograms	Thermograms and thermography.
Vision Care	Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this book. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
Vision Surgeries	Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
Waived Fees	Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) an Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.
War / Military Duty	Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
Workers' Compensation	Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

Medical Plan Individual Case Management

The Claims Administrator's medical plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your medical plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, the Claims Administrator will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service through the Claims Administrator's Case Management program. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator's will make any recommendation of alternate or extended benefits to the Plan on a case-by-case, if in the Claims Administrator's discretion, the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

Pharmacy

We have your prescription drugs covered with whatever medical plan option you choose. You'll receive pharmacy benefits through OptumRx. When covered prescriptions are filled under the pharmacy program, you share a portion of the cost and Bath & Body Works pays the rest. Here's what you'll pay for prescription drugs based on the type of drug you fill:

	Tier One	Tier Two	Tier Three
Retail (30-day supply)	You pay 15% Min: $15 Max: $30	You pay 20% Min: $40 Max: $80	You pay 40% Min: $55 Max: $95
Retail (90-day supply)	You pay 15% Min: $45 Max: $90	You pay 20% Min: $120 Max: $240	You pay 40% Min: $165 Max: $285
Mail Order (90-day supply)	You pay 15% Min: $35 Max: $75	You pay 20% Min: $95 Max: $200	You pay 40% Min: $130 Max: $270

Note: Certain HIV drugs will be offered for a co-pay of $25 for 30 days and $75 for 90 days to ensure affordable access to these critical, life-sustaining medications.

The Difference Among the Tiers

The amount you pay for a prescription drug is based on the type of drug you fill, whether it's a generic, preferred brand or non-preferred brand. Here's how the costs compare based on the tier of drug you fill:

Tier	Coinsurance Option
One	**Lowest Coinsurance Option.** Always consider tier one medications if you and your doctor decide they are right for your treatment.
Two	**Middle Coinsurance Option.** Consider tier two medications if you and your doctor decide there are no tier one options appropriate to treat your condition. Ask your doctor if there are tier one alternatives or over-the-counter brands that are equivalent to tier two medications — they may be used to treat the same condition, but are less expensive.
Three	**Highest Coinsurance Option.** If you are currently taking a medication in tier three, ask your doctor whether there are tier one or two alternatives appropriate for your condition. Compounded medications containing one or more ingredients that are prepared on-site by a pharmacist are classified at the tier three level, provided that the individual ingredients used in compounding are covered under the pharmacy benefit.

Understand How the Tiers Work

What are Tiers, and How Do They Affect What I Actually Pay at the Pharmacy? Prescription medications are categorized within three tiers. Each tier is assigned a Coinsurance, which is the amount you pay when you visit the pharmacy or order your medications at **optumrx.com**. Certain drugs will be offered for a co-pay of $25 for 30 days and $75 for 90 days to ensure affordable access to these critical, life-sustaining medications.

How Do I Know What Tier My Medication Falls Under? A prescription drug list (PDL) is created by OptumRx that categorizes brand name and generic medications, which have been approved by the U.S. Food and Drug Administration as safe and effective. Once you and your doctor have agreed upon a treatment plan, your doctor can consult the PDL to prescribe you the most effective, affordable option.

- Doctors in the network receive a copy of the PDL from OptumRx. In addition, the PDL is available to doctors online at **optumrx.com**.
- The PDL does not restrict what your physician can prescribe or what a pharmacist can dispense. You and your physician decide which medications you should take.

How Does My Pharmacist Know Which Tier My Medication Falls Under? The pharmacist receives an electronic message advising the applicable Coinsurance based on the medication prescribed by your doctor.

What If I Am Currently Taking a Medication that Moves Up a Tier and Causes Me to Pay Higher Coinsurance? Ask your doctor if there are alternatives under a lower tier, or over-the-counter medications. Also, keep in mind there are other savings opportunities, such as the home delivery pharmacy.

Where Do I Find Information About My Pharmacy Benefits, such as Tier Pricing? Go to **optumrx.com**.

Can My Medication Change Tiers Throughout the Year? Updates to the PDL are made periodically, which means when a medication changes tiers, you may be required to pay more or less for that medication. These changes may occur without prior notice to you. Log on to **optumrx.com**, or call the customer service number on your medical/prescription drug ID card for prescription tier information about a particular medication

Coordinating with a Copay Card

Manufacturer copay cards are a way to save on medications. They can help you afford expensive prescription medications by lowering your out-of-pocket costs. You can request a copay card from the drug's manufacturer or your prescriber and can enter it on **optumrx.com** to be sure it's applied to your fills.

If a copay card (manufacturer assistance) is used to fill specialty medications at an Optum Specialty Pharmacy to offset the amount you would be charged under the plan, you will only receive accumulator (out-of-pocket) credit for the amount you pay. You will still receive the benefit of the copay card financially; however, you will not receive the deductible or out-of-pocket credit for amounts you have not paid out of your own pocket. Only your actual out-of-pocket costs are applied to your deductible and out-of-pocket totals.

Calendar Year Pharmacy Out-of-Pocket Maximum

Each medical plan option has a calendar year pharmacy out-of-pocket maximum, which is the maximum amount you will pay out of your pocket for prescription drugs. Once you reach the calendar year out-of-pocket maximum, the plan pays the rest.

	Lower Premium	Lower Deductible	In-Network Only
Individual	$3,650	$3,650	$3,650
Family	$7,300	$7,300	$7,300

Save on Prescription Drugs

Here are some ways you can save on prescription drugs:

- **USE THE WELLNESS CENTER AT DC3.** Fill prescriptions for you and your dependents at the Wellness Center's full-service pharmacy and pay less. You can also get free FedEx delivery or curbside pick-up. Call 380.529.4024.
- **PREVENTIVE PRESCRIPTION DRUGS.** Certain preventive care drugs are offered at no-cost when you fill your prescription through a network pharmacy, including contraceptives, aspirin, fluoride, folic acid and iron supplements, smoking cessation drugs and preventive immunizations. Ask your doctor about no-cost options that are right for you.

- **CONNECT WITH OPTUMRX.** Find a pharmacy with the lowest cost drug, learn about your drug, manage your Home Delivery prescriptions, keep track of your health history and more at **optumrx.com** or through the OptumRx app. You'll need your member ID (found on your ID card) to register. You can also contact member services 24/7 at 855.295.9142.
- **VISIT A PHARMACY THAT OFFERS REDUCED-COST PRESCRIPTION DRUG OPTIONS**. If your prescription drug is offered at an amount that is less than the tier-one Coinsurance, take advantage of it. If you live or work near DC 3 in Columbus, Ohio, consider using the Walgreens pharmacy at DC 3. Bath & Body Works associates get discounts on prescriptions and over-the-counter medications and products.
- **SAVE WITH GENERIC MEDICATIONS.** Generic medications contain the same active ingredients as brand name medications, but they often cost less. Generic medications become available after the patent on the brand name medication expires. Generic medications cost less because they do not require the same level of sales, marketing, research and development as brand name equivalents. Ask your doctor about lower cost alternatives, so you'll pay less at the pharmacy.
- **HALF TABLET PROGRAM.** Ask your doctor if your medication is appropriate for the voluntary tablet splitting program. Here's how it works:
  - Your doctor writes your prescription for twice the dosage and half the quantity, noting your intent to split the tablets on your prescription.
  - Fill prescription at your local "network" pharmacy or through the online home delivery program.
  - Split each tablet and take half – you'll get your usual dose for half the cost.

  Note: Not all medications are appropriate for tablet splitting. Always consult with your doctor before splitting any medication. Ask your pharmacist about devices that are appropriate for tablet splitting.
- **HOME DELIVERY PHARMACY.** If you take a prescription medication on an ongoing basis, consider the home delivery pharmacy. The Home Delivery Pharmacy Service (HDPS) is the fastest and easiest way to get your ongoing prescription medications. And it costs less than going to your local retail pharmacy.
  - Prescription drugs are sent directly to your home, plus standard shipping is always free!
  - Orders include up to a 90-day supply on most medications (with up to three refills). You will be charged a home delivery Coinsurance regardless of the day supply written on the prescription (i.e., a 30-day supply prescription filled through the home delivery pharmacy service will be assessed the 90-day home delivery Coinsurance). Therefore, to maximize your savings, be sure your physician writes the prescription for a 90-day supply with up to three refills as appropriate.
  - Save on medications, compared to your local pharmacy costs.
  - If you're enrolled in the Health Care Flexible Spending Account (FSA), use your HealthEquity® visa card to pay for your home delivery prescriptions. You'll not only save by using the home delivery service, you'll also save by using your pre-tax FSA dollars

Important Home Delivery Pharmacy Service (HDPS) Reminders

- When your doctor prescribes a new medication that you will be taking on an ongoing basis, consider using the HDPS.
- When using HDPS for a new medication, be sure to request two copies of the prescription. The first prescription, up to a one–month supply to be filled at your local retail pharmacy. The second prescription, for a 90–day supply with additional refills, to be filled by HDPS. (When half of the first prescription is gone, mail in the 90–day prescription to the home delivery service.)
- You can fill your first prescription of a new medication by mail. All subsequent refill prescriptions can be filled online (**optumrx.com**), mail, fax or phone. And remember, vitamins and other over-the-counter medicines are available at discounted prices.

To get started, call 855.295.9142 or log on to **optumrx.com** > Pharmacies & prescriptions.

Preventive Health Services

The Bath & Body Works medical plan offers no-cost preventive health services to help you get and stay healthy. We encourage you to get preventive care annually to help prevent and detect conditions early, so you can treat them right away.

Preventive care physical exams, screenings, tests and vaccines are covered at no cost to you when you use an in-network provider. Not all services may be right for every person, so seek your doctor's guidance. Here's a list of the types of covered preventive services.

Preventive Versus Diagnostic Care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, if your doctor suggests you have a colonoscopy because of your age when you have no symptoms, that's considered preventive care. However, if you have symptoms, and your doctor suggests a colonoscopy to see what's causing them, that's considered diagnostic care.

PREVENTIVE SERVICE	Child (Birth through 18 years)	Adult (19 years and older)
Preventive physical exams	•	•
SCREENING TESTS		
Aortic aneurysm screening (men who have smoked)		•
Behavioral screening and counseling to promote a healthy diet	•	•
Blood pressure	•	•
Bone density test to screen for osteoporosis		•
Breast cancer, including exam and mammogram		•
Breastfeeding support, supplies and counseling (female)		•
Cervical dysplasia screening	•	
Cholesterol		•
Lipid level		•
Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)		•
Depression screening	•	•
Development and behavior screening	•	
Type 2 diabetes screening	•	•
Hearing screening	•	•
Height, weight and body mass index (BMI)	•	•
Intervention services (includes counseling and education): ■ Counseling related to aspirin use for the prevention of cardiovascular disease		•
■ Counseling related to genetic testing for women with a family history of breast or ovarian cancer		•
■ Counseling related to chemoprevention for women with a high risk of breast cancer		•
■ Primary care intervention to promote breastfeeding	•	•
■ Screening and behavioral counseling related to alcohol misuse	•	•
■ Screening and behavioral counseling related to tobacco use	•	•
■ Screening and counseling for interpersonal and domestic violence	•	•

PREVENTIVE SERVICE	Child (Birth through 18 years)	Adult (19 years and older)
SCREENING TESTS (CONT.)		
Newborn screening	•	
Oral (dental health) assessment when done as part of a preventive care visit	•	
Pelvic exam and Pap test, including screening for cervical cancer		•
Screenings during pregnancy (including, but not limited to,gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)		•
Screening and counseling for obesity	•	•
Screening and counseling for sexually transmitted infections.	•	•
Vision screening when done as part of a preventive care visit	•	
IMMUNIZATIONS		
Diphtheria, tetanus and pertussis (whooping cough)	•	•
Haemophilus influenza type b (Hib)	•	
Hepatitis A	•	•
Hepatitis B	•	•
Human papillomavirus (HPV)	•	•
Influenza (flu)	•	•
Measles, mumps and rubella (MMR)	•	•
Meningococcal (meningitis)	•	•
Pneumococcal (pneumonia)	•	•
Polio	•	
Rotavirus	•	
Varicella (chicken pox)	•	•
Zoster (shingles)		• (Age 50 and older)

Stop Tobacco Use

You can connect with the resources you need to quit tobacco forever through Optum's Quit for Life® program. You and your covered dependents can participate in the program at no cost when you're enrolled in a Bath & Body Works medical plan.

Quit for Life provides free round-the-clock, confidential, telephone-based coaching. No-cost nicotine replacement therapy is also available, with counseling. You have access to:

- A personal coach who provides guidance, support and encouragement to stick with a plan and quit tobacco.
- Individualized strategies to manage urges with Mini Quit milestones, including nicotine replacement therapy (patch or gum) that's right for you.

You can enroll in Quit for Life at **quitnow.net** or by calling 866-QUIT-4-LIFE TTY 711.

Health Advocate

We want to help you better navigate and resolve health care and insurance-related issues, which is why we provide Health Advocate at no cost to you and your eligible dependents (including your parents and parents-in-law) Use Health Advocate to:

- Find doctors and hospitals
- Make doctor's appointments
- Resolve claims and billing issues
- Arrange second opinions
- Navigate insurance plans
- Find low-cost alternatives
- Locate elder care

How Health Advocate Works

Here's how Health Advocate works:

- Provide your name as it's listed in HR Access and the Health Advocate will confirm your eligibility.
- During your first call, you will be assigned a Personal Health Advocate who will begin helping you right away.
- Personal Health Advocates are typically registered nurses, supported by medical directors and benefits and claims specialists. They'll help cut through the red tape and assist with complex conditions, find specialists, address eldercare issues, clarify insurance coverage, work on claim denials, help negotiate fees for non-covered services and get to the heart of your issue.

How Health Advocate Can Help

NEED HELP GETTING HEALTH CARE?	■ Find the right doctors, dentists, specialists and other providers. ■ Schedule appointments. Arrange for special treatments and tests. ■ Answer questions about test results, treatments and Medications.
CONFUSED BY HEALTH INSURANCE OR NEED HELP WITH A CLAIM?	■ Clarify benefits and uncover billing errors. ■ Get to the bottom of coverage denials. ■ Get appropriate approvals for covered services.
WANT TO SAVE ON HEALTHCARE COSTS?	■ Find options for non-covered services. ■ Negotiate payment arrangements with providers. ■ Provide information about generic drug options.
NEED ELDERCARE SERVICES FOR YOUR PARENTS OR PARENTS-IN-LAW?	■ Find in-home care, adult day care, assisted living and long-term care. ■ Clarify Medicare, Medicare Supplement plans and Medicaid. ■ Research transportation to appointments.

Your Privacy is Protected

The Health Advocate staff follows careful protocols and complies with all government privacy standards. Your medical and personal information is kept strictly confidential.

Health Advocate is not affiliated with any insurance or third-party provider. Health Advocate complies with all government privacy standards. Health Advocate does not replace health insurance coverage, provide medical care or recommend treatment.

Dental

Bath & Body Works provides you a choice when it comes to dental coverage. Through Delta Dental you have two options to choose from:

- Delta Dental Base Plan
- Delta Dental Plus Plan

Save Money When You Receive Network Care

Delta Dental offers two networks to allow you to receive higher in-network benefits, regardless of which plan you select. When you receive care from an in-network provider, you'll pay less because you're charged discounted rates that are negotiated with Delta Dental. To get a better sense of your out-of-pocket costs, ask your network dentist which of the two Delta Dental networks they participate in. You can also visit **deltadentaloh.com** and check for yourself.

Delta Dental Networks	Delta Dental PPO	No balance billing on covered services ■ Most significant network discounts with more than 381,800* office locations nationwide ■ Dentists file claims for member
	Delta Dental Premier	No balance billing on covered services ■ Significant network discounts with the most office locations nationwide—more than 448,400* ■ Dentists file claims for member
Out of Network	Out-of-Network Dentist	May be balance billed** ■ No discounts ■ May need to file own claims

*National network statistics: Delta Dental Plans Association, December 2020.

**When you receive services from an out-of-network dentist, the coinsurance percentage indicates the portion of Delta Dental's non-participating dentist fee that will be paid for those services. This amount may be less than what the dentist charges and you are responsible for the difference.

Bath&BodyWorks

Dental Plan Benefits: At a Glance

Both dental plan options provide the same level of benefits for diagnostic and preventive, basic and major services. The difference is in the maximum payments you have under both plans and the Delta Dental PPO Plus covers orthodontic services with no age limit.

Check out the benefits under each plan by clicking the link below.

Delta Dental Base Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist*
Annual Deductible** (per person/family)	$50/$150	$50/$150	$50/$150
Annual Maximum Payment*** (per person)	$1,000	$1,000	$1,000
Diagnostic & Preventive			
Diagnostic and Preventive Services. Exams, cleanings, fluoride and space maintainers	Covered 100%	Covered 100%	You pay 30%
Emergency Palliative Treatment to temporarily relieve pain	Covered 100%	Covered 100%	You pay 30%
Sealants to prevent decay of permanent teeth	Covered 100%	Covered 100%	You pay 30%
Brush Biopsy to detect oral cancer	Covered 100%	Covered 100%	You pay 30%
Radiographs. X-rays	Covered 100%	Covered 100%	You pay 30%
Basic Restorative Services			
Minor Restorative Services. Fillings and crown repair	You pay 20%	You pay 20%	You pay 40%
Endodontic Services. Root canals	You pay 20%	You pay 20%	You pay 40%
Periodontal Maintenance. Cleanings following periodontal therapy	You pay 20%	You pay 20%	You pay 40%
Oral Surgery Services. Extractions and dental services	You pay 20%	You pay 20%	You pay 40%
Relines and Repairs to prosthetic appliances	You pay 20%	You pay 20%	You pay 40%
Major Services			
Periodontic Services to treat gum disease	You pay 50%	You pay 50%	You pay 50%
Major Restorative Services. Crowns	You pay 50%	You pay 50%	You pay 50%
Other Basic Services. Miscellaneous services	You pay 50%	You pay 50%	You pay 50%
Prosthodontic Services. Bridges, implants and dentures	You pay 50%	You pay 50%	You pay 50%

* When you receive services from an out-of-network dentist , the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

**Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, sealants, brush biopsy and X-rays.

***Maximum payment is per person total per calendar year on diagnostic & preventive, basic services and major services.

STANDARD EXCLUSIONS AND LIMITATIONS:

The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:

- No pre-existing condition exclusions or limitations.
- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five year period.
- Posterior composite resin restorations are covered services.

NON-STANDARD EXCLUSIONS AND LIMITATIONS INCLUDE:

- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease.
- Fluoride treatments are payable once per calendar year for people up to age 14.
- Sealants are payable once per five-year period per tooth for first and second permanent molars up to age 19. The surface must be free from decay and restorations.
- Crowns, bridges, dentures and implants are payable once per tooth per seven-year period.
- Inlays are payable once per tooth per seven-year period.
- Veneers are payable on incisors, cuspids and bicuspids once per tooth per seven-year period when necessary due to fracture or decay for people age 12 and older. Veneers for cosmetic purposes are not Covered Services.

Children under age 26 are eligible for benefits, including children who are married, who do not live with the Subscriber, who are not dependents for Federal income tax purposes, and/or who are not permanently disabled.

Delta Dental Plus Plan

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist*
Annual Deductible** (per person/family)	$50/$150	$50/$150	$50/$150
Annual Maximum Payment*** (per person)	$2,000	$2,000	$2,000
Diagnostic & Preventive			
Diagnostic and Preventive Services. Exams, cleanings, fluoride and space maintainers	Covered 100%	Covered 100%	You pay 30%
Emergency Palliative Treatment to temporarily relieve pain	Covered 100%	Covered 100%	You pay 30%
Sealants to prevent decay of permanent teeth	Covered 100%	Covered 100%	You pay 30%
Brush Biopsy to detect oral cancer	Covered 100%	Covered 100%	You pay 30%
Radiographs. X-rays	Covered 100%	Covered 100%	You pay 30%
Basic Restorative Services			
Minor Restorative Services. Fillings and crown repair	You pay 20%	You pay 20%	You pay 40%
Endodontic Services. Root canals	You pay 20%	You pay 20%	You pay 40%
Periodontal Maintenance. Cleanings following periodontal therapy	You pay 20%	You pay 20%	You pay 40%
Oral Surgery Services. Extractions and dental services	You pay 20%	You pay 20%	You pay 40%
Relines and Repairs to prosthetic appliances	You pay 20%	You pay 20%	You pay 40%
Major Services			
Periodontic Services to treat gum disease	You pay 50%	You pay 50%	You pay 50%
Major Restorative Services. Crowns	You pay 50%	You pay 50%	You pay 50%
Other Basic Services. Miscellaneous services	You pay 50%	You pay 50%	You pay 50%
Prosthodontic Services. Bridges, implants and dentures	You pay 50%	You pay 50%	You pay 50%
Orthodontic Services			
Orthodontic Services. Braces	You pay 50%	You pay 50%	You pay 50%
Orthodontic Lifetime Maximum	$2,000	$2,000	$2,000
Orthodontic Age Limit	No age limit	No age limit	No age limit

* When you receive services from an out-of-network Dentist, the percentages in this column indicate the portion of Delta Dental's out-of-network Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

**Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, sealants, brush biopsy and X-rays.

***Maximum payment is per person total per calendar year on diagnostic & preventive, basic services and major services.

STANDARD EXCLUSIONS AND LIMITATIONS:

The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:

- No pre-existing condition exclusions or limitations.
- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Bitewing X-rays are payable once per calendar year and full mouth Xrays (which include bitewing X-rays) are payable once in any five year period.
- Posterior composite resin restorations are covered services.

NON-STANDARD EXCLUSIONS AND LIMITATIONS INCLUDE:

- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease.
- Fluoride treatments are payable once per calendar year for people up to age 14.
- Sealants are payable once per five-year period per tooth for first and second permanent molars up to age 19. The surface must be free from decay and restorations.
- Crowns, bridges, dentures and implants are payable once per tooth per seven-year period.
- Inlays are payable once per tooth per seven-year period.
- Veneers are payable on incisors, cuspids and bicuspids once per tooth per seven-year period when necessary due to fracture or decay for people age 12 and older. Veneers for cosmetic purposes are not Covered Services.

Children under age 26 are eligible for benefits, including children who are married, who do not live with the Subscriber, who are not dependents for Federal income tax purposes, and/or who are not permanently disabled.

Bath&BodyWorks

Bi-weekly Dental Premiums

	Delta Dental Base Plan	Delta Dental Plus Plan
Associate Only	$4.14	$6.67
Associate + Spouse/ Domestic Partner	$9.88	$15.86
Associate + Child(ren)	$8.45	$13.57
Associate + Family	$14.34	$22.99

Connect with Delta Dental

Stay current on your dental benefits with Delta Dental's easy-to-use Member Portal. This secure online tool gives you 24/7 access to important information about your dental benefits, including:

- Eligibility information.
- Current benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, levels of coverage for specific dental services, etc.)
- Specific claims information, including what has been approved and when it was paid.
- Your dental ID card. Print it, take a screen shot or pull it up on your phone through the Delta Dental app to share with your dentist.

You can elect to receive your Explanation of Benefits (EOB) statements electronically, print claim forms and identification cards, and browse oral health information.

Get started at **memberportal.com**.

Manage Your Benefits on the Go!

The Delta Dental mobile app makes it easy for you to get the most out of your dental benefits anytime, anywhere. Once registered for Member Portal, on the app, you can find a dentist, use a toothbrushing timer, check claims, view coverage and display your ID card. Plus, you can access information for yourself and your covered dependents! Visit the App Store (Apple) or Google Play (Android), and search for Delta Dental to download and install the app.

Vision

We offer flexibility when it comes to your vision coverage. Through Vision Service Plan (VSP), you have two options to choose from:

- VSP Vision Signature
- VSP Vision Signature Plus

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you and discover savings with Exclusive Member Extras.

Bi-weekly Vision Premiums

	VSP Vision Signature	VSP Vision Signature Plus
Associate Only	$4.14	$6.00
Associate + Spouse/ Domestic Partner	$6.14	$8.89
Associate + Child(ren)	$5.60	$8.12
Associate + Family	$11.14	$16.14

Check if Your Provider is In the Network

To determine if your doctor is a part of the VSP provider network:

- Log on to **www.vsp.com**
- Select Members or Prospective Members
- Find a VSP Network Doctor or call 800.877.7195

Not every doctor will be in-network. However, it's your choice — if you choose a network doctor you will save money! Keep in mind it is not necessary to specify if your doctor is in- or out-of-network at the time of enrollment.

Vision Plan Benefits: At a Glance

Both options provide comprehensive vision care; however, with the VSP Vision Signature Plus option, you have a higher frame allowance, and you have additional benefits, including VSP EasyOptions and VSP LightCare.

VSP Vision Signature

Benefit	Description	Copay
WellVision Exam	■ Focuses on your eyes and overall wellness ■ Routine retinal screening ■ Every calendar year	$15 Up to $39
Essential Medical Care	■ Retinal imaging for members with with diabetes covered-in-full ■ Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions, such as dry eye, diabetic eye disease, glaucoma and more. ■ Coordination with your medical coverage may apply. Ask your VSP network doctor for details. ■ Available as needed	$20 per exam
Prescription Glasses		
Frame	■ $200 Featured Frame brands allowance ■ $180 frame allowance ■ 20% savings on the amount over your allowance ■ $100 Costco frame allowance ■ Every calendar year	Included in prescription glasses
Lenses	■ Single vision, lined bifocal,and lined trifocal lenses ■ Impact-resistant lenses for dependent children ■ Every calendar year	Included in prescription glasses
Lens Enhancements	■ Standard progressive lenses ■ Premium progressive lenses ■ Custom progressive lenses ■ Impact-resistant lenses (adult) ■ Average savings of 40% on other lens enhancements ■ Every calendar year	$0 $80 - $90 $120 - $160 $0
Contacts (Instead of Glasses)	■ $180 allowance for contacts; copay does not apply ■ Contact lens exam (fitting and evaluation) ■ Every calendar year	Up to $60

VSP Vision Signature Plus

Benefit	Description	Copay
WellVision Exam	■ Focuses on your eyes and overall wellness ■ Routine retinal screening ■ Every calendar year	$15 Up to $39
Essential Medical Care	■ Retinal imaging for members with diabetes covered-in-full ■ Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. ■ Coordination with your medical coverage may apply. Ask your VSP network doctor for details. ■ Available as needed	$20 per exam
Prescription Glasses		
Frame	■ $230 Featured Frame brands allowance ■ $230 Visionworks frame allowance on any frame ■ $180 frame allowance ■ 20% savings on the amount over your allowance ■ $100 Costco frame allowance ■ Every calendar year	Included in prescription glasses
Lenses	■ Single vision, lined bifocal, and lined trifocal lenses ■ Impact-resistant lenses for dependent children ■ Every calendar year	Included in prescription glasses
Lens Enhancements	■ Standard progressive lenses ■ Premium progressive lenses ■ Custom progressive lenses ■ Impact-resistant lenses (adult) ■ Average savings of 40% on other lens enhancements ■ Every calendar year	$0 $80 - $90 $120 - $160 $0
Contacts (Instead of Glasses)	■ $180 allowance for contacts; copay does not apply ■ Contact lens exam (fitting and evaluation) ■ Every calendar year	Up to $60
Additional Benefits		
VSP EasyOptions	■ An additional $100 frame allowance, or fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or fully covered anti-glare coating, or an additional $100 contact lens allowance ■ Every calendar year	Included in prescription glasses
VSP LightCare	■ $280 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts ■ Every calendar year	$25

Additional Savings under the Vision Options

Glasses and Sunglasses

- Discover all current eyewear offers and savings at **vsp.com/offers**.
- 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.

Laser Vision Correction

- Average of 15% off the regular price; discounts available at contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Exclusive Member Extras for VSP Members

- Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**.
- Save up to 60% on digital hearing aids with TruHearing. Visit **vsp.com/offers/special-offers/hearing-aids** for details.
- Everyday savings on health, wellness, and more with VSP Simple Values

Vision Plan Expenses Not Covered

We offer a comprehensive vision plan. However, it is not possible to cover every expense. The following list will tell you generally what is not covered. This is not a complete or all-inclusive list, so if you still have questions, call 800.877.7195 for more information. Below is a partial list of vision expenses not covered:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a + .50 diopter power)
- Two pairs of glasses in lieu of bifocals
- Replacement of lenses and frames that are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an employer as a condition of employment
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK surgery

Receiving Benefits Authorization Under the Vision Plan

If you enroll in the vision plan, you must receive benefit authorization before receiving services.

You will not receive a vision ID card from VSP, and you will not be required to fill out any claim forms if you use an in-network provider. Once you have been confirmed as a VSP member, your doctor will take it from there! It's that easy.

- Call 800.877.7195 or log onto **vsp.com** to locate a VSP doctor (also see is my doctor in the network?).
- Make an appointment and tell the doctor's office you are a VSP member.
- Provide the doctor's office with your your 11-digit employee number (your employee ID with leading zeros). The doctor's office will use this information to obtain benefits authorization.
- Review your coverage details before your appointment.

Important Note: If you are in the vision plan and receive services from an in-network doctor prior to receiving benefit authorization, the services will be paid at the out-of-network level even if received by an in-network doctor.

Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you set aside a certain amount from your paycheck before federal, FICA and most state taxes are applied to your pay to pay for eligible health care and dependent care expenses.

Here's how much you can contribute to the FSAs in 2025:

- **HEALTH CARE FSA** Up to $3,200 to the Health Care FSA. You can rollover up to $640 of your unused Health Care FSA funds to the next year. Any amounts over the $640 remaining in your account will be forfeited, so be sure to estimate carefully. **Note:** The $640 roll over does not reduce the maximum amount you are able to set aside into your Health Care FSA, instead, it will increase your account $640, in the following year.
- **DEPENDENT CARE FSA** Up to $5,000 if married and file income taxes jointly ($2,500 if married filing separately). Unlike the Health Care FSA, you cannot roll over any unused amount to the next year. Any funds remaining in your account at the end of the year will be forfeited, so be sure to estimate carefully.

Managing Your FSA

Get up-to-the-minute account information at any time by logging into your account at **healthequity.com** (select Login > WageWorks) or by calling HealthEquity® at 877.924.3967.

To manage your account on the go, download the EZ Receipts app from the App Store or Google Play.

HealthEquity® (formerly WageWorks) provides easy-to-use online tools that help you learn more about what expenses are covered and how much you can save. Check with your tax advisor to determine if it is best for you to take advantage of the child care tax credit or to enroll in the Dependent Care FSA.

Accessing your FSAs

Throughout the year, you'll have access to the money you've saved in your Health and/or Dependent Care FSA. HealthEquity® provides these easy ways to access your account funds:

- **Use your HealthEquity® Card for Health Care FSA expenses.** You'll receive your personalized HealthEquity® Card by mail once you enroll (unless you were enrolled previously and your card is not due to expire). Whenever you make an eligible purchase or pay a provider, use it just like a credit card. The card pays directly from your account, so you don't have to pay the expense out-of-pocket, file a claim form and wait for reimbursement. The dollars you elect when you enroll will all be available to use upon receipt of your card.
- **Pay online.** Pay bills directly from your Health Care or Dependent Care FSA using the online Pay My Provider tool available through HealthEquity®. Just log in to your account, identify your health care or dependent care provider and the amount, upload your receipts and pay your bill online. You can even schedule automatic payments for recurring expenses, like adjusting braces or chiropractic treatments.
- **File a claim.** Claims are easy to complete and submit through either a paper form or online.

When Funds Are Available

- For the Health Care FSA, you'll have access to the full amount you elected to contribute for the year on January 1.
- For the Dependent Care FSA, you will only have access to the amounts you have contributed to your Dependent Care FSA. For example, on February 1, if you have contributed $300 in your Dependent Care FSA, you submit a day care claim for $400 (two weeks' worth of day care expenses). HealthEquity® will automatically reimburse you $300 (what you currently have in your account) and will then reimburse the remaining $100 as your account builds back up.

Eligible Expenses

Here's a look at the expenses that are eligible under the FSAs:

Health Care FSA

- Prescriptions for almost any medical condition
- Bandages, band-aids, wraps and splints
- Co-pay, coinsurance and deductibles — but not insurance premiums
- Dental care, both preventive and restorative
- Orthodontia, child and adult
- Vision care, including eyeglasses, contact lenses and saline solution
- Eye surgery, including laser vision correction
- Counseling and therapy
- Insulin, glucose test strips, other medical devices (crutches, blood sugar monitors, etc.) and supplies
- Chiropractic care, acupuncture and some other alternative treatments
- Sunscreens with SPF 30+

Visit **healthequity.com** for a complete list of eligible expenses.

Dependent Care FSA

If you pay to care for dependents while at work, your Dependent Care FSA will cover these types of expenses for your eligible dependents:

- Babysitting (work-related, your home or someone else's home) or au pair services
- Before- and after-school programs
- Expenses for pre-school, day care, summer day camps, nursery school or similar pre-kindergarten programs
- Adult or senior day care or elder care in or outside of your home nursery school or similar pre-kindergarten programs
- Adult or senior day care or elder care in or outside of your home

Making Changes During the Year

Other than open enrollment, you can only change your enrollment election if you experience a life-changing event. For the Health Care FSA, this includes:

- A change in your legal marital status (marriage, legal separation, divorce, annulment, or death of spouse).
- A change in the number of your dependents (birth, adoption, placement for adoption, or death).
- A change in your or your spouse's employment status impacting benefits eligibility (including an unpaid leave of absence).
- A dependent who satisfies or ceases to satisfy eligibility requirements.

For the Dependent Care FSA, this includes:

- All of the above.
- Change in coverage (change in provider, cost, and/or hours).

All election changes must be made within 30 days of the date of the qualifying events listed above by contacting Associate Connect

Health Care Card Verification Deadline

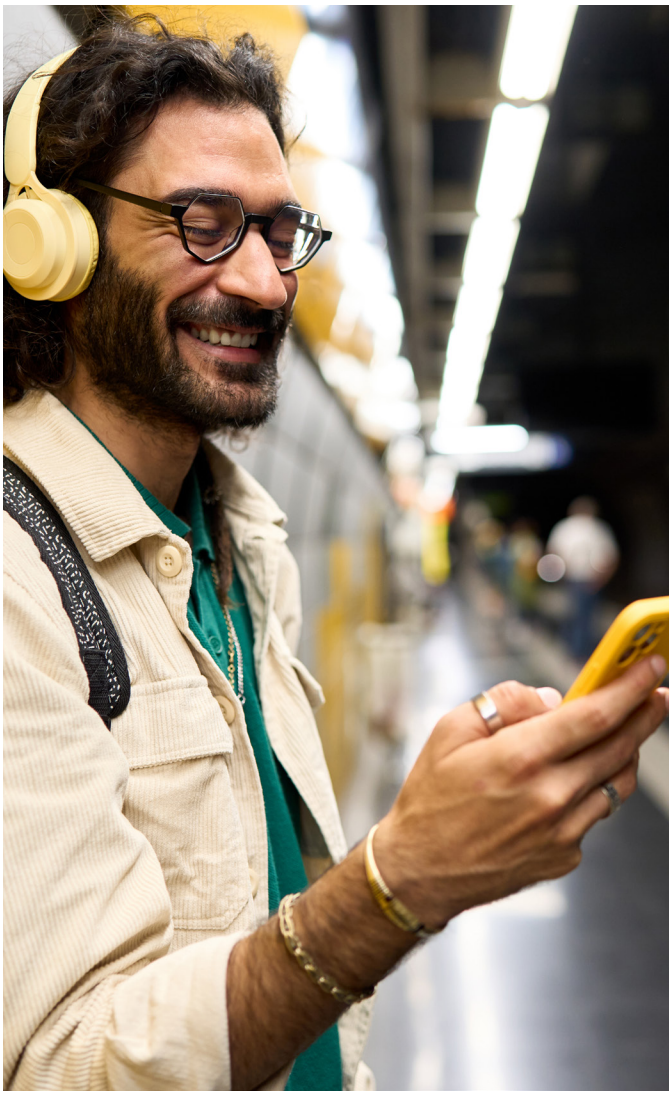
All unverified health care card purchases will require verification within 90 days of the transaction date. HealthEquity® will notify you if the transaction cannot be automatically verified. If you do not take action and the transaction remains unverified for 90 days, the Card will be at risk of suspension and the unverified amount will be deducted from future reimbursement payments. Card privileges will be automatically reinstated once outstanding unverified card transactions no longer account for more than 50% of available balance.

Commuter Program

The Commuter Program allows you to use tax-free dollars deducted from from your salary to pay for eligible transit and parking expenses. Because you use tax-free dollars, you reduce your taxable income, which means there's less income to tax, so you pay less in taxes! The Commuter Program, which is administered by HealthEquity, is available to all U.S. associates and their dependents who take public transportation, ride in a vanpool or pay to park near work or public transportation.

You can contribute up to $315* per month in 2025 to pay for transit expenses and another $315* per month to pay for parking expenses.

*These limits may change for 2025. Bath & Bodyworks will provide an update when the new limit is announced.



Bath&BodyWorks

Mental Wellbeing

We care about the whole you, that's why we offer the Employee Assistance Program (EAP), which offers no cost, confidential support, resources and someone to talk to whenever and wherever you need them – they'll be there for you 24/7. Provided through ComPsych, the EAP provides:

CONFIDENTIAL EMOTIONAL SUPPORT. Highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

WORK-LIFE SOLUTIONS. Specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

LEGAL GUIDANCE. Talk to attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

- Financial Resources. Financial experts can assist with a wide range of issues. Talk to them about:
  - Retirement planning, taxes
  - Relocation, mortgages, insurance
  - Budgeting, debt, bankruptcy and more

INTERACTIVE DIGITAL TOOLS. Digital self-care platform offers interactive behavioral health tools and resources. Log on for:

- Guided programs for anxiety, depression, mindfulness, sleep, stress and more
- Personalized, guided resources & motivational support
- Secure access through GuidanceResources® Online

WELL-BEING COACHING. Certified coaches work one-on-one with you to address health and well-being issues holistically, before they become long-term, costly problems. Call for help with:

- Burnout and work-life balance
- Developing self-compassion
- Goal-setting and building resiliency
- Coping with stress, improving sleep and more

ONLINE SUPPORT. GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- GuidanceConnect℠, which allows you to find a network therapist through the portal
- Articles, podcasts, videos, slideshows
- On-demand trainings

Who's Eligible

All U.S. associates – including seasonal associates – their dependents and housemates – including partners, roommates or anyone else living under your roof. You do not need to be enrolled in a Bath & Body Works medical plan to use the EAP.

The services provided through the EAP are strictly confidential. ComPsych will not release any information about you, your family members or housemates, unless you give written permission or unless the law requires it.

How to access ComPsych

There are three ways to access ComPsych:

1. Download the GuidanceNow App. Go to the App Store or Google Play and search for "GuidanceNow" to download the app.
2. Visit GuidanceResource Online. Go to **guidanceresources.com** (Organization Web ID: BBW)
3. Call 866.483.1481. When you call ComPsych, a GuidanceResources counselor will listen to your concerns and get a referral for you to talk to an expert counselor located in your area. During the appointment, the counselor will discuss your situation and help you develop a plan of action. You can visit a ComPsych counselor up to 8 times per person per issue each year at no cost to you, your dependents or housemates. If it is determined you need additional services beyond 8 visits, your medical plan may cover any additional care.

Life Insurance

Bath & Body Works provides Life insurance for you and your dependents to provide the financial protection you need if you or they die.

Basic Term Life Insurance

Bath & Body Works provides all full-time benefits-eligible associates, at no cost, with basic term life insurance at one time your annual base salary through Lincoln Financial Group (LFG).* Part-time benefits-eligible associates are eligible for $10,000 of basic term life insurance at no cost.**

We automatically enroll you whether or not you enroll in the medical or dental plan. So, for example, if you enroll in your spouse's medical plan, you'll still have life insurance provided and paid for by Bath & Body Works.

*The maximum coverage amount is $2 million.

**If you were a full-time benefits-eligible associate enrolled in the medical plan on December 31, 2005, your Basic Term Life insurance coverage amount will continue to be two times your December 31, 2005 annual base salary (legacy) until which point one times your current annual base salary becomes equal to or greater than your legacy coverage amount. If you leave the company for any reason and return after 30 days, you will lose your legacy status. Vice Presidents and above receive basic life insurance equal to two times annual base salary.

Optional Life Insurance (Full Time)

If you want to increase your total life insurance coverage beyond the basic term life insurance coverage that Bath & Body Works provides, you may choose and pay for optional life insurance coverage through LFG. You'll also have the option to purchase life insurance for your spouse, civil union or domestic partner and/or dependents.

Associate Coverage

All full-time, benefits-eligible associates may purchase from one to six times their annual base salary, up to $3 million. This coverage is offered through LFG at affordable group rates and, in most cases, below what you could purchase on an individual basis.

The optional life insurance rates are based on your age and your annual base salary. Rates and coverage amounts will automatically adjust during the year as you receive pay increases.

You will be guaranteed coverage up to three times your annual base salary at the highest multiple of your annual base salary that does not exceed $500,000. Any coverage you elect above these amounts will require Evidence of Insurability (EOI) prior to being granted. Evidence of insurability = proof of good health.

Evidence of Insurability (EOI)

Sometimes when you select additional life insurance coverage, LFG will want to verify whether or not you qualify for the new level of coverage. In this case, you must complete a health questionnaire – also known as Evidence of Insurability (EOI)—within 31 days of your election. You can access the application link through the Benefits home page on HRAccess. LFG will approve or deny coverage based on the information you provide. Until approval is received from LFG, you will be covered at the maximum guaranteed issue amount that does not require EOI. If approved, Bath & Body Works will be advised of the higher level of coverage and your coverage and premium will increase. However, if you are not actively at work on the date an increase in Optional Life Insurance coverage would be effective, the increase in coverage will be postponed until you return to work.

Coverage Maximums

- Basic Term Life: $2 million
- Optional Life: $3 million
- Combined Maximum (Basic Term Life and Optional Life): 7 x annual base salary

Associate Calculation

If you would like to purchase optional life insurance for yourself, please refer to the Rate Calculation Chart below. To calculate your cost per pay after tax, divide the dollar amount of coverage you would like to purchase by 1000 and multiply by the rate associated with your age range.

Rate Calculation Chart

Associate Age	Biweekly Rate per $1,000 of Coverage	Associate Age	Biweekly Rate per $1,000 of Coverage
under 25	$0.014770	50 - 54	$0.066920
25 - 29	$0.017080	55 - 59	$0.124150
30 - 34	$0.023540	60 - 64	$0.190620
35 - 39	$0.026310	65 - 69	$0.366920
40 - 44	$0.028620	70 and above	$0.594920
45 - 49	$0.043850		

Optional Dependent Life Insurance

Spouse/Domestic Partner Coverage/Child(ren)
You can purchase life insurance for your spouse/domestic partner or child(ren) starting from birth through age 25 in the following amounts:

	Spouse/ Domestic Partner	Children (Birth through age 25)
Coverage Amount Choice	$10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000 $80,000 $90,000 $100,000	$5,000 $10,000 The coverage amount you choose covers each eligible child for the full dollar amount.
Evidence of Insurability (EOI)	$10,000 - $20,000 – no EOI required $30,000 - $100,000 – EOI required*	Not required
Termination of Coverage	At termination of employment, divorce or termination of the domestic partnership. See Continuing Life Insurance below.	At termination of employment or the child reaches age 26. See Continuing Life Insurance below.

*If you enroll your spouse/domestic partner in coverage amounts that require EOI, you must complete the EOI application within 31 days of your election. You can access the application link on the Benefits page in HR Access. LFG will approve or deny coverage based on the information you provide. Until approval is received for the coverage amount selected, your spouse/domestic partner will be covered at the maximum guaranteed issue amount ($20,000).

Rate Calculation Chart

Spouse/ Domestic Partner Age	Biweekly Rate per $1,000 of Coverage	Spouse/ Domestic Partner Age	Biweekly Rate per $1,000 of Coverage
under 25	$0.027230	55 - 59	$0.270000
25 - 29	$0.032770	60 - 64	$0.499380
30 - 34	$0.043380	65 - 69	$0.853380
35 - 39	$0.048920	70 - 74	$1.272920
40 - 44	$0.054460	75 - 79	$2.091230
45 - 49	$0.086770	80 and above	$3.327230
50 - 54	$0.165230		

Child	Biweekly Rates
$5,000	$0.336900
$10,000	$0.673800

Take Note

- If an associate is enrolled in Optional Life, they cannot be covered by a spouse/domestic partner under Spousal Life when both work for Bath & Body Works.
- An associate cannot enroll in Optional Life if they are already covered by a spouse/domestic partner under Spousal Life when both work for Bath & Body Works.
- If an associate is enrolled in Optional Life, they cannot be covered by the Parent under Child Life when both work for Bath & Body Works.
- An associate cannot enroll in Optional Life if already covered by parent (when both work for Bath & Body Works) under Child Life.
- If an associate is covering children under Child Life, the same children cannot be covered by their spouse (when both work for Bath & Body Works) under Child Life.
- Benefits-eligible part-time associates are not eligible for Optional Associate and Dependent Life Insurance.
- A spouse/domestic partner or child who is in the military or who is living outside the United States and Canada cannot be covered.
- The amount of life insurance you, your spouse or domestic partner has or may purchase will be reduced by 25% at age 65 and 50% at age 70.

Beneficiaries

You can name one or more beneficiaries to your life insurance benefits at any time. To designate or change a beneficiary, log on to HR Access at **HRAccess.bbwcorp.com** or contact Associate Connect at 866.473.4728. If no beneficiary exists at the time of your death, your life benefits may be paid to one or more of the following who survive you: your estate, your spouse/domestic partner, your child(ren), your parent(s) or your sibling(s).

Continuing Life Insurance Coverage

If you leave the company, (or lose coverage for a certain reason) but still want life insurance coverage, there is a conversion option or a portability feature that will allow you to continue your basic term life and associate/dependent optional life insurance. Information will be mailed to your home address from Lincoln Financial Group about life insurance conversion and portability options.

Disability Coverage

If you need to take time away from work due to an injury or illness for an extended period of time, we provide Short-Term and Long-Term Disability benefits. This provides you the financial protection you need while you recover.

Full-time Benefits-Eligible Associates are eligible for Short-Term and Long-Term Disability on their first day of active service with the company.* These plans are designed to provide you income, so you can focus on taking care of yourself. Disability benefits do not provide job-protected leave; rather, they can be used along with job-protected leave to provide income supplementation.

*Please note, if this description of short-term disability or long- term disability plans conflicts with the terms of the actual plans, the language in the plans prevails.

Short-Term Disability*

You may qualify for Short-Term Disability (STD) benefits if you are unable to work at all or if your doctor puts you on a reduced schedule due to physical limitations.

To apply for STD benefits, notify your manager, then:

1. Call Associate Connect at 866.473.4728 and follow the prompts or
2. Call Lincoln Financial Group (LFG) at 844.869.3454; or
3. Log on to **www.MyLincolnPortal.com**.
   - First time users must register using Company Code BBWI
4. Please have the following information available when you report your claim:
   - Reason for absence (symptom or diagnosis)
   - Your medical care provider's name, address, phone and fax numbers
   - Your last day worked, first day absent from work, and anticipated return to work date

Short-Term Disability (STD) benefits begin on your eighth consecutive calendar day of absence. During your first through seventh calendar days of absence, you will have the option to take them unpaid or use your PTO (if available). Unless you request the time to be unpaid by calling Associate Connect, the Company will automatically apply any available PTO (up to 40 hours). If approved, STD benefits may be paid following the below schedule:

Day 1 – 7	**Day 8 – 30**	Day 31 – 181
Unpaid or PTO	100% of base pay	66-2/3% of base pay

* STD and LTD benefits are subject to review and approval by LFG according to established duration and treatment guidelines

Long-Term Disability*

If you are a full-time Benefits-Eligible Associate, Long-Term Disability (LTD) coverage is automatically provided at no cost to you, regardless of whether you are enrolled in the medical plan. If approved, LTD benefits may be paid following the below schedule:

Day 182+
60% of base pay (up to $25,000 per month)

If your long-term disability is approved, you'll be paid an income equal to 60% of your base salary**, up to a maximum annual benefit of $300,000 ($25,000 per month). This amount will be coordinated with other sources of compensation, including Workers' Compensation, Social Security, federal, and state or Employer-Sponsored Plans. LTD benefits are coordinated with Social Security benefits for you and your family members attributable to your disability. LTD does not include a percentage of overtime, bonuses or any other special form of payment. This means that the total combined monthly benefit you receive from the LTD plan and from the above sources of disability income will be 60% of your pre-disability monthly base earnings.

LTD benefits are insured by Lincoln Financial Group (LFG). All determinations regarding eligibility and benefits are by LFG. Your pay will be sent by LFG directly to your home.

Federal and state tax deductions are voluntary and must be requested by contacting LFG.

*STD and LTD benefits are subject to review and approval by LFG according to established duration and treatment guidelines

**Base pay is determined by your rate of pay as of the beginning of your leave. until

How LTD Benefits are Paid

LTD benefits will continue as long as you remain totally and permanently disabled, until your Social Security normal retirement age or, if later:

Age When You Become	Duration Of Benefits (In Years)	Age When You Become	Duration Of Benefits (In Years)
61 or less	to age 65	66	1 3/4
62	3 1/2	67	1 1/2
63	3	68	1 1/4
64	2 1/2	69 or more	1
65	2		

To receive LTD benefits, you must be under a doctor's care and be determined by the Claims Administrator to be unable to perform the material duties of your job. Benefits continue under this definition for 24 months. After that, you may continue to receive LTD benefits if the Claims Administrator determines you to be "totally disabled." All disabilities are subject to periodic review and additional ongoing medical certification.

If you do not pursue Social Security benefits within the established timeframe, the Social Security benefits that the Claims Administrator estimates you and your family Members would be eligible to receive may be deducted from your LTD benefit payments.

Important Notes

- If you receive STD benefits, it does not guarantee you'll be approved for LTD benefits.
- If you work in a state that has a state disability or paid medical leave benefit, your disability benefits will be reduced by the amount payable under the state program. Except for associates working in New York or Hawaii, it is the associate's responsibility to apply for and coordinate directly with the state to receive the state benefits. Please contact the state agency responsible for administration of these benefits as soon as possible. If you are awarded statutory benefits, you must provide a copy of your award letter to Lincoln Financial to calculate your benefits due under the company paid disability program. Until Lincoln Financial receives the awards letter, your disability pay will be reduced by an estimated amount.
- In no instance will the combined state and Bath & Body Works benefit exceed the applicable STD/LTD pay schedule. Contact LFG for more information.

Limitations and Exclusions

LIMITATIONS: A pre-existing condition is any sickness or Injury that began or occurred during the three months immediately prior to the Effective Date of insurance (LTD coverage). This includes conditions for which an Associate received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines during the three months immediately prior to their Effective Date of insurance (LTD coverage). If you become disabled during your first 12 months of coverage and the disability is a result of (in whole or in any part) a pre-existing condition, you will not be entitled to LTD benefits.

If your LTD claim is denied under the pre-existing clause, you must return to work full-time before you can file another claim for the same condition.

MENTAL HEALTH/SUBSTANCE ABUSE: Benefits for disabilities resulting from alcoholism, drug addiction, chemical dependency or mental and/or nervous disorders are subject to a lifetime limit of 24 months.

EXCLUSIONS: Our LTD plan does not cover disabilities due to any of the following:

- Intentionally self-inflicted injuries.
- Act of war, declared or undeclared.
- Pre-existing conditions.
- Injury, sickness or pregnancy not treated by a doctor.
- Injury incurred while committing or attempting to commit a felony.
- Injury or sickness incurred while confined in any penal or correctional institution.

PARTIAL DISABILITY: You may have instances in which you are placed on partial Disability Leave or are released for a partial return to work. In these instances, you should work with your manager and human resources department to determine what work you are able to do and what restrictions are to be placed on your work routine and hours. These restrictions must be put in writing by a licensed Doctor and submitted to LFG. Partial disability may be used during both STD and LTD periods.

CONTINUING BENEFITS DURING DISABILITY: You may continue your medical, dental, vision, life insurance and legal, benefits while you are on an approved leave of absence provided you timely pay the applicable premiums. Please refer to the Leave of Absence Guide at **mybbwbenefits.com** under Resources.

Group Legal Plan

We make it easy for you to get the quality, affordable legal help you need with our Group Legal Plan, provided through ARAG. If you are a full-time, benefits-eligible associate, you may enroll in and pay for legal insurance benefits for you and your dependents.

The Group Legal Plan helps you address everyday situations, like dealing with traffic tickets, resolving warranty issues or buying a home.

When you need help, don't waste time looking for the right attorney or paying costly attorney fees. Like health insurance, legal insurance offers:

- **PROTECTION:** Feel secure knowing if you or one of your dependents suffered a serious legal issue, your assets would be protected.
- **PREVENTION:** Legal insurance will help you gain and maintain your legal health by offering legal preventive maintenance services – like wills and estate planning.
- **CONVENIENCE:** Enroll in legal insurance through HR Access.
- **COVERAGE:** As an ARAG member, you have access to professional Network Attorneys, financial planners and other valuable resources.

You'll simply pay the $8.78 biweekly contribution for legal coverage - with no co-pays or deductibles required. Additionally, when you work with a Network Attorney for a covered legal matter, you don't pay any attorney fees for legal consultation, office work or representation.

Your legal insurance covers both contested and uncontested matters, plaintiff and defendant issues, which means lower out-of-pocket costs for you compared to other legal insurance.

When you enroll, you get:

- In-office access to a nationwide network of more than 10,000 credentialed attorneys.
- Phone access to a Network Attorney for unlimited legal advice to help prepare documents, letters or a Will.
- You can use DIY Docs® to help you create any of 300+ state- specific, legally valid documents online.

How to Find a Network Attorney

To determine if your attorney is a part of the ARAG Network or to locate an attorney in the ARAG Network:

- Log on to **www.ARAGLegalCenter.com** and enter Access Code: 15661bbw
- Click on **Plan Details** scroll down and select **Search the Attorney Finder**

If you choose to use a non-network attorney, you can still receive coverage for the amount listed in the certificate of insurance. Contact ARAG's Customer Care Center at 800.247.4184 for a list of covered services and amounts.

Access Legal Help on the Go!

You can use the ARAG Legal app to start a case, find an attorney, view attorney ratings and sort attorney search. You can also contact an ARAG Customer Care specialist directly from the app to get help with your coverage or claims questions. Plus, you can create state-specific legal documents, such as a will or power of attorney. Just search for "ARAG Legal" on the App Store or Google Play.

Waiver Of Premium

If a military member who participates in the plan is called away on active duty, they receive a Waiver of Premium. Or if a plan member should die while enrolled in the plan, their dependents can remain in the plan with the premium waived for the remainder of the policy year.

For More Information on the Group Legal Plan

Talk to an ARAG Customer Care Specialist toll-free from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday at 800.247.4184.

Visit **ARAGLegalCenter.com** and enter Access Code: 15661bbw for more information, including a complete list of covered services and coverage levels.

Leaves of Absence

Applying for a Family/Medical Leave

When you need to be off work for family, medical, maternity or parental leave, notify your manager and then follow the steps below to request a leave of absence. Depending upon your eligibility, you may qualify for a leave under the Family Medical Leave Act (FMLA) or Company Medical leave. Your leave will be managed by Lincoln Financial (LFG), our disability/FMLA provider.

1. Call Associate Connect at 1-866-473-4728 and follow the prompts or
2. Call Lincoln Financial Group (LFG) at 1-844-869-3454; or
3. Log on to **mylincolnportal.com**, Company code: BBWI (first time users)
4. Have the following information available when you make your request:
   A. Reason for absence (symptom or diagnosis)
   B. Medical care provider's name, address, telephone and fax numbers
   C. Last day worked, first day of absence and anticipated return to work date
5. LFG will determine your eligibility and notify you regarding next steps. You must provide required documentation within the timeline given to you. Failure to do so may result in the delay or denial of leave and/or benefits and, in some circumstances, violations of the Company's attendance policy.

Types of Family/Medical Leaves Family & Medical Leave Act (FMLA)

ELIGIBILITY: FMLA leave is governed by applicable law. Eligible Associates must have at least 12 months of service and at least 1,250 hours worked in the 12 months prior to the requested leave.

ENTITLEMENT: Under the FMLA, you may be eligible to take up to 12 weeks of unpaid leave during a 12-month period for your own or a family member's serious health condition, to bond with a new child, to manage activities related to a call to active military duty, or to take a one-time leave of up to 26 weeks to care for a Covered Service Member of the Armed Forces.

FMLA LEAVE IS FOR:

- Eligible Associates who have new children, whether through birth, adoption or foster care.
- Eligible Associates who have a serious health condition as defined by the FMLA
- Associates who need to care for a spouse, son, daughter, or parent with a serious health condition as defined by the FMLA
- Associates who need to support a spouse, parent, or son or daughter who is on or called to active duty in the Armed Forces (including the National Guard and Reserves).
- Associates who need to care for a spouse, son, daughter, parent or next of kin who is a covered service member with a serious injury or illness suffered in the line of duty.

CALCULATION: The company uses a rolling year method to calculate how much FMLA leave you have to use. Under this method, each time you request FMLA leave, the company measures back 12 months from your first date of absence. You would be eligible for the FMLA leave not used in the preceding 12-month period. For example, if you used 3 weeks of FMLA in the preceding 12 months you would be eligible to use the remainder of 9 weeks.

LFG will let you know if you qualify under the FMLA and how much time you have available. In some cases, you may request that FMLA leave be taken on a reduced leave schedule (shorter work hours or a shorter work week) or intermittent basis.

Please be aware that we may ask for a second opinion, or, in some circumstances, a third opinion. It is your choice if you want to cover your leave with PTO or have it be unpaid. You may also apply for Short-Term or Long-Term Disability to provide for wage replacement during your leave (See Short and Long-Term Disability Pay).

DEFINITION OF SERIOUS HEALTH CONDITION: For purposes of this policy, a "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

GENERAL INFORMATION: The FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

An associate may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. The FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Company Medical Leave

(for non-FMLA eligible Associates) Associates who need leave for their own serious health condition and are not eligible under the FMLA or a similar state protected leave may request a company provided medical leave of absence ("Company Medical Leave"). Company Medical Leave covers continuous absences due to illness or injury of 8 or more consecutive days and must be supported by medical documentation from a doctor. It is not for short-term illnesses of 1-7 days such as a cold, stomach flu, etc. and may not typically be used for intermittent leave. Generally, this leave type is unpaid unless you choose to substitute PTO or any sick leave that is available to you. The Company may in its sole discretion fill your role while you are on Company Medical Leave. Please also refer to our policy for "Leaves Greater than 12 Months". You may also apply for Short- Term or Long-Term Disability to provide for wage replacement during your leave (See Short and Long-Term Disability Pay).

State Sick Leave

You may work in a state that provides paid leave time for sickness or other issues. Log on to HR Access > Benefits > Benefits Information to see if you are eligible for paid sick leave. If you are eligible for any such leave and you want to use it, talk to your manager and Associate Connect.

Maternity Leave and Parental Leave for Birth Mothers

We think it's important for you to take time off from work to bond with your new family member. The Maternity Leave and Parental Leave benefits for new parents allow you to take time off, with full pay, to bond with your child. Full time Associates who give birth (Birth Mothers) are eligible for a total of 14 weeks of job protected paid Maternity Leave and Parental Leave combined, unless entitled to additional leave under state or local law.

ELIGIBILITY: Immediate for Associates who are actively employed in a full time, benefits-eligible position at the time of birth.

MATERNITY LEAVE (FIRST 8 WEEKS):

- Birth Mothers may take 8 weeks of paid Maternity Leave.
- Maternity Leave begins on the day you deliver.
- If you experience a medical complication that requires your leave to start early, you may apply for a medical leave (See Short and Long-term Disability pay to learn about income replacement during that time.)
- If you would like to voluntarily take time off prior to the start of your maternity leave, you may do so with manager approval using PTO time.
- Once Maternity Leave begins, it runs consecutively for 8 weeks.

PARENTAL LEAVE FOR BIRTH MOTHERS (6 ADDITIONAL WEEKS):

- Following Maternity Leave, Birth Mothers may also take 6 weeks of paid Parental Leave.
  - Six weeks is the maximum amount of Parental Leave for each birth/adoption event, regardless of whether that birth event includes multiple births.
  - Parental Leave must be taken within 6 months of the birth of the baby.
  - You may take all 6 weeks immediately following Maternity Leave or split the total time once within the 6-month period (coordinate with your manager). If you split the time, the minimum leave period allowed is a 5-day increment.
  - Example: Associate takes 8 weeks of Maternity Leave, followed immediately by 2 weeks of Parental Leave and then decides to return to work. One month later, she takes the remaining 4 weeks of Parental Leave, assuming the request has been coordinated with her manager.

ADDITIONAL PROGRAM INFORMATION – MATERNITY AND PARENTAL LEAVE: Paid at 100% of your base rate of pay in effect as of the beginning of your leave (taxes and standard deductions will still apply).

  - If you earned a merit increase while on leave, you will receive your increase and any applicable retro-active payments as soon as administratively feasible upon your return.
- Special Note: If you work in a state that has a state disability or paid medical leave benefit, your maternity leave/parental leave benefits will be reduced by the amount payable under the state program. Except for associates working in New York or Hawaii, it is the associate's responsibility to apply for and coordinate directly with the state to receive the state benefits. Please contact the state agency responsible for administration of these benefits as soon as possible. If you are awarded statutory benefits, you must provide a copy of your award letter to Lincoln Financial in order to calculate your benefits due under the company paid maternity/parental leave program. Until Lincoln Financial receives the awards letter, your maternity pay will be reduced by an estimated amount.
- Your leave may cross over in to the following calendar year.
- You will not be paid out for any unused Maternity or Parental Leave, either during or after your employment.
- You are responsible for filling out any forms or submitting any documentation required to receive payment during your leave or to otherwise process your request. Failure to complete the required documentation may result in a denial of leave and/or a disruption in pay.

COORDINATION WITH OTHER PROGRAMS:

- Government benefits, such as FMLA, state leave entitlement or disability payments, will run concurrently with Maternity and Parental Leave and vice versa, and all statutory requirements and limitations will apply. Where government benefits are more generous than this policy, the government policy will apply.
- Example: A birth mother who is FMLA eligible who takes 8 weeks of Maternity Leave followed immediately by 6 weeks of Parental will also be using 12 weeks of FMLA leave at the same time.
- Where government benefits provide for unpaid Maternity/Parental Leave in excess of 14 total weeks, the first 14 weeks will be paid pursuant to this policy, and any remaining time will be provided as unpaid leave pursuant to the applicable law.
- Where government benefits allow unpaid Maternity/Parental Leave to be taken outside of the first 6 months after the birth (e.g. FMLA bonding leave), Associates may choose to do so, instead of taking paid Maternity or Parental Leave during the first 6 months after the birth.
  - Example: A birth mother who is FMLA eligible delivers on August 1 and returns to work 8 weeks later. She has used 8 weeks of FMLA leave and 8 weeks of paid Maternity Leave, running concurrently. She chooses to go back on leave on March 1, more than 6 months after the baby was born. She has up to 4 weeks of FMLA leave remaining, but that time will be unpaid. The remainder of the paid Parental Leave is forfeited since it was not taken within 6 months of the baby's birth.

Bath & Body Works Parental Leave for Non-Birth Parents

Full-time Associates who are non-birth mothers, fathers, and adoptive parents are entitled to 6 weeks of job protected paid Parental Leave, unless entitled to additional leave under state or local law.

ELIGIBILITY: Immediate for Associates who are actively employed in a full time, benefits-eligible position at the time of birth or adoption.

Program Details

Paid at 100% of your base rate of pay in effect as of the beginning of your leave (taxes and standard deductions will still apply).

- If you earned a merit increase while on leave, you will receive your increase and any applicable retro-active payments as soon as administratively feasible upon your return.
- Qualifying events include birth and placement after adoption (or with intent to adopt) or following surrogacy birth. The Company reserves the right to request proof of birth or placement.
- To be eligible for Parental Leave, the adopted child must be under age 18.
- Parental Leave must be taken within 6 months of the birth or adoption of your child.
  - You may take all 6 weeks immediately following the birth or adoption, or
  - You may split the total time once within the 6-month period (coordinate with your manager). If you split the time, the minimum leave period is a 5-day increment.
  - Example: Associate takes 3 weeks following the birth or adoption, returns to work for one month, and then takes the remaining 3 weeks.
- You can begin using Parental Leave the day the baby is born or the child is placed with you. Documentation of intent to adopt may be required.
  - Flexible arrangements may be considered for adoption based on travel or other circumstances. Contact your HR partner if you believe you need such flexibility.
- Six weeks is the maximum amount of Parental Leave for each birth/adoption event, regardless of whether that birth event includes multiple births.
- Your leave may cross over into the following calendar year.
- You will not be paid out for any unused Parental Leave, either during or after your employment.
- You are responsible for filling out any forms or submitting any documentation required to receive payment during your leave or to otherwise process your request. Failure to complete the required documentation may result in a denial of leave.
- If the parents are both BBW Associates, each associate is eligible for six weeks of Parental Leave.

COORDINATION WITH OTHER PROGRAMS:

- Government benefits, such as FMLA, state leave entitlement or disability payments will run concurrently with Parental Leave and vice versa, and all statutory requirements and limitations will apply. Where government benefits are more generous than this policy, the government policy will apply.
  - Example: An adoptive father who is FMLA eligible who takes 6 weeks of Parental Leave immediately following the adoption of his child will also be using 6 weeks of FMLA leave at the same time.
- Where government benefits provide for unpaid parental leave in excess of 6 weeks, the first 6 weeks will be paid pursuant to the company Parental Leave policy, and the remaining time will be provided as unpaid leave pursuant to the applicable law.
- Where government benefits allow unpaid parental leave to be taken outside of the first 6 months after the birth or adoption of a child (e.g. FMLA bonding leave), Associates may choose to do so, instead of taking paid Parental Leave during the first 6 months after the birth or adoption.
  - Example: A father who is FMLA eligible has a child born on August 1 and returns to work 2 weeks later. He has used 2 weeks of FMLA leave and 2 weeks of paid Parental Leave, running concurrently. He chooses to go back on leave on March 1, more than 6 months after the baby was born. He has up to 10 weeks of FMLA leave remaining, but that time will be unpaid. The remainder of the paid Parental Leave is forfeited since it was not taken within 6 months of the baby's birth.

PLEASE NOTE: f you want to cover your child in the health or welfare plans, you must call Associate Connect to add your child within 30 days of the birth or adoption. If you do not add your child within the first 30 days, you will not be able to enroll the child for coverage until the next Open Enrollment period.

Coverage is not automatic. You must call Associate Connect at 1-866-473-4728 to enroll or no coverage will be provided.

Pay During a Family/Medical Leave

If you are a full-time benefits-eligible Associate and are requesting leave for your own health condition, you might be eligible to receive pay through the Short or Long-Term Disability programs. (See Short and Long-Term Disability Pay). A full-time or part time Associate might also be eligible for state provided paid leave, depending on which state you work in (see HR Access>Benefits>Benefits Information). For pay after birth or placement of a child, see Maternity Leave and Parental Leave.

Foster Care Leave

Full-time benefits eligible Associates may qualify for paid Foster Care Leave if a child has been placed into your care through foster care by a state or county agency or gaining temporary custody of a child(ren) through a kinship program by the county or state. Eligible associates can take up to one week of paid leave per placement, for a maximum of three weeks of paid leave in a rolling twelve month period.

Military Leave

Military Leave permits full-time and part-time Associates to fulfill their military obligations as members of the Uniformed Services in accordance with federal and state laws. This includes, but is not necessarily limited to, service in the Army, Navy, Air Force, Marines, Coast Guard, National Guard, Reserves, National Medical Disaster Service, or the commissioned corps of the Public Health Service. Military leave allows associates to be away from their job for training and/or active military service for up to five years (and sometimes longer depending upon the type of service) with the right to re- employment and without loss of length-of-service credit. If you need a Military Leave, please inform your manager and then contact Associate Connect at 1-866-473-4728. You will need to provide notice of your need for leave as soon as possible so that we have time to find someone to fill in for you while you're gone and make certain you are paid, when applicable.

ANNUAL MILITARY TRAINING: Full-time and part-time Associates, may be given a leave of absence with partial pay when required to participate in military training. The company will pay you the difference between your weekly base compensation with the company and your base military pay for up to 30 days of training per Calendar Year. Part-time Associates' base compensation is calculated on an average of the last 12 weeks of earnings prior to their military training.

Associates participating in military trainings can be paid one (1) day when missing a scheduled shift due to travel, upon request. Associates are eligible to be paid one (1) day of travel before and/or upon returning from training. An associate is eligible for travel pay if the training is 200 miles or greater from their home. The requested travel day will be considered part of the eligible 30 days of military training pay and must be requested in conjunction with the differential pay. Please submit your training orders/paystubs as soon as possible, using the contact information below.

PAY WHILE ON MILITARY SERVICE LEAVE: If you are on a long-term military assignment, you will be paid the difference between your weekly base compensation and your base military pay according to the below chart:

Length of Service	Pay Duration
Less than 2 years of consecutive service	Up to 6 Months
More than 2 years of consecutive service	Up to 12 Months

Part-time Associates' base compensation is calculated on an average of the last 12 weeks of earnings prior to your Military Leave. Once you return from military service for a period of one year or greater, you may again qualify to receive pay differential during a subsequent long-term military assignment.

Please submit your military/training orders to Associate Connect prior to your leave begin date unless military rules or regulations make this impossible, in which case please submit your orders as soon as practicable. In addition, please submit your military paystubs, if applicable, in order to be reviewed for military pay differential to the following:
Email: **BBWLOA@bbw.com** | Fax: 917-522-7589

Please contact Associate Connect at 1-866-473-4728 with any questions. After your military service, you will be eligible for reinstatement in accordance with federal and state law provided you have documentation showing you have completed your military service in a satisfactory manner. You must also apply for reinstatement within the time period established by federal and state law.

BENEFIT COVERAGE WHILE ON A MILITARY SERVICE LEAVE: You may choose to remain on the company's health, vision and dental plans for you and your dependents for up to 24 months of your military service at full cost through COBRA. Otherwise, all benefit coverage except for company provided basic term life insurance will end on the 30th day after your last day of work before your leave. Basic term life insurance will continue while you are on Military Leave. Optional life insurance for yourself, Spouse, Domestic Partner or Dependent(s) will not continue while on Military Leave.

HOW MILITARY LEAVES AFFECT PTO: Contact Associate Connect to discuss your PTO benefits during Military Leave.

Personal Leave

After 30 days of service, both full-time and part-time Associates may request a Personal Leave of Absence. Generally, any approved Personal Leave of Absence will be unpaid, unless you request PTO (or use of PTO is required by the approving manager). Generally, personal leaves will not exceed 120 days. Approval is not automatic. Your manager and HR Partner, if applicable, must approve your request for Personal Leave. Your performance and service with the company, the reason for the leave, and whether business conditions can support your time away will all be considered. Examples of reasons a Personal Leave may be granted include a family member or domestic partner or children of domestic partner's serious illness, extended overseas family visits, or catastrophic personal events.

TO REQUEST A PERSONAL LEAVE:

1. Contact Associate Connect at 1-866-473-4728 to request a Personal Leave packet.
2. Request a personal leave from your manager.
3. Return completed forms, with manager and HR approval, to Associate Connect.

Bereavement Leave

Full-time benefits-eligible Associates with at least 30 days of service may take Bereavement Leave with pay. If you are a part-time Associate or an Associate with less than 30 days of service and need to take Bereavement Leave, your time off will be unpaid.

Bereavement Leaves are available in the event of the death of a specified family member.

- You may take up to 80 hours of leave for normal scheduled missed shifts following the death of your Spouse, Domestic Partner, parent or child.
- You may take up to 40 hours of leave for normal scheduled missed shifts following the death of your Spouse's or Domestic Partner's child or parent, or your or your Spouse's or Domestic Partner's grandchild, grandparent, sister, sister-in-law, brother or brother-in-law.
- You (the associate) may take up to 3 days off if you experience a miscarriage.
    - Associates who work in California may be entitled to up to 5 days of unpaid leave if the associate, associate's spouse, associate's domestic partner, or other individual who would have been a parent of a child born recently experienced a reproductive loss event (e.g., miscarriage, still birth, unsuccessful assisted reproduction, failed adoption, or failed surrogacy). Contact Associate Connect at 866-473-4728 with any questions.
- Bereavement leave must be taken within 30 days of the passing of the family member. If you need to use bereavement outside of 30 days, please see your manager and/or HR partner.

Time off to attend the funeral or service of another individual may be taken using PTO or unpaid time off.

TAKING BEREAVEMENT LEAVE:

- If you need to take time off to attend a funeral or service, your manager will code bereavement hours in the payroll system, so you are appropriately paid.
- Prior to approving pay for the Bereavement Leave, your manager may request proper verification of the funeral/service, date, location and, where applicable, verification of Domestic Partnership. See Covering a Domestic Partner in the Health Benefits Book to view what constitutes a Domestic Partner under this policy.
- The company understands the deep impact that death can have on an individual or family. If you face circumstances that requires additional time off, PTO may be used or unpaid time off may be granted. Please work with your manager prior to taking time off.

Emergency Leave

Full-time benefits-eligible Associates with at least 30 days of service may receive from one- to three-days of Emergency Leave with full pay. If You are a part-time Associate or an Associate with less than 30 days of service and need to take emergency leave, your time off will be without pay from the company.

Emergency Leave is for sudden and unexpected events such as the critical illness or Injury of a family member. This includes your spouse/ domestic partner, parents, children, grandparents, grandchildren, sisters, sisters-in-law, brothers, and brothers-in-law of either you or your spouse/ domestic partner. Your own illness, staying home to care for a sick child, lack of transportation or issues with available child care are NOT examples of needs for Emergency Leave. Emergency Leave will not be provided during a period of time in which an Associate is already absent from work on a paid or unpaid leave of absence. To request Emergency Leave, contact your manager. You must inform your manager of your situation before you are scheduled to report to work. Your manager may ask for documentation.

Jury & Witness Duty

If you have been summoned to serve as a juror or witness in court and you are a full-time benefits-eligible Associate with at least 30 days of service, we will pay you for regularly scheduled hours while on jury duty. If you are a part-time Associate or an Associate with less than 30 days of service and have been summoned to serve as a juror or witness in court, your time off will be without pay from the company, unless otherwise required by applicable law.

You must provide a copy of your summons to your manager as soon as possible after receipt of the summons. If your day ends early, we ask that you report back to work. You will not be paid when you are required to appear in court as a result of your own personal situation unless you use PTO or other paid leave.

Additional Leave Details

RETURNING FROM LEAVE:

- For leaves longer than two weeks, please check in with your manager two weeks before the date your leave expires. If your leave was shorter than two weeks, please check in a day or two before your leave ends.
- For Medical Leaves, call LFG on your first day back to work. (Store Associates: Your information will not appear in the scheduling system for up to 48 hours after your return to work.)

For all leaves, if we don't hear from you at the end of your approved leave, we'll assume that you have resigned and your employment will be terminated. For information regarding your COBRA, re-hire status, and all related benefits, contact Associate Connect at 1-866-473-4728.

JOB PROTECTION: Whether or not your old job will be waiting for you upon your return from leave depends upon a variety of factors, including your situation, business needs, and the type of leave you took. When appropriate, you may be able to return to work on a part-time basis provided we have a position available that suits your needs and ours.

HERE ARE THE DETAILS FOR SOME SPECIFIC SITUATIONS:

- **FMLA Leave or Maternity/Parental Leave:** If you are on an approved FMLA leave or Maternity/Parental Leave and come back within the FMLA 12-week leave (26 weeks for Caregiver Military Leave), 14-week Maternity Leave, or state law permitted period, you'll have your old job back, or an equivalent position with comparable benefits and pay.
- **Military Leave:** The company follows the USERRA guidelines with respect to returning from a short or long-term military leave. Contact HRD with questions regarding your return.
- **Company Medical Leave or Personal Leave:** If you are on a leave that is not FMLA protected or otherwise legally job-protected, we will do our best to hold your job, but we cannot make any promises.

IF YOUR FORMER POSITION IS NO LONGER AVAILABLE: If your original position is no longer available when you return from leave, we may try to find you something else, and you may be offered a position as similar as possible to your former position. Depending on the kind of leave you take, we may not be required to create an opening for you. If you are being offered a new position, your pay will reflect your new position. If you decide not to accept the new position, your employment will be terminated.

SPECIAL NEEDS OR RESTRICTIONS: If you still have special needs or restrictions after your leave ends, your doctor must explain in writing anything that limits the scope of your normal job. We will work together to make any reasonable accommodations.

LEAVES GREATER THAN 12 MONTHS: If you are on an extended leave of absence (except Military Leave) and are unable to return to work after 12 months, typically your employment will end. However, we will look at individual circumstances in each case when such leave is related to a disability. If during your leave you returned to work but then went back out on leave again within 120 days, both leave periods will count toward this 12-month policy. Depending upon the circumstances, you may be eligible for rehire following termination under this policy.

TEMPORARILY WORKING ANOTHER JOB: Leaves are not granted for temporarily working another job. If this happens, your position with the company will be terminated.

INCENTIVE COMPENSATION (IC) AND BONUS PAYMENTS: If you are eligible for IC and work for at least four weeks during the season, your payment will not be impacted by the first 14 weeks of leave. If your leave of absence exceeds 14 weeks during a season, your IC payment will be prorated for any time away from work in excess of 14 weeks for that season. If you are eligible for store bonus or sales incentive programs or plans, your eligibility for payout will be determined by your brand payout policy while on leave.

MAINTAINING YOUR BENEFITS WHILE YOU'RE ON LEAVE: If you are already enrolled in benefits (e.g., health, life insurance etc.), you can continue your coverage while you are on an approved leave of absence.

Normal deductions will be taken from your short-term disability payments. However, if you are receiving long-term disability or are on an unpaid leave, you are required to submit payment for your portion of benefits premiums that would normally have been deducted. Associate Connect will send you invoices for the amounts due. Failure to make the required payments may result in the cancellation of your benefits. Please make payments on a regular basis to avoid cancellation of coverage. Any unpaid premiums will be deducted from your first paycheck upon your return to work.

WHAT HAPPENS TO YOUR FSA WHILE ON LEAVE? Payroll deductions for flexible spending accounts (FSA), both dependent and health care, stop while you are on leave if you are not receiving pay from the company. When you return to work, your payroll deductions will be increased to make up the contributions missed while you were on leave.

HOLIDAYS DURING LEAVE OF ABSENCE: If you are on a leave of absence during a company observed holiday, you will not be eligible for holiday pay.

CITY AND STATE LEAVE BENEFITS: There are numerous leave programs that are specific by city and/or state so your rights and responsibilities under city and state laws may differ. To learn more about these leaves, contact Lincoln Financial Group at 1-844-869-3454.

Key Terms

A

ACCIDENTAL INJURY: Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

ANESTHESIA: General Anesthesia: The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Local Anesthesia: The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

Anesthetic: A drug that produces loss of feeling or sensation either generally or locally.

AMBULANCE SERVICES: A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

AUTHORIZED SERVICE(S): A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. For more information, see the "Claims Payment" section.

B

BEHAVIORAL HEALTH CARE: Includes services for Mental Health Disorders, and Substance Abuse.

BENEFITS-ELIGIBLE ASSOCIATE: You are eligible to enroll in benefits if:

- You are a full-time Associate. A full-time associate is a non- seasonal associate who is classified as full-time (full-time associates are generally expected to work at least 30 hours per week).
- You are a legacy home office, distribution center or client contact center associate hired prior to January 1, 2004, or legacy store management.

In addition, if you are hired into a part-time or seasonal position, you may become benefits-eligible if you work an average of 30 or more hours per week over a 12-month measurement period. During your initial measurement period (a 12-month period ending 1 year from your date of hire), if you average 30 or more hours per week, you will benotified of your eligibility to enroll in benefits for a 12-month period. After that, your hours will be measured for a 12-month period beginning in October and ending in September to determine benefits- eligibility during the following calendar year. If you are paid on a salaried basis, you will be credited with hours based on 52 weeks worked.

Associates in Hawaii are eligible if they work 20 or more hours per week over a four week period.

BENEFIT PERIOD (CALENDAR YEAR): One year, January 1 – December 31 (also called year or the Calendar Year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

BITEWING: Dental X-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

C

CLAIMS ADMINISTRATOR: The company chooses Anthem and to be the Claims Administers for the medical plans. Other claims administrators are named in the sections of this book describing the Programs. Bath & Body Works, as the official Plan administrator, delegates discretionary authority for the administration and determination of claims and appeals to Anthem, the other Claims Administrators that administer self-insured benefits, and the insurers as Claims Administrators of insured benefits. Anthem and the Claims Administrators of other self-insured benefits do not assume any financial risk or obligation with respect to claims.

COINSURANCE: If a Member's coverage is limited to a certain percentage, for example 90%, then the remaining 10% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

COMPLICATIONS OF PREGNANCY: Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Doctor prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

COORDINATION OF BENEFITS: A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more

Plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which Plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this provision, it does not have to pay its benefits first.

CO-PAY: A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

COSMETIC SURGERY: Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

COVERED DEPENDENT: Any Dependent in a Benefits-Eligible Associate family who meets all the requirements of the Eligibility section of this book, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

COVERED CHARGES: Charges that may be used as the basis for a claim.

COVERED SERVICES: Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/ Investigative and (d) provided in accordance with such Plan.

COVERED TRANSPLANT PROCEDURE: Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

CUSTODIAL CARE: Any type of care, including Room and Board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

D

DEDUCTIBLE: The portion of the bill you must pay before your medical expenses become Covered Service. It usually is applied on a Calendar Year basis.

DENTIST: A person who is either of these:

- A licensed Dentist acting within the scope of the dental profession.
- Any other doctor furnishing dental services that he or she is licensed to perform.

DEPENDENT:

- Same or opposite-sex Spouse
- Same or Opposite-Sex Civil Union
- Children under the age of 26 through:
  - Birth
  - Legal adoption or the verifiable process of legal adoption
  - Marriage, civil union or Domestic Partnership
  - Foster care
  - Legal guardianship

COVERING A CHILD: Your child is eligible regardless of whether he or she is a student, married, eligible for coverage from his or her own job, or your tax Dependent. However, in the case of a child of your Domestic Partner or a child subject to guardianship, you may be taxed on the value of the child's benefits if he or she is not your tax Dependent.

See "Spouse - Same or Opposite-Sex Civil Union" and/or "Domestic Partner".

Coverage becomes effective the same day as the Associate.

Domestic Partner:A same or opposite-sex Domestic Partnership or civil union partnership must meet the following requirements:

- You have a legal civil union in a state that uses the civil union to formally recognize same-sex relationships or, if you don't have a civil union, you:
- are in a single dedicated relationship of at least 12 months and intend to remain in the relationship indefinitely; and

- share the same permanent residence and have done so for at least 12 months
- You are not related by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside
- Each of you are at least 18 years old
- Each of you are mentally competent to consent to a contract
- Neither of you are currently married to another person under either statutory or common law
- You are financially interdependent
- You both would sign an affidavit of Domestic Partnership and
- furnish evidence of the partnership if asked

To receive appropriate tax treatment, be sure to properly designate your Dependent partner during your benefits enrollment:

- Same-sex Spouse: for marriages in states which recognize (see "Spouse - Same or Opposite-Sex Civil Union")
- Domestic Partner: for same or opposite sex Domestic Partnerships, or for civil union partnerships

DETOXIFICATION: The process whereby an alcohol or drug intoxicated or alcohol or drug Dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug Dependent factors or alcohol in combination with drugs as determined by a licensed Doctor, while keeping the physiological risk to the patient to a minimum.

DEVELOPMENTAL DELAY: The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

DOCTOR (PHYSICIAN): Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform Oral Surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

DURABLE MEDICAL EQUIPMENT: Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

E

EFFECTIVE DATE: The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

ELECTIVE SURGICAL PROCEDURE: A surgical procedure that is not considered to be an emergency and may be delayed by the Member to a later point in time.

EMERGENCY MEDICAL CONDITION: ("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

EMPLOYER: An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer

ENDODONTICS: See Root Canal Therapy.

EXPERIMENTAL/INVESTIGATIVE: Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/ Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

Has been determined by the FDA to be contraindicated for the specific use; or

Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/ Investigative based on the criteria above may still be deemed Experimental/ Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

The scientific evidence is conclusory concerning the effect of the service on health outcomes;

The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/ Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

Documents of an IRB or other similar body performing substantially the same function; or

Consent document(s) and/or the written protocol(s) used by the treating Doctors, other medical professionals, or facilities or by other treating Doctors, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or Medical records; or

The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

F

FILLINGS: Silver Amalgam: Material used to fill cavities. It is usually placed on the tooth surface that is used for chewing because it is a particularly durable material.

Porcelain, Silicate, Acrylic, Plastic, or Composite Fillings: Materials used to fill cavities. They have less durability than Silver Amalgam Fillings, so are placed on the non-stress-bearing surfaces of front teeth because the color more closely resembles the natural tooth.

FLUORIDE: A solution of Fluorine which is applied Topically to the teeth for the purpose of preventing dental decay.

FORMULARY: A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

FREESTANDING AMBULATORY FACILITY: A facility, with a staff of Doctors, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The facility offers continuous service by both Doctors and registered nurses (R.N.s). It must be licensed by the appropriate agency. A Doctor's office does not qualify as a Freestanding Ambulatory Facility.

G

GINGIVAE: The gums or soft tissue surrounding the teeth and bone.

H

HOME HEALTH CARE: Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Doctor.

HOME HEALTH CARE AGENCY: A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Doctor. It must be licensed by the appropriate agency.

HOSPICE: A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

HOSPICE CARE PROGRAM: A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual, and social needs of the terminally ill Member and his or her covered family Members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate agency and must be funded as a Hospice as defined

by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

HOSPITAL: An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Doctors duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally: an extended care facility; nursing home; place for rest; facility for care of the aged; a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or an institution for exceptional or disabled children.

I

IDENTIFICATION CARD: The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective.

INELIGIBLE CHARGES: Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

INELIGIBLE PROVIDER: A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment.

INJURY: Bodily harm from a non-occupational accident.

INPATIENT: A Member who is treated as a registered bed patient in a Hzospital and for whom a Room and Board charge is made.

INTENSIVE CARE UNIT: A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

M

MATERNITY CARE: Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit, and the newborn infant is an eligible Member under the Plan.

MAXIMUM ALLOWED AMOUNT: The maximum amount that the Plan will allow for Covered Services you receive. For more information on Maximum Allowed Amount, see the "How to file/appeal a claim" section.

MCSO OR NMCSN – MEDICAL CHILD SUPPORT ORDER OR NATIONAL MEDICAL CHILD SUPPORT NOTICE: A MCSO or NMCSN requires you to enroll your eligible child in a health plan for which you are eligible. An order or notice must meet specific requirements and include specific information in order for it to be approved and implemented. It must include the name and last known address of you and your child, a reasonable description of the type of coverage to be provided, the period for which coverage must be provided and each program to which it applies. Bath & Body Works has procedures to determine whether to approve a MCSO or NMCSN. You may obtain a copy of those procedures, without charge, from Associate Connect.

MEDICAL FACILITY: A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this book. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

MEDICAL NECESSITY OR MEDICALLY NECESSARY: An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or Injury and that is determined by the Claims Administrator to be: Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or Injury; Obtained from a Provider; Provided in accordance with applicable medical and/or professional standards; Known to be effective, as proven by scientific evidence, in materially improving health outcomes; The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting); Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, Injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate; Not Experimental/Investigative; Not primarily for the convenience of the Member, the Member's family or the Provider.

Not otherwise subject to an exclusion under this book. The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and does not guarantee payment.

MEDICARE: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

MEMBER: Individuals, including the Benefits-Eligible Associate and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, and been enrolled for Plan benefits.

N

NETWORK PHARMACY: A registered and licensed pharmacy which participates in the Network, including mail order pharmacy.

NETWORK PROVIDER: A Doctor, health professional, Hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

NURSE-MIDWIFE: A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of the following requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Midwives.

NURSE-PRACTITIONER: A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of the following requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

NON-COVERED SERVICES: Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

O

ORAL SURGERY: Surgery pertaining to the teeth and surrounding gum tissues.

ORTHODONTIC PROCEDURE: Use of an active appliance to move teeth to correct faulty position (malposition) or abnormal bite (malocclusion).

ORTHODONTIC TREATMENT PLAN: A Dentist's report that states the class of the malposition or malocclusion and describes the recommended treatment and total estimated charges. Also includes cephalometric X-rays, study models, and any other supporting evidence that may be reasonably required. The Dentist's report must be on a form from Delta Dental.

OUT-OF-NETWORK PROVIDER: A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Doctor, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

OUT-OF-POCKET EXPENSE: The expense you are required to pay because that expense is not covered under the Plan.

OUT-OF-POCKET MAXIMUM: The maximum amount of a Member's Coinsurance payments during a given Calendar Year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services The Out-of-Pocket Maximum excludes balance billing by out-of-network providers.

P

PERIODONTAL DISEASE: A disease which weakens and destroys the gums, bone, and membrane surrounding the teeth. Periodontal Disease is the principal cause of tooth loss in people over age 30. This disease is sometimes called Vincent's Disease, Gingivitis, or Pyorrhea.

PERIODONTIST: A Dentist whose practice is limited to the treatment of Periodontal Disease.

PHYSICAL THERAPY: The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

PLAN: The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health and welfare benefits

PLAN ADMINISTRATOR: Bath & Body Works, Inc. is the Plan Administrator and, as such, is responsible for management of the Plan. The Claims Administrators are not the Plan Administrator.

PLAN SPONSOR: Bath & Body Works, Inc. is the sponsor of the Plan and, as such, has authority regarding its operation, amendment and termination. The Claims Administrators are not the Plan Sponsor.

PRE-DETERMINATION OF BENEFITS: An optional procedure used if filing claims over $300 under the dental Plan.

PREVENTIVE CARE: Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well-person care.

PSYCHOLOGIST: A person who specializes in clinical psychology and fulfills one of the following requirements:

- A person licensed or certified as a Psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

PRIOR AUTHORIZATION: The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

PROPHYLAXIS: The removal of tartar and stains from your teeth through a cleaning by your Dentist or dental hygienist.

Q

QMCSO, OR MCSO – Qualified Medical Child Support Order or Medical Child Support Order

R

REASONABLE AND CUSTOMARY CHARGES: The benefits available for eligible dental expenses, as determined by the Claims Administrator.

REASONABLY NECESSARY: Customary dental care services.

Retail Health Clinic: A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Doctor Assistants and Nurse Practitioners.

ROOM AND BOARD: The term includes room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Doctor nor special nursing services rendered outside of an Intensive Care Unit by whatever name called.

ROOT CANAL THERAPY: The treatment of a tooth with a damaged pulp. This is usually performed on the pulp, sterilizing the pulp chamber and root canals, and filling the spaces with sealing material. Also called Endodontic Therapy.

S

SKILLED CONVALESCENT CARE: Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

SKILLED NURSING FACILITY: An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

SPOUSE - SAME OR OPPOSITE-SEX: Meets the following requirements: legally married in a marriage recognized by the IRS for federal income tax purposes.

SUBSTANCE ABUSE OR CHEMICAL DEPENDENCY: Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Substance Abuse services include:

Substance Abuse Rehabilitation Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment Plans;

Substance Abuse Residential Treatment which is specialized 24-hour care that occurs in a licensed Residential Treatment Center (RTC) or intermediate care facility. It offers individualized and intensive treatment in a residential setting and includes:

- observation and assessment by a psychiatrist weekly or more frequently; and an individualized program of rehabilitation, therapy, education, and recreational or social activities in compliance with existing law.

Residential Treatment provides an intermediate-term approach to treatment that attempts to return the patient to the community.

Substance Abuse Services within a General Hospital Facility (a general Hospital facility that provides services, on an Inpatient, 24-hour basis, for medical Detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

T

THERAPEUTIC EQUIVALENT: Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

TOPICAL: Dental procedures performed on the surface of something. Fluoride treatment is Topical, because it paints the surface of teeth. Some Anesthetic treatments are also Topical because they are applied as a cream-like Anesthetic formula to the surface of the gum.

TRANSPLANT PROVIDERS: Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee of the Claims Administrator. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to: certain Covered Transplant Procedures; or all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

U

URGENT CARE: Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

UTILIZATION REVIEW: A function performed by the Claims Administrator or by an organization or entity selected by the Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

Administrative Information

Summary Plan Description

This book is the official Summary Plan Description for the Bath & Body Works Health and Welfare Benefits Plan for and Benefits-Eligible Associates and is current as of January 1, 2025.

Not all the details of the Bath & Body Works Health and Welfare Benefits Plan are provided. For more information about the Plan documents, refer to the section, ERISA. For complete and total details, please consult the official Plan documents and group disability, vision, life insurance and legal services policies, available by contacting Associate Connect.

We have the right to change or discontinue all or any part of the health and welfare benefits program at any time. The Summary Plan Description does not create a contract of employment.

See Bath & Body Works ERISA Plans in the chart on page 66.

If you want a paper copies of this book, legal notices and/or any other materials related to your benefits, call Associate Connect at 1.866.473.4728 to request that a free paper copy be mailed to you.

ERISA

STATEMENT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare Plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this document.

You may examine, without charge, all Plan documents including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Employee Benefit Security Administration (EBSA). You can examine copies of these documents in the Plan Administrator's office, or you can ask your manager where copies of the documents are available.

If you want a personal copy of the Plan documents or related materials, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You are also entitled to:

- Receive a statement that tells you your accumulated balance under the Bath & Body Works 401(k) Savings and Retirement Plan and the number of years you have to work before you have the right to receive your account balance. This statement must be requested in writing and is not required to be given more than once a year. The company must provide this statement free of charge.
- Continue health care coverage for yourself or enrolled dependents if there is a loss of coverage under the medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description to determine your COBRA continuation coverage rights.
- Benefit from the Newborns' and Mothers' Health Protection Act.
- In connection with a birth, you are allowed benefits for hospitalization of a mother and newborn not below 48 hours for a normal delivery (or 96 hours for cesarean sections), unless the attending medical professional in consultation with the mother approves an earlier discharge. Additionally, the medical Plan does not use financial incentives or financial or other penalties to discourage mothers from seeking or doctors from providing such care.
- Benefit from the federal Women's Health and Cancer Rights Act of 1998. The medical Plan covers certain elective reconstructive surgical procedures for you in connection with a mastectomy. In a manner determined in consultation with the treating Doctor, the medical Plan provides benefits for: reconstruction of a breast on which a mastectomy was performed; reconstruction of another breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Associate benefit Plan. These individuals, called fiduciaries, have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The Claims Administrators, listed on page 64, are fiduciaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining or receiving benefits or exercising your rights under ERISA. When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the 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 Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is ignored, or a final appeal which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are 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. For example, if you are successful, the court may order the person who was sued to pay these costs and fees. If you lose, or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.
- If you have questions about the Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERlSA, or if you need assistance in obtaining Plan documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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.

BENEFIT PLANS INFORMATION

NAMES AND NUMBERS

All benefits programs identified with Plan number 501 below are part of the Bath & Body Works Health and Welfare Benefits Plan and are sponsored by Bath & Body Works Inc.

PLAN AMENDMENT AND TERMINATION

Bath & Body Works reserves the right to modify, suspend, or terminate any benefits Plan at any time. Bath & Body Works does not promise the continuation of any benefits, nor does it promise any specific level of benefits at or during retirement. Any benefits, rights, or obligations of participants and beneficiaries under any Plan following employment termination are described in detail in the body of this document.

SOURCE OF CONTRIBUTIONS AND FUNDING

All benefits under the Plans (except Savings and Retirement Plan) are funded by Bath & Body Works Inc. as described below

The company's contribution toward the cost of each Plan is at a rate determined by Bath & Body Works.

All benefits programs identified with Plan number 501 below are part of the Bath & Body Works Health and Welfare Benefits Pl-an and are sponsored by Bath & Body Works Inc.

	BATH & BODY WORKS BENEFIT PLANS								
	Medical	**Dental**	**Vision**	**Legal**	**Life Insurance**	**Long-Term Disability**	**Employee Assistance Program**	**Health Advocate**	**Healthcare FSA**
ID number	31-1048997								
Plan Number	501								
Plan Sponsor	Bath & Body Works, Inc.								
Type of Plan	Welfare Benefit Plan								
Plan Year	Calendar Year								
Plan Administrator	Bath & Body Works, Inc. 3 Limited Parkway Columbus, OH 43230								
Funding Arrangement	Self-Insured	Fully-Insured	Fully-Insured	Fully-Insured	Fully-Insured	Fully-Insured	N/A	N/A	N/A
Claims Administrator and/or Insurer	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348	Dental Director Delta Dental P.O. Box 30416 Lansing, Michigan 48909-7916	Vision Service Plan Member Services 3333 Quality Drive Rancho Cordova, CA 95670	ARAG 400 Locust Street, Suite 480 Des Moines, IA 50309	Lincoln Financial Group Group Life Claims P.O. Box 2578 Omaha, NE 68172-9688	Lincoln Financial Group 8801 Indian Hills Drive Omaha, NE 68114	ComPsych GuidanceResources NBC Tower 455 N. Cityfront Plaza Drive, 13th Floor Chicago, IL 60611-5322	Health Advocate 3043 Walton Road, Suite 150 Plymouth Meeting, PA 19462	HealthEquity®, Inc. P.O. Box 14053 Lexington, KY, 40512
Plan Costs	Paid by Associate and Company contributions	Paid by Associate and Company contributions	Paid by Associate contributions	Paid by Associate contributions	Paid by Associate and Company contributions	Paid by Company contributions	Paid by Company contributions	Paid by Company contributions	Paid by Associate and Company contributions
Agent for Service of Legal Process*	General Counsel								
Plan Benefits Funded Through	Bath & Body Works, Inc.					Bath & Body Works, Inc.			

* Process may also be served on the Plan Administrator or Trustee

** All other benefits described in this book are not covered under ERISA.

How to File/Appeal a Claim

ANTHEM CLAIM DECISION AND APPEALS PROCEDURES

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination
If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you
- For claims involving urgent/concurrent care:
- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals
You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims

Administrator at (the number shown on your identification card) and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals, P.O. Box 105568, Atlanta, GA 30348

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced while making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

How Your Appeal will be Decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level

appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review
If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at [the number shown on your identification card] and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, GA 30348

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

PRESCRIPTION DRUG CLAIMS

If a pharmacy (retail or home delivery) fails to fill a prescription that you have presented and you believe that it is a Covered Service and Supply, you may submit a pre-service claim as described in this section.

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- You pay a Co-Pay and you believe that the amount of the Co-Pay was incorrect.

Prescription drug expenses generally are not reimbursed except when the prescription was obtained at a Network Pharmacy after the Effective Date of coverage but prior to the covered individual receiving his or h 1.855.295.9142 er ID card.

Pharmacy Claim Appeals:
OptumRx
Prior Authorizations and Appeals Department
P.O. Box 5252
Lisle, IL 60532
Fax: 1.866.773.3499

DENTAL RECONSIDERATION AND CLAIMS APPEAL PROCEDURE

Reconsideration
If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure
If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but **you must file your request for review within 180 days** of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Enrollee's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary

or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice
Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling 614-644-2673 or 800- 686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 50 W. Town St., Third Floor, Suite 300, Columbus, Ohio, 4321543215 or visit the Department's website at http://insurance.ohio.gov.

VSP CLAIM DECISIONS AND APPEALS PROCEDURES

Covered Persons have the right to expect quality care from VSP Network Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670-7985
Or verbally by calling VSP's Customer Care Division at 1.800.877.7195.

VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

Initial Determination
VSP will pay or deny claims within thirty (30) calendar days of receipt. 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.

Claim Denial Appeals
If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal
The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered

Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal
If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies
When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Time of Action
No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

Adverse Determinations of a Claim for EAP Benefits
If your request for EAP benefits is wholly or partially denied, ComPsych will notify you of its denial of benefits as appropriate. ComPsych will send you a written notice that will: give the specific reason or reasons for the denial decision; identify Plan provisions on which the decision is based; describe any additional material or information necessary for an appeal review and an explanation of why it is necessary; explain the review procedure, including time limits for appealing the decision and to sue in federal court; identify your right to receive, free of charge, upon your request, any internal rules, guidelines, protocols or similar criteria relied on in making the decision; and identify your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate).

Appeals of Adverse Determinations
If you believe your request for EAP benefits was denied in error, you may appeal the decision. Your appeal must be submitted in writing within 180 days following your receipt of a denial notice to:

ComPsych GuidanceResources
NBC Tower
455 N. Cityfront Plaza Drive, 13th Floor
Chicago, IL 60611-5322

Your appeal should state the reasons why you feel your request for EAP benefits is valid and include any additional documentation that you feel supports your request for EAP benefits. You can also include any additional questions or comments. You may submit written comments, documents, records and other information relating to your appeal, whether or not the comments, documents, records or information were submitted in connection with the initial request for EAP benefits. Upon request, ComPsych will make relevant documents available.

The review of the initial decision will consider all new information, whether or not it was presented or available for the initial decision. The person who conducts the appeal review will be different from the person(s) who originally denied your request for EAP benefits and will not report directly to the original decision maker or prior reviewer.

You or your authorized representative will be notified of the appeal decision within the following time frames:

- If the appeal involves an adverse determination on a request for EAP services or a pre-service adverse determination relating to reimbursement, within thirty (30) days of ComPsych's receipt of the request for appeal.
- If the appeal involves a post-service adverse determination relating to reimbursement, within sixty (60) days of ComPsych's receipt of the request for appeal.

Appeal Decisions

ComPsych will send you or your authorized representative a written decision on your appeal. If the denial is upheld on appeal, the notice will include the following information:

- the specific reason or reasons for the denial decision;
- identification of Plan provisions on which the decision is based;
- notice of your right to receive, free of charge, upon your request, any internal rules, guidelines, protocols or similar criteria relied on in making the decision;
- notice of your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate);
- notice of your right to receive, free of charge, upon your request, reasonable access to, and copies of, all documents, records and other information relevant to the appeal; and
- notice of your right to bring a civil lawsuit under ERISA §502(a).

FLEXIBLE SPENDING ACCOUNT CLAIMS PROCEDURES

FSA claims must be submitted within 120 days following the end of the year during which the expenses were incurred. See page 47 for information on the claims procedures for flexible spending accounts.

You will be notified in writing if a claim you submit is denied. An explanation will be provided to you, including a description of any required but missing documentation. You can resubmit the claim with the required documentation without filing a formal appeal. You may file an appeal by submitting a letter describing the circumstances along with a copy of the denied claim, all documentation used to substantiate the claim, the denial letter and any further documentation to support your appeal to:

HealthEquity® Claims (Formerly WageWorks)
Appeal Board
P.O. Box 14053
Lexington, KY, 40512

Appeals are reviewed by the HealthEquity® Claims Appeal Board on a weekly basis. Additional information may be requested from you during this process. The Board's final determination will be communicated to you in writing within 60 days from receipt of your appeal.

LEGAL INSURANCE CLAIMS PROCEDURES

Notice of the claim must be submitted to the Claims Administrator within two years after your first contact with an attorney or, for legal disputes, the event that gave rise to the dispute. Also, you must file a claim form and itemized bill within 120 days after the completion of the legal services for which you are seeking payment.

Processing a Claim

When a claim for benefits is presented to the Claims Administrator, it will usually be processed within 90 calendar days after receipt of the claim. If due to special circumstances the Claims Administrator needs more time to decide a claim, it may take a 90-day extension. If an extension is taken, you will be notified of the circumstances and the date by which the Claims Administrator expects to decide the claim.

You will receive a written notice of denial if your claim is denied.

Right of Appeal

If your claim is denied, you may ask the Claims Administrator for a review. A request for review of a denied claim must be submitted, in writing, to the Claims Administrator within 60 calendar days after the date that the claim is denied. Include the claim number provided on notice of denial, the date you are submitting the appeal and identifying and contact information. You may submit any written comments, documents, records and other information relating to your claim that you think the Claims Administrator should see in connection with deciding your appeal. You have the right to

reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

ARAG
Attention: Claims
P.O. Box 93180
Des Moines, IA 50309

Review Procedure

A decision on your appeal will normally be made within 60 calendar days after receipt of your request for review. If the Claims Administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date that the Claims Administrator expects to make a decision. The extension will not exceed an additional 60 calendar days.

LEGAL CLAIMS	
Step 1	If you see a Network attorney, the attorney will directly bill ARAG for his/her attorney fees. If using a Non-Network attorney, see Step 2.
Step 2	If you choose a Non-Network ATTORNEY, you or your attorney must manually submit a claim form. ARAG will pay your attorney fees for covered legal services according to the Non-Network attorney schedule. Instructions for submitting a claim are printed on the claim form.
Step 3	To obtain a claim form for Non-Network claims, call 1.800.247.4184 or download a form at www.araggroup.com

DISABILITY CLAIM PROCEDURES

Notice of the disability must be submitted to the Claims Administrator within 30 days after the start of your disability or as soon as reasonably possible. In any event, notice of the disability must be given within one year after the start of your disability unless you are legally incapable of doing so.

Processing a Claim

When a claim for benefits is presented to the Claims Administrator, it will usually be processed within 45 calendar days after receipt of the claim. If your claim does not include necessary information, the Claims Administrator may either deny your claim or contact you to obtain the missing information. If you are contacted, you will be given a period of 45 calendar days to provide the missing information. If due to matters beyond its control the Claims Administrator needs more time to decide a claim, it may take up to two 30-day extensions. If an extension is taken, you will be notified of the circumstances and the date by which the Claims Administrator expects to decide the claim.

You will receive a written notice of denial if your claim is denied.

Right of Appeal

If your claim is denied, you may ask the Claims Administrator for a review. A request for review of a denied claim must be submitted, in writing, to the Claims Administrator within 180 calendar days after the date that the claim is denied. Include identifying and contact information. You may submit any written comments, documents, records and other information relating to your claim that you think the Claims Administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

LINCOLN LIFE ASSURANCE COMPANY OF BOSTON
Attn: Appeal Review Unit
Group Benefits Disability Claims
P.O. Box 7213
London, KY 40742-7213

The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of the individual who decided the claim). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim (or a subordinate of a health care professional who was consulted in connection with the decision on the claim).

Review Procedure

A decision on your appeal will normally be made within 45 calendar days after receipt of your request for review.

If the Claims Administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date that the Claims Administrator expects to make a decision. The extension will not exceed an additional 45 calendar days.

LIFE INSURANCE CLAIMS PROCEDURES

Processing a Claim

When a claim for benefits is presented to the Claims Administrator for payment, it will usually be processed within 90 calendar days after receipt of the claim. If due to special circumstances the Claims Administrator needs more time to decide a claim, it may take up to a 90-day extension. If an extension is taken, you will be notified of the circumstances and the date by which the Claims Administrator expects to decide the claim.

You will receive a written notice of denial if your claim is denied.

DISABILITY CLAIMS PROCEDURES	
Step 1	Call Associate Connect at 1-866-473-4728 and follow the prompts or Call Lincoln Financial Group (LFG) at 1-844-869-3454; or Log on to www.mylincolnportal.com Company code: BBWI (first time users)
Step 2	Have the following information available when you make your request: ■ Reason for absence (symptom or diagnosis) ■ Medical care provider's name, address, telephone and fax numbers ■ Last day worked, first day of absence and anticipated return to work date
Step 3	LFG will determine your eligibility and notify you regarding next steps. You must provide required documentation within the timeline given to you. Failure to do so may result in the delay or denial of leave and/or benefits and, in some circumstances, violations of the Company's attendance policy.

Right of Appeal

If your claim is denied, you may ask the Claims Administrator for a review. A request for review of a denied claim must be submitted, in writing, to the Claims Administrator within 180 calendar days after the date that the claim is denied. Include identifying and contact information. You may submit any written comments, documents, records and other information relating to your

claim that you think the Claims Administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

Lincoln Financial Group
PO Box 2578
Omaha, NE 68103

Review Procedure

A decision on your appeal will normally be made within 60 calendar days after receipt of your request for review. If the Claims Administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date by which the Claims Administrator expects to make a decision. The extension will not exceed an additional 60 calendar days.

EXPLANATION OF DECISIONS ON CLAIMS AND APPEALS

Disagreements about benefits are rare. However, if any portion of your claim is denied or if a claim denial is upheld on appeal, you will receive written explanation.

An explanation of a denial of a claim will state:

- the reasons for the denial;
- a reference to the relevant Plan provisions;
- a description of any additional information needed and an explanation of why the additional information is needed;
- an explanation of the appeal procedures; and
- a statement regarding your right to bring an action under Section 502(a) of ERISA following exhaustion of the appeal procedures.

An explanation of a denial of a medical, prescription drug, dental, vision, disability or EAP claim will also include:

- if relevant to the denial, a copy of any specific internal rule, guideline, protocol, or other similar criterion relied upon; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

An explanation of a denial of an appeal will state:

- the reasons for the denial;

- a reference to the relevant Plan provisions;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents,
- records and other information relevant to your claim for benefits;
- an explanation of any additional appeal procedures including any additional voluntary appeal procedures offered by the claims administrator; and
- a statement regarding your right to bring an action under Section 502(a) of ERISA following exhaustion of the appeal procedures.

An explanation of a denial of an appeal of a medical, prescription drug, dental, vision, disability or EAP claim will also include:

- if relevant, a copy of any specific internal rule, guideline, protocol or other similar criterion relied upon; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request; and
- If the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event a Claims Administrator offers a voluntary level of appeal, you will receive sufficient information relating to the appeal procedure to enable you to make an informed judgment about whether to submit the benefit dispute to the voluntary level of appeal. You must complete all levels of appeal under the Plan prior to participating

LIMITATION OF ACTION

The Claims Administrator (or, in the case of a second appeal of a medical claim, the Plan Administrator) will make a determination, in its sole discretion, based upon the applicable provisions of the Plan, whether to approve or deny appeals. Benefits will be paid only if the Claims Administrator decides in its discretion that a claimant is entitled to benefits under the terms of the Plan. The construction, interpretation, and application of Plan provisions are vested with the claims administrator (or Plan Administrator), in its absolute discretion, including, without limitation, the determination of facts, benefits, and eligibility.

You cannot bring any action to recover denied benefits against the Plan, the Plan Administrator or a Claims Administrator until you have exhausted all of the administrative remedies available under the Plan with the exception of any voluntary appeals offered by a claims administrator. Failure to comply with the time frames for submitting claims and appeals constitute a failure to exhaust your administrative remedies available under the Plan and precludes you from bringing any action to recover denied benefits against the Plan, the plan administrator or a Claims Administrator.

An action to recover denied disability benefits, an action to recover denied benefits against the Plan, the Plan Administrator or a Claims Administrator must be filed within three years of the date you are notified of the final decision on your claim. An action to recover denied disability benefits must be filed within three years after written proof of loss is given to the Claims Administrator. The time frame will be tolled for any period that you participate in a voluntary appeal offered by a Claims Administrator.

Coordinating With Other Plans

When you or your dependents are covered by more than one medical or dental Plan, we need to coordinate benefits. We do this by designating one Plan primary and the other Plan secondary.

Other Plans

Other Plans are any of the following types of Plans that provide health benefits or services for medical care or treatment:

- Another Employer's medical or dental Plan
- Government or tax-supported programs, but not Medicare or Medicaid

Primary vs. Secondary

The primary Plan pays benefits first. Basically, it ignores the fact that you're covered under another Plan and pays you the full benefits for which you are eligible.

The secondary Plan pays next. First, it temporarily ignores the fact that you're covered under another Plan and calculates your benefits.

Next, it takes the benefits you're due, subtracts the amount the primary Plan paid, and gives you or your provider the

difference. When your secondary Plan is through our company, the amount you can be paid in total will not be more than the Plan would have paid alone. Whenever there is more than one Plan, the total amount of benefits paid in a Calendar Year under all Plans cannot exceed more than the reasonable expenses charged for that Calendar Year. The expenses must be covered in part under at least one of the Plans.

Determining Which Plan is Primary
The following rules are used to determine which is the primary Plan and which is the secondary Plan.

Rule #1: You must provide any facts about coverage needed to pay the claim.

Rule #2: If one of the Plans does not have a Coordination of Benefits (COB) provision, the Plan without COB provisions pays its benefits first. If both Plans have COB provisions, the following rules apply.

Rule #3: If you are covered as an Associate by one Plan and as a dependent by another, the Plan that covers you as an Associate will pay the benefits first.

Rule #4: If you and your child's other parent are married (not separated) or living together, your dependent children will receive primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the primary Plan is the one that has been in effect the longest. This rule applies to Domestic Partnerships.

Rule #5: If two or more Plans cover a dependent child of divorced or separated parents (or unmarried parents living apart) and if there's no court decree stating that one parent is responsible for health care, the primary Plan is determined in this order:

1. First, the Plan of the parent with custody of the child
2. Second, the Plan of the Spouse of the parent with custody of the child (the step-parent)
3. Finally, the Plan of the parent who does not have custody of the child

Rule #6: If you have coverage as an Associate (or as a dependent of an Associate) from Bath & Body Works or another Employer and COBRA continuation coverage, the Plan that covers you as an Associate (or a dependent of an Associate) is primary and continuation coverage is secondary.

When Two Plans Pay for the Same Expense
This situation involves the rights of Subrogation and Reimbursement. The following are examples of these rights:

- If "Plan A" pays an amount that should have been paid under "Plan B," the two Plans straighten it out. "Plan B" pays "Plan A" back.
- "Plan A" then lists it as a paid benefit and will not have to pay that amount again.
- If the amount of payments made by a Plan is more than should have been paid, the Plan can take it back. It may recover funds from an individual, insurance companies or any other organization that received payment.
- If you have a claim against any third party for medical expenses paid by a Plan, the Plan has the right to recover those payments. This amount includes the reasonable cash value of any benefits provided in the form of services.

You and your dependents agree to help the Plan use this right when requested. The amount of the reimbursement will be reduced to cover your proper share and any legal fees and expenses needed to obtain the reimbursement.

Please note: Coordination of Benefits (COB) does not apply to the Outpatient Prescription Drug Benefits.

Effect of Government Plans on this Plan

If the Covered Person is also covered under a government Plan, the Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to the Covered Person under the government Plan.

This provision does not apply to any government Plan which by law requires the Plan to pay primary.

Please note: A government Plan is any Plan, program, or coverage, other than Medicare or Medicaid, which is established under the laws or regulations of any government, or in which any government participates other than as an Employer.

Effect of Medicare
When a Covered Person becomes eligible for Medicare, the Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law.

WHEN THE PLAN IS PRIMARY TO MEDICARE

The Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the Associate has current employment status with Bath &

Body Works, as defined by federal law and determined by Bath & Body Works.

- Eligibility for Medicare is due to disability and the Associate has current employment status with Bath & Body Works, as defined by federal law and determined by Bath & Body Works.
- Eligibility for Medicare is due to end-stage renal disease (ESRD)

Exception: The Plan is primary only during the first 30 months of entitlement to Medicare due to ESRD.

Medicare pays primary to the Plan if the above are not met and if so required under federal law.

EFFECT OF MEDICAID AND TRICARE

The Plan is always primary to Medicaid and TRICARE.

Subrogation & Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source.

Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The ''common fund'' doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The ''common fund'' doctrine does not apply to any funds recovered by any attorney you

hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  1. the amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Refund of Overpayments

If the Plan pays benefits to or on behalf of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the benefits under the Plan.

The refund equals the amount the Plan paid in excess of the amount it should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan obtain the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Benefit Coverage While on a Military Service Leave

You may choose to remain on the company's health, vision and dental plans for you and your dependents for up to 24 months of your military service at full cost through COBRA. Otherwise, all benefit coverage except for company provided basic term life insurance will end on the 30th day after your last day of work before your leave. Basic term life insurance will continue while you are on Military Leave. Optional life insurance for yourself, Spouse, Domestic Partner or Dependent(s) will not continue while on Military Leave.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Continuation During Family and Medical Leave

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor. During any leave taken under FMLA, the employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered employee had been continuously employed during the entire leave period. If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the employee and their covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Bath&Body Works®

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official plan documents will govern.