WESTERN GROWERS ASSURANCE TRUST
SUMMARY PLAN DESCRIPTION WESTERN
PREFERRED-ADVANTAGE
A GRANDFATHERED EMPLOYER BENEFIT PACKAGE

This Summary Plan Description (SPD) is intended to give You a working knowledge of the benefits provided by Your Employer and Western Growers Assurance Trust (WGAT). Review this SPD carefully before You need to use Your benefits. Capitalized terms throughout this SPD have specific meanings that are explained in this booklet or contained in the glossary in the back. Defined terms have the same meaning throughout this booklet.

The information in this booklet describes the general eligibility, description of Covered Expenses, Limitations and Exclusions on benefits and coverage. Additionally, the booklet provides important information on termination of benefits, continuation of coverage, how benefits are coordinated with other plans and when this Plan will subrogate and recover certain costs from a third party.

Specific benefits, such as the deductible amount, copayments, coinsurance, and annual out-of-pocket maximum can be found in the Summary of Benefits and Coverage (SBC) included with this booklet. Certain terms, benefits and other provisions described in this SPD booklet may not apply to the specific benefit package purchased by Your Employer. Whenever possible, this booklet will refer you to the SBC, your Coverage Certificate included with this SPD or to your Employer for further information. The combination of the SBC, the Coverage Certification and this booklet are intended as the Summary Plan Description for this Plan.

Your Employer has the option to select dependent coverage for this Plan through 2015 but take affirmative steps in 2015 to add dependent coverage for plan years beginning in 2016. If dependent coverage was NOT selected the references to dependent coverage do not apply and no benefits will be paid for dependents. Please see Your SBC to determine if dependent coverage is provided.

Along with knowledge of Your benefits, it is important to be aware of the most appropriate method for obtaining healthcare. Healthcare is expensive and You, the consumer, play an important part in controlling cost. Whenever possible seek outpatient care, use generic drugs, avoid the Emergency Room, and review Your healthcare bills carefully for mistakes.

Your Plan benefits increase with healthcare Providers who have contracts to discount their fees with WGAT. Your benefits will be greater if You use these Participating Providers and Your out-of-pocket expenses will be less. You can obtain lists and directories of Participating Providers in Your area from Your Employer, Your local WGAT office, or WGAT's home office in Irvine, California as well as the following web sites:

California	Anthem Blue Cross	www.anthem.com/ca
Arizona	Blue Cross Blue Shield of Arizona*	www.azblue.com
All other states†	PHCS/Multiplan or First Health Network	www.multiplan.com or www.firsthealth.coventryhealthcare.com

It is important for You to fill out an enrollment card and inform Your Employer and WGAT immediately of any changes in Your status, such as new dependents or an address change. Information supplied on the enrollment card will be used to pay claims for You and Your covered dependents.

To file a claim You will need to give the Provider Your name, Identification (ID) Number, and birth date as reported on Your enrollment card. If the claim is for a dependent, the dependent's name, birth date, and relationship to You must be included. You must sign the Authorization to Release Information and the Provider will take all itemized bills and send them to WGAT. Itemized bills must include each date of service, the diagnoses, a complete description of the services performed, the patient's name, and the charges incurred.

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* Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. Western Growers Assurance Trust has assumed all liability for claims payment. No network access is available from Blue Cross Blue Shield of Arizona outside of Arizona.

† Please refer to your Health Identification Card to find the applicable network.

You will receive a check and/or explanation of benefits as soon as possible after all necessary information has been received. If You sign the assignment of benefits, or utilize one of our Participating Providers, the benefits will be paid directly to the Provider of services. You will be notified of the payment at the time the Provider's check is mailed.

You can access Your personal healthcare information through the Internet at www.wga.com/healthview. If You have questions about HealthView, please email healthview@wga.com.

Solicitud De Informaciones En Español
(Spanish Language Offer of Assistance)

Este documento está escrito en ingles y contiene un resumen de los derechos y beneficios de su plan de seguro. Si ud. tiene dificultad en comprender cualquier parte de este documento, comuniques:

Western Growers Assurance Trust
15525 Sand Canyon
Irvine, CA 92618

El horario de la oficina es: las ocho de la mañana hasta las cuatro de la tarde, lunes a viernes. Ud. tambien puede llamar a la oficina del administrador del plan de seguro a estos teléfonos 800.777.7898 para pedir ayuda.

WP ADV - Grandfathered Rev. 06/16

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PART 1 – GENERAL PROVISIONS

THIS PLAN IS CONSIDERED A GRANDFATHERED PLAN. PLEASE READ THE INFORMATION CAREFULLY AS IT WILL AFFECT HOW CERTAIN BENEFITS, PROVISIONS AND LIMITATIONS ARE ADMINISTERED BY THE PLAN.

The benefits provided herein and as described in the corresponding Summary Plan Description were in place prior to March 23, 2010, and are exempt from some of the changes required under the Patient's Protection and Affordable Care Act (PPACA). Any adoption of benefits and terms required by the PPACA for non-grandfathered plans is done solely at the discretion of the Plan Administrator and is not intended to relinquish the Plan's grandfathered status, or otherwise effect the benefits, terms, conditions and limitations of the Plan.

AFFIRMATION OF GRANDFATHERED HEALTH PLAN

WGAT believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at WGAT, P.O. Box 2130, Newport Beach, CA 92658. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

YOUR BENEFITS UNDER A MULTIPLE EMPLOYER WELFARE ARRANGEMENT

THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST FUND ESTABLISHED AND FUNDED BY THE WESTERN GROWERS ASSURANCE TRUST (WGAT) PLAN, SPONSORED BY WESTERN GROWERS ASSOCIATION. WGAT IS A SELF-FUNDED PLAN ESTABLISHED UNDER ERISA (29 U.S.C. 1001 ET SEQ.). THIS IS NOT AN INSURANCE CONTRACT AND THE PLAN AND WGAT ARE NOT ACTING AS, OR DEEMED TO BE, AN INSURANCE COMPANY.

THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF A MULTIPLE EMPLOYER WELFARE ARRANGEMENT BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

THE HEALTHCARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT THAT IS LICENSED BY THE STATE OF CALIFORNIA.

FOR ADDITIONAL INFORMATION ABOUT THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR OR YOU MAY CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT 1-800-927-4357.

HOW TO USE THE LIFE AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

If Your Employer has selected life benefits for You, the claims for Employee Life, Accidental Death, or Dismemberment are paid by Anthem BC Life & Health Insurance Company, 21555 Oxnard Street, Woodland Hills, California 91367. However, to use the Plan correctly, these steps should be followed:

1. The beneficiary should contact Your Employer or local WGAT office for claim form and filing instructions.

2. At that time Your beneficiary or Employer will be advised by the Plan Administrator or local WGAT office of all documents necessary to complete filing of the claim.

FILING FOR A TOTAL DISABILITY EXTENSION

If Your coverage terminates because You are unable to work, ask for a Total Disability claim form from Your local WGAT office or WGAT's home office in Irvine, California.

IMPORTANT FILING DATE FOR ALL CLAIMS

It is important to file a claim within 90 days to assure payment. Failure to file within this time limit will not necessarily invalidate the claim if it was not reasonably possible for You to do so, provided it is filed as soon as possible thereafter. **However, in no event will a claim be accepted more than a year after the 90-day time limit has expired.**

HIPAA NOTICE OF PRIVACY PRACTICES

(For further updates to the HIPAA privacy practices notice please see www.wgat.com/hipaa-privacy-practices)

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of eligible Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the eligible Plan Participant's PHI, and inform him/her about:

a) the Plan's disclosures and uses of PHI;

b) the eligible Plan Participant's privacy rights with respect to his/her PHI;

c) the Plan's duties with respect to his/her PHI;

d) the eligible Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and

e) the person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

a) to carry out Payment of benefits;

b) for Health Care Operations;

c) for Treatment purposes; or

d) if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

a) not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

b) ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c) establish safeguards for information, including security systems for data processing and storage;

d) maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

e) receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

f) not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

g) report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

h) make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

i) make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

j) make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

k) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

l) report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

m) train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

n) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

o) ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

I. the following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

- Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

II. in the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Sponsor will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the eligible Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Sponsor or the Plan Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose an eligible Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the eligible Plan Participant's information.

Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to an eligible Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if an eligible Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

a. a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities; and

c. locate and notify persons of recalls of products they may be using; and (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the eligible Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the eligible Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the eligible Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the eligible Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the eligible Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

Disclosures to eligible Plan Participants: The Plan is required to disclose to an eligible Plan Participant most of the PHI in a Designated Record Set when the eligible Plan Participant requests access to this information. The Plan will disclose an eligible Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the eligible Plan Participant's personal representative if it has a reasonable belief that the eligible Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the eligible Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the eligible Plan Participant.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the eligible Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The eligible Plan Participant has the following rights regarding PHI about him/her:

Request Restrictions: The eligible Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The eligible Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

Right to Receive Confidential Communication: The eligible Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the eligible Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

Copy of this Notice: The eligible Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

Accounting of Disclosures: The eligible Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The eligible Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the eligible Plan Participant of the basis of the disclosure, and certain other information. If the eligible Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

Access: The eligible Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the eligible Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the eligible Plan Participant's request. If the Plan denies the request, the eligible Plan Participant may be entitled to a review of that denial.

Amendment: The eligible Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the eligible Plan Participant's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the eligible Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The eligible Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the eligible Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the eligible Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:
Jon Alexander, General Counsel
Western Growers Assurance Trust
P.O. Box 2130
Newport Beach, CA 95653
Phone: (949) 863-1000
Email/Website: jalexander@wga.com

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")
The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions;
"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

b) ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

c) ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

d) report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

a) notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach.

b) notify the media if the breach affected more than five-hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.

c) notify the HHS Secretary if the breach involves five-hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five-hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each calendar year.

d) when a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the

affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ADMINISTRATIVE PROVISIONS

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Participant.

The Plan will provide such alternative benefits at WGAT's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If WGAT elects to provide alternative benefits for a Participant in one instance, it will not be obligated to provide the same or similar benefits for that person or other Participants in any other instance, nor will such election be construed as a waiver of WGAT's right to provide benefits thereafter in strict accordance with the provisions of the Plan Document and this SPD.

Amending the Plan
While it is goal of the Employer and WGAT to provide Employees and their families with comprehensive benefits, the Employer and WGAT reserves the right, at its discretion, to:

- reduce, modify or terminate health care benefits hereunder, if any;
- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those Plan benefits to which he has become entitled.

Plan participants and beneficiaries must be furnished a Notice of Modification reflecting the change not later than 60 days prior to the effective date of the change, or 30 days before the Plan Year anniversary date, whichever is earlier, if such change is a benefit required to be detailed in the Summary of Benefits and Coverage. All other material reductions shall be provided by written notice no later than 60 days after the adoption of the change. Any such amendment shall be binding upon all Participants (including those Participants on continuation coverage). You may also be sent amendments to the SPD. Be sure to read and save all Plan communications.

Compliance with Applicable Laws and Regulations
It is the intent of the Plan to comply with all Federal, State, and local laws and regulations where compliance is required and mandatory. Any current provisions needing amendment, as well as any new language needing to be added that will allow the Plan to be in compliance with a mandate will be considered automatically added to this Summary Plan Description.

In the event the language in this Summary Plan Description does not accurately reflect any legally required and mandatory language, this Summary Plan Description will be considered amended and interpreted as if the Plan included those changes.

Choice Of Providers
The persons covered under this Plan have the sole right to select their own Providers of health care. The Plan Administrator or the Employer is not responsible for the providing for, or the quality of, any type of Hospital, medical, pharmacy, dental or similar care. Benefits provided under this Plan do not regulate the amounts charged by Providers.

This Plan in no way interferes with the right of any person entitled to benefits to select any Hospital, clinic, or any Provider, whether affiliated or not affiliated with a Hospital or clinic.

Contractual Limitations Period
You must file any action arising directly or indirectly from Your participation in this Plan no later than fifteen (15) months after the action has accrued. In the context of a claim for benefits, this is defined as the date a claim is paid or denied. By enrolling and participating in this Plan You agree to waive any statute of limitations to the contrary that might extend the right to file any action arising directly or indirectly from Your participation in the Plan. This Contractual Limitations Period applies to all enrollees, beneficiaries, and assignees and runs concurrently with the Plan's underlying administrative provisions.

Any action arising directly or indirectly from Your participation in the Plan must be filed in accordance with the Contractual Limitations Period above and shall be filed in the courts located in the city of Santa Ana, County of Orange, State of California.

Discrepancies
In the event that there may be a discrepancy between any separate written or oral information provided to the Participants and this SPD, this SPD will prevail.

Discretionary Authority
WGAT shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

Fiduciary Responsibility & Authority
Fiduciaries will serve at the discretion of the Plan Administrator and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan Administrator and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Genetic Information Nondiscrimination Act
The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from discriminating against individuals on the basis of genetic information. The law, in general: 1) Prohibits a group health plan from adjusting contribution amounts for a group based on genetic information; 2) Prohibits the requesting or mandating by a group health plan that an individual or family undergo a genetic test; 3) allows group health plans to request, but not mandate, that a participant undergo a genetic test for research purposes as long as the information is not used for underwriting

purposes and the request meets specific disclosure requirements; 4) prohibits a group health plan from requesting, requiring, or purchasing genetic information for underwriting purposes; and 5) amends the meaning and definition of protected health information under HIPAA to include genetic information.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence);
- Claims experience;
- Receipt of healthcare;
- Medical history;
- Evidence of insurability;
- Disability; or
- Genetic information
- Any other factor provided by law

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Plan Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Plan Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the eligible Plan Participant or the provider of service in the event it is determined that such care or services are not covered. The eligible Plan Participant (parent, if a minor) will execute and deliver to the Plan Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Plan Administrator, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Right To Terminate Or Merge The Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Employer reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Claimant. The date of the merger or termination will be the date specified in the enabling resolution. Termination of the Plan shall apply to all Claimants including those on continuation coverage. Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Claimants for Plan coverage.

Termination for Fraud or Misrepresentation

The Plan will retroactively rescind the benefits and/or coverage under this Plan, upon 30 days written notice to the Participant, for any intentional material misrepresentation or fraud committed by the Participant and relied upon to the detriment of the Plan in providing coverage and/or benefits under the Plan.

Territorial Limitations

Any Medical, Dental and Vision Care benefits provided by the Plan are subject to reduction if services are rendered or expense is incurred outside the United States. The Trust reserves the right to determine benefits payable, if any, for all such services.

Assignment of Benefits to Providers located outside the United States will not be honored unless approved by the Trust in advance of the date of services.

PART 2 – ELIGIBILITY PROVISIONS

SECTION 1 – EMPLOYEE

To participate as an Employee in the Plan coverages that are described herein, an individual must be in active employment for a Participating Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Participating Employer requires him to travel) and regularly scheduled to work at least twenty (20) hours per week. Part-time, temporary, and/or retired employees are not included unless listed in a separate classification on the Trust's Group Benefit Application, approved by the Trust and enrolled in a benefit plan, which permits inclusion of such employees. Part-time, temporary and/or retired employees may qualify as Participants even where working fewer than twenty (20) hours per week as long as these classifications and expected hours of work are explicitly described on the Group Benefit Application and approved by the Trust. You may work fewer hours and qualify for benefits coverage if You are actively at work and eligible for coverage during a qualifying Stability Period. If Your employer is using the Patient Protection and Affordable Care Act's Look Back Safe Harbor Rules Your Employer should document its such use of these provisions including describing measurement periods for all employee classifications, develop and maintain a tracking methodology and understand that it is ultimately responsible for determining employee eligibility and any penalties or fines assessed against it for failing to offer coverage under the ACA's large employer mandate to otherwise eligible employees. WGAT is not responsible for determining Your or Your dependent's eligibility but rather relies on employers for the accurate employee eligibility information, which employers have an affirmative duty to provide.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Participating Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **Administrative Provisions** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees
An Employee's coverage is effective on the first day of the month following completion of a waiting period as described on the Group Benefit Application and approved by the WGAT. If an Employee fails to enroll within thirty (30) days after completion of the waiting period, his coverage can become effective only in accordance with the "Special Enrollment Rights" provisions below.

Waiting Period. Your Employer may require a waiting period, or period of active employment established by the Employer and agreed to by WGAT, which precedes the initial date of Your coverage. Employer groups waiting periods must be described on the Group Benefit Application and approved by WGAT.

Eligibility Requirements - Dependents
Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a) a legally married spouse. A "spouse" will mean a person of the opposite or the same sex possessing a marriage license who is not divorced from the Employee. "Married" will not include a common law spouse.

b) a "registered domestic partner" or "domestic partner" will mean the adult dependent of the same sex employee who has filed a Declaration of Domestic Partnership with the Secretary of State in California and has received a legal conformed copy of that Declaration. A domestic partner will also include a person who is eligible for Social Security benefits if at least one partner is over age 62 and has filed and received a conformed copy of the Declaration of Domestic Partnership. WGAT will recognize domestic partners who have validated their relationship under the laws of another jurisdiction in the United States and can provide legal documentation of that validation.

c) a Child who is under age twenty-six (26) (i.e., through age twenty-five (25)). The Child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.

An eligible "Child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted Child, a Child who is placed with the Employee for legal adoption, or a Child under the legal guardianship of the Employee). An eligible Child also includes one for whom coverage is required due to a Qualified Medical Child Support Order.

An eligible Child who is currently under age twenty-six (26), who meets the above criteria but who is not currently enrolled, will be provided with an opportunity to enroll (a "special enrollment right").

Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any child of a Plan Participant who is recognized under a Medical Child Support Order that is "Qualified" according to the procedures listed herein as having a right to enrollment under this Plan as the Plan Participant's eligible Dependent.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events. However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall, as soon as administratively possible:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

    a. Whether the child is covered under the Plan; and

    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

The Plan Administrator reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

NOTES:
Eligible Employees who are married to each other may enroll as individuals or as a family unit. If Your Employer has an established retirement policy, agreed to by WGAT, Employer contributions for Employees who are eligible at the time of retirement may be continued. Providing a Social Security Number is necessary for administrative purposes, but not required to submit your enrollment.

Newborns: Benefits will be payable under this Plan for thirty-one (31) days after the birth of the child. However, if dependent coverage is offered by Your Employer, You must submit an enrollment card to WGAT through your employer within thirty (30) days after the birth of the child and make the required contribution for dependent coverage in order for the coverage to continue.

An eligible Dependent does not include:

a) a spouse following legal separation or a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage);

b) a registered domestic partner following a legal dissolution of the partnership (including any children of the domestic partner who were eligible only because of the partnership);

c) any person who is on active duty in any military service, except where eligibility is required by U.S. law;

d) the child of a Dependent Child; or

e) the spouse of a Dependent Child.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents
Dependents who are eligible and enrolled concurrently with the Employee will have coverage effective on the Employee's coverage effective date. Dependents acquired later will be effective on the first day of the month following the date they become eligible.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Open Enrollment
If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held each year. Plan coverage will be effective on the 1st of the month following the end of the Open Enrollment period.

Eligible Plan Participant will receive detailed information regarding open enrollment from their Participating Employer.

Late Enrollee – A "late enrollee" is an individual who submits an application for health benefits coverage on a date after the initial thirty (30) day enrollment period or thirty (30) days after a special enrollment date. A late enrollee will not be able to enroll in the Plan until the next Annual Open Enrollment or You meet a Special Enrollment provision.

Persons enrolling after the initial 30-day enrollment period will not be considered late enrollees under the following circumstances numbered one (1) through (6):

1. Health Plan Coverage from Other Employer: You and Your dependents ("You") shall not be considered late enrollees if:
   a. You are currently covered under another Employer health Plan;
   b. You provide written verification that You are covered by another Employer health plan and for that reason decline coverage. Acceptable documentation would be a HIPAA certificate or a Certificate of Creditable Coverage;
   c. You learn that You have lost or will lose coverage under the other Employer's health plan because of:
      i. The termination of Your employment or the employment of the person through whom You are a covered dependent;
      ii. A change in Your employment status or the employment status of the person through whom You are a covered dependent;
      iii. The termination of coverage under the other Employer's health plan;
      iv. The termination of the other Employer's monetary contribution toward Your coverage under the other Employer's health plan;
      v. The death of the person through whom You are covered as dependent;
      vi. The legal separation or divorce; or
      vii. Loss of no share-of-cost Medi-Cal coverage from the person through whom You are covered as a dependent; and
      viii. Your declination of coverage when enrollment was previously offered and You subsequently acquired a dependent;
      ix. The termination of coverage under the other Employer's health plan for Your dependents; and

   d. You request enrollment no later than thirty (30) days after termination of Your coverage under the Employer's health plan due to one of reasons stated here in subsection 1(c).

2. Multiple Plans. If Your employer offers one or more other plans and You enrolled in one of these plans during an open enrollment period, You will not be classified as a late enrollee if You enroll with WGAT at a later date.

3. Court Order. You, Your spouse or Registered Domestic Partner and/or minor child will not be classified as late enrollees if a court has ordered that coverage be provided for a spouse, Registered Domestic Partner or minor child under an employee's health plan.

4. No Waiver Form.

   You will not be considered a late enrollee in the event that WGAT cannot produce a written statement from Your Employer stating that You were provided with and signed acknowledgement of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits WGAT to deny enrollment in the Plan until the next Annual Open Enrollment or upon meeting a provision to allow Special Enrollment.

5. COBRA. You and Your dependents shall not be considered late enrollees if You otherwise meet the requirements of paragraph 1 and were under a COBRA continuation provision and that provision has been exhausted.

6. New Dependent: You and Your dependents shall not be considered late enrollees if You were eligible to enroll but previously declined, and have subsequently acquired a dependent that would be eligible for coverage as Your dependent whether through marriage, birth, adoption, or placement for adoption. Dependent must enroll for coverage within 30 days following the date of marriage, birth, adoption, or placement for adoption. The effective date shall be the first day of the month following the date the completed request for enrollment is received.

Special Enrollment Rights -The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009

Employees and dependents who are eligible but not enrolled for coverage in the Plan may enroll upon termination of the employee or dependent's Medicaid or CHIP coverage or if the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP. In both instances, the employee must request coverage under the Plan, in writing, within 60 days after the termination or determination of subsidy eligibility.

RETIREES

If Your Employer has an established **retirement policy**, agreed to by WGAT, Employer contributions for Employees who are eligible at the time of retirement may be continued.

PART 3 – UTILIZATION REVIEW AND PARTICIPATING PROVIDER PROVISIONS

SECTION 1 – UTILIZATION REVIEW

Utilization Review – To get the most out of Your benefit Plan and avoid any unpleasant surprises, You must understand the Utilization Review requirements. If You have any questions or are in doubt about whether Utilization Review is required for a proposed procedure, please call the Utilization Review Center at 1-800-274-7767. Your Provider may take care of this requirement for You, but You and another family member or friend should be familiar with these Utilization Review requirements to ensure that they are carried out. It is Your responsibility to see that Your Provider contacts the Utilization Review Center before scheduling You for any service subject to the Utilization Review Program. **If You receive any such service, and do not follow the procedures set forth in this section, Your benefits will be reduced.** When WGAT is the secondary carrier, no Utilization Review will be required. If a pre-service claim is denied, You may request a review by writing to the Plan Administrator. Please refer to the Claim Appeal Procedures section.

Inpatient Hospital Admission – At least three working days prior to admission, authorization must be obtained from the Utilization Review Center for all non-Emergency Hospital confinements to establish Medical Necessity. In the event of an Emergency admission, WGAT must be notified within **48** hours of the admission to the Hospital. If the Physician wishes to extend the number of days past the originally authorized stay, WGAT must be notified before the end of the originally authorized stay. The additional days will be covered if Medically Necessary. **When authorization is not obtained, the Percentage Payable will be reduced by 50% and Covered Expense will not apply to the Out of Pocket Maximum.**

Case Management – WGAT in conjunction with Anthem Blue Cross monitors potentially large dollar claims and/or long-term treatment claims. With the cooperation of the patient, Physician, and WGAT, alternate healthcare may be considered Covered Expense to the benefit of all concerned.

If You or Your dependents are **admitted to a non-Participating Hospital** during the course of Emergency care, the Utilization Review Center will inform Your Physician and the Hospital that a transfer to a Participating Hospital is necessary to maintain Your maximum healthcare benefits. Participating Provider benefits will be payable until the patient is eligible to be transferred (as determined by WGAT). This transfer will occur when the patient is stable enough to be moved and with the patient's consent. If the patient does not consent, benefits will be limited to the non-Participating Hospital rates until discharged. **The maximum allowable at a non-Participating Hospital shall not exceed 60% of the billed charges, payable at Plan Percentage.**

For Example:

Non-Participating In-Patient Hospital Charge (Per Day)	=	$ 1,100.00
And Maximum Covered Expense Percentage Payable* (60%)	=	$ 660.00
Less Deductible ($250)*	=	$ 410.00
Payable at Plan Percentage (60%)	=	$ 246.00
Less Copayment (if applicable)		

*Percentage Payable is that share of cost paid by the Plan. Co-insurance is your share of the cost (in addition to Deductible, Copayments and non-Covered Expense). See Your SBC for Your Plan's Deductible and Percentage Payable.

Transition of Care/Continuity of Care

To help ensure that your care is not disrupted, a transition assistance program is available to Participants who are in an active course of treatment, such as a behavioral health condition, pregnancy or newborn care, or terminal illness. This process is subject to the discretion of the Plan Administrator. For additional information contact WGAT customer service department at 800.777.7898.

SECTION 2 – PARTICIPATING PROVIDER

Participating Providers – The Participating Provider program is made up of many Hospitals, doctors, and medical clinics throughout California and Arizona that are committed to providing You with quality healthcare at affordable rates. No Hospital, Physician or medical clinic is an Employee or agent of WGAT.

HOW TO USE THIS PROGRAM

It is Your responsibility, both personally and financially, to verify Participating Provider status for Your care at or from:

- **the Provider You select or are referred to at the specified location, because some Providers participate at one location, but not at others;**
- **the Physician who will be providing care to You;**
- **the Hospital or other facility.**

1. Select a Physician from the following Participating Provider Network and make an appointment.

California	Anthem Blue Cross	www.anthem.com/ca
Arizona	Blue Cross Blue Shield of Arizona‡	www.azblue.com
All other states*	PHCS/Multiplan or First Health Network	www.multiplan.com or www.firsthealth.coventryhealthcare.com

Be sure to inform the Physician's office that your health plan is administered by Western Growers, and bring your identification card with you to the Physician's office. It is your responsibility to verify with the Physician that the Physician is still a Participating Provider at the time of treatment. Your benefits will be reduced if you utilize a non-Participating Provider, even if the directory shows the Provider as a Participating Provider. Please remember to re-verify with your Provider prior to any treatment.

2. If required, You will need to make a Copayment to the Physician's office. This would be the amount You would normally be responsible for under Your Plan benefits.

3. The Physician will bill WGAT and You should make no additional payment until You receive an explanation of benefits (EOB) from our claims office. Participating Providers have agreed not to charge You more than the negotiated fee. When You choose a Participating Provider, You will not be responsible for any amount in excess of the negotiated fee for the Covered Expense of a Participating Provider.

4. Benefit payments are automatically assigned to the Provider when You use Participating Providers.

5. The Participating Provider Directory may contain Providers that have discontinued their relationship with the Participating Provider network or may not include Providers who have recently joined the network. For the most current information, please check the website as noted in above item 1. **Remember, it is Your responsibility and in Your best financial interest to verify current Participating Provider status.**

6. If You have questions regarding the program, please call Your local WGAT office or the WGAT customer service department at 1-800-777-7898.

APPLICABLE PROVISIONS TO PARTICIPATING PROVIDERS

If a Participating Provider treats You and refers You to a non-Participating Provider, and You had no ability to control the choice (for example, a non-Participating anesthesiologist, laboratory, or x-ray facility), Your charges will be paid at the Participating Provider Percentage Payable.

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‡ Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. Western Growers Assurance Trust has assumed all liability for claims payment. No network access is available from Blue Cross Blue Shield of Arizona outside of Arizona.

* Please refer to your Health Identification Card to find the applicable network.

If there are no Participating Providers within 30 miles from You, You must contact the Western Growers Utilization Review at 1-800-777-9428 for authorization to use a non-Participating Provider. After receiving authorization, **Your charges will be processed at the Participating Provider Percentage Payable of Usual, Customary and Reasonable.**

Emergency Care: If a Covered Person who resides within the Network service area requires immediate treatment for a Medical Emergency and must use a Non-Network provider, such Non-Network services will be covered at the Network benefit levels. All Medical Emergency services are payable at the percentage payable for Network services of like kind.

PART 4 – MEDICAL BENEFITS

Benefits are paid by taking the amount of Covered Expense, subtracting any applicable Deductible, calculating the remaining at the Plan's Percentage Payable, **then subtracting any Copayment**. If You do not use a Participating Provider, the Plan's Percentage Payable will be reduced and Covered Expense will be no more than the Usual, Customary and Reasonable.

For non-Participating Providers benefits are limited to the allowance listed in the following **Limited Fee Schedule** subject to the RBRVS Schedule: Refer to the Covered Expense section for the specific paid amount of these benefits.

1. Inpatient Hospital - 60% of billed charges
2. Outpatient Hospital – 60% of billed charges, validated against the current charge master on file in the relevant state.
3. Emergency Room - 60% of billed charges, validated against the current charge master on file in the relevant state.
4. Surgery Center/Birthing Center - 100% of ASC Schedule
5. Surgeon – 125% of RBRVS Schedule.
6. Anesthesia – Negotiated Contracted Rate.
7. Medicine (Doctor visits and all other outpatient professional services) - 125% of RBRVS Schedule.
8. Diagnostic x-ray – 125% of RBRVS Schedule.
9. Diagnostic laboratory – 125% of RBRVS Schedule.
10. Ambulance (Air and Ground):
    a. Emergency: 500% of Medicare allowances.
    b. Non-Emergency: 250% of Medicare allowances.
11. Dialysis – 100% of RBRVS Schedule

Determination of Covered Expenses and Medical Necessity

Subject to the exclusions, conditions and limitations stated in this SPD, the Plan will pay benefits to, or on behalf of, a Claimant for covered Medical Expenses up to the maximums specified within the SPD. The Plan will pay benefits for the Negotiated Fee or Usual, Customary and Reasonable charges for services and supplies, which are ordered by a Physician. Covered Expense is limited to those charges that are necessary to prevent, diagnose or treat disease, defect or injury. Services and supplies must be furnished by an eligible Provider and be Medically Necessary. All payments made under the Plan for allowable charges will be limited to Usual, Customary and Reasonable charges or Negotiated Fee Rate.

The fact that a procedure or level of care is prescribed by a Physician does not mean that it is Covered Expense under the Plan and shall not bind WGAT in determining the liability under the Plan. Services which are not reasonable and necessary shall include, but are not limited to:

(1) procedures that are experimental, of unproven value or of questionable current usefulness;
(2) procedures that tend to be redundant when performed in combination with other procedures;
(3) procedures that are unlikely to provide a Physician with additional information when they are used repeatedly;
(4) procedures that can be performed with equal efficiency at a lower level of care.
(5) errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in safety and creditability of a health care facility; also known as "Never Events" as adopted by the Centers for Medicare and Medicaid Services ("CMS").
(6) reasonably preventable condition(s) that are not present or identifiable at the time of Hospital admission, but was present at the time of discharge; also known as "Hospital Acquired Condition(s)" as adopted by the CMS.
(7) services, procedures, drugs, or treatments that have been previously performed or provided to the patient for the same diagnosis and have not effectively treated or cured the patient when performed or provided in the past; unless approved through Case Management.

Approval of a claim is subject to the determination of the Medical Necessity of provided services. Medical Necessity is a broadly accepted professional term meaning services were essential to treatment of the Illness or Injury. Treatment determined to be Medically Necessary will follow guidelines where such treatment:

- is consistent with symptoms or diagnosis and treatment of the condition, disease, ailment or Injury
- is deemed appropriate, essential and is recommended for the diagnosis or treatment of the patient's symptoms by a licensed Provider who is practicing within the scope of his or her license and specialty, or primary area of practice,
- is within to scope, duration and intensity of that level of care that is required to provide safe, adequate and appropriate diagnosis or treatment,
- is prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigational,
- is appropriate with regard to standards of good medical practice
- is not primarily for the conveniences of the patient, the Physician or other Provider
- is the most appropriate supply or level of services that can safely be provided to the patient. When applied to an inpatient, it means the patient's medical symptoms or condition require services or supplies which cannot be safely provided to the patient as an outpatient.

In determining Medical Necessity, the Plan may choose to utilize any of the following:

- Utilization Review Center
- Case Management Organization
- Medicare
- Standard Accepted Medical Practice
- Other Third Party Experts and Professionals

All Medical Necessary determinations will be made on a non-discriminatory basis and will be consistently applied to all Claimants with the same medical symptoms, diagnosis, and history.

Please refer to the definitions section of this SPD for a complete definition of Medical Necessity or Medically Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with this SPD. Benefits will be paid for the reimbursement of Medical Expense incurred by the Claimant if all provisions mentioned in this SPD are satisfied.

The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

SECTION 1 – PLAN FACTORS

Your Plan includes one of each of the following factors:

1. **Copayment:** Your Participating Physician office visit Copayment is listed on the SBC. This amount is Your responsibility and is not reimbursable, except in the case of coordination of benefits. If You use a Hospital that is not a Participating Provider, You must pay a Copayment equal to the amount of Your Deductible for each admission. The Copayment is separate from the Deductible. The Copayment is not considered when calculating the Out of Pocket Maximum and is separate from the Deductible.

2. **Co-insurance:** Your Co-insurance is listed on the SBC. Co-insurance is your share of the costs of a covered health care service, calculated as a percent of the Covered Expense (allowed amount) for the service. You pay Co-insurance ***plus*** any Deductibles and Copayments You may owe.

3. **Deductible:** Your Deductible is listed on the SBC. This Deductible amount is required for each eligible family member per Calendar Year. The maximum amount of family Deductible per Calendar Year is two times the Deductible amount listed on the SBC. The Deductible is the amount of Covered Expense which must be incurred before benefits are payable. Charges that do not qualify as Covered Expense cannot be used to satisfy the Deductible. The Deductible is exclusive of the Out of Pocket Maximum any Copayments.

4. **Percentage Payable:** Your Percentage Payable is listed on the SBC found in the back of this SPD. When You use a Participating Provider, Your Percentage Payable will be higher. When You use a non-Participating Provider, Your

Percentage Payable will be lower. Percentage Payable is the percentage of Covered Expense payable after any applicable Deductible has been satisfied.

5. **Out of Pocket Maximum:** The Out of Pocket Maximum is the point at which the Covered Expense is payable at 100% for each Participant or Covered Family during any and each Calendar Year. Covered Expenses in excess of the Out of Pocket Maximum are payable at 100% by the Plan. Amounts in excess of Usual, Customary and Reasonable, charges for a non-Participating Hospital, Copayments, Deductibles, Prescription Drug Card services, non-Covered Expense and/or when the Utilization Review requirements were not met are not included in calculating the Out of Pocket Maximum, nor paid in full once the Out of Pocket Maximum is reached.

   Except as noted, a Participant will not be required to pay more than the amount specified in the SBC found in the back of this SPD in any Calendar Year. Your Family Out of Pocket Maximum is two times the amount of the Out of Pocket Maximum.

SECTION 2 – COVERED EXPENSE

This section is a listing of those medical services, supplies and conditions that are offered to employers. Unless mandated by law, employers may not necessarily offer all of these Eligible Medical Expenses to their Employees. This section must be read in conjunction with the applicable **SBC** to understand the applicable Eligible Medical Expenses and how Plan benefits are determined (application of Deductible requirements and Copayment requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted herein or in the applicable **SBC**, eligible medical expenses ("Covered Expenses") are the Usual, Customary and Reasonable charges for the items listed below and that are incurred by an eligible Plan Participant - subject to the **Definitions**, **Medical Limitations and Exclusions, General Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by and received from a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

Accident. If listed on the SBC as covered, WGAT will pay the first $300 of Covered Expense for an Accident prior to applying Your Deductible or Percentage Payable. These charges must have been incurred within 90 days of the Accident's occurrence.

Acupuncture. Needle puncture or application of pressure at specific points, used to relieve pain, is a Covered Expense. Benefits are payable as any other professional service.

Ambulance (including Air Ambulance). Licensed professional Ambulance service for Medically Necessary transportation to or from the nearest Hospital where appropriate care can be obtained is payable at the Plan's Percentage Payable for Participating Providers.

Use of an Ambulance is subject to retrospective Utilization Review to determine if the type of transportation services were Medically Necessary. Distance from a facility is not in and of itself a Medically Necessary reason for use of ambulance services. WGAT shall base benefits, if any, on the facts and circumstances of each transport by ambulance.

Assistant Surgeon. Benefits will be covered for the following practitioners who perform services as an Assistant Surgeon: Physician, Physician's Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CSN), or Registered Nurse First Assistant (RNFA), if RNFA holds a degree as a Nurse Practitioner or Clinical Nurse Specialist. For a Participating Assistant Surgeon, benefits will be allowed at 25% of the contract allowed amount, payable at the Plan's Percentage Payable after any applicable Deductible. For a non-Participating Assistant

Surgeon, benefits will be allowed at 25% of the Usual, Customary and Reasonable amount, payable at the Plan's Percentage Payable after any applicable Deductible.

Attention Deficit Hyperactivity Disorder. Medically Necessary medical treatment including prescription drugs for the behavioral learning disorder diagnosed as Attention Deficit Hyperactivity Disorder (ADHD) is covered for children up to age 18. Medical treatment is payable after any Deductible at the Plan Percentage Payable of Covered Expense subject to any applicable Copayment. Prescription drugs for this diagnosis are payable as any other Covered Expense except when obtained through the drug card. Prescription drugs under the drug card are payable as any other medication less the Copayment or Coinsurance on the Pinnacle RX Solutions schedule.

Behavioral Health Treatment Services. Services are limited to the treatment of Pervasive Developmental Disorder or autism and are limited to professional services and treatment programs including Applied Behavior Analysis and evidence-based behavior intervention programs that develop or restore, to the extent practicable, the functioning of the Participant. Specific criteria must be met and can be found in the Plan Document. Pre-certification is required or no benefits payable.

Birthing Center. A Birthing Center must be operated by a Physician or registered nurse/midwife, is designed for normal deliveries and postpartum newborn care, and is in compliance with licensing and other legal requirements in the jurisdiction where it is located. It is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients and maintains daily clinical records. **The maximum allowable for non-Participating Birthing Centers will be no more than two times the average semi-private room rate, payable at Plan Percentage.**

Blood Transfusions, Blood, and Blood Plasma. Blood Transfusions, Blood, and Blood Plasma are a Covered Expense if ordered by a Physician for the treatment of a sickness or injury, when not available to the Participant without charge.

Chemical Dependency/Substance Abuse. Your Employer must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) if an average of 51 or more employees were employed during the preceding calendar year. The MHPAEA prevents the Plan from imposing financial requirements and treatment limitations on covered mental health and substance abuse benefits that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits.

Employers with less than 51 Employees:

You must seek treatment for Chemical Dependency or Substance Abuse with a Participating Chemical Dependency Rehabilitation Facility after you obtain authorization from the Utilization Review Center. All benefits are payable up to one course of treatment per lifetime at 100% of negotiated fee after any applicable Deductible. When prior authorization is not performed, payable benefits are reduced by 50%.

Employers with 51 or more Employees

Your Employer must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) if an average of 51 or more employees were employed during the preceding calendar year. The MHPAEA prevents the Plan from imposing financial requirements and treatment limitations that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. For Employers with 51 or more employees the following applies:

Chemical Dependency/Substance Abuse Care benefits are a Covered Expense. Benefits are payable as any other claim and are subject to the provisions based on the type of services provided and the location of those services.

Chiropractic Care. Chiropractic Care is a Covered Expense for diagnostic evaluations and treatments by spinal manipulation and other modalities. All chiropractic care x-rays are limited to $75 per Calendar Year and the maximum benefit payable for all chiropractic treatment, including x-rays, is limited to $500 per Calendar Year for each eligible family member.

Contraceptive Drugs and Devices. When prescribed by a Physician and include: oral contraceptive drugs, intrauterine contraceptive devices (IUD's), intradermal contraceptive devices (e.g. Norplant), Depo-Provera injections, and insertion and/or removal of intradermal contraceptive devices. Oral contraceptive medications are available under the Prescription Benefit only. All other contraceptive methods are payable as any other claim, if Medically Necessary.

Cosmetic Surgery after Mastectomy. In a manner determined in consultation with the attending Physician and the patient are payable for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery or reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications with all stages of the mastectomy, including lymphedemas.

Benefits are payable as any other surgical claim and are based on location of services.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
In compliance with Section 2706 of the Public Health Service Act (PHSA), Women's Health and Cancer Rights, added to PHSA by the 1998 Omnibus Budget Bill, the following services complementing medical and surgical benefits for mastectomies, in a manner determined in consultation with the attending Physician and the patient are considered Covered Expense and subject to all Plan provisions:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery or reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications with all stages of the mastectomy including lymphedemas.

Diabetic Treatment and Management. This is a Covered Expense and includes glucose monitors and test strips, glucose monitors for the visually impaired, insulin pumps and related supplies, urine test strips and lancets, pen delivery systems for insulin, syringes, podiatric devices for diabetic-related complications, and visual aids (but not eyewear) for proper dosing of insulin. When prescribed, insulin, glucagons, and other medications for treatment of diabetes are covered.

Diabetes self-management training, education, and nutrition therapy are covered to the extent necessary to enable the effective use of equipment, supplies, and medication as prescribed by the patient's Provider. Benefits are payable like any Physician's visit.

The following are Covered Expense under Your Prescription Drug program:

Urine Test Strips
Syringes & Needles
Insulin
Blood Test Strips
Sugar Test Tablets or Tapes
Acetone Test Tablets or Strips.

All others are Covered Expense as any other supply.

Diagnostic Laboratory and X-ray Tests are covered if ordered by a Physician, licensed technician, or clinic. These tests must be for the diagnosis of a sickness or injury being treated. Medically Necessary tests include, but are not limited to, mammogram, colonoscopy, and sigmoidoscopy when referred by your Physician.

Dialysis Services. Services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, when provided at a freestanding dialysis Center or other appropriate covered Provider.

Dressings and Surgical Supplies. Dressings and Surgical Supplies are a Covered Expense if ordered by a Physician.

Emergency Room. Outpatient treatment in the Emergency Room of a Hospital requires a $100 Copayment for each illness or Accident. The Copayment is waived if an inpatient admission occurs at the time You are initially treated in the Emergency Room or care for Your Accident occurs within 48 hours of the Accident. Covered Expense is payable at the Plan's Percentage Payable for Participating Providers.

Foot Care. Treatment of mycotic toenails and removal of nail matrix or root. The treatment of routine foot care and removal of corns, calluses, toenails, or subcutaneous tissue when care is prescribed by a Physician treating metabolic or peripheral vascular disease, is also a Covered Expense.

Gender Identity Disorder Treatment: Coverage for medical benefits under the Plan shall not be denied or limited based on the individual's actual or perceived gender identity or because the individual is transgender. Additionally, medical services that are ordinarily or exclusively belong to one sex will not be denied to the other sex or to an individual who is in the process of undergoing, or has undergone, gender transition.

Medically Necessary services related to gender transition are a Covered Expense if comparable services are also covered when not related to gender transition, including but not limited to, hormone therapy, hysterectomy, mastectomy, breast reconstruction, surgical treatment for gynomastia, reconstructive surgery for genital injuries or abnormalities, and vocal training.

Benefits are payable based on the location of services and subject to the terms, conditions and limitations expressed in this **Summary Plan Description** booklet and the **Plan Document**, including eligibility and utilization management.

Health Management Program. WGAT and its partner Pinnacle Health Management encourage members to take advantage of our Health Management Program. The purpose of the program is to help educate, motivate, and empower WGAT participants and/or their dependents to counteract the effects of one or all of the following three disease states – High Blood Pressure, High Cholesterol, Diabetes, or Asthma. Additionally the Health Management Program will work with you and your Dependents with weight management and smoking cessation. The Health Management Program provides WGAT participants that have been identified with these disease states and conditions with free access to care managers, along with patient-specific literature and direct physician correspondence. WGAT will offer a significant discount on the cost of medications prescribed to help manage or alleviate the diagnosed disease states and conditions to all participants enrolled and compliant in the program. If enrolled in the disease management program, the formulary change in Copayments for brand name medications are reduced from a 50% copayment to a 37.5% copayment reduction. A 50% reduction in non-formulary Copayments for those Participants who have tried all generic and formulary brand name medications. There is no Copayment for generic medications. For more information or to register in the Health Management, please feel free to contact Pinnacle Health Management Program at (844) 230-1121.

Home Healthcare. Home Healthcare is a Covered Expense if ordered by a Physician. Home Healthcare is limited to 60 four-hour days per Calendar Year that must include services consistent with Your injury or illness.

Hospice Care. Hospice Care is covered at the Plan's Percentage Payable for Participating Providers. The National Hospice Organization and WGAT must approve the setting. The patient must be diagnosed as terminally ill with a life expectancy of six months or less. It is necessary to seek case management with the Utilization Review Center prior to receiving this benefit.

Hospital. Hospital is covered for room and board to the Hospital's average semi-private room accommodations, and other Medically Necessary services or supplies used during Hospital confinement and/or qualified Hospital treatment, not to include services, drugs, or supplies that are dispensed, but not used in the Hospital. Routine newborn nursery care benefits will be payable until the newborn is released from the initial Hospital stay. Hospital confinement means any one or more of the following: (1) Confinement as a registered bed patient for 24 hours or more; (2) Emergency care in the outpatient department of a Hospital within 48 hours of an Accident; (3) Death of a patient while being treated in the Emergency Room of a Hospital; (4) Admitted as a registered bed patient directly from the Emergency Room. You must have all routine tests that are related to Your Hospital confinement done prior to Your admission to Your Hospital. These tests and studies must be conducted after confinement is scheduled and within one week prior to an admission. If these tests are done on an inpatient basis, the charges for confinement will be reduced by one day. Also, please refer to Part 1, Section 1 regarding Utilization Review requirements.

Intensive Care Unit (critical care unit, coronary care unit, concentrated care unit) means a separate Hospital area that is solely for treatment of patients in critical condition, providing around-the-clock observation by special duty nurses and monitoring by medical equipment.

Participating Hospital:	Room & Board is subject to the Plan's Percentage Payable of the negotiated fee, after any applicable Deductible, and if applicable, less a Copayment per each admission. All Ancillary Services are subject to the Plan's Percentage Payable of the negotiated fee, after any applicable Deductible.

Intensive Care Unit & Coronary Care Unit are payable Plan's Percentage Payable of the negotiated fee, after the Deductible and if applicable, less a Copayment per each admission.

Non-Participating Hospital: Room & Board subject to the Plan's Percentage Payable of the average semi private rate, after any applicable Deductible, and if applicable, less a Copayment per each admission.

All Ancillary Services are subject to the Plan's Percentage Payable of Covered Expense, after any applicable Deductible.

Intensive Care Unit & Coronary Care Unit are subject to payable of three times the average semi private room rate, after the Deductible and if applicable, less a Copayment per each admission.

Non-Participating Hospital benefits do not apply to the Out of Pocket Maximum.

I**nfertility.** Infertility services are available after You pay a separate $500 Deductible that is in addition to Your Plan Deductible. These services are then covered to a lifetime maximum of $2,000 and all related Prescription Drugs to a lifetime maximum of $3,000. Prescription Drugs are available through the Prescription Drug card program only and are payable at the Percentage Payable for Participating Providers.

Infusion Therapy/Chemotherapy/Pain Management. Services and supplies provided by an Infusion Therapy/Chemotherapy/Pain Management Provider are covered on an outpatient basis for the intravenous administration of the total daily nutritional intake or fluid requirements, medications related to illness or injury, chemotherapy, antibiotic therapy, tocolytic therapy, intravenous hydration, or pain management.

Injectables. Injectables are medicines that are dispensed using a hypodermic syringe and/or needle for Medically Necessary conditions ordered by a Physician in a medical clinic, Physician's office, or by a Physician for the patient to self-inject. Injectables are paid at the Plan's Percentage Payable of Covered Expense after the Deductible is met. For Injectables dispensed in the Physician's office that are in the following categories, benefits are payable as any other Physician office visit:

- Antibiotics, Pain Medications, and Medically Necessary steroids;
- Non-routine immunizations (not for Well Child Care or Preventive Care); or
- Immunotherapy agents (allergy injections)

Self-Injectables are Covered Expense only when dispensed through Pinnacle Rx Solutions (specialty Rx vendor see Prescription Drugs Benefit). Self-injectables are payable at the Plan's Percentage Payable of the negotiated fee, after a 20% Copayment. The patient must receive authorization before the self-injectable medication can be dispensed. (See Utilization Management Section.)

Maternity. Maternity is covered as any other claim for the eligible Employee, eligible dependent Spouse, or Registered Domestic Partner, and eligible Dependent daughter. No separately billed charges are available to the child of the Dependent daughter.

Benefits are not restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Also, these benefits do not require that a Provider obtain authorization from the Plan or the insurance carrier for prescribing a length of stay not in excess of the above periods.

Medical or Surgical Supply House (includes Durable Medical Equipment). A Medical or Surgical Supply House is covered for rental of oxygen equipment, wheelchairs, crutches, or other durable therapeutic equipment. Payment of rental fees shall not exceed the actual cost of equipment and includes purchases of certain non-rentable medical equipment and post-surgical supplies unobtainable in a regular drug or department store and usable only for the medical care of the patient. Covered Services include, but are not limited to, dressings, casts, splints, crutches, braces or supports, and blood lancets necessary for testing the blood sugar level of diabetics as well as insulin pumps and accucheck monitors (blood/glucose monitors).

Mental Healthcare.

Employers with less than 51 Employees:
(Also, see your SBC for additional information on non-severe mental health benefits, if applicable)

Severe Mental Illnesses are payable as any other claim for the following diagnoses:

- Schizophrenia
- Bipolar disorder (manic-depressive)
- Major depressive disorders
- Panic disorders
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa.

"Severe emotional disturbances of a child" are covered (up to age 18) and benefits are payable as any other claim with the following limitations:

1. The child must have one or more mental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to expected developmental norms, and

2. These disorders meet the criteria in the California Welfare and Institutions Code, §5600.3.

Employers with 51 or more Employees
Your Employer must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) if an average of 51 or more employees were employed during the preceding calendar year. The MHPAEA prevents the Plan from imposing financial requirements and treatment limitations that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. For Employers with 51 or more employees the following applies:

Covered Expense

Mental Health Care benefits are a Covered Expense. Benefits are payable as any other claim and are subject to the provisions based on the type of services provided and the location of those services.

Mexico Benefits.

Treatment in Mexico (Participating Provider):

Non-Emergency treatment is covered if You or Your dependents receive covered services in Mexico, in Mexicali, Tijuana, San Luis, or Los Algodones from a Participating Provider. If You or Your eligible dependents require medical services, You must obtain a certified medical claim form from Your Employer or Your local WGAT office. Your employer may be part of the Claimless Program. In this case, WGAT will forward a list of covered employees to each Participating Provider on a monthly basis. A Copayment and valid identification will be required from You each time You visit a Participating Provider. If You do not have a medical claim form or Your name does not appear on the monthly eligibility list, the doctor will require payment in full for services rendered. Information related to eligibility of benefits may be obtained from Your Employer or WGAT local offices. If You do not use a Participating Provider for non-Emergency treatment while in one of the cities listed above, WGAT will not pay Your health claim for that treatment.

If You or Your dependents receive treatment in Mexico from a non-Participating Provider, it will be covered if WGAT approves the illness or injury for **Emergency** treatment. Emergency treatment, is defined as a time when You or Your dependents need immediate medical attention because a delay in the treatment would result in Your or Your dependent's death, serious Disability, or significant jeopardy to Your or Your dependent's condition. For benefit

information on approved Emergency treatment with a non-Participating Provider in Mexico, please refer to treatment in Mexico from a non-Participating Provider.

PARTICIPATING PROVIDER COPAYMENT FOR TREATMENT IN MEXICO

1. Physician Office Visit Copayment: $6
2. Outpatient Services Copayment: $6
   Lab & x-ray Copayment: $5
3. Prescription Drug Copayment: $5 per Medication.
   Mandatory Generic Substitution: When available, the generic drug will be dispensed unless Your physician specifically states not to dispense the generic alternative.
4. Inpatient Hospital Copayment: $65 per admission.
   (up to 30-day length of stay)
   Outpatient Hospital Copayment: $25 per day.
5. Surgical Services Copayment 15% Copayment.

Treatment in Mexico (non-Participating Provider): Except for approved Emergency treatment, no benefits are payable for non-Participating Providers. If You or Your dependents receive treatment in Mexico for approved Emergency treatment and You use a non-Participating Provider, Your benefits will be limited to the non-Participating Mexico Provider fee schedule. If You would like a copy of the non-Participating Provider fee schedule, please contact our customer service department at 1-800-777-7898.

Additional Expenses Not Covered In Mexico:

1, Physical Therapy
2. Transplant Services (Heart, Lung, Kidney, Bone Marrow, Etc.)
3. Eye Care/Vision Services
4. Mental Health Care
5. Open Heart Surgery
6. Cardiac Bypass Surgery
7. Treatment for Weight Loss, Smoking Cessation or Drug & Alcohol rehabilitation
8. Orthotics & Prosthetics (artificial limbs, eyes, hearing aids, shoe implants, orthopedic appliances).
9. Occupation injuries
10. Speech & Occupational Therapy
11. Infertility Treatment
12. Durable Medical Equipment
13. Skilled Nursing Care
14. Chemotherapy
15. Dental Care
16. Cosmetic Surgery
17. Brain Surgery
18. HIV-Aids
19. Out of Area

Nurse. A Nurse is covered for professional services provided the services require the specialized training of an R.N., L.V.N., or L.P.N. and were not primarily for housekeeping, personal hygiene, or Custodial Care.

Outpatient Diagnostic Imaging. Outpatient Diagnostic Imaging is covered if ordered by a Physician, licensed technician, or clinic for the diagnosis of an illness or injury being treated and is paid at the Participating Provider Plan Percentage Payable of Covered Expense. Outpatient Diagnostic Imaging includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) scans, Bone Density testing, Computed Tomography (CT) scans, and any cardiac diagnostic procedure utilizing nuclear medicine.

Oxygen. Oxygen is a Covered Expense if ordered by a Physician.

Physical Therapist. A Licensed Physical Therapist is covered for treatment of a condition requiring physical therapy to restore an impaired bodily function.

Physician. A Physician is covered for professional, medical, surgical, diagnostic, or anesthetic services.

A **Physician Office/Home Visit** for the exam only at a Participating Provider is subject to the Copayment. The Deductible and Plan Percentage do not apply. All other Covered Services performed as part of the Physician visit are payable, after Your Deductible, at the Participating Provider Percentage Payable of Covered Expense.

Non-Participating Provider benefits are subject to the Deductible and payable at the Percentage Payable of Usual, Customary and Reasonable.

Primary Care Physician service is covered the same as any other Physician, unless listed otherwise on the SBC. If the SBC lists a specific benefit for Primary Care Physician services, then covered services **billed** by that Primary Care Physician for the office visit, lab, x-rays, and injections will be payable as part of the office visit Copayment. A Primary Care Physician is a General Practitioner, Family Physician, Gynecologist, Internist, and/or Pediatrician. Any surgical services or procedures performed or supplies dispensed during the office visit will be subject to Your Deductible and the Percentage Payable.

An **Inpatient Physician Visit** or consultation is payable, after Your Deductible, at the Percentage Payable of Covered Expense.

Anesthesia Services is a Covered Expense for the administration of regional or general anesthesia to a Participant by a qualified anesthesiologist or a certified registered nurse anesthetist (C.R.N.A.) in connection with a covered surgical service and not administered by the operating surgeon or assistant surgeon. Covered Expense is payable, after Your Deductible, at the Percentage Payable of Covered Expense.

Surgical Services is a Covered Expense for Medically Necessary services performed by a healthcare Provider licensed and acting within the scope of his or her license and payable at the Plan's Percentage Payable of Covered Expense.

- **Dental Surgery** for the treatment of tumors of the gums, a fractured jaw, or an Injury to sound natural teeth sustained while covered under this Plan, provided that treatment is rendered within six (6) months after the Accident's occurrence.

- **Mastectomies** are a Covered Expense for the following services: repair or correction from illness or injury sustained in an Accident that occurred while the person was eligible under the Plan; reconstructive surgery following a mastectomy, including surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy;

- **Reconstructive surgery** that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improved function or create a normal appearance is Covered Expense. Orthodontic services deemed Medically Necessary for cleft palate, cleft lip or related craniofacial anomalies shall also be covered if prior authorization is received.

  For the following Surgical Services Covered Expense, negotiated fee applies to Participating Providers and "Usual, Customary and Reasonable" applies to non-Participating Providers.

- Multiple Surgical Procedures performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:

1. The lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable will be allowed for the primary surgical procedure.
2. Fifty percent of the lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable for the secondary surgical procedure.
3. Twenty-five percent of the lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable for the third and all other procedures billed.

- Bilateral Surgical Procedures performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:

1. The lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable will be allowed for the primary surgical procedure.
2. Fifty percent of the lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable for the secondary or bilateral surgical procedure.

- Multiple Traumatic Injuries performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:

1. The lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable will be allowed for each procedure performed on a separate bodily area or system.
2. The lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable will be allowed for the primary procedure performed on the same bodily area or system.
3. Fifty percent of the lesser of the actual charges, the negotiated fee, or Usual, Customary and Reasonable for the secondary surgical procedure.

- Co-Surgeons for Medically Necessary and approved surgical procedures requiring two (2) or more Physicians for the same operative procedure, where each Physician is the primary surgeon, will be considered Covered Expense according to the following:

1. The lesser of the actual charges or either the negotiated fee or Usual, Customary and Reasonable will be allowed for each Physician.

Prescription Drugs. You must receive Your outpatient Prescription Drugs through a Participating Pinnacle Rx Solutions (PRxS) Pharmacy, which is a national network of Participating Pharmacies. For all covered medications, You are responsible to pay the prescription Copayment based upon the type of drug dispensed for a Participating pharmacy, or the mail order program, and the Plan will pay the remainder of the Covered Expense.

Retail Pharmacy Vendor: PRxS
www.prxsolutions.com
Toll-Free Telephone Number: 877.782.9658

Mail Order Pharmacy: WellDyne Rx
Enroll at www.myWDRX.com
Telephone Number: 877.782.9658
Toll-Free Telephone Number: 800.900.6570

Specialty Rx Vendor: Acaria Health Specialty Pharmacy
Toll-Free Telephone Number: 800.511.5144

The Participating Pinnacle Rx Solutions prescription Copayment amounts are listed on Your Identification Card and on the SBC. Copayments apply to each new and refill prescription drug. Copayments are not reimbursable. Outpatient prescription drugs are limited to a quantity not to exceed a 30-day supply for retail pharmacies and up to a 90-day supply for Formulary maintenance medications only through the mail order program.

The pharmacist will collect the Copayment at the time the drugs are obtained. If the Participant requests a Brand Name Drug when a Generic Drug is available, the Participant is responsible for paying the entire cost of the Prescription. If the prescription specifies a Brand Name Drug and the prescribing Physician has written “Dispense as Written” or “Do Not Substitute” on the prescription, the Participant is responsible for paying the applicable Formulary Brand Name Copayment or Non-Formulary Drug Copayment.

Prescriptions may be refilled at Your local pharmacy after 75% of the medication has been used. Prescriptions being refilled through the mail order program may occur after 65% of the medication has been used.

Note: Insulin syringes and bee sting kits will fall under the Formulary Brand drug Copayment.

Drug Coverage is based on the use of the Plan's Managed Formulary through Pinnacle Rx Solutions, which is updated on an ongoing basis by Pinnacle's Formulary Committee. Non-Formulary drugs may be covered subject to higher Copayments. Selected drugs and drug dosages may require prior authorization by WGAT for Medical Necessity and appropriateness of therapy. Prenatal vitamins, Prilosec, Claritan and Zrytec and their generic forms are Covered Expense when You use the Pinnacle Rx Solutions prescription drug card.

Formulary Drugs – Formulary Drugs are a comprehensive list of drugs maintained by Pinnacle Rx Solutions' Formulary Committee for use under the Plan. It is designed to assist Physicians in prescribing drugs that are Medically Necessary and cost effective. Medications are selected for inclusion in the Plan's managed drug Formulary based upon safety, efficacy, FDA bioequivalency data, and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Pinnacle Rx Solutions' Formulary Committee.

Non-Formulary Drugs – Non-Formulary Drugs are determined by Pinnacle Rx Solutions' Formulary Committee as being duplicative or as having preferred Formulary drug alternatives available. Benefits may be provided for Non-Formulary drugs and are always subject to the Non-Formulary Copayment. The mail order program does not provide Non-Formulary drugs.

Brand Name Drugs – Brand Name Drugs are FDA approved drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

Specialty Oral Drugs – are drugs that are determined by Pinnacle Rx Solutions. These drugs are for the specific treatment of certain debilitating and life-threatening illnesses.

Specialty Self-Injectables – are drugs that are determined by Pinnacle Rx Solutions. These drugs are for the specific self-treatment of certain debilitating and life-threatening illnesses. The patient must receive authorization from the WGAT Utilization Review Center at 1-800-274-7767 before the self-injectable medication can be dispensed. A Copayment based on a percentage of the drug cost is required for specialty injectable medications. See the SBC for specific copayments.

Generic Drugs – Generic Drugs are drugs that are: 1) approved by the Food and Drug Administration (FDA) as safe and effective; 2) produced and sold under the chemical name after the original patent has expired; and 3) cost less than the Brand Name equivalent.

Claims for drugs obtained at a Participating Pharmacy without using the Prescription Drug Card should be submitted with the receipt and a completed Prescription Drug Claim Form to Pinnacle Rx Solutions for reimbursement. Pinnacle Rx Solutions will reimburse the Participant for Covered medications according to the Negotiated Contract Rate less the applicable Copayment as indicated above. Prescription Drug Claim Forms may be obtained from WGAT's home office or one of the local offices of WGAT. Claims must be received within six months from the date of service to be considered.

Non-Participating Pharmacy – For prescriptions obtained at a non-Participating Pharmacy the Participant must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The Participant will be reimbursed at the lesser of the price actually paid for the drugs or the reasonable charge (as determined by Pinnacle Rx Solutions), for the prescription drug(s), minus the Participant's applicable Copayment. Claims must be received within six months to be considered for payment.

Mail Order Program - All provisions of the Prescription Drug Card apply to the Mail Order program except for the Copayment amount. If the medication is not on the Maintenance Formulary, then the medication will not be covered. If the Participant's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply. Prescriptions being refilled through the mail order program may occur after 65% of the medication has been used.

How to use Your Managed Formulary

Your Prescription Drug Benefit program includes a Managed Formulary. To help You understand how the Managed Formulary works, we have put together the following information.

WHAT IS A MANAGED FORMULARY?

- A Managed Formulary is a list of preferred prescription medications that encourages the use of medications by three criteria: safety, efficacy, and cost. It consists mostly of covered generic medications and a broad selection of brand name drugs in a range of therapeutic categories

WHAT PRESCRIPTION DRUGS ARE COVERED IN MY MANAGED FORMULARY?

- Your Managed Formulary is extensive and covers all therapeutic classes of drugs, which means we have medications that treat both acute and chronic conditions. Acute conditions include cold, flu and other short-term illnesses, and chronic conditions include glaucoma, diabetes, high blood pressure, heart disease, asthma, etc.
- Your prescription drug plan will continue to provide coverage under the Pinnacle Rx Solutions drug card program for Non-Formulary medications which are medically necessary to treat a covered illness at a higher Copayment.

WHO DETERMINES WHICH DRUGS WILL BE INCLUDED ON THE MANAGED FORMULARY?

- The Managed prescription Formulary is developed and maintained by American HealthCare and their clinical pharmacy department, which is comprised of qualified Physicians and pharmacists. The group meets regularly to update the Formulary list.

HOW ARE NEW DRUGS ADDED TO THE MANAGED FORMULARY?

- If it meets the criteria for safety and efficacy and is accepted, it will be included in the Formulary list. **Because of the frequent changes made to the Managed Formulary, Western Growers Assurance Trust cannot guarantee that medications listed in this Summary Plan Description will continue to be covered.**

HOW CAN I FIND OUT IF MY CURRENT PRESCRIPTION MEDICATION IS COVERED IN THE MANAGED FORMULARY?

- First, look through the Formulary Mini Guide listed below to find Your prescription medication. The medications are listed alphabetically under common drug class groupings. For a specific drug which is not listed or any questions You may have, just call Pinnacle Rx Solutions at **1-877-782-9658.**

• Commonly Prescribed Medications – Formulary Mini Guide •

ANTIBIOTICS
Amoxicillin*
Augmentin*
Bactrim*
Cipro*
Dynapen*
Erythromycin*
Keflex*
Pediazole*
Penicillin VK*
Tetracycline*
Vibramycin*
Zithromax*

ARTHRITIS & PAIN
Clinoril*
Indocin*
Motrin*
Naprosyn*

ASTHMA
Advair
Brethine*
Maxair
Medrol*
Theo-dur*
Ventolin*
Provera*

DIABETES
Avandia
Byetta
Diabeta*
Glucophage*
Glucophage XR*
Glucovance*
Insulins
Metphormin

ESTROGEN
Estance*
Premarin
Prempro

MUSCLE RELAXANTS
Flexeril

OPTHALMIC
Lumigen
Xalatan

SLEEPING AIDS
Ambien
Altivan*
Restoril*
Valium*

ANTIDEPRESSANTS

Asendin*
Celexa*
Desyrel* Elavil*
Lexapro
Norpramin*
Pamelor* Paxil*
Sinequan*
Tofranil*
Wellbutin* Zoloft

ANTI-VIRAL

Hivid
Epivir
Retrovit*
Symmetrel*
Videx Zovirax*

CHOLESTEROL

LOWE RING AGENT S

Crestor
Lescol
Lipitor
Lopid*

COLD/ALLERGY

Entex*
Flonase
OTC
Claritin
Phener

HEART/BLOOD PRESSURE

Adalat CC*
Aldomet*
Apresoline*
Calan*
Capotan*
Cardizern
Catapres*
Hytrin*
Inderal*
Lanoxin*
Lopressor*
Lotensin*
Minipress*
Nitro-dur
Plendil*
Tenormin*
Univasc

STOMACH AILMENTS

Aciphex
Carafate*
Prilosec OTC
Reglan*
Tagamet*
Zantac*

THYROID

Lavothroid
Levoxyl
Snthroid*

*Generic equivalent available – Mandatory substitution required

Preventive Care.
Participating Provider Preventive Care. You pay no cost for Covered Expense when you use a Participating Provider. Your health plan's Preventive Care benefit will only cover preventive services at a frequency recommended by the U.S. Preventive Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. California law requires that mammograms be payable regardless of age when referred by a participating certified nurse-midwife, participating physician assistant, or participating physician, who is providing care to the Participant and operating within the scope of practice. Additionally, Well-Woman (Female) Preventive Care is covered for annual well-woman visits, screening for gestational diabetes, HPV DNA testing for women 30 years and older, Sexually-transmitted infection counseling, HIV screening and counseling, and breastfeeding support, supplies and counseling. Well-Woman Preventive Care includes Dependent daughters when such care is mandated. Note: Medications, whether prescribed or not and whether or not considered preventive, are not covered under the Preventive Care Benefit. See **Appendix** for further information.

No benefits are available for preventive care services obtained from a non-Participating Provider.

Prosthesis. Provider of the initial Prosthesis for (1) replacement of a natural part of the body removed while the patient was eligible under the Plan; (2) needed to correct a congenital deformity of a child covered under the Plan at birth; or (3) repair of such prosthetic device.

Routine Patient Costs for Participation in Cancer Treatment Clinical Trials. Routine patient care costs are a Covered Expense for patients participating in Phase I. II. III. IV cancer treatment trials approved by the National Institutes of Health, the U.S. Food and Drug Administration, U.S. Department of Defense or Department of Veterans Affairs.

Routine patient care costs include doctor visits, hospital stays, lab tests, X-rays and other tests, and any medications or treatments that would be covered if you were not in a trial. These also include tests needed to see if a treatment is controlling Your cancer. Routine patient care costs also include the fees for any treatment You might need in order to prevent, diagnose or treat another covered medical problem while You are in a clinical trial.

Benefits do not include anti-cancer agents that are not yet approved by the U.S. Food and Drug Administration or any item or service not included elsewhere in this Plan.

Skilled Nursing Facility. Skilled Nursing Facility during a covered confinement for other than Custodial Care is payable at the Participating Provider Percentage Payable up to 100 days per Calendar Year and You are required to obtain authorization from the Utilization Review Center prior to admission, failure to do so will result in a reduction in benefits by 50%.

Surgery Center. A Surgery Center is an outpatient facility that exclusively performs outpatient surgeries, complies with all licensing and other legal requirements, and is operating lawfully in the jurisdiction where it is located. The maximum allowable for non-Participating ambulatory surgery centers will be 100% of ASC RBRVS, payable at Plan Percentage.

Transplants. Services for Transplants will only be considered Covered Expense if the patient submits to case management by the Utilization Review Center. Although the patient does not have to abide by the decisions of the case manager, WGAT will not consider any treatment for this condition as Covered Expense unless the process of case management is performed.

Weight Control: Benefits are payable only for Medically Necessary Bariatric surgery for Morbid Obesity provided at a center of excellence.

Generally, "Morbid Obesity" means a) Claimant's body mass index (BMI) is 40 or greater, or a BMI of 35 or greater with an obesity-related co-morbid condition; and b) Claimant has previously undergone unsuccessful medical treatment of obesity.

24 Hour NurseLine. If listed on Your SBC this program provides You 24-hour access to a registered healthcare professional for Your medical questions. To access this service call 1-800-700-0197.

Eligible Medical Expenses not specifically listed are payable based on the type and location of services and subject to all terms, conditions, limitations and exclusions of the Plan.

SECTION 3 – MEDICAL EXCLUSIONS AND LIMITATIONS

WGAT is not responsible for the provision or quality of any type of Hospital, medical, or similar care. No Hospital or Physician is an employee or agent of WGAT.

Benefits provided under this Plan do not regulate the amounts charged by Providers of medical care.

When the amount WGAT paid exceeds the amount for which WGAT is liable under the Plan, WGAT has the right to recover the excess amount. This amount may be recovered from the Participant or the person to whom payment was made, or from any other plan.

This Plan in no way interferes with the right of any person entitled to Hospital benefits to select any Hospital. That person may choose any Physician who is a member of, or acceptable to, the attending staff and board of directors of the Hospital where services are received. However, that person's choice may affect the benefits payable according to the terms of the Plan.

The fact that a procedure or level of care is prescribed by a Physician does not mean that it is covered under the Plan and shall not bind WGAT in determining its liability under the Plan. Services that are not Usual, Customary and Reasonable shall include, but are not limited to: (1) procedures that are experimental, of unproven value, or of questionable current usefulness; (2) procedures that tend to be redundant when performed in combination with other procedures; (3) procedures that are unlikely to provide a Physician with additional information when they are used repeatedly; (4) procedures that can be performed with equal efficiency at a lower level of care.

Territorial Limitations include any benefits provided by the Plan and are subject to reduction if services are rendered or expense is incurred outside the United States. WGAT reserves the right to determine benefits payable, if any, for all services. Assignment of benefits to Providers located outside the United States (except Mexico Panel) will not be honored unless approved by WGAT in advance of the date of service.

Except as specifically stated otherwise, no benefits will be payable for:

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Alcohol-Illegal Activity/Use: Services, supplies, care, or treatment to a Covered Person, arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Alcoholism: see "Substance Use Disorders."

Behavior Disorders: Hyperkinetic syndromes, learning disabilities, behavior problems, or mental retardation, including the medications necessary to treat these as diagnosed, except for Attention Deficit Hyperactivity Disorder (ADHD) and Autism as specifically described in Medical Benefits, Covered Expense;

Biofeedback: Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Chiropractic Appliances: Appliances which include, but not limited to braces for the leg, wrist or foot. These appliances are also excluded from Durable Medical Equipment.

Complications of Non-Covered Treatment: Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered hereunder, unless expressly stated otherwise.

Cosmetic & Reconstructive Surgery, Etc.: Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

services necessitated by an Accidental Injury;

reconstructive surgery to correct damage to a body part resulting from disease or infection;

coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient; and

treatment necessary to correct a congenital abnormality (birth defect) resulting in the malformation or absence of a body part.

Custodial & Maintenance Care: Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Dental & Oral Care: Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

excision of oral tumors or cysts;

excision of benign bony growths of the jaws and hard palate;

external incision and drainage of cellulitis;

incision of sensory sinuses, salivary glands or ducts;

repair or prosthetic replacement of sound natural teeth that are damaged in an Accidental Injury;

Hospital room and board and necessary ancillary Hospital services when Inpatient confinement is necessary for a dental procedure;

surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

No charge will be covered under Medical Benefits for Dental or oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diagnostic Hospital Admissions: Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Developmental Delay: Treatment of or any services relating to mental retardation or learning disabilities, unless otherwise specified.

Ecological or Environmental Medicine: Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Environmental change, including Hospital or Physician expenses incurred in connection with prescribing an environmental change.

Educational or Vocational Testing or Training: Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Training of an eligible Plan Participant for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Elective Abortions: Charges incurred for the interruption of a pregnancy at the woman's request for reasons other than maternal or fetal disease.

Exercise Equipment / Health Clubs: Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Experimental / Investigational Treatment: See **General Exclusions**.

Eye Care: Radial keratotomy or other eye Surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting except as covered with the Preventive Care benefit at Appendix A. Reversals or revisions of these surgical procedures and complication of those surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

Foot Care, Routine: Routine and non-surgical foot care services and supplies including, but not limited to:

a) trimming or treatment of toenails;

b) foot massage;

c) treatment of corns, calluses, metatarsalgia or bunions;

d) treatment of weak, strained, flat, unstable or unbalanced feet;

e) orthotic inserts; and

f) orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Genetic Counseling or Testing: Counseling or testing concerning inherited (genetic) disorders in non-Plan members. Genetic counseling or testing in Plan members who do not have a Physician diagnosed symptomatic illness.

NOTE: The Plan will not limit benefits for treatment of a condition that is genetic but will cover any such condition in the same manner as for any other Sickness.

Habilitative services: Include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

Hair Restoration: Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hearing Exams & Hearing Aids: Hearing exams, hearing aids or the fitting of hearing aids.

NOTE: This exclusion will not apply to hearing screenings for newborns.

Homeopathic: Services, supplies, drugs or accommodations provided in connection with homeopathic treatment.

Hypnotherapy: Treatment by hypnotism.

Impotence; Sexual Dysfunction: Care, treatment, services and medication for impotence and sexual dysfunction; including, but not limited to, penile implants, sexual devices or any medications or Drugs pertaining to sexual dysfunction or impotence.

Impregnation: Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Inpatient Admissions: That are the following:

primarily for Diagnostic Services or Therapy Services; or

when the eligible Plan Participant is Ambulatory or confined primarily to bed rest, special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care.

Learning & Behavioral Disorders: Testing or treatment for learning or behavioral disorders.

Maintenance Care: See exclusions for “Custodial & Maintenance Care.”

Newborn Care: A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

Nicotine Addiction: See exclusions for “Smoking Cessation”.

Non-Prescription Drugs: Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the Plan’s prescription coverages.

Not Generally Accepted: Any services or supplies that are not in accordance with generally accepted professional medical standards.

Not Medically Necessary: Any services or supplies that are not Medically Necessary.

Not Physician Prescribed: Any services or supplies that are not recommended on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Obesity: Services or supplies for obesity, weight reduction or dietary control, except when provided for treatment of Morbid Obesity and Medically Necessary when prescribed by a Physician, where prior authorization is obtained and case management performed. Benefits are payable only for Surgical Services provided at a center of excellence.

Generally, “Morbid Obesity” means a) Claimant’s body mass index (BMI) is 40 or greater, or a BMI of 35 or greater with an obesity-related co-morbid condition; and b) Claimant has previously undergone unsuccessful medical treatment of obesity.

Orthognathic Surgery: Surgery to correct discrepancies in the relationship of the jaws.

Personal Comfort or Convenience Items: Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Personality Disorders: Services or supplies to treat a personality disorder.

Private Duty Nursing: Charges in connection with care, treatment or services of a private duty nurse.

Replacement Braces: Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the eligible Plan Participant’s physical condition to make the original device no longer functional.

Reversals or Revisions: Charges for surgical procedures and complications of those surgical procedures are excluded except when required to correct an immediately life-endangering condition.

Routine Exams - School/Sports/License: Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury, Pregnancy, or for an examination required through or on account of employment; for a marriage license, or for insurance, school, or camp application; or screening examination.

Self-Procured Services: Services rendered to an eligible Plan Participant who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sleep Disorders: Care and treatment for sleep disorders unless deemed Medical Necessary.

Smoking Cessation: Smoking cessation programs or any other services or supplies intended to assist an individual to quit smoking. Limited benefits are available for counseling and intervention (including cessation medications when prescribed) in the federally-required Preventive Care benefit. See **Appendix.**

Speech Therapy: Unless performed to assist in the restoration of normal speech that has been interrupted by injury or illness.

Sterilization Reversal: A sterilization reversal of a prior sterilization procedure.

Substance Use Disorders: A condition not diagnosed by a licensed Physician as a physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. In addition, this Plan does not cover dependence on ordinary drinks containing caffeine, regardless of diagnosis.

Surrogate Pregnancy: Coverage for a contracted pregnancy (any pregnancy entered into for a third party) is excluded from this Plan. Any complications due to such a pregnancy will not be covered by the Plan.

Therapy: Care and treatment related to aversion therapy, hypnosis therapy, primal therapy, Rolfing, psychodrama or megavitamin therapy.

TMJ / Jaw Joint Treatment: Treatment of jaw joint problems, including temporomandibular joint syndrome, cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.

Transplant-Related Expenses: Expenses incurred for or in connection with donations of organs.

Vaccinations: Immunizations or vaccinations other than: (1) those included within the "Preventive Care" coverages (see **Appendix**), and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Vitamins or Dietary Supplements – Prescription or non-prescription organic substances used for nutritional purposes, including Megavitamin therapy, except under Federally-required **Preventive Benefits**. See **Appendix.**

Vocational Testing or Training: Vocational testing, evaluation, counseling or training.

Weekend Admissions: Hospital expenses incurred on a weekend which coincides with admission to a Hospital between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless: (1) the admission occurs one day prior to a scheduled surgery, (2) the eligible Plan Participant is admitted on an emergency basis, or (3) the admission is for Pregnancy delivery.

Weight Control, Etc.: Services or supplies for obesity, weight reduction or dietary control, except when provided for treatment of Morbid Obesity and Medically Necessary when prescribed by a Physician. Generally, "Morbid Obesity" means a) Claimant's body mass index (BMI) is 40 or greater, or a BMI of 35 or greater with an obesity-related co-morbid condition; and b) Claimant has previously undergone unsuccessful medical treatment of obesity.

Wigs or Wig Maintenance: see "Hair Restoration."

EXPENSES FOR TREATMENT OR CARE NOT SPECIFICALLY INCLUDED AS A COVERED EXPENSE

Additional Expenses Not Covered In Mexico:

1, Physical Therapy
2. Transplant Services (Heart, Lung, Kidney, Bone Marrow, Etc.)
3. Eye Care/Vision Services
4. Mental Health Care
5. Open Heart Surgery
6. Cardiac Bypass Surgery
7. Treatment for Weight Loss, Smoking Cessation or Drug & Alcohol rehabilitation
8. Orthotics & Prosthetics (artificial limbs, eyes, hearing aids, shoe implants, orthopedic appliances).
9. Occupation injuries
10. Speech & Occupational Therapy
11. Infertility Treatment
12. Durable Medical Equipment
13. Skilled Nursing Care
14. Chemotherapy
15. Dental Care
16. Cosmetic Surgery
17. Brain Surgery
18. HIV-Aids
19. Out of Area

*- (See also **General Exclusions** section) -*

PART 5 – DENTAL BENEFITS

Please refer to the enclosed Schedule of Dental Benefits to determine whether or not Dental Benefits are provided for You and Your dependents. Actual payment for Covered Expense listed may be limited by Usual, Customary and Reasonable fees, negotiated fee, Deductible, Percentage Payable and/or benefit maximums as shown on the Schedule of Dental Benefits. Covered procedures not included will be paid at comparable values as determined by WGAT.

SECTION 1 – PLAN FACTORS

A. **Deductible:** Your Deductible is listed on the Schedule of Dental Benefits found in the back of this SPD. This Deductible amount is required for each eligible family member per Calendar Year. The maximum amount of family Deductible per year is three times the Deductible amount listed on the Schedule of Dental Benefits. The Deductible is the amount of Covered Expense that must be incurred before benefits are payable. Charges that do not qualify as Covered Expense cannot be used to satisfy the Deductible.

B. **Percentage Payable:** Your Percentage Payable is listed on the Schedule of Dental Benefits found in the back of this SPD. It is the percentage of Covered Expense payable after any applicable Deductible has been satisfied.

C. **Plan Maximum:** Your Plan Maximum is listed on the Schedule of Dental Benefits found in the back of this SPD. This amount of Covered Expense is the aggregate of benefits payable during any one Calendar Year.

SECTION 2 – COVERED EXPENSE

Unless excluded on the enclosed Schedule of Dental Benefits, Covered Expense includes the following:

A. Dentist for **diagnostic x-rays, prophylaxis, fluoride treatments** for children under age 19, **routine examinations**, and **Emergency palliative treatment.**

B. Dentist for dental **restorations,** including the materials necessary to complete the restoration, and for endodontic therapy, including necessary pulp capping and pulpotomy.

C. Dentist for removable and fixed **prosthetics**, including the Usual, Customary and Reasonable lab charges and materials necessary for construction of the **bridgework or dentures**.

D. Dentist for periodontal and general **oral surgery** (removal of tumors or cysts that are not related to teeth or dental tissue will only be payable under the medical Plan.)

E. Dental hygienist for **prophylaxis** if the hygienist is working under the supervision of a dentist.

F. Technician or **laboratory for materials or x-rays** ordered by a dentist if they do not duplicate charges for services billed by the dentist.

SECTION 3 – EXPENSE LIMITATIONS

Covered Expense for the following services is limited as shown below:

A. Examinations and/or prophylaxes are limited to two routine exams and two prophylaxes (with or without fluoride) per Calendar Year.

B. Topical fluoride is limited to children under age 19, limited to two treatments per Calendar Year.

C. Diagnostic x-rays are limited to one full mouth x-ray series in a 36-month period and two supplemental bitewings per Calendar Year.

D. Dentures or dental bridges are limited as follows:

1. Benefit payment for any denture or bridge includes all repairs or adjustments within six months of the date of placement.

2. Services necessary to replace teeth extracted prior to Your effective date under the Plan will be paid at 50% of the regular plan benefits.

SECTION 4 – PLAN PROVISIONS

Preexisting Condition (Dental): A Preexisting Dental Condition is any planned treatment program that was proposed, or teeth missing, prior to the date You or one of Your dependents became eligible under the Plan.

SECTION 5 – DENTAL EXPENSE NOT COVERED

Regardless of Prescription, application, cause, or purpose, the following charges are not covered unless otherwise stated in Your Schedule of Dental Benefits.

1. Services performed for correction of congenital malformations or solely for Cosmetic reasons.

2. Replacement of a bridge or denture within five years of the original date of installation for any reason, including loss or theft, unless:
   a. Necessary because of placement of a new opposing appliance;
   b. Due to extraction of additional natural teeth; or
   c. The appliance, while in the patient's mouth, was damaged beyond repair by an Accidental injury that occurred while covered under the Plan.

3. Replacement of any bridge or denture that is satisfactory or can be made satisfactory.

4. Any appliance or restoration, except full dentures, where the primary purpose is to change position of the teeth, stabilize teeth involved in periodontal, or restore occlusion.

5. Duplicate dentures or appliance, dental implants, regardless of the diagnosis, or protective mouth guards.

6. Experimental procedures, training in plaque control or oral hygiene, or dietary instruction.

7. Charges for a patient's failure to keep a scheduled appointment or for completion of claim forms.

8. Orthodontic services, except space maintainers, regardless of the diagnosis, unless indicated as a Covered Expense on the enclosed Schedule of Dental Benefits.

PART 6 – LIFE BENEFITS

Please refer to the enclosed Schedule of Life Benefits to determine whether or not life insurance benefits are provided for You and Your dependents, the amount of total benefits, and the exclusions and limitations.

Life insurance benefits are provided through a separate insurance contract between WGAT and BC Life & Health Insurance Company. Terms, conditions, limitations and exclusions are governed by the contract and shall prevail if there are any discrepancy between the terms, conditions, limitations and exclusions, unless otherwise required by Federal law. For additional information regarding the life insurance benefits, terms, conditions, limitations and exclusions, contact the life insurance provider noted below.

HOW TO USE THIS PROGRAM

All of the following Information must be provided to the life insurance provider in order to process a life insurance claim:

1) Copy of Death Certificate
2) Proof of current eligibility
3) A completed Beneficiary Claim Form (contact the customer service for a copy of this form).

Send the above documentation to:

Life Insurance Provider
BC Life & Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367
Customer Service: 818.234.2700

Life insurance benefits in excess of $25,000 require a health evidence application and approval from BC Life & Health Insurance Company. This is known as the **Non-medical Limit**. If the amount of insurance for your classification and age at any time is more than the Non-medical Limit, you must give health evidence satisfactory to BC Life & Health Insurance Company *before the part over the Limit can become effective*. This requirement applies when You first become insured, when Your classification changes, or if the amount for your classification changes, or if the amount for your classification is changed by amendment. Even if You are insured for an amount over the Limit, You will still have to meet this evidence requirement before any increase in your amount of insurance can become effective. The amount of Your insurance will be increased to the amount for Your classification and age when BC Life & Health Insurance Company has determined that the health evidence is satisfactory and You meet the actively at work requirement.

SECTION 1 – ELIGIBILITY

Eligible Status

1. Employees. Permanent full-time employees are eligible to enroll as insured employees. A full-time employee is one who works at least 20 hours a week in the conduct of the business of the group.
2. Family Members. The following are eligible to enroll as family members: (a) The employee's spouse or Registered Domestic Partner; and (b) An unmarried child.

Definition of Family Member

1. Spouse is the employee's spouse under a legally valid marriage. Spouse does not include any person who is: (a) covered as an insured employee; or (b) in active service in the armed forces.
2. Domestic partner is the employee's domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as an employee; or (b) in active service in the armed forces.
3. Child is the employee's, spouse's or domestic partner's unmarried natural child, stepchild, or legally adopted child, subject to the following:

    a. The child depends on the employee, spouse or domestic partner for financial support. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

b. The unmarried child is 8 or more days old, but, under 19 years of age, or if age 19 or over, that child is eligible until his or her 23rd birthday, provided he or she is enrolled as a full-time student (for 12 or more credits) in a properly accredited two year community college, four year college or university, or an accredited post-high school trade or technical school.

c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both:
   (i) the intent to adopt; and
   (ii) that the employee, spouse or domestic partner have assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

d. The term "child" does not include: (i) any child for whom the employee , spouse or domestic partner is the legal guardian, but who is not the employee's , spouse's or domestic partner's natural child, stepchild or adopted child;
   (ii) any person who is covered as an employee ; or
   (iii) any person who is in active service in the armed forces.

e. If both parents are covered as employees , their children may be covered as the family members of either, but not of both.

Deferred Effective Dates: If You are not actively at work on a full-time basis on the effective date of Your life insurance or on the effective date of an increase in benefits, then the life insurance or increase shall not apply to You until the date You return to active work on a full-time basis. The deferred effective date also applies to any change in this life insurance benefit.

Deferred Effective Date For Dependents Term Life Insurance:
A family member may be confined for medical care or treatment, at home or elsewhere. If a family member is so confined on the day that your insurance under a coverage for that family member, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the family member's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

Important Note for Newborn and Newly-Adopted Children: If the insured employee (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the employee, spouse or domestic partner will be covered from 8 days of age; and (2) any child being adopted by the employee, spouse or domestic partner will be covered from the later of the date on which: (a) the child is 8 days of age; or (b) the employee, spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

SECTION 2 – PLAN FACTORS

A. Your regular life insurance[§]:
   Under 65: total benefits are paid.
   Age 65 – 69: benefits are paid at 65% of total benefit.
   Age 70 – 74: benefits are 50% of total benefit.
   Age 75 – 79: benefits are 30% of total benefit.
   Age 80 & Over: 20% of total benefit, but not less than $1,000.

B. Additional amounts for Your Accidental death:
   Under 65: total benefits are paid.
   Age 65 – 69: benefits are paid at 65% of total benefit.
   Age 70 – 74: benefits are 50% of total benefit.
   Age 75 – 79: benefits are 30% of total benefit.
   Age 80 & Over: 20% of total benefit, but not less than $1,000.

C. Your dismemberment insurance: (loss of one hand, at or above wrist, or; loss of one foot, at or above ankle, or; loss of sight in one eye, complete & permanent is):
   Under 65: 50% of total benefits are paid.
   Age 65 – 69: benefits are 50% of the 65% of total benefit.

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§ Please refer to your Schedule of Life Benefits to determine which benefit apply to your insurance

Age 70 – 74: benefits are 50% of the 50% of total benefit.
Age 75 – 79: benefits are 50% of the 30% of total benefit.
Age 80 & Over: benefits are 50% of the 20% of total benefit, but not less than $1,000.

(loss of more than one of the above in any one Accident)
Under 65: total benefits are paid.
Age 65 – 69: benefits are paid at 65% of total benefit.
Age 70 – 74: benefits are 50% of total benefit.
Age 75 – 79: benefits are 30% of total benefit.
Age 80 & Over: 20% of total benefit, but not less than $1,000.

D. Please refer to the enclosed Schedule of Life Benefits to determine whether or not dependent life benefits are provided. When provided, benefits are payable as follows:

Classification	**Amount of Insurance****
Dependent Spouse or Registered Domestic Partner:	See Schedule of Life Benefits
Eligible Dependent Child(ren), according to their attained age:	
8 days or over but less than 6 months:	See Schedule of Life Benefits
6 months and over:	See Schedule of Life Benefits

** A family member's amount of insurance may not exceed 50% of the amount of your Employee life insurance benefit.

SECTION 3 – EMPLOYEE LIFE INSURANCE

Beneficiary Information: The benefits payable as a result of Your death will be paid to the beneficiary You designate on Your enrollment card, if such card is filed with WGAT or Your Employer. If You designate more than one person to share the any death benefit, You should indicate how the benefit is to be divided. Otherwise, the beneficiaries will share the benefit equally. All rights of any beneficiary cease if he or she dies before you do. If You did not designate a beneficiary prior to Your death, the insurance company shall pay benefits to the person or persons who appear first in the following list and who live to receive payment: Spouse, Registered Domestic Partner, child or children, parents, siblings, or to the executor of Your estate.

If Your beneficiary is a minor, or is incapable of giving valid receipt, the insurance company has the option of paying the benefits to any person or institution the insurance company believes has assumed custody and principal support of the beneficiary.

Alternate Payment Provisions: If there is no living beneficiary when Your death occurs, or non has been named, the death benefit will be paid to the executors or administrators of your estate. If there is no executor or administrator, we may at our option: (a) pay the benefit to your then living spouse; or (b) if there is no living spouse, pay equal shares of the benefit to your then living children; or (c) if there are no living children, pay the benefit in equal shares to your direct parents then living.

Accelerated Death Benefit: You may elect to receive a portion of your employee life insurance benefit while you are still living. This accelerated death benefit will be paid, provided:

1. You are in a class eligible for this benefit as shown in the Schedule of Life Benefits;
2. You elect the benefit in writing on the form provided by BC Life & Health Insurance Company;
3. You submit to BC Life & Health Insurance Company written certification from a physician that You have a life expectancy of 12 months or less, and receive approval this certification.

BC Life & Health Insurance Company reserves the right to have You examined by one or more physicians in connection with your claim for a accelerated death benefit.

Payment Provisions

If available, the accelerated death benefit must be paid to You during your Lifetime and while eligible under this insurance benefit. You may elect less than the maximum benefit, but You can receive an accelerated death benefit only once. Your payment will be made in one lump sum. If You have received an accelerated death benefit and then You recover from the qualifying condition, You will not be required to refund the benefit paid.

Effect of Payment on Other Benefits

The amount of Your employee life insurance will be reduced by the amount of accelerated death benefit paid. The remaining employee life insurance benefit, if any, will be paid in accordance with the terms of the policy. The accelerated death benefit paid to You does not affect the amount of Your employee accidental death and dismemberment insurance.

Payment of Premium

When the group stops paying premium for you, you are no longer eligible for an accelerated death benefit unless:

1. Your physician certifies that the qualifying condition was present before the date that premium payments ceased;
2. Your physician certifies that You have a life expectancy of 12 months or less from the date that premium payments ceased; and
3. You apply for an accelerated death benefit within 31 days from the date that premium payments ceased.

Change of Beneficiary: You are the only one who has the right to change Your beneficiary. You may designate a new beneficiary by filing a written request or new enrollment card with the Trust Fund Administrator and Your Employer. Consent of a previous beneficiary is not required to change beneficiaries. The change will become effective when WGAT receives the notice.

Optional Methods of Settlement: Your beneficiary may elect certain minimum monthly installments, based on the amount of Your insurance coverage, in place of a lump sum settlement. The insurance company should be contacted if Your beneficiary wishes this option.

Retiree Life Coverage: To qualify for life insurance benefits after You retire, You must be actively at work at the time You become covered under the Plan.

SECTION 4 – EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Death Benefit: We will pay a benefit if your death occurs under these conditions:

1. the death is a result of Your accidental injury; and
2. the injury occurred while You were insured by this coverage; and
3. the death occurred within 180 days of the injury.

This accidental death benefit will be paid when BC Life & Health Insurance Company receives due written proof that your death occurred under the conditions stated in this section. The benefit will be paid to your beneficiary. This benefit is the "full amount" of your accidental death and dismemberment insurance in effect under the terms of the Schedule of Life Plan Benefits on the date the accident occurred.

Benefit For Loss Of Hand, Foot Or Sight: BC Life & Health Insurance Company will pay a benefit if You incur the permanent loss of a hand, foot or sight under these conditions:

1. The loss is a result of your accidental injury which occurred while you were insured by this coverage; and
2. The loss occurred within 180 days of the injury; and
3. An accidental death benefit is not payable by this coverage for the same accident.

The benefit will be paid to You when we receive due written proof of a loss as specified in this section. Your "full amount" of accidental death and dismemberment insurance will be determined under the terms of the Schedule of Life Plan Benefits as of the date the accident occurred. The benefit to be paid is that full amount or one-half of it as shown in the schedule below. Payment will be made for each loss without regard to prior losses. But, the total benefit to be paid for two or more losses in any one accident will not exceed your full amount of accidental death and dismemberment insurance under the policy on the date the accident occurred.

Additional Benefit For Repatriation Of Remains, Using A Seat Belt, and Children's Education: Additional benefits in limited circumstances may be available. Please request a copy from BC Life & Health Insurance Company of the insurance contract excerpts for specific information.

SECTION 5 – PLAN EXCLUSIONS AND LIMITATIONS

A. The supplemental life portion of this coverage does not pay for Your loss of life if it results from or is caused by **suicide**, while sane or insane, and occurs within two years from the date You became insured with these life benefits.

B. The **accelerated death benefit** will not be paid if
   1. You submit written certification from Your Physician that You have a life expectancy of twelve months or less and the insurer disapproves this certificate.
   2. the reason for Your life expectancy being twelve months or less is due to Your attempted suicide while sane or insane, or Your intentionally self-inflicted injury.

C. If You have received an **accelerated death benefit** under this policy You are required by law or court order to use Your employee life insurance benefit to meet the **terms of Your creditors**, whether in bankruptcy or otherwise
   1. if You live in a community property state and the insurer has not received consent in writing form Your spouse or Registered Domestic Partner;

2. You are divorced or Your registered domestic partnership is legally dissolved, and as part of Your divorce agreement all or part of Your employee life insurance must be paid to Your children or former spouse or Registered Domestic Partner; or,
3. You have assigned Your rights under the employee life insurance coverage to an assignee or an irrevocable beneficiary, and the insurer has **not received consent**, in writing, that the assignee or irrevocable beneficiary has agreed to payment of the accelerated death benefit.

D. **Accidental death benefits** will not be paid by this coverage for a death that resulted from, or that is caused directly, wholly or partly by:
1. an illness or mental illness;
2. medical or surgical treatment of an illness or mental illness, whether the loss resulted directly or indirectly from the treatment;
3. an infection, unless it is pyogenic and occurs through and at the time of an accidental cut or wound;
4. suicide or attempted suicide, while sane or insane;
5. intentional self-injury;
6. commission of, or an attempt to commit, an assault or felony;
7. war, or any act of war;
8. participation in a riot;
9. being under the influence of any drug or substance (conviction is not necessary for determination of being under the influence). This does not apply if You are using a drug or substance prescribed by Your Physician. “Drug or substance” means any drug, narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison, or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as such act now exists, or is amended from time to time.
10. being intoxicated (conviction is not necessary for determination of being intoxicated). “Intoxicated” means being legally intoxicated as determined by the laws of the jurisdiction where the accident occurred.

PART 7 – VISION BENEFITS

Please refer to the enclosed Schedule of Vision Benefits to determine whether or not Vision Benefits are provided for You and Your dependents. Please refer to this insert for vision benefit options selected by Your Employer.

The vision care Plan features a panel of Providers who provide necessary vision services at a minimal charge to You, if You choose to use a Participating Provider. After any applicable Copayment, the Participating Provider will accept the fees as payment in full for the balance of covered services.

SECTION 1 – PLAN FACTORS

A. **Copayment Amount:** Your Copayment is listed on the Schedule of Vision Benefits.

SECTION 2 – PLAN BENEFITS USING A PARTICIPATING PROVIDER

A. **Vision Examination:** (each 12 months). Is a complete analysis of the eyes to determine the presence of vision problems or abnormalities.

B. **Lenses:** (each 12 months). Plan provides necessary single vision, bifocal, trifocal, or other complex lenses required for the patient's visual welfare.

C. **Necessary Contact Lenses:** (each 12 months). When the Participating Provider secures prior approval, the Plan covers contact lenses necessary: (1) after cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for anisometropia; (4) for keratoconus. Contact lenses selected for any other reason are considered "cosmetic."

D. **Frames:** (each 24 months). Offers a selection of standard frames. If You select a frame that costs more than the standard, or a large frame that requires oversize lenses, there will be an additional charge to You.

SECTION 3 – PLAN BENEFITS USING A NON-PARTICIPATING PROVIDER

If You choose not to use a Provider who is a member of the panel of providers, You may go to any other optometrist, ophthalmologist, and/or optician, pay the Provider his full fee, and be reimbursed according to the following schedule:

A. **Vision Examination:** up to $40 each 12 months.

B. **Materials:**
Single Vision Lenses ..... up to $ 40 a pair.
Bifocal Lenses ..... up to $ 60 a pair.
Trifocal Lenses ..... up to $ 80 a pair.
Lenticular Lenses ..... up to $125 a pair.
Frame ..... up to $ 45 a pair.

C. **Contact Lenses** (including vision exam):
Necessary* ..... up to $210 a pair.
Cosmetic..... up to $105 a pair.

*Determination of "necessary" versus "elective" contact lenses under the non-member reimbursement schedule will be consistent with Participating Provider services.

Remember, there is no assurance that these benefits will be sufficient to pay for the services from a non-Participating Provider.

The above lens allowance is for two lenses. If only one lens is needed, the allowance will be one-half of the pair allowance.

SECTION 4 – PLAN PROVISIONS

A. **Extra Costs:** The Plan is designed to cover Your visual needs, not cosmetic materials. If You select any of the following and Your Participating Provider does not receive prior approval, there may be an extra charge to You: (1) blended lenses; (2) contact lenses; (3) double segment bifocals; (4) multifocal lenses; (5) oversize lenses; or (6) photochromic lenses or tinted lenses other than Pink #1 or #2.

If a Participating Provider fits "necessary contact lenses" without obtaining prior authorization, the doctor will be paid at the rate shown for a non-Participating Provider for cosmetic contact lenses and You may be required to pay the difference.

B. **Experimental:** A treatment of an experimental nature is one that is not used universally or accepted by the vision care profession, as determined by the vision care plan.

Certain benefits require prior authorization before such benefits are covered. If You would like more information regarding the criteria for authorizing or denying benefits, You may contact the vision care plan's Customer Service number listed on the enclosed Schedule of Vision Benefits.

SECTION 5 – HOW TO USE YOUR VISION BENEFITS

Claims for vision care are paid by the vision care plan. However, to use the Plan correctly, You should:

1. Call the number on the enclosed Schedule of Vision Benefits for a listing of member doctors.

2. Select a member doctor and make an appointment. Within the limits of the Plan You will be required to pay a Plan Copayment for all services of a Participating Provider for the vision care plan.

SECTION 6 – NOT COVERED EXPENSES

A. Orthotics or vision training and any associated supplemental testing; plano lenses; or two pair of glasses in lieu of bifocals.

B. Replacement of lenses and frames furnished under this plan that are lost or broken except at the normal intervals when services are otherwise available.

C. Medical or surgical treatment.

D. Corrective vision treatment of an experimental nature.

E. Services/materials not indicated as covered.

PART 8 – GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Court-Ordered Care, Confinement or Treatment – Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

Criminal Activities: Any Injury resulting from or occurring during the eligible Plan Participant's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Drugs in Testing Phases: Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Error: Charge for care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the eligible Plan Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Sponsor, in its sole discretion, unreasonably gave rise to the expense.

Excess Charges: Charge for care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Sponsor's determination as set forth by and within the terms of this document.

Excluded Providers or Facilities: Except as provided elsewhere in the Plan; the following are excluded Providers or Facilities:

a) Naturopaths;

b) Audiologists;

c) Christian Science service providers;

d) Homeopathic Physicians; and

e) Massage Therapists.

Experimental / Investigational Treatment: Expenses that are Experimental or Investigational as determined by Medicare. The term "experimental procedures" or "experimental treatment" refers to medications, therapy, surgery, clinical trials, treatment protocols or other medical treatment still under study, not recognized as accepted medical practice and/or defined as experimental by the American Medical Association and/or by any governmental agency, including but not limited to, the Food and Drug Administration, the Office of Health Technology Assessment, the HCF Medicare Coverage Issues Manual and/or the Centers for Medicare and Medicaid (CMS). Items, drugs or substances which come under the jurisdiction of the United States federal Food and Drug Administration which are being tested but have not been approved by the FDA and/or CMS or approved drugs used for unrecognized, unaccepted or not approved treatment protocol, are also considered experimental. The determination that a particular drug or treatment is experimental for any one treatment does **not** mean that the drug or treatment is deemed appropriate in another treatment. For example, a drug deemed non-experimental for the treatment of breast and kidney cancer may be Experimental for the treatment of breast and liver cancer. See **Definitions** for further information.

Food Supplements: Charges related to food supplements or augmentation, in any form (unless Medically Necessary to sustain life in a critically ill person).

Forms Completion: Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities: Services furnished to the eligible Plan Participant in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments and for which the eligible Plan Participant has no legal obligation to pay.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Hospital Employees: Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.

Illegal acts. Charges for any illness or injury which is incurred while taking part or attempting to take part in an illegal activity, including misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications: Services, supplies, care or treatment to an eligible Plan Participant for Injury or Sickness resulting from that eligible Plan Participant's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured eligible Plan Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Late-Filed Claims: Claims that are not filed with the Trust for handling within the required time periods as included in the **Claims Procedures** section.

Medical Necessity: Services that are not Medically Necessary.

Medicare: No benefit shall be provided for a Covered Medical Service, supply, equipment, device, procedure, test Drugs or other charges for which payment has been made under Medicare Part A or would have been made if the eligible Plan Participant had applied for such payment when payment under this Plan is required by federal law.

Military Service: Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments: Expenses incurred for failure to keep a scheduled appointment.

Negligence: Charge for care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

No Charge / No Legal Requirement to Pay: Services for which no charge is made or for which an eligible Plan Participant is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts an eligible Plan Participant is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Non-Compliance: All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

Not Accepted/Non-Standard: Charges for care, supplies, treatment, and/or services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Actually Rendered: Charge for care, supplies, treatment, and/or services that are not actually rendered.

Not Listed Services or Supplies: Any services, care or supplies that are not specifically listed in this Summary Plan Description or as described in the corresponding Plan Document as Covered Expenses.

Other Coverage: Services or supplies for which an eligible Plan Participant is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States: Charges incurred outside of the United States if the eligible Plan Participant traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc.: Any postage, shipping or handling charges that may occur in the transmittal of information to the Plan Administrator. Interest or financing charges, except when such charges are a result of untimely claim processing in accordance with state law.

Prior to Effective Date / After Termination Date: Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

Provider Error: Charge for care, supplies, treatment, and/or services required as a result of unreasonable provider error.

Relative or Resident Care: Any service rendered to an eligible Plan Participant by a relative (i.e., a spouse, or a parent, brother, sister, or Child of the Employee or of the Employee's spouse) or anyone who customarily lives in the eligible Plan Participant's household.

Sales Tax, Etc.: Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury: Any expenses resulting from voluntary self-inflicted Injury or voluntary attempted self-destruction, except that, this exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Subrogation, Reimbursement, and/or Third Party Responsibility: Charge for care, supplies, treatment, and/or services of an Injury or Sickness not payable by virtue of the Plan’s subrogation, reimbursement, and/or third party responsibility provisions.

Telecommunications: Advice or consultation given by or through any form of telecommunication.

Travel: Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

War or Active Duty: Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions: Any condition that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not the eligible Plan Participant has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. If the Plan elects to provide benefits for any such condition, the Plan will be entitled to establish a lien upon such other benefits up to the amount paid.

PART 9 – COORDINATION OF BENEFITS/ SUBROGATION

SECTION 1 – COORDINATION OF BENEFITS

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan: Shall include, but is not limited to:

any primary payer besides the Plan;

any other group health plan;

any other coverage or policy covering the eligible Plan Participant;

any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

any policy of insurance from any insurance company or guarantor of a responsible party;

any policy of insurance from any insurance company or guarantor of a third party;

worker's compensation or other liability insurance company; or

any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan: The coverages of this Plan.

Allowable Expense: The Usual, Customary and Reasonable charge for any Medically Necessary eligible medical, dental and vision items of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision herein, this Plan's Covered Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Any expense or service that is not covered by any of the plans is not a Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

a) the difference in cost between a hospital's semi-private room and a private room unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one (1) of the plans routinely provides coverage for private rooms;

b) any amount in excess of the highest usual and customary allowance, if a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances;

c) any amount in excess of the lowest of the negotiated fees, if a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees; and

d) the lesser of the amounts, if a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees.

e) If both Spouses or Registered Domestic Partners are eligible as Employees under WGAT and cover each other as dependents, benefits will be processed under both coverages, except under the Prescription Drug card program. For Participants who have dual (two or more) insurance policies, WGAT does not offer coordination of benefit for prescriptions. Participants must choose only one of the available policy prescription benefits.

f) WGAT does not honor or coordinate benefits with drug coupon/copay cards. Participants are responsible for their copayments or co-insurance as indicated in this document or their summary of benefits and coverage.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements) will not be considered an Allowable Expense.

Claim Determination Period: A period that commences each January 1st and ends at 12 o'clock midnight on the next succeeding December 31st, or that portion of such period during which the Claimant is covered under this Plan. The Claim Determination Period is the period during which this Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

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

EFFECT ON BENEFITS UNDER THIS PLAN

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules. However, these rules do not apply when This Plan provides “excess” benefits. See the “When This Plan Provides Excess Benefits Only” provision at the end of this section for more information.

When Other Plan Does Not Contain a COB Provision: If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits after such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Covered Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision: When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits before an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits after an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules. The first of the following rules that describes which plan pays its benefits before another plan is the rule to be used. However, these rules do not apply when This Plan provides “excess” benefits. See the “When This Plan Provides Excess Benefits Only” provision at the end of this section for more information.

No COB Provision: If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary.

Automobile Coverage: When medical benefits are available under vehicle insurance, This Plan will always be considered an excess (or secondary) coverage and will not reimburse vehicle plan deductibles. This applies without

regard to an individual's election under PIP (personal Injury protection) coverage with an auto carrier. This Plan shall always be considered secondary and will coordinate with benefits provided or required by any no-fault insurance state, whether or not a no-fault policy is in effect, and/or any other carrier.

HMO Coverage: If an individual is covered as a primary beneficiary under a Health Maintenance Organization (HMO) but does not use the HMO provider for health care services, then This Plan will provide a secondary benefit equal to 20% of Covered Expenses incurred.

Application to Benefit Determinations: The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

the Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

the rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination: For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

- a plan without a coordinating provision will always be the primary plan;
- the benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
- if the person for whom claim is made is a dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    - when the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a dependent of the parent without custody; or
    - when the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the stepparent, and the benefits of a plan which covers that Child as a dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody.
    - notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a dependent Child; and
- when the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Medicare as an "Other Plan": Medicare will be the primary, secondary or last payer in accordance with federal law.

Benefits under this Plan will be integrated with any benefits payable under the federal Medicare program. Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan will make this determination based on the information available through CMS.

NOTE: An active Employee (or spouse) age sixty-five (65) or older who is eligible for Medicare and who chooses to have Medicare as their primary carrier, may not also have coverage hereunder.

Medicaid Issues: Eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

Disability Extensions: If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

TRICARE: The Plan will pay primary to TRICARE and a State child health plan to the extent required by federal law.

Automobile Limitations: When medical payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

Non-Dependent vs. Dependent: The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, subscriber or retiree is secondary and the Other Plan is primary.

Child Covered Under More Than One Plan: When the Claimant is a dependent Child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the Child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent Child and the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent Child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

a) the plan of the Custodial Parent;

b) the plan of the spouse of the Custodial Parent;

c) the plan of the noncustodial parent; and then

d) the plan of the spouse of the noncustodial parent.

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

Active vs. Inactive Employee: The plan that covers the Claimant as an Employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an Employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee: If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an Employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage: If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information: For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Plan Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Plan Administrator such information as may be necessary to enforce this provision.

Facility of Payment: A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Plan Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery: In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the eligible Plan Participant or his or her Dependents. Please see the Recovery of Payments provision within the Claims Procedures section for more details.

WHEN "THIS PLAN" WILL PROVIDE EXCESS BENEFITS ONLY

Excess Benefits: If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (see "Coverage" as defined in the **Subrogation and Reimbursement, Third Party Recovery & Erroneous Payment** section and including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under This Plan shall apply only as an excess over such other sources of Coverage. This Plan's benefits shall be excess to:

a) any responsible third party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation: When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Internal Plan COB: If Spouses or Registered Domestic Partners are eligible as Employees under WGAT and cover each other as dependents, benefits will be processed under both coverages, except under the Prescription Drug card program.

SECTION 2 – SUBROGATION AND REIMBURSEMENT, THIRD PARTY RECOVERY

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Covered Person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or another party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or another party for payment of medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or another party and will be entitled to reimbursement. In addition, the Plan shall have the first lien against any recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first reimbursement out of any recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

- execute and deliver a Subrogation and Reimbursement Agreement;
- authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid;
- immediately reimburse the Plan, out of any Recovery made from another party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
- notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full

reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

When a Covered Person Retains an Attorney
The Covered Person agrees not to retain an attorney who does not recognize and consent to the fact that the Plan precludes the operation of the "made-whole'' and "common fund" doctrines, and as such, will not assert either doctrine against the Plan's lien. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the recovery only after the Plan has received full reimbursement.

A Covered Person who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the Covered Person or his or her attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor, Deceased or of Legal Incapacity
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Defined Terms for Subrogation:

Another Party – Any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Person – Anyone covered under the Plan, including minor Dependents.

Reasonable Cooperation – For purposes of this Plan, reasonable cooperation is defined as the Claimant, the Claimant's representative and/or the Claimant's Provider responding to a request from the Plan Sponsor, Plan Administrator and/or Third Party Administrator by the third request or within ninety (90) days from the first request.

Recovery – Any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.
Reimbursement – Repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

Subrogation – The Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

Third Party - means any individual or entity (including an insurance company) who is legally obligated to pay a Recovery to, or on behalf of, a Covered Person.
Erroneous Payments

To the extent payments made by this Plan with respect to a Covered Person are in excess of the maximum amount of payment necessary under the terms of the Plan whether such payment is applicable Negotiated Contract Rate or the Usual, Customary and Reasonable rate, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Person.

Excess Insurance - Except as otherwise provided under the Plan's Coordination of Benefits Section, the following rule applies: (a) If at the time of injury, illness, disease, or disability there is available, or potentially available, any Coverage (including Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits Article. (b) The Plan's benefits shall be excess to—

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- workers' compensation or other liability insurance company; or
- any other source, including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Severability
In the event that any provision of this Article is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Article and Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been inserted in the Plan.

Right To Receive And Release Information
For purposes of determining the applicability of the coordination of benefits and subrogation provisions of this Plan, or any provision with a similar purpose of another plan, and implementing those provisions, the Plan Administrator may release necessary information to, or obtain necessary information from, any other organization or person.

PART 10 – TERMINATION AND CONTINUATION OF COVERAGE

SECTION 1 – TERMINATION

Your coverage will end on the earliest of the following dates, according to WGAT records: 1) the last day of the calendar month for which the Employer has made the required contribution; 2) the date the Plan is discontinued; 3) the date Your Employer terminates participation.

If You cover dependents, their coverage will automatically terminate when Yours does. Coverage for any one dependent will cease on the earliest of the following dates: 1) for a Spouse or Registered Domestic Partner, on the last day of the month in which a dissolution of marriage or Registered Domestic Partnership occurs; 2) for a child, on the last day of the month in which the child ceases to meet the definition of eligible dependent; 3) the date dependent coverage is discontinued under the Plan.

Certificate of Coverage – A certificate stating when You were covered under the Plan will be provided to You when You lose coverage under the Plan.

SECTION 2 – CONTINUATION OF COVERAGE

If Your Employer has an established policy, approved by WGAT, of providing coverage for You during periods of **temporary layoff, leave of absence, or Disability,** the Employer may continue contributions for You in a manner that precludes selection against WGAT for a maximum of 180 days following the date Your active full-time service has ended.

California Family Rights Act and Family Medical Leave Act (Applies if Your Employer has 50 or more employees)

If a covered Employee takes a qualified leave of absence, as recognized by the Family Medical Leave Act (FMLA) of 1993 or similar state law, the health care coverage for the Employee and eligible Dependents may be continued at the Employee group rate during an authorized FMLA leave as if the Employee were Actively at Work.

In accordance with the FMLA, an Employee is entitled to continue coverage if he or she: 1) has worked for the Employer for at least 12 months, 2) has worked at least 1,250 hours in the year preceding the start of the leave and 3) is employed at a worksite where the Employer employs at least fifty (50) employees within a 75-mile radius.

If the Employee does not return after the leave period for reasons other than a serious medical condition of the Employee or a family member or circumstances beyond the Employee's control, the Employee will be charged retroactively for the full contribution (employee plus Employer portions) for group health care coverage paid on behalf of the Employee during the leave.

The maximum duration of the qualified leave is up to twelve (12) weeks under the Family Medical Leave Act in any 12-month period. Such leave must be for one or more of the following reasons:

- The birth of a Child of the Employee and in order to care for the child, if the leave is concluded within 12 months of the birth;
- The placement of a Child with the Employee for adoption or foster care, if the leave is concluded within the 12 months of the placement;
- To care for a spouse, son or daughter, or parent of the Employee where such relative has a serious health condition; or
- Employee's own serious health condition that makes the Employee unable to perform the function of his or her position.

Plan benefits are to be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. An Employee can obtain a more complete description of their FMLA rights from their Employer. Any Plan provisions, which are found to conflict with the FMLA, will be modified in order to comply with at least the minimum requirements of the law itself.

In addition, the **National Defense Authorization Act of 2009** amends FMLA and permits a spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a member of the Armed Forces, including a

member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

California Pregnancy Disability Act
If your Employer has an established policy of continuing benefits while on a pregnancy leave of absence the Plan will continue benefits for up to four months. This continuation of benefits runs concurrently with the Family Medical Leave Act if applicable.

Organ Donor (Michelle Maykin Memorial Protection Act)
If you are granted a leave of absence under the Michelle Maykin Memorial Protection Act (California Labor Code Section 1508) your health Plan benefits will be maintained by your Employer for up to 30 days and up to five business days for bone marrow transplant.

Following A Military Leave of Absence – USERRA
Regardless of an Employer's established termination or leave of absence policies, the Plan will always comply with the regulations of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and any amendments, for an Employee entering service in the "uniformed services."

In order for the Employee to be entitled to USERRA rights, the following conditions must be met:

- The Employee's absence must be for service in the uniformed services;
- If possible, the Employee (or appropriate officer of the military) must give the Plan Sponsor advance notice of the Employee's absence from work;
- The Employee's absence from work must not exceed five (5) years (subject to certain exceptions); and
- The Employee was released from military service under honorable conditions.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months, or the duration of active military service, whichever is shorter. The Employee must pay the entire cost of the coverage if the leave duration is over 30 days. The premium may not exceed 102% of the actual cost of the coverage.

Regardless of whether an Employee elects continuation coverage under USERRA, the coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions subject to the following:

- The Employee must return to employment on the first full business day following completion of military service for military leave of 30 days or less.
- The Employee must submit an application for employment.
  within 14 days of completion of military service for leaves of 31-180 days; or
  within 90 days of completion of military service for leaves of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. The Employee and any Eligible Dependents will not be subject to a Waiting Period.

An Employee who is ordered to active military service is considered to have experienced a COBRA qualifying event along with any of their Eligible Dependents. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the above stipulations.

Any Deductible or coinsurance satisfied prior to the leave of absence will be credited if reinstatement takes place within the same Calendar Year.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain eligible Plan Participants whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of

the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

NOTE: COBRA—APPLIES TO EMPLOYERS WITH 20 OR MORE EMPLOYEES AND EXCLUDES REGISTERED DOMESTIC PARTNERS (CAL-COBRA APPLIES TO EMPLOYERS WITH 2-19 EMPLOYEES AND INCLUDES REGISTERED DOMESTIC PARTNERS).

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse (as defined by the federal Defense of Marriage Act) or Child of a covered Employee.

Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such Child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the Child's birth or placement for adoption, the same coverage that a Dependent Child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the Child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent Child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

a. voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

b. reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

c. for an Employee's spouse or Child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

d. for an Employee's spouse or Child, the divorce or legal separation of the Employee and spouse;

e. for an Employee's spouse or Child, the death of the covered Employee; or

f. for an Employee's Child, the Child's loss of Dependent status (e.g., a Dependent Child reaching the maximum age limit).

Non-COBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notice Responsibilities - If the Employer is the Plan Sponsor and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Sponsor must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within

forty-four (44) days of the event. If the Employer is not the Plan Sponsor, then the Employer's notification to the Plan Sponsor must occur within thirty (30) days of the Qualifying Event and the Plan Sponsor must provide Qualified Beneficiaries with their COBRA rights notice within fourteen (14) days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Sponsor must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a Child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent Child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the section entitled **COBRA Notice Requirements for Eligible Plan Participants** (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Sponsor must notify the Qualified Beneficiary(ies) of their continuation rights within fourteen (14) days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) sixty (60) days after coverage ends due to a Qualifying Event, or (2) sixty (60) days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the sixty (60)-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Sponsor.

Open enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second sixty (60)-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a twelve (12)-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the eleven (11)-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within forty-five (45) days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a thirty (30)-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's twelve (12)-month determination period if:

the cost previously charged was less than the maximum permitted by law;

the increase occurs due to a disability extension (i.e., the eleven (11)-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least thirty (30) days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State

through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is eighteen (18) months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the eighteen (18) months is extended to twenty-nine (29) months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is thirty-six (36) months from the date the Employee is enrolled in Medicare; and

for any other Qualifying Event, the maximum coverage period ends thirty-six (36) months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an eighteen (18)-month or twenty-nine (29)-month maximum coverage period and is followed by a second Qualifying Event that allows a thirty-six (36)-month maximum coverage period, the original period will be expanded to thirty-six (36) months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than thirty-six (36) months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An eleven (11)-month disability extension (an extension from a maximum eighteen (18) months of COBRA continuation coverage to a maximum twenty-nine (29) months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled in the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the Plan Sponsor must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable period. The notice must be provided within sixty (60) days of the disability determination and prior to expiration of the initial eighteen (18)-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Sponsor of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the eleven (11)-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the twenty-nine (29)-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary (where applicable);

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social

Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

a. twenty-nine (29) months after the date of the Qualifying Event, or the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension; and

c. the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than thirty (30) days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Administrator can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted Child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 (“TAA”), the Plan is deemed to be “Qualified Health Insurance” pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation (“PBGC”), pursuant to TAA as of or after November 4, 2002. The Plan Sponsor shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Non-electing TAA-Eligible Individual - A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual - An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period - with respect to a TAA-related loss of coverage, the sixty (60)-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage - means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

Total Disability – If You, or any eligible dependent, are totally Disabled due to injury or sickness at the time **medical benefits** would otherwise terminate, such benefits will be continued only for the Disabling condition and through the earliest of the following dates: (1) the date Your Physician certifies that total Disability ends; (2) the date maximum Plan benefits have been paid for the Disability; (3) one year from the date major medical coverage terminated; (4) the date Your former Employer ceases to provide coverage to Your class of Employees with WGAT; (5) the date You or Your dependents become effective with another group health plan.

You will be considered totally Disabled when Your attending Physician certifies that You are unable to perform the duties of any gainful employment for wages or profit for which You are reasonably qualified by training and education. Your eligible dependent will be considered totally Disabled when an attending Physician certifies that he or she is unable to engage in the normal activities of a person of the same age and sex due to injury or sickness.

If You are totally Disabled prior to Your sixtieth birthday due to injury or sickness at the time Your eligibility terminates, You may be eligible for an extension of **life insurance** coverage for the duration of Your total Disability. Application for such extension must be filed with the insurance company after You have been unable to work for at least six (6) months, but before twelve (12) months of total Disability have elapsed. To apply for a life benefit extension, please ask Your Employer or Your local WGAT office for a life benefit extension application.

Conversion - If the Plan Sponsor offers a conversion privilege to Non-COBRA Beneficiaries and in conjunction with the health benefits of the Plan, then a Qualified Beneficiary has the right to exercise the conversion option when he reaches the end of his COBRA continuation coverage.

The option to enroll in the conversion health plan must be given within one-hundred eighty (180) days before COBRA coverage ends. The premium for a conversion policy may be more expensive that the cost of COBRA coverage or the cost of Plan coverage. Also, the conversion policy may provide a lower level of coverage.

The conversion option is not available if the Qualified Beneficiary terminates COBRA coverage before reaching the end of the maximum period of COBRA coverage.

There may be other coverage options for the Employee and his or her dependents. The Covered Person will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, the Covered Person could be eligible for a new kind of tax credit that lowers his or her monthly premiums right away, and the Covered Person can see what your premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit eligibility for coverage for a tax credit through the Marketplace. Additionally, the Covered Person may qualify for a special enrollment opportunity for another group health plan for which he or she is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

PART 11 – ERISA INFORMATION AND STATEMENT OF RIGHTS

SECTION 1 – ERISA INFORMATION AND CLAIM APPEAL PROCEDURES

As a Participant in this Plan You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents that the Plan filed with the U.S. Department of Labor, such as detailed annual reports and Summary Plan Descriptions;

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and

3. Receive a summary of the Plan's annual financial report if the Plan covers 100 or more Participants. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of Your Employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied in whole or in part, You may receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider Your claim. WGAT reserves to itself discretionary authority to determine benefit eligibility.

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 that is denied or ignored in whole or in part, You must first file an appeal with the Plan Administrator of WGAT. Filing an appeal with the Plan Administrator is the only way to protect Your appeal rights. Following a denial from the Plan Administrator, You may file suit in a federal court. Suit must be filed with the court within no more than ninety (90) days from the date of the denial. 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 a suit in federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay those costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim frivolous.

If You have any questions about Your Plan, contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.

NOTE: If You are a member of a union that negotiated for these benefits on Your behalf, You are entitled to request a copy of the union agreement from the Plan Administrator.

SECTION 2 – CLAIM APPEAL PROCEDURES

SUBMITTING A CLAIM

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the Utilization Management section for that information.

   Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee

of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. Failure to furnish complete proof of loss within the time required will invalidate any claim. In no event will a claim be accepted more than a year after the 90-day time limit has expired.

   NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to Non-Participating Providers of service unless the Participant requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Participant who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Participant, as created by an assignment of rights made by the Participant or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the

	completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial Complete Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), plan responds with written or electronic benefit determination.
Claimant Appeals	See "appeal procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of claimant's appeal.
An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary is subject to the urgent claim rules.
"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.
A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	
Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, plan notifies claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives Completing Information	Within 15 days, plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to claimant - see definition of "full notice" below.

Claimant Makes Initial Complete Claim Request	Within 15 days, plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to claimant - see definition of "full notice" below.
Claimant Appeals	See "appeal procedures" subsection.
Plan Responds to Appeal	Within 15 days for each appeal.
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.	
"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant – see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 30 days for each appeal.
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

If a claim is denied in whole or in part, You may request a review by writing to the Plan Administrator, giving the reason(s) You disagree with the denial of the claim. This written appeal must be filed within 180 days from the date the notice of denial was mailed to You as indicated on the postmarked envelope. You may request a “claim appeal form” from Your local WGAT office or You may submit a letter to the Plan Administrator containing Your name, address, ID Number, the claim number assigned by WGAT, the date services were provided, a brief explanation of the reasons for the appeal, and any additional information You feel might apply. You may request copies of any documents created by this office regarding Your denial. The Administrator may make a reasonable charge for the copies.

Upon receiving Your request, Your claim will be reviewed as follows:

A. **LIFE AND ACCIDENTAL DEATH OR DISMEMBERMENT**

BC Life & Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367, will make a full and fair review and may request additional documents it deems necessary. A final decision will be made within 60 days of the date the company receives Your written request for review. If special circumstances require a longer period of time, You will be notified of the reasons for the extension and a final decision will be made no later than 180 days after receipt of Your review request. The final decision will be mailed to You, including the reasons for the decision and reference to the exact policy provisions on which the final appeal is based.

Legal Action: No attempt to recover of the life insurance plan through legal or equity action may be made until at least 60 days after written proof of loss has been furnished. No action may be started later than three (3) years from the time written proof of loss is required to be furnished.

B. **VISION CARE SERVICES**

EYEMED GRIEVANCE PROCESS

If You ever have a question or problem, Your first step is to call EyeMed's Customer Service Department's toll-free number at (866) 723-0514 Monday through Friday, 6:00 a.m. to 7:00 p.m. Pacific Standard Time. EyeMed's Customer Service Department will make every effort to answer Your question and/or resolve the matter informally. If a matter is not initially resolved to Your satisfaction, You may communicate a complaint or grievance to EyeMed in writing by using the complaint form that may be obtained upon request from the EyeMed Customer Service Department. Complaints and grievances include disagreements regarding access to care, quality of care, treatment, or services. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in EyeMed's review. EyeMed will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of the complaint or grievance. If EyeMed determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to You to indicate EyeMed's expected resolution date. Upon final resolution, You will be notified of the outcome in writing.

VSP GRIEVANCE PROCESS

If You ever have a question or problem, Your first step is to call VSP's Customer Service Department's toll-free number Monday through Friday, 6:00 a.m. to 7:00 p.m. Pacific Standard Time. VSP's Customer Service Department will make every effort to answer Your question and/or resolve the matter informally. If a matter is not initially resolved to Your satisfaction, You may communicate a complaint or grievance to VSP in writing by using the complaint form that may be obtained upon request from the VSP Customer Service Department. Complaints and grievances include disagreements regarding access to care, quality of care, treatment, or services. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to You to indicate VSP's expected resolution date. Upon final resolution, You will be notified of the outcome in writing.

C. **HEALTH PLANS**

All claims and questions regarding health claims should be directed to the Plan Administrator. The Plan Sponsor shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Sponsor decides in its discretion that the eligible Plan Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Plan Administrator; provided, however, that the Plan Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each eligible Plan Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Sponsor in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Sponsor in its sole discretion shall determine that the eligible Plan Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the eligible Plan Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

An eligible Plan Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the eligible Plan Participant receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the eligible Plan Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to an eligible Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the eligible Plan Participant or the eligible Plan Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the eligible Plan Participant's medical condition, would subject the eligible Plan Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan does not require the eligible Plan Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The eligible Plan Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

The Plan Sponsor determines that the course of treatment should be reduced or terminated; or

The eligible Plan Participant requests extension of the course of treatment beyond that which the Plan Sponsor has approved.

If the Plan does not require the eligible Plan Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Sponsor to request an extension of a course of treatment. The eligible Plan Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed within 90 days of date expense is incurred. In no event will the claim be payable if submitted to WGAT more than 1 year after the due date required under this provision. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Plan Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Plan Administrator within forty-five (45) days from receipt by the eligible Plan Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Sponsor shall notify the eligible Plan Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the eligible Plan Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.

If the eligible Plan Participant has not provided all of the information needed to process the claim, then the eligible Plan Participant will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim.

The eligible Plan Participant will be notified of a determination of benefits as soon as possible, but not later than seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:

the Plan's receipt of the specified information; or

the end of the period afforded the eligible Plan Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the eligible Plan Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the eligible Plan Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the eligible Plan Participant may request an expedited review under the external review process.

Pre-service Non-urgent Care Claims:

If the eligible Plan Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15)-day extension period.

If the eligible Plan Participant has not provided all of the information needed to process the claim, then the eligible Plan Participant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The eligible Plan Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Sponsor and the eligible Plan Participant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Sponsor is notifying the eligible Plan Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The eligible Plan Participant will be notified sufficiently in advance of the reduction or termination to allow the eligible Plan Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

Request by Eligible Plan Participant Involving Urgent Care. If the Plan Sponsor receives a request from an Eligible Plan Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the eligible Plan Participant makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the eligible Plan Participant submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

Request by Eligible Plan Participant Involving Non-urgent Care. If the Plan Sponsor receives a request from the eligible Plan Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

Request by Eligible Plan Participant Involving Rescission. With respect to rescissions, the following timetable applies:

Notification to Eligible Plan Participant	thirty (30) days
Notification of Adverse Benefit Determination on appeal	thirty (30) days

Post-service Claims:

If the eligible Plan Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15)-day extension period.

If the eligible Plan Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the eligible Plan Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the eligible Plan Participant will be notified of the determination by a date agreed to by the Plan Sponsor and the eligible Plan Participant.

Extensions - Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

Extensions - Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Sponsor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the eligible Plan Participant, prior to the expiration of the initial fifteen (15)-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions - Post-service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Sponsor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the eligible Plan Participant, prior to the expiration of the initial thirty (30)-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Sponsor shall provide an eligible Plan Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- information sufficient to allow the eligible Plan Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- a reference to the specific portion(s) of the plan provisions upon which a denial is based;

- specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- a description of any additional information necessary for the eligible Plan Participant to perfect the claim and an explanation of why such information is necessary;

- a description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the eligible Plan Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- a statement that the eligible Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the eligible Plan Participant's claim for benefits;

- the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the eligible Plan Participant, free of charge, upon request;

- in the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the eligible Plan Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the eligible Plan Participant, free of charge, upon request;

- information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- in a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the eligible Plan Participant believes the claim has been denied wrongly, the eligible Plan Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide an eligible Plan Participant with a reasonable opportunity for a full and fair

review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Eligible Plan Participants at least one-hundred eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
- Eligible Plan Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- Eligible Plan Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
- for a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the eligible Plan Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
- That an eligible Plan Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the eligible Plan Participant's claim in possession of the Plan Sponsor or Plan Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the eligible Plan Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the eligible Plan Participant's medical circumstances; and
- That an eligible Plan Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the eligible Plan Participant to respond to such new evidence or rationale.

Requirements for Appeal

The eligible Plan Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within one-hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the eligible Plan Participant chooses to orally appeal, the eligible Plan Participant may telephone:

Western Growers Assurance Trust
(800) 777-7898

To file an appeal in writing, the eligible Plan Participant's appeal must be addressed as follows and mailed as follows:

Western Growers Assurance Trust
P.O. Box 2130
Newport Beach, CA 92663

It shall be the responsibility of the eligible Plan Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- the name of the Employee/eligible Plan Participant;
- the Employee/eligible Plan Participant's social security number;
- the group name or identification number;

- all facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the eligible Plan Participant will lose the right to raise factual arguments and theories which support this claim if the eligible Plan Participant fails to include them in the appeal**;

- a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- any material or information that the eligible Plan Participant has which indicates that the eligible Plan Participant is entitled to benefits under the Plan.

  If the eligible Plan Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Sponsor shall notify the eligible Plan Participant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

Post-service Claims: Within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Sponsor shall provide an eligible Plan Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

a) information sufficient to allow the eligible Plan Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

b) a reference to the specific portion(s) of the plan provisions upon which a denial is based;

c) specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

d) A description of any additional information necessary for the eligible Plan Participant to perfect the claim and an explanation of why such information is necessary;

e) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

f) a description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the eligible Plan Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

g) a statement that the eligible Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the eligible Plan Participant's claim for benefits;

h) the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

i) any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the eligible Plan Participant, free of charge, upon request;

j) in the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the eligible Plan Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the eligible Plan Participant, free of charge, upon request; and

k) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the eligible Plan Participant does not receive a written response to the appeal within the appropriate time period set forth above, the eligible Plan Participant may assume that the appeal has been denied. The decision by the Plan Sponsor or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. Scope

The independent external review process does **not** apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that an eligible Plan Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The independent external review process applies only to:

an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Independent Medical Review: California Covered Persons

In the event that health care services are denied, modified, or delayed by WGAT based in whole or in part on a finding that the health care service was not Medically Necessary, You have the right to seek independent medical review through the California Department of Insurance's Independent Medical Review program. However, before you request an Independent Medical Review with the California Department of Insurance, You are required to first file an appeal/grievance with WGAT in an effort to resolve the issue (as explained above). If you do not receive a satisfactory response after 30 days You may thereafter seek review by filling out an Independent Medical Review form (available online at www.WGAT.com/IMRapp) or by calling (800) 777-7898 or requesting one from the California Department of Insurance by calling 800-927-HELP. You must file the request for Independent Medical Review within 6 months of WGAT's denial of Your appeal. If there is a serious or imminent threat to your health You may apply for expedited Independent Medical Review. Your provider (doctor/medical professional) or the California Department of Insurance must certify in writing that an imminent and serious threat to Your health may exist including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health. In this instance, the California Department of Insurance may waive the requirement that You first file an appeal/grievance with WGAT.

External Independent Review: Arizona Covered Persons

In the event that health care services are denied, modified, or delayed by WGAT based in whole or in part on a finding that the health care service was not Medically Necessary, You have the right to seek independent medical review through the Arizona Department of Insurance's External Independent Review program. However, before you request an External Independent Review with the Arizona Department of Insurance, You are required to first file an appeal/grievance with WGAT in an effort to resolve the issue. If WGAT notifies You that Your Appeal is denied You have four months to seek and External Independent Review. To file Your request for External Independent Review You must send Your written request to: Western Growers Assurance Trust, Attn: Appeals Department – External Independent Review Request, 15525 Sand Canyon Irvine, California 92618.

Expedited External Independent Review may be available for some denied services. If your doctor (or treating provider) certifies in writing that delaying the needed health care service could cause a significant negative change in your medical condition WGAT will review these urgent claims requests quickly. WGAT will respond after receiving a complete claim request within not more than 72 hours (and as soon as possible considering the urgency of the medical situation) with a written or electronic benefit determination. If WGAT upholds the denial You have five business days to request an Expedited External Independent Review from WGAT following the procedures outlined above or by calling (800) 777-7898**.**

PART 12 – TRUSTEE AND TRUST FUND OFFICES

Names, addresses, and principal places of business of the Trustees are:

David Gill – Chairman
Rio Farms
P.O. Box 605
King City, CA 93930

John D'Arrigo – Vice Chairman
D'Arrigo Bros. of CA
P.O. Box 850
Salinas, CA 93902

Dennis Johnston
Johnston Farms
P.O. Box 65
Edison, CA 93220-0065

Tom Finn
Ready Roast Nut Company LLC
6049 Leedom Road
Hughson, CA 95326

John Maulhardt
San Ysidro Farms
P.O. Box 819
Guadalupe, CA 93434-0819

Stephen Patricio
Westside Produce
P.O. Box 7
Firebaugh, CA 93622

Bill Chaney
The Marlin Group
P.O. Box 5839
Yuma, AZ 85366

Ronald Ratto
Ratto Bros. Inc.
P.O. Box 6032
Oakland, CA 94603

The addresses and telephone numbers of WGAT Offices are:

Irvine, CA 92618
MAIN OFFICE
15525 Sand Canyon
Customer Service:
(800) 777-7898

Modesto, CA 95356
4230 Kiernan Av., Ste. 100
(209) 572-5171

Imperial, CA 92251
485 Business Pkwy., Ste. B
(760) 355-3943

Fresno, CA 93711
7575 N. Palm Ave., Ste. 101
(559) 230-0507

Bakersfield, CA 93308
4900 California Ave., Tower B, Suite 200
(661) 322-4400

Phoenix, AZ 85014
1110 E. Missouri, Suite 340
(602) 266-6147

Sacramento, CA 95814
1415 L St., Suite 1060
(916) 446-1435

Salinas, CA 93901
928 East Blanco Rd., Suite 210
(831) 422-8831

Yuma, AZ 85364
3970 W. 24th Street
(928) 627-3766

Santa Maria, CA 93455
2605 South Miller, Ste. 105
(805) 934-1500

Washington, D.C., 20006
1776 Eye Street, NW, Suite 255
(202) 296-0191

EMPLOYER IDENTIFICATION NUMBER (E.I.N.) - 95-2500201

PLAN NUMBER: 501

NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PLAN SPONSOR

Western Growers
15525 Sand Canyon
Irvine, California 92618
(949) 863-1000

NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR

Western Growers Assurance Trust
P.O. Box 2130
Newport Beach, CA 92658
(949) 863-1000

NAME AND ADDRESS OF THE PERSON DESIGNATED TO ACT AS AGENT FOR SERVICE OF LEGAL PROCESS

Jon Alexander
15525 Sand Canyon
Irvine, CA 92618

SOURCE OF PLAN CONTRIBUTIONS: The benefits described herein are funded by contributions of the Participating Employer and the eligible Employees.

FUNDING MEDIUM THROUGH WHICH BENEFITS ARE PROVIDED: The Western Growers Assurance Trust provides health and welfare benefits to Participants/beneficiaries of Western Growers Assurance Trust.

DATES OF THE END OF THE PLAN YEAR: WGAT's Plan year ends on June 30th of any year.

FOR CLAIM APPEAL PURPOSES CONTACT:

Western Growers Assurance Trust
P.O. Box 2130
Newport Beach, CA 92658
(949) 863-1000

DEPARTMENT OF LABOR:

Pension Welfare Benefit Administrator
790 E. Colorado Blvd., Suite #514
Pasadena, CA 91101

PART 13 – GLOSSARY/DEFINITIONS

The following is a summary of certain definitions for terms found through this SPD. A complete list of applicable definitions can be found at www.Healthview.com or by calling WGAT Customer Service at 800.777.7898.

ACCIDENT: An unexpected event that occurs without the patient's intent of injury, involving some unusual outside force or object. An Accident does not include an injury or illness that is intentionally self-inflicted or results from: (1) a fight in which the patient is intentionally involved; (2) a family quarrel; (3) an act of war; (4) disease or mental disorder; (5) medical, dental, or surgical treatment.

CALENDAR YEAR: The term "Calendar Year" shall mean the period beginning January 1 at 12:00 a.m. and ending December 31 at 12:00 midnight.

CALENDAR YEAR MAXIMUM: Various non-Essential Health Benefits described in this SPD that are subject to annual payment limitations and are the total benefits payable for that benefit per Calendar Year.

CO-INSURANCE: Your share of the costs of a covered health care service, calculated as a percent of the Covered Expense (allowed amount) for the service. You pay Co-insurance ***plus*** any Deductibles and Copayments You may owe.

COPAYMENT: The amount that You are responsible to pay before receiving certain services described in this SPD. The Copayment is separate from the Deductible and is excluded from the Out of Pocket Maximum. The Copayment is Your responsibility and is not reimbursable, except in the case of Coordination of Benefits.

COVERED EXPENSE: Covered Expense includes only charges for services described that are Medically Necessary and You are eligible for up to any limits under Your Plan. Covered Expense for a Participating Provider is the negotiated fee and for a non-Participating Provider, Covered Expense will be limited to Usual, Customary and Reasonable.

CUSTODIAL CARE: Care provided primarily to meet the personal needs of the Participant. This includes help in walking, bathing, dressing, preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of medical personnel.

DEDUCTIBLE: The amount of Covered Expense that You are responsible to pay before receiving any benefits described in this SPD unless otherwise noted in the Medical Benefits, Covered Expense section. The Deductible is excluded from the Out of Pocket Maximum.

DISABILITY: Any illness or injury resulting from the same cause or related causes, including complications. Unrelated illnesses that are being treated concurrently by one Physician shall be considered one Disability. The time period for a Disability shall be: (1) for an active Employee a Disability shall begin on the day the condition is first diagnosed or treated, or the Accident occurs, and shall end when the Employee returns to work for one full day, or remains treatment free for six consecutive months; (2) for a dependent or eligible Retiree, a Disability will begin on the day the condition is first diagnosed or treated, or the Accident occurs, and shall end when the person remains treatment free for six consecutive months.

EMERGENCY: A time when You or Your dependent need immediate medical attention because a delay in the treatment would result in Your or Your dependent's death, serious Disability, or significant jeopardy to Your or Your dependent's condition.

EMPLOYER: An Employer is a participating Employer who has entered into an agreement with WGAT to provide health benefits.

ESSENTIAL HEALTH BENEFITS: Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXPERIMENTAL AND/OR INVESTIGATIONAL: Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

a) do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

b) are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

b) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

- maximum tolerated dose;
- toxicity;
- safety;
- efficacy; and
- efficacy as compared with the standard means of treatment or diagnosis; or

c) if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies are necessary to determine its:

- maximum tolerated dose;
- toxicity;
- safety;
- efficacy; and
- efficacy as compared with the standard means of treatment or diagnosis.

d) Reliable evidence shall mean:

e) only published reports and articles in the authoritative medical and scientific literature;

f) the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

g) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

HOSPITAL: Any Provider that meets all the following requirements: (1) maintains permanent facilities for care of resident patients; (2) has a licensed Physician on duty; (3) has a facility for major surgery; (4) provides 24 hours a day nursing by registered graduate nurses; (5) operates lawfully in the area where it is located and is Joint Commission of

Hospitals accredited; (6) primarily provides diagnostic and therapeutic medical care on a basis other than a rest home, nursing home, convalescent Hospital, home for the aged, or treatment of alcoholism or drug addiction.

MAINTENANCE FORMULARY: Consists of a subset of covered medications for generic drugs and brand name drugs. It is intended to cover the therapeutic class of drugs for chronic or ongoing medical conditions. Acute conditions are covered under the Managed Formulary.

MANAGED FORMULARY: Consists of a subset of covered medications for generic drugs and a broad selection of brand name drugs. It covers all therapeutic classes of drugs that treat both acute conditions and chronic conditions. It is managed and updated by Pinnacle Rx Solutions..

MEDICAL EMERGENCY**:** A sudden onset of a condition with acute symptoms requiring immediate medical care and include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions. For purposes of benefits payable under this Plan, WGAT will determine the existence of Medical Emergency.

MEDICALLY NECESSARY: The benefits of this Plan are provided only for services that are Medically Necessary as determined by WGAT. The attending Physician must order the services for the direct care and treatment of a covered illness, injury, or condition. The services must be standard medical practice where received for the illness, injury, or condition being treated and must be legal in the United States. See **Determination of Paid Medical Plan Expenses** for further information.

“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to an eligible Plan Participant for the purposes of evaluation, diagnosis or treatment of that eligible Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the eligible Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the eligible Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the eligible Plan Participant’s Sickness or Injury without adversely affecting the eligible Plan Participant’s medical condition.

a) it must not be maintenance therapy or maintenance treatment;

b) its purpose must be to restore health;

c) it must not be primarily custodial in nature;

d) it must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and

e) the Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the eligible Plan Participant is receiving or the severity of the eligible Plan Participant’s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “Medically Necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that any other services are deemed to be “Medically Necessary.”

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Sponsor’s own medical advisors. The Plan Sponsor has the discretionary authority to decide whether care or treatment is Medically Necessary.

MEDICAL NON-EMERGENCY: Care which can safely and adequately be provided by other than in a Hospital. A Medical Non-Emergency is subject to limitations and exclusions as described in this **Summary Plan Description** booklet and the applicable **SBC**.

NEGOTIATED CONTRACT RATE: Shall mean the rate determined for a Participating Provider that represents an amount less than or equal to the Provider's normal charges. A Participant is not responsible for the difference between the Providers billed charges and the Negotiated Contract Rate.

NON-PARTICIPATING PROVIDER: Health Care Providers that are not Participating Providers or in-network. When Covered Persons seek Covered Services from Non-Participating Providers, they will generally receive a lower level of benefit payment. In addition to Cost-Sharing Amounts, the Covered Individual will be responsible for any charges above Usual, Customary and Reasonable amounts when receiving Covered Services from Non-Participating Providers.

OUT-OF-POCKET-EXPENSE: The cost to the eligible Plan Participant for Deductibles, co-payments, co-insurance and non-covered expenses.

OUT OF POCKET MAXIMUM: The Out of Pocket Maximum amount that if satisfied by the Covered Person in a Calendar Year will cause the Covered Person to be treated as having met the Out of Pocket Maximum for the remainder of that Calendar Year.

PARTICIPANT: A Participant is the Employee of an Employer as defined in the Employer Participation Agreement.

PARTICIPATING PROVIDER: A Participating Provider is a Provider who has an agreement with WGAT to accept a negotiated fee. A Participating Provider includes a Participating Anthem Blue Cross PPO, a Preferred Participating Provider, and an EPO Contract Provider.

PERCENTAGE PAYABLE: Is the percentage of Covered Expense paid by the Plan after any applicable Deductible has been satisfied. Co-insurance is your share of the cost (in addition to Deductible, Copayments and non-Covered Expense).

PHYSICIAN: A Provider, who is not a member of your immediate family or your eligible Spouse's or Registered Domestic Partner's immediate family, who is practicing within the scope of his or her license as a Doctor of Medicine (M.D.) or Osteopathy (D.O.); or, to the extent that specific benefits are provided, a Doctor of Dentistry, Podiatry, Optometry, or Chiropractic. A licensed Optician, Acupuncturist, Marriage Family Counselor, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor referred by an M.D. or D.O, or Psychologist or Christian Science Practitioner is included if performing services that are covered by the Plan.

PLAN: The plan of Employee welfare benefits provided by the Plan Sponsor. The term "Plan" is the Western Growers Assurance Trust Plan and is also defined as a configuration of benefits, that may be shared by multiple Participating Employers, which includes Deductibles, Out-of-Pocket Maximums, Plan Maximums, Benefit Maximums, exclusions and major medical percentiles. The Plan is comprised of employee welfare benefits provided by Western Growers Assurance Trust through funding arrangements that are self-funded, partially self-funded or insured.

The Plan and the Participating Employer or Participating Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

PRESCRIPTION DRUG: Any of the following: a Food and Drug Administration-approved Drug or medicine which under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such Drug must be Medically Necessary in the treatment of an Illness or Injury.

PROVIDER: Any individual or organization, licensed by the state or appropriate governing body, that dispenses, supplies, or performs the necessary care and treatment for an injury or sickness within the scope of its required licensing.

REGISTERED DOMESTIC PARTNER: The adult dependent of the same sex employee who has filed a Declaration of Domestic Partnership with the Secretary of State in California and has received a legal conformed copy of that Declaration. A domestic partner will also include a person who is eligible for Social Security benefits if at least one partner is over age 62 and has filed and received a conformed copy of the Declaration of Domestic Partnership. WGAT

will recognize domestic partners who have validated their relationship under the laws of another jurisdiction in the United States and can provide legal documentation of that validation.

SCHEDULE OF BENEFITS: Is the information found in the back of this booklet that explains what dental, vision and life benefits are provided for You and is an integral part of this SPD.

SPOUSE: A Participant's lawful Spouse is one that is under a legally valid marriage meeting all legal requirements in the Employee's state of residence and can provide legal documentation of the marriage. The Trust does not recognize common-law marriages as valid.

SUBROGATION/THIRD PARTY RECOVERY: Means the Plan's right to not pay benefits and/or recoup benefits paid because of any illness, injury, disease or other condition for which another person might be responsible or legally liable by reason of his wrongful act, whether or not You are made whole. The Plan's rights extend to any Participant and beneficiary under the Plan, including individuals or entities that may receive a recovery on behalf of a Participant or beneficiary.

SUMMARY OF BENEFITS AND COVERAGE: The summary document included with this booklet that briefly describes the medical benefits, limitations and exclusions that correlate to this Plan.

USUAL, CUSTOMARY AND REASONABLE ("UCR"): Covered expenses which are identified by the Plan Sponsor, Usual and Customary charges are determined and established by the Plan Sponsor using Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

For non-Participating Providers benefits are limited to the allowance listed in the following **Limited Fee Schedule** subject to the RBRVS Schedule: Refer to the Covered Expense section for the specific paid amount of these benefits.

1. Inpatient Hospital - 60% of billed charges
2. Outpatient Hospital – 60% of billed charges, validated against the current charge master on file in the relevant state.
3. Emergency Room - 60% of billed charges, validated against the current charge master on file in the relevant state.
4. Surgery Center/Birthing Center - 100% of ASC Schedule
5. Surgeon – 125% of RBRVS Schedule.
6. Anesthesia – Negotiated Contracted Rate.
7. Medicine (Doctor visits and all other outpatient professional services) - 125% of RBRVS Schedule.
8. Diagnostic x-ray – 125% of RBRVS Schedule.
9. Diagnostic laboratory – 125% of RBRVS Schedule.
10. Ambulance (Air and Ground):
    a. Emergency: 500% of Medicare allowances.
    b. Non-Emergency: 250% of Medicare allowances.
11. Dialysis – 100% of RBRVS Schedule

In the event that Medicare cost to charge ratios, AWP and/or MRP are unavailable, the Plan Sponsor may take into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

Reasonable and/or Reasonableness**:** In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Sponsor, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Sponsor retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Sponsor. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

USUAL, CUSTOMARY AND REASONABLE (DENTAL): Charges made for Dentally Necessary services or supplies essential to the care of the patient, if they are the amount normally charged by the Provider for similar services in the geographic area where the services or supplies were furnished, as determined by WGAT. WGAT reserves the right to make this initial determination as well as any subsequent evaluations or modifications of the Usual, Customary and Reasonable fee standard.

WESTERN GROWERS ASSURANCE TRUST: Western Growers Assurance Trust (WGAT) is a nonprofit Employee Retirement Income Security Act Trust fund regulated by the U.S. Department of Labor and the California Department of Insurance.

YOU, YOUR: whenever used in this Summary Plan Description shall mean the Covered Person, Participant, Eligible Employee or Eligible Dependent.

APPENDIX A - FEDERALLY-REQUIRED PREVENTIVE CARE BENEFITS

When the following covered preventive care services are provided by a Network provider, an eligible Plan Participant will not have to a meet a deductible, pay a Co-Pay or pay a percentage share of the cost. See **IMPORTANT DETAILS** at the end of this section for coverage information when Non-Network providers are used.

NOTE: The following list is subject to change periodically. Check the website references at the end of this section for the most up-to-date and more comprehensive information.

Preventive Services for Adults

Abdominal Aortic Aneurysm	one-time screening for men of specified ages who have ever smoked
Alcohol Misuse	screening and counseling
Aspirin	use for men and women of certain ages
Blood Pressure	screening for all adults
Cholesterol	screening for adults of certain ages or at higher risk
Colorectal Cancer	screening for adults over 50
Depression	screening for adults
Type 2 Diabetes	screening for adults with high blood pressure
Diet	counseling for adults at higher risk for chronic disease
Vitamin D	when prescribed to adults age 65 and over for risk of falling
HIV	screening for all adults
Immunization	vaccines for adults--doses, recommended ages, and recommended populations vary: - Hepatitis A - Hepatitis B - Herpes Zoster - Human Papillomavirus - Influenza (Flu Shot) - Measles, Mumps, Rubella - Meningococcal - Pneumococcal - Tetanus, Diphtheria, Pertussis - Varicella Link for more information on immunizations: http://www.healthcare.gov/news/factsheets/2010/09/affordable-care-act-immunization.html
Obesity	screening and counseling for all adults
Sexually Transmitted Infection (STI)	prevention counseling for adults at higher risk
Tobacco Use	screening for all adults and cessation interventions for tobacco users
Syphilis	screening for all adults at higher risk

Preventive Services for Women, Including Pregnant Women and Dependent Daughters, when such care is mandated

Anemia	screening on a routine basis for pregnant women
Bacteriuria	urinary tract or other infection screening for pregnant women
BRCA	counseling about genetic testing for women at higher risk
Breast Cancer Mammography	screenings every 1 to 2 years for women over 40
Breast Cancer Chemoprevention	counseling for women at higher risk
Breast Cancer Preventive Medicine	Tamoxifen and Raloxifene with prescription for women over age 35
Breastfeeding	comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
Cervical Cancer	screening for sexually active women
Chlamydia Infection	screening for younger women and other women at higher risk
Contraception	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs

Domestic and interpersonal violence	screening and counseling for all women
Folic Acid	supplements for women who may become pregnant
Gestational diabetes	screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea	screening for all women at higher risk
Hepatitis B	screening for pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV)	screening and counseling for sexually active women
Human Papillomavirus (HPV) DNA Test	high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Osteoporosis	screening for women over age 60 depending on risk factors
Rh Incompatibility	screening for all pregnant women and follow-up testing for women at higher risk
Tobacco Use	screening and interventions for all women, and expanded counseling for pregnant tobacco users
Sexually Transmitted Infections (STI)	counseling for sexually active women
Syphilis	screening for all pregnant women or other women at increased risk
Well-woman visits	Well-woman visits to obtain recommended preventive services

Preventive Services for Children

Alcohol and Drug Use	assessments for adolescents
Autism	screening for children at 18 and 24 months
Behavioral	assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Blood Pressure	screening for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Cervical Dysplasia	screening for sexually active females
Congenital Hypothyroidism	screening for newborns
Depression	screening for adolescents
Developmental	screening for children under age 3, and surveillance throughout childhood
Dyslipidemia	screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Fluoride Chemoprevention	supplements for children without fluoride in their water source
Gonorrhea	preventive medication for the eyes of all newborns
Hearing	screening for all newborns
Height, Weight and Body Mass Index	measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Hematocrit or Hemoglobin	screening for children
Hemoglobinopathies	or sickle cell screening for newborns
HIV	screening for adolescents
Immunization	vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: - Diphtheria, Tetanus, Pertussis - Haemophilus influenzae type b - Hepatitis A - Hepatitis B - Human Papillomavirus - Inactivated Poliovirus - Influenza (Flu Shot) - Measles, Mumps, Rubella - Meningococcal - Pneumococcal

	- Rotavirus - Varicella Link for more information on immunizations: http://www.healthcare.gov/news/factsheets/2010/09/affordable-care-act-immunization.html
Iron	supplements for children ages 6 to 12 months at risk for anemia
Lead	screening for children at risk of exposure
Medical History	for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Obesity	screening and counseling
Oral Health	risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
Phenylketonuria (PKU)	screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI)	prevention counseling and screening for adolescents at higher risk
Tuberculin	testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Vision	screening for children age one to five.

IMPORTANT DETAILS:

- If the group health plan uses a network of providers, be aware that the plan is only required to provide these preventive services through a network provider. The plan may allow an eligible Plan Participant to receive these services from a Non-Network provider, but the eligible Plan Participant may have to pay all or part of the cost.

- A doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that the plan can require the eligible Plan Participant to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if the doctor bills the claimant for the preventive service separately from the office visit.

- For questions about whether these provisions apply to this group health plan, contact the Plan Sponsor or Plan Administrator.

- An eligible Plan Participant should ask his health care provider to help him understand which covered preventive services are right for him – based on his age, gender and health status.

- If the plan is a "grandfathered" plan, these benefits may not be available.

WEBSITE REFERENCES:

- **Regulation:** http://www.uspreventiveservicestaskforce.org/
- **Overview:** https://www.healthcare.gov/preventive-care-benefits/