WESTERN GROCERS
EMPLOYEE BENEFITS TRUST

Summary Plan Description
for Alaska Members
Effective January 1, 2019

This Summary Plan Description (SPD) describes the plan provisions that are in effect as of January 1, 2019 for Alaska Members, and supersedes all previous communications, written or oral, regarding medical benefits. Any changes occurring to these medical benefits are announced through special communications sent out to each subscriber at their last known address.

This booklet is only a summary of benefits provided under the Plan. Full details are contained in the master contract which is the legal document governing the operations of the Plan. Copies of this document, as well as the annual financial report of the Plan filed with the U.S. Department of Labor, are available for review during normal business hours. In the event of any conflict between the booklet and the master contract, the master contract prevails.

WELCOME!

Welcome to membership in the group Health Plan provided for you and your dependents by Western Grocers Employee Benefits Trust, hereinafter referred to as *the Trust*.

To secure all of the benefits to which you are entitled under the Plan and to avoid any unnecessary delay in processing your claim, you are urged to read this booklet carefully. If you read any terms that are unfamiliar to you, turn to the Definitions section for more information. Many of the terms found in the Definitions section are *italicized* throughout the booklet.

This booklet describes benefits of the Plan available to members of *the Trust* working in Alaska. It has been written to describe the benefits and other provisions of the program as fully and simply as possible. **Please note that this booklet is not a contract**.

This booklet is only a summary of benefits provided under the Plan. Full details are contained in the master contract which is the legal document governing the operation of the Plan. Copies of this document, as well as the annual financial report of the Plan filed with the U.S. Department of Labor, are available for review during normal business hours. In the event of any conflict between the booklet and the master contract, the master contract prevails.

Finally, carry your identification card with you at all times. The information it contains is required to process your claim and to handle your inquiries efficiently and accurately.

If you have additional questions after reading the handbook, or need assistance at any time, please call us at (503) 968-2360 or 1-800-777-3603. You may also visit www.westerngrocerstrust.com.

TABLE OF CONTENTS

DEFINITIONS

Accidental Bodily Injury – an injury to *your* body caused by an accident not expected or intended.

Active Work – performing the usual duties of *your* job at *your* employer's usual place of business. *You* will not be considered "actively at work" if *you* are disabled as a result of *sickness*, accidental bodily injury or pregnancy or on leave.

Calendar Year – the 12-month period beginning on January 1 of each year.

Chemical Dependency – a condition characterized by a physiological or psychological dependence, or both, on alcohol or a state-regulated controlled substance and the person:

- Loses self-control over the amount and circumstances of use
- Develops symptoms of tolerance, or
- Substantially impairs or endangers his or her health or disrupts him or her socially.

Child – a person who is 26 years of age or younger.

Clean Claim – A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985. The provisions state that *you* and *your eligible dependents* may generally continue coverage if *your* employment terminates.

Coordination of Benefits (COB) – a method of determining the amount of *your* medical Plan coverage pays if *you* are also covered by another medical plan. COB is designed to ensure that covered, *out-of-pocket* expenses are paid according to Plan provisions, without reimbursing a covered *employee* for more than 100% of all medical costs.

Coinsurance – means the relative percentages paid by *you* for covered services.

Co-payment – means the fixed dollar amount paid by *you* for covered services. For plans with office visit co-Payments, the Laboratory and Pathology benefits will be paid at 100% when billed in conjunction with the office visit. For this purpose, Laboratory and Pathology benefits will be considered to be performed in conjunction with the office visit if they are ordered by the Provider of the office visit, acting within the scope of the Provider's license, and performed within 10 calendar days of the office visit.

Custodial Care – Care that assists the individual in activities of daily living or service that constitute personal care, including but not limited to: personal hygiene, movement, bathing, eating, meal preparation, protection of the person from his or her own actions or from harming others, administration or supervision of medical which is under usual circumstances, self-administered and other activities which are not required to be provided by trained medical personnel.

Day treatment – for mental health and *chemical dependency* treatment, treatment at a licensed or certified facility which provides treatment on a full-day or part-day basis (lasting at least four hours).

Director – A "Director" shall mean: (i) an individual who has been duly elected as a member of the board of directors of a corporation; (ii) an individual designated as a Manager of a limited liability company; or (iii) an individual designated as a manager or director of a partnership. "Director" shall not include an individual, including without limitation an owner or former owner of the entity, who has merely been provided with the title of director or Manager but who is not actively involved with the management of the company.

Durable Medical Equipment – mechanical equipment which can stand repeated use and is used in connection with the direct treatment of an *illness* or accidental injury.

Eligible Dependent – *your* legal *spouse* or *Domestic Partner* and any of *your* eligible children under age 26. (See page 7 for comprehensive definition.)

Employee- any individual performing services for an employer for wages who has been classified by the employer as an employee and reported to *the Trust* as such.

Enrollee –an *employee* or covered dependent enrolled in the Plan.

ERISA – the Employee Retirement Income Security Act of 1974 as amended from time to time by the federal government.

Essential Health Benefits –Essential Health Benefits covered by the Plan include: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorders including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric vision care.

Experimental/Investigational – Any experimental or investigational drug, device, medical procedure, service, supply or treatment: for which scientific assessment has not been completed or effectiveness established in peer reviewed authoritative medical and scientific literature; or for which any substance, drug or device used in connection with a procedure cannot be lawfully used in that manner without approval of the U.S. Food and Drug Administration or other governmental agency, and such approval has not been granted for other than investigational or clinical purposes; or which is the subject of ongoing Phase I, II or III clinical trials, or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy as compared with standard treatments; or which is performed under a written protocol or is the same or similar treatment as that being performed under a written protocol at the facility or another facility regarding substantially the same drug, device, treatment or procedure.

Health benefit plan – means any *hospital* expense, medical expense or *hospital* or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in ERISA.

Hospital – is an acute care facility accredited by and operated in accordance with the laws of the jurisdiction in which the hospital is located. The facility must be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of injured and sick persons on an *inpatient* basis. These services are provided by or under the supervision of physicians and a 24-hour staff of registered, graduated nurses. Any facility which is primarily a resting place or a place for the aged, a nursing home, a convalescent home or any facility operated by the federal government or its agencies will not be considered a hospital under this definition.

The term **Hospital** also includes a free-standing psychiatric facility which is properly licensed to operate within the jurisdiction it is located.

Illness – a *sickness*, disease, medical condition, complication of pregnancy, or pregnancy.

In-network – services provided by provider with whom the Trust has contracted for favorable rates. Services from in-network providers will be reimbursed at a higher rate than services from providers who do not participate in the network. *PARE* providers will be reimbursed at in-network rates provided that the hospital and surgeon associated with the procedure are in-network. See *PARE*.

Inpatient – confined in a medical facility as an overnight bed patient. For nervous and mental and *chemical dependency* treatment, acute care in an inpatient setting providing 24-hour nursing and medical supervision.

Late Enrollee – "Late Enrollee" means an individual who enrolls in a group *health benefit plan* subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. §300gg as amended;

b) The individual applies for coverage during an open enrollment period;

c) A court has ordered that coverage be provided for a *spouse* or *child* under a covered employee's *health benefit plan* and request for enrollment is made within 30 days after issues of the Court Order;

d) The individual is employed by an employer who offers multiple *health benefit plans* and the individual elects a different *health benefit plan* during an open enrollment period; or

e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan has been involuntarily terminated within 63 days of applying for coverage in a group health benefits plan.

Medical Emergency –

- "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or fetus in the case of a pregnant woman, in serious jeopardy.

- "Emergency medical screening exams" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

- "Emergency services" means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

All members are eligible for and may obtain emergency services. The Trust will not charge members more for out of network services than for in-network emergency services.

The emergency care may be obtained at any *hospital* or emergency facility near *you*.

If *you* or a member of *your* family needs immediate assistance for a medical emergency, call 9-1-1 or go directly to an emergency room.

Medical foods – foods that are formulated to be consumed or administered enterally under the supervision of a physician, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

Medically Necessary – "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 a Plan Participant for the purposes of evaluation, diagnosis or treatment of that 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 Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the 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 Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;

2. Its purpose must be to restore health;

3. It must not be primarily custodial in nature; and

4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the 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, service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association, CMS (Medicare) guidelines, and the Plan Administrator's own medical advisors.

Non-covered Services – services for which no Plan benefits are payable.

Non-emergency Surgery/Confinement – services which need not be performed as an emergency, but may be required in process of recovery from injury or disease and are *medically necessary*.

Officer – An "Officer" shall mean: (i) an individual who has been duly appointed as an executive officer of a corporation; (ii) an individual who has been duly appointed as an executive officer of a limited liability company; or (iii) an individual who has been duly appointed as an executive officer of a partnership. "Officer" shall not include an individual, including without limitation an owner or former owner of the entity, who has merely been provided with the title of an officer but who is not actively involved with the operation of the entity.

Out-of-Network -- services provided that are not in-network. See *In-Network*.

Out-of-Pocket Expenses – the amount an individual pays toward Plan benefits in any given *Calendar Year*, including deductibles, co-payments and *prescription drugs*, which accumulate toward *your* out-of-pocket expenses. The Summary of Benefits for a year sets out the Plan's out-of-pocket maximum for the year. Charges that do not accumulate toward *your out-of-pocket expenses* include but are not limited to amounts for non-covered services, amounts for covered services from out-of-network providers, or amounts for which you or a Dependent is provided a coupon that refunds some or all of the member's cost for a product or service.

Outpatient – treatment received in a setting other than an *inpatient* in a medical facility.

PARE – Pathology, Anesthesiology, Radiology and Emergency Room Services. See *In-Network*.

Participating Provider – a provider contracted with the Trust to provide in-network services.

Pervasive Developmental Disorder – a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.

Precertification – Precertification is a process whereby the Trust can determine in advance whether a procedure meets the Plan requirement of medical necessity. It does NOT guarantee that the Plan will pay for the procedure. The procedure may still be subject to the Plan's exclusions or other limitations.

Provider – one of the following licensed practitioners (unless otherwise specified)

- Doctor of Medicine, M.D.
- Doctor of Osteopathy, D.O.
- Doctor of Dentistry, D.D.S., or D.M.D.
- Denturist

- Podiatrist, D.P.M.
- Psychologist, Ph.D., or Psy.D., licensed according to state law
- Licensed Clinical Social Worker, R.C.S.W., C.C.S.W., L.C.S.W., or A.C.S.W.,
- Certified Psychiatric Mental Health Nurse Practitioner, P.M.H.N.P.
- Licensed Marriage & Family Therapist, M.F.C.C./ L.M.F.T., L.M.H.C.
- Doctor of Chiropractic, D.C.
- Doctor of Naturopath, N.D.
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Practitioner
- Certified Pediatric Nurse Practitioner
- Registered Nurse First Assistant
- Registered Physical Therapist
- ASHA Certified Speech Therapist
- Acupuncturist
- Physician Assistant
- Optometrist
- Advanced Practice Registered Nurse
- Occupational Therapist
- Psychological Associate
- Professional Counselor
- Certified Direct-Entry Midwife

Prescription Drug – any medical substance bearing a label which, under the Federal Food, Drug and Cosmetic Act as amended, is required to bear the legend "Caution: federal law prohibits dispensing without a prescription." This includes insulin. It does not include any drugs labeled "Caution – limited by federal law to *investigational* use" or other similar labeling. It consists of legend drugs.

Residential treatment – For mental health and *chemical dependency* treatment, treatment in a licensed or certified facility that provides subacute overnight care in conjunction with an intensive treatment program in a setting other than a *hospital*.

Sickness – a covered *illness* or disease.

Skilled Nursing Care – care that requires the services of an R.N. or L.P.N., such as injections, change of I.V., central lines, or N.G. tubes, dressing changes, etc. These are services that cannot be performed by an aide.

Skilled Nursing Facility – a facility approved for payment under the Medicare Act. This does not include any facility or institution owned, operated or maintained by any government or governmental agency. It is a medical facility providing services requiring the direction of a physician and nursing supervision by registered nurses.

Spouse – an employee's current husband or wife, determined under the state of the employee's residence.

STD Benefit – Short term disability benefits payable to *you* every two weeks according to the terms of this contract.

The Trust – Western Grocers Employee Benefits Trust.

Total Disability/Totally Disabled (For the Medical Plan Only) – an *illness* or injury which prevents *you* from working in any occupation for at least six months; (For the Short Term Disability Plan Only) – *your* inability, as a result of *sickness*, accidental bodily injury or pregnancy, to perform the duties of *your* own occupation.

Transplant – means a procedure or a series of procedures by which an organ, tissue, bone marrow or peripheral stem cell is either removed from the body of one person and implanted in the body of another person, or removed from and replaced in the same person's body.

In treatment of cancer, the term "transplant" includes any chemotherapy and related course of treatment which the transplant supports.

Usual and Customary Charges (U&C) – amounts or charges for services or supplies that do not exceed reasonable charges or fees for services. This may also be referenced as Usual, Customary and Reasonable (UCR). There is a specific definition of UCR for outpatient dialysis treatment. See Outpatient Dialysis Treatment Section.

Waiting Period – (1) for eligibility for health benefits, the length of time you must be employed by your employer before you become eligible for benefits; (2) for eligibility for short-term disability, the length of time *you* must be continuously *totally disabled* before *STD benefits* become payable. The waiting period for health benefits will be set by your employer. However, in no event will it be longer than 90 days.

War – declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

Weekly Earnings – *your* weekly rate of earnings from *your* employer excluding bonuses, overtime pay and any extra compensation (other than commissions).

Women's Health Care Provider – For Plans requiring selection of a primary care physician (PCP): Females enrolled in this Plan may designate a Women's Health Care Provider as their primary care provider. A Women's Health Care Provider means a participating obstetrician or gynecologist, physician assistant specializing in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice. A Women's Health Care Provider designated as a primary care provider must meet standards established by *the Trust* and must request *the Trust* to make the provider available for designation as a primary care provider. If a female has designated a Women's Health Care Provider as her primary care provider, *the Trust* has the right to establish the maximum number of participating primary care providers and participating Women's Health Care Providers necessary to serve a defined population or geographic service area.

You* or *your – The employee covered under the Plan.

ELIGIBILITY

1. Employee

Effective January 1, 2018, to qualify and be eligible, an *employee* must be employed with a regular work schedule of 20 hour or more per week by a participating member of *the Trust*, which contributes at least 50% of the *employee's* premium for coverage under *the Trust*.

Employees must **also meet the eligibility criteria of their employer** and have worked for that employer long enough to **satisfy the required employer waiting period**.

Officers and Directors

To qualify and be eligible, an *Officer* or *Director* of a participating member who is not otherwise eligible as an employee must be dedicated to, or credited with, not less than 20 hours per week of service by an agreement in writing with the participating member, which contributes at least 50% of the *Officer's* or *Director's* premium for coverage under *the Trust*.

Officers and *Directors* must also meet the eligibility criteria of the participating member.

Such coverage shall be subject to the terms and conditions of the Plan, including coordination with Medicare benefits for *Officers and Directors* age 65 and over.

2. Family Member Dependents

Dependent – Your legal spouse or *your or your spouse's* child under the age of 26. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A newly born child of a covered individual, from the moment of birth.
- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

Status as a Dependent will not be affected by the parent's marital status at the time of the child's birth, support and maintenance requirements for tax purposes, or residence requirements. The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions. A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

3. Changes in Membership Status

Coverage is not automatic for new dependents. *You* must add dependents even if *you* already have family coverage. *You* can add dependents by completing a new enrollment form which *you* can get from *your* employer.

4. New Family Members

A newly-married *spouse* and any additional dependents acquired by marriage may be added to *your* plan if a new application card is submitted **within 31 days** of the marriage. Coverage for the new dependents will then become effective on the first day of the month following the date the application is submitted and for which payment is made.

5. Domestic Partners

Domestic Partners who are legally qualified as such under any applicable state or local laws are eligible for coverage. If not recognized by state or local laws, a Domestic Partner Qualification form can be completed for eligibility purposes.

6. Newborn Infants

Your newborn *child* will be automatically insured for 31 days after birth. Newborn *child* will have primary coverage under the plan of its biological parents. To continue coverage after 31 days, *you* must submit an application showing the new *child* as a dependent within 31 days of the date of birth. If *the Trust* does not receive the application within 31 days after the birth, coverage of the new *child* will end.

7. Adopted Children

Coverage for adopted children will be provided from the date the *child* is legally placed with the Subscriber for the purpose of adoption. "Legally placed" means the Subscriber member has both physical custody and has assumed the financial responsibility for the support and care of the *child*. A new application card must be submitted within 31 days of the placement.

If the *child*'s legal placement is disrupted prior to legal adoption, insurance for the *child* will end on the date the *child* is removed from placement.

8. Divorced Spouse

Divorced *spouse* is covered only to the end of the month during which the divorce decree is signed by the court (not when the divorce becomes final). Subscriber should submit written notice to *the Trust*, advising them of the date the decree is signed by the court.

9. Qualified Medical Child Support Order

Includes children who become eligible for coverage under this Plan due to a Qualified Medical Child Support Order (QMCSO).

Procedures concerning determination of children that are eligible for coverage through a QMCSO are available without charge from the Plan Administrator.

10. Re-enrollment

Once deleted, any eligible family members may be re-enrolled if application is submitted **within 31 days** of the time they become eligible or at the next regularly scheduled open enrollment period.

11. When Coverage Begins

Your coverage will become effective on the first day of the month following the date *your* application card is submitted to *the Trust*, and for which authorized payroll deduction and/or employer contribution is made.

At approximately the time *your* coverage becomes effective, *you* will be issued two Identification Cards which contain the information necessary for submission of claims (keep one in *your* wallet or purse at all times and give the other to *your spouse*, if enrolled).

12. When Coverage Ends

Your coverage under this Plan will end without further notice to *you* if:

a *Your* employer does not timely pay the premium.

b. *You* or *your* employer commits fraud or misrepresentation with respect to any aspect of *your* or *your* employer's obligations under the Plan or communications with *the Trust*. The Trust will provide 30-days' notice before terminating or rescinding coverage on this basis.

c. Participation of active employees in the Plan drops below 75% of eligible employees.

d. *The Trust* discontinues offering or renewing, or offering and renewing all of its small employer benefit plans in Oregon or in a part of Oregon. If this occurs, *the Trust*:

   i. Must give notice of its decision to the Director of the Oregon Department of Consumer and Business Services and to all employees covered under the Plan.

   ii. Must not cancel coverage under the Plan for at least 180 days after the notice required in Subsection 4a above is given.

   iii. Must discontinue offering all small employer group health plans in Oregon.

   iv. *The Trust* will allow a minimum grace period of 10 days after the premium due date for payment of premium.

e. *The Trust* discontinues offering this Plan to all groups in Oregon. If this occurs, *the Trust* must, without regard to claims experience of the group and without regard to the health status of any current or prospective *enrollee*, offer one or more *health benefit plans* which it offers in Oregon. The offer must be made at least 90 days prior to acceptance.

f. The Director of the Oregon Department of Consumer and Business Services orders *the Trust* to discontinue offering the Plan.

g. *You* no longer meet the eligibility requirements as described in the "Eligibility" section.

h. *You* terminate employment. If employment is terminated for any reason, your coverage will end on the last day of the month during which you worked.

i. *The Trust* discontinues offering this Plan to all groups in Alaska.

Coverage for *your* dependents will end if they no longer meet the eligibility requirements as described in the "Eligibility" section. If coverage for *you* or *your* dependents ends, *you* may be eligible for coverage under *COBRA*. See "Continuation of Coverage" for more information on *COBRA*.

Your former group maternity benefits **do not** extend beyond the date the group terminates.

13. Death of Subscriber

The family members will be terminated at the end of the month in which the Subscriber died, unless Continuation Coverage is elected.

14. How to Enroll

Complete an application card with all required information on *your*self and all dependents to enroll and return it to *your* employer. If *you* are a new employee, this must be done within 31 days of hire, or at the end of any required waiting period.

15. Late Enrollment

If *you* and/or *your eligible dependents* wish to enroll under *the Trust*, but did not enroll within 31 days of first becoming eligible (*late enrollee*), *you* may apply for coverage at the next open enrollment period. Coverage will begin on the first of the month after applicable open enrollment period. See the Special Enrollment provision for an explanation of when individuals will not be considered *late enrollees*.

16. Special Enrollment Provisions

Employees of participating members of the Trust may defer enrollment or re-establish eligibility in the Plan for himself and eligible Dependents under any of the following circumstances:

(a) Employees of participating members of the Trust who acquire a new spouse or dependent child(ren) may enroll himself and his newly acquired Dependents in the Plan, but no later than 31 days from the date he or she acquires the new Dependents;

(b) Employees of participating members of the Trust who defer or terminate eligibility because he or his dependent spouse has other health coverage under another health insurance policy or program (including COBRA Continuation Coverage, individual insurance or other public program) may enroll himself and any eligible dependents in the Plan within 31 days after he is no longer covered by the other health insurance due to:

- the loss of eligibility for other coverage as a result of termination of employment or a reduction in the number of hours of employment, or death, divorce or legal separation (but does not include loss due to termination of the other coverage for cause);
- termination of employer contributions toward that other coverage: (an employer's reduction but not cessation of contributions does not trigger a special enrollment right);
- the exhaustion of COBRA Continuation Coverage (COBRA is considered **"exhausted"** if it ceases for any reason other than nonpayment of the required premium in a timely manner); or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;
- the other plan ceasing to offer coverage to a group of similarly situated individuals;
- the loss of dependent status under the other plan's terms;
- the termination of a benefit package option under the other plan, unless substitute coverage is offered; or
- the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan.

(c) The loss of coverage through Medicaid or a State Children's Health Insurance Program (CHIP), provided that you enroll within 60 days from the date employees of participating members of the Trust and/or their Dependents lose eligibility for that coverage; or

(d) The participating member of the Trust and/or Dependents become eligible for a premium assistance program through Medicaid or CHIP provided that you enroll within 60 days from the day you become eligible.

However, in order for a Dependent to enroll in the Plan, the Employee of the participating member of the Trust must also enroll, except in the case of a surviving spouse.

17. Plan Modification

The Trust may modify Plan provisions at the time of the Plan renewal.

HOW THE PLAN WORKS

1. Cost

Employees are frequently asked to share in the cost of their benefits. Check with *your* employer for details on the cost (if any) of participating in this Plan.

2. Lifetime Maximum

The *Plan* has no lifetime limit or lifetime maximum. This means, there is no lifetime limit on the dollar value of all benefits a Participant can receive under the *Plan*.

3. Annual Maximum

The *Plan* has no annual limit on in-network *Essential Health Benefits*. This means there is no annual limit on the dollar value of the *Essential Health Benefits* provided by an in-network provider that a Participant can receive under the *Plan*.

4. Deductible

Each *calendar year*, the Subscriber is responsible for the medical *deductible* amount specified in the "Summary of Benefits" before benefits for covered services and supplies are provided under this Plan.

Policy benefits are based on a Calendar Year. If the benefits under this Policy are modified, or if you change to another policy, the benefit limits shall be prorated accordingly.

Once the family *deductible* is met, benefits for all enrolled family members will be available without further *deductibles* for that year.

Also, if two or more family members are injured in the same accident, only one *deductible* amount will be applied to all eligible medical expenses incurred as a result of said accident during the year in which the accident occurs.

Charges that do not accumulate toward the *deductible* include but are not limited to all *co-payments.*

5. Coinsurance limit

After deductible is met, *the Trust* generally reimburses covered services at the percentage shown on *your* "Summary of Benefits," and *you* are responsible for the remaining percentage. The remaining percentage is *your coinsurance*. Once the eligible charges submitted to *the Trust* exceed the maximum shown on *your* "Summary of Benefits," *you* are no longer responsible for *coinsurance* and plan benefits are payable at 100% for the remainder of the *calendar year*. This applies to each individual, not to the family as a whole.

Certain expenses may not count toward *your coinsurance* limit, for example:

- Charges above what is *U&C (usual and customary)*
- Charges applied to deductible
- *Co-payment*s for medical care or *prescription drugs*
- Chiropractic care
- Additional costs *you* must pay if *you* do not follow plan procedures, such as obtaining preauthorization for services which require preauthorization
- Charges for which you or a Dependent is provided a coupon that refunds some or all of the member's cost for a product or service.

Additionally, some covered services are not reimbursed at 100% after the *coinsurance* limit has been met. Circumstances in which services are not reimbursed at 100% after the *coinsurance* limit has been met are specifically noted in this summary plan description. Preferred Provider Plans (PPO) out-of-pocket expenses are capped if you use providers in the network. There is no cap to your out-of-pocket expenses should you use out-of- network services.

6. Usual and Customary

For all Out-of-Network covered services, including Out-of-Network outpatient dialysis services, benefits are based on usual and customary charges ("U&C"). U&C charges are a range of billed charges for each covered health care service and supply in a given geographic area during the 12 months prior to the date that the range is updated. The range is

updated not less frequently than every six months. Where statistically credible information is not available to create a range for a particular service or supply in a given geographical area, then the range will be based on another geographical area and adjusted for the general cost differences between the area used to establish the range and the area where the service or supply is received.

Providers of Out-of-Network covered services are entitled to payment equal to not less than the lesser of the amount billed for each covered service and supply or the 80th percentile of the U&C charges.

The payment includes the amount paid by the Plan and your portion of coinsurance (e.g. 40%, 20%) for Out-of-Network covered services. The amount paid by you for such Out-of-Network covered services cannot be applied to your deductible or out-of-pocket expenses. Where the amount billed for Out-of-Network covered services exceeds the sum of the benefit payments made by the Plan and your coinsurance payment for the services, the provider may bill you for the balance and you will be responsible for paying the balance.

7. Medicare

At age 65, *you* typically become eligible for Medicare. While *you* are an eligible employee working for an employer with 20 or more employees, this Plan will be *your* primary coverage and Medicare will be secondary.

If *you* are age 65 and work for an employer with fewer than 20 employees, this Plan will be *your* secondary coverage and Medicare will be *your* primary coverage. However, the Trust must submit a request for a small employer exception to the Coordination of Benefits Coordinator. This also applies to an employee's *spouse* if over age 65 and covered as a dependent under the Plan, even if the worker is still under age 65.

Under the Retiree Plan through *the Trust* you must enroll in both Medicare Part A & B coverage. You are not required to enroll in Medicare Part D. This is applicable to both employee and enrolled spouse.

Retiree coverage is excess coverage over other available coverage rather than merely being coordinated with such other coverage. If the retiree or dependent is eligible to receive Medicare, Medicaid, or any other federal or state health benefits, or if there is any other coverage available as a subscriber or dependent to the retiree, *spouse*, or family member through a group health benefit program, such coverage will render *the Trust* retiree coverage as excess to that coverage, whether that coverage was purchased or not.

8. Twelve Month Claims Filing Limitations

Subscriber and dependents are encouraged to submit medical, prescription, vision, and dental claims to *the Trust* as soon as possible. However, *the Trust* shall not be required to furnish any benefits under this agreement unless written request for such benefits is made within **twelve (12) months** from the date on which the expenses were incurred.

MEDICAL BENEFITS

The Medical Plan provides payments for the following services when *medically necessary* and when expenses are incurred while the Subscriber or Enrolled Family Member is covered under this Medical Plan.

This is an alphabetical listing of benefits and the maximum payments available under *your* Group Health Plan. Benefits are described, as well as any exclusions and limitations, which might affect payment.

For a list of preventive of services that have a rating of A or B from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act see the following website:

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

1. Covered Expenses and Limitations

Covered medical expenses are paid after *you* satisfy the *deductible*. The following expenses are covered, provided they are *medically necessary* and meet other terms and conditions of this plan (*** identifies covered expenses that must be precertified by *the Trust*—see page 5 for more information on precertification):**

- **Ambulance – see *Emergency Ground Ambulance Transportation.***

- **Accidental injury to natural teeth or fractured jaw,** if treated during the 12-month period immediately following the injury.

- **Anesthetic supplies** and administration of anesthesia by an anesthesiologist or CRNA.

- **Approved Clinical Trial** means a clinical trial that is: (a) funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States or the United States Department of Veterans Affairs; (b) supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs; (c) conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or (d) exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

- **Approved Clinical Trial Related to Cancer** means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by (a) an institutional review board that complies with 45 C.F.R. Part 46; and (b) one or more of the following:

  (1) the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers;

  (2) the United States Department of Health and Human Services, United States Food and Drug Administration;

  (3) the United States Department of Defense;

  (4) the United States Department of Veterans Affairs; or

  (5) a nongovernmental research entity abiding by current National Institutes of Health guidelines.

- **Birthing Centers**, if service is performed by a Certified Nurse Midwife and/or Medical Doctor and if the facility meets the requirements of the State Licensing Body.

- **Blood or blood plasma**, unless available to the *hospital* at no cost. The lab fees for the collection of self-donated blood are covered, but not storage or shipment expenses (This benefit will apply only if the self-donated blood is used).

- ***Chemical/Drug dependency** – *inpatient, residential/day* or *outpatient* treatment (including detoxification) must be preauthorized by *the Trust*. This benefit is limited to services furnished by a State- approved treatment facility (within a *hospital* or free-standing facility), *physician* (M.D. or D.O.), or licensed clinical psychologist. (See "Exclusions" for services relating to *chemical dependency* that are not covered.)

- **Chemotherapy –** some chemotherapy will require precertification.

- **Chiropractic spinal manipulation services** rendered by a chiropractor for manipulations of the spine, are limited to 12 visits per *calendar year*. Charges for related, supporting services such as office visits and x-rays are not covered when performed by a chiropractor. The chiropractic spinal manipulation benefit is not subject to *your* yearly deductible. In-network $20 co-pay, out-of-network 60%.

- **Clinical Trials.** The Plan shall provide coverage for the routine costs of the care of patients enrolled in and participating in *Approved Clinical Trials.* "Routine costs" means medically necessary conventional care, items or services covered by the health benefit plan if typically provided absent a clinical trial. "Routine costs" do not include: (i) the drug, treatment or service being tested in clinical trials; (ii) items or services required solely for the provision of the drug, device or service being tested in the clinical trial; (iii) items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial; (iv) items or services that are provide solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; (v) items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial, or (vi) items or services that are not otherwise provided by this Plan outside the clinical trial setting. Routine costs covered by this section are subject to the same co-pays, deductibles and coinsurance that apply to the same costs outside the clinical trial setting.

- **Clinical Trials Related to Cancer.** The Plan shall provide coverage for routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders if the patient's treating physician determines that (a) there is no clearly superior non-investigational treatment alternative; and (b) available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as efficacious as any non-investigational alternative.

  The coverage for routine patient care includes payment for the costs of (a) prevention, diagnosis, treatment, and palliative care of cancer; (b) medical care for an approved clinical trial related to cancer that would otherwise be covered under a health care insurance plan if the medical care were not in connection with an approved clinical trial related to cancer; (c) items or services necessary to provide an investigational item or service; (d) the diagnosis or treatment of complications; (e) a drug or device approved by the United States Food and Drug Administration without regard to whether the United States Food and Drug Administration approved the drug or device for use in treating a patient's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device; (f) services necessary to administer a drug or device under evaluation in the clinical trial; and (g) transportation for the patient that is primarily for and essential to the medical care.

  The coverage for routine patient care shall not include payment for the costs of: (a) a drug or device that is associated with the clinical trial that has not been approved by the United States Food and Drug Administration; (b) housing, companion expenses, or other nonclinical expenses associated with the clinical trial; (c) an item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the patient; (d) an item or service excluded from coverage under the patient's health care insurance plan; and (e) an item or service paid for or customarily paid for through grants or other funding.

Routine costs covered by this section are subject to the same co-pays, deductibles and coinsurance that apply to the same costs outside the clinical trial setting.

- **Colorectal cancer screening** exam and laboratory tests is available at age 50 and older or as recommended by your physician if you are high-risk. Benefits are available for one fecal occult blood test every twelve months; one flexible sigmoidoscopy every five years; one colonoscopy every 10 years; and one double contrast barium enema every five years.

- **Contraceptives**, covered expenses shall include charges for medical procedures or supplies related to contraception, including contraceptive counseling and procedures or supplies related to contraception, including contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices, such as Norplant implants. Over the counter contraceptives shall not be a covered expense. See *Women's Healthcare Screening* for additional information.

- **Diabetes self-management programs** will be covered for one program of assessment and training after diagnosis and no more than three hours per year of assessment and training upon a material change in condition, medication or treatment that is provided by an education program credentialed or accredited by a state or national entity accrediting such programs, or a program provided by a licensed physician, registered nurse, nurse practitioner, certified diabetes instructor or licensed dietician with demonstrated expertise in diabetes.

- ***Diagnostic x-ray and laboratory services** related to treatment for an *illness* or accident when recommended as *medically necessary* by the *physician*. MRIs and CT scans have a $200 co-pay per procedure (includes radiologist fee).

- ***Durable medical equipment rental** for therapeutic use, including but not limited to wheelchair, crutches, casts, splints, trusses, braces (but not for teeth), kidney dialysis equipment, hospital bed, iron lung, traction equipment and equipment for providing oxygen. Coverage includes sales tax where required by law.

- **Emergency ground ambulance transportation** to the nearest medical facility equipped to render treatment of the condition. In areas where ground ambulance is not available (such as an island), air ambulance to the nearest *hospital* will be considered. If other transportation would endanger the patient's life, services of a licensed air ambulance will be covered. The Trust will pay the provider of the ambulance care and transportation directly.

- **"Emergency** medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or fetus in the case of a pregnant woman, in serious jeopardy.

  "Emergency medical screening exams" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

  "Emergency services" are defined within the definition of "Medical Emergency" (see page 3).

  All members are eligible for and may obtain emergency services.

  Emergency services are covered for both in-network and out-of-network providers. The *Trust* will not charge participants more for out-of-network emergency services than for in-network emergency services.

  A co-pay amount of $75 per Emergency Room visit will be applied. Emergency coverage which is available under the Western Grocers Employee Benefits Trust program does not require prior preauthorization even if the services are provided out of network.

- **Enteral formula** for home use, if the formula is *medically necessary* for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source of nutrition.

- **Eye bank materials**.

- **Genetic Testing.** Tests and services for the diagnosis of chromosomal abnormalities when recommended by the member's physician and the following criteria are met:

  - The patient has current signs and/or symptoms which render the test necessary for diagnostic purposes;

  - Conventional diagnostic procedures are inconclusive;

  - The patient has risk factors or a particular family history that place them at a high genetic risk for the condition;

  - The test is not considered experimental or investigational;

  - The test is performed by a CLIA-certified laboratory; and

  - The test results will directly influence the disease treatment management of the covered member.

  Genetic testing is *not* covered for:

  - Population screening without a personal or family history, with the exception of newborn screening and preconception or prenatal carrier screening for certain conditions such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies;

  - Informational purposes;

  - Minors for adult-onset conditions; and

  - A relative of the plan member who is not also a plan member unless (1) the genetic test results are necessary for the medical care of the plan member and (2) the relative can provide evidence of coverage denial from his or her health insurance plan.

  Advance notice to the Trust is required.

- **Gestational Diabetes Screening**. See *Women's' Healthcare Screening*.

- **Hearing Aid Devices.** The Plan shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired ear if: (a) prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and it is (b) necessary for the treatment of hearing loss in an enrollee in the plan who is either under 18 years of age or 18 years of age or older, eligible as a dependent under the plan and enrolled in an accredited educational institution. The maximum benefit amount is $4,000 every 48 months. This dollar amount does not apply to enrollees under the age of 18 or dependents enrolled in an accredited educational institution.

  "Hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

  For employees not qualified under the paragraph above, the Plan shall provide a maximum benefit of $350 every 3 years for all hearing aid devices.

- **Home Health Care.** Services when provided to a homebound patient by a registered nurse, licensed practical nurse, licensed social worker or by an occupational, physical, respiratory or speech therapist. Services provided by a home health care aide are not covered. Visits are limited to a maximum of 60 consecutive days per condition when significant improvement in function is anticipated. All home health

care visits must be ordered by a physician. Visits must be intermittent and not more than two hours in length.

- **Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period. $100 per day benefit, maximum of 30 days. Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required. Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

- ***Hospitalization** charges for a semi-private room and board, and medical services and supplies. If the hospital does not have semi-private rooms available, coverage is limited to the most common semi- private rate in the community. Private room charges will be covered if the patient requires isolation to protect the health of others or the patient. A co-pay of $500 per admission will be applied (maximum of two co-pays per calendar year). Precertification is required.

- **HPV Vaccine**. The Plan shall provide coverage of the human papillomavirus vaccine for female beneficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years of age.

- **HPV Genetic Testing.** See *Women's Healthcare Screening.*

- **Treatment for inborn errors of metabolism** involving amino acid, carbohydrate and fat metabolism for which medically standard methods of diagnosis, treatment and monitoring exist; coverage includes diagnosis, monitoring and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis and *medical foods* used in the treatment of such disorders.

- ***Inpatient* rehabilitative** care to restore and improve lost functions following injury or disease, if the *hospital* has a specialized department for rehabilitative care. Benefits for *inpatient* rehabilitative services are subject to preauthorization and will cover no more than 30 days per condition, per calendar year, except that head or spinal cord injuries will be covered for no more than 60 days per condition, per calendar year.

- **Magnetic Resonance Imaging (MRI), CT scans** and other procedures using a body scanner, *see* ***Diagnostic x-ray and laboratory services***

- **Mammograms** - See *Women's Healthcare Screening*.

- **Manipulative Therapy**, but only when provided by a chiropractor or osteopath. *See* "Chiropractic spinal manipulation services" under covered expenses and limitations for additional restrictions on chiropractic services.

- **Maternity care**, including pre- and post-natal care, screening and diagnostic procedures during pregnancy, obstetrical delivery, cesarean section, miscarriage, complications resulting from pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders. The Trust will not restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn child to less than 48 hours following a vaginal delivery, or to less than 96 hours following a caesarian section.

- **Mental Health and Chemical Dependency Conditions**, these conditions will be covered under the terms of the Plan on the same basis as all other medical conditions. This means that the services provided for these types of conditions are subject to: Plan Deductibles, Co-Payments, Coinsurance limits, and Pre-Authorization and Co-Payment requirements for hospital confinements. In addition the Plan will only pay for services that are medically necessary and provided by practitioners and facilities properly licensed to render these services.

- **Naturopathic Care** will be limited to a $30 co-pay per visit and 12 visits per calendar year. Naturopathic care is not subject to your annual deductible. Charges for nutritional supplements, naturopathic or homeopathic remedies, or other non-prescription drug are not covered under the Plan.

- ***Non-emergency, *inpatient* or *outpatient* surgical procedures and confinements and inpatient mental, emotional and psychiatric conditions** must be precertified by *the Trust* prior to surgery or confinement.

- **Optometrist services**—Professional services of a licensed optometrist which are covered medical expenses (excludes routine eye examinations/refractions and vision hardware; see Vision Plan on page 32 for vision benefits).

- **Other special medical items**, including braces; surgical and orthopedic appliances, colostomy bags and supplies; catheters; syringes and needles for diabetes or allergic conditions; dressings for surgical wounds, cancer, burns, or diabetic ulcers; and oxygen when medical necessary for treatment.

- ***Outpatient* rehabilitative care** for physical therapy, functional occupational therapy and speech and hearing therapy to restore or improve functions lost following an *illness* or injury (provided by a *physician* or a licensed or registered therapist) is covered provided:

  - The patient is not confined to a *hospital*, and

  - Treatment is part of the formal written treatment program prescribed by a physician and approved by *the Trust*.

  - *Outpatient* rehabilitative care is limited to 60 visits per year.

- ***Pain Control Facilities/Programs**, treatment from accredited institutions (those accredited by the Commission of Accredited Rehabilitation Facilities) is covered at 50%, if the treating physician provides a written treatment plan to *the Trust* requesting the referral. The request must be pre- authorized by *the Trust* or no payment will be made. Pain center reimbursement for authorized services is made at 50% and does not increase to 100% after *your* yearly *out-of-pocket* maximum has been met.

- **Pelvic exams and Pap smears** —See *Women's Healthcare Screening*

- ***Treatment for Pervasive Developmental Disorders**. All medical services, including rehabilitation services that are medically necessary and are otherwise covered under the plan, for children under the age of 18 diagnosed with a Pervasive Developmental Disorder. Advance notice to the Trust is required. Subject to deductible and co-pay. For services related to Autism Spectrum Disorders (as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-IV-TR (as amended or reissued from time to time), coverage is extended to age 21.

- **Phenylketonuria.** The Plan shall provide coverage for the formulas necessary for the treatment of phenylketonuria. The deductible or copayment required for the cost of treating phenylketonuria shall not be greater than the deductible or copayment required for the cost of treating another condition or illness under the Plan. For this purpose, "cost" means the lowest of the following: (a) the actual charge for the treatment received for phenylketonuria (b) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or (c) the charge agreed to by contract between the provider and the Plan.

- ***Prescription drugs*** or medicine (including insulin, needles and strips necessary for administration of insulin, and urine and block strips for diabetes monitoring) that is approved by the FDA or the Health Resources Commission for marketing for the diagnosis and in the dosage and method of administration, directly related to an *illness* or injury, requires written prescription by a *physician* and dispensed by a licensed pharmacist (limited to a 30-day supply) and paid at 70%, subject to *your* yearly medical deductible. *Your* coverage does include a *prescription drug* card. For additional information, see page 30 for the benefits available through the *prescription drug* card program.

- **Professional services of a licensed physician**. When multiple surgical procedures are performed, benefits are based on the *U&C* charge for the primary or major surgical procedure and one-half of the *U&C* charge for the secondary surgical procedure (it must be independent of the first or major surgical procedure and be on a different organ system). If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's *U&C* allowance. This does not apply, if you belong to a PPO network and services were provided by a network physician. This will apply for out-of-network services.

- **Prostate cancer screening exam** is available for men 40 years and older and for younger men at high risk and will be covered as any other medically necessary service. The benefit is subject to deductible and coinsurance.

- **Prosthetic devices** to replace all or part of an absent body limb or the function of a permanently inoperative or malfunctioning body organ, as a result of an *illness* or injury, including but not limited to: artificial limbs or eyes, intraocular lens(es) following cataract surgery or to replace a missing portion of the eye, pacemakers, artificial joints. This benefit is limited to patients who require services or supplies as a result of an illness or injury incurred while covered under this Plan. Only the initial charge for the first prosthetic device will be included.

  Maxillofacial prosthetic services considered necessary for adjunctive treatment, which means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of

  - controlling or eliminating infection;

  - controlling or eliminating pain; or

  - restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

- ***Proton Beam Radiation Therapy** – requires notification to *the Trust*.

- ***Reconstructive surgery and supplies**, including cosmetic reconstructive services following an *illness* or injury; or for congenital malformations that are restoring function and are not cosmetic. The *illness* or injury that leads to reconstructive surgery must have occurred while *you* were covered under this Plan.

- ***Registered nurse or a licensed practical nurse** care (full-time or visiting), if the care is provided outside the *hospital*, requires the skills of an RN or LPN and is ordered by the attending *physician*. (See "Exclusions" for private nursing services not covered under this Plan.)

- **Second Opinions** and receipt of information, diagnosis and treatment plan from another *physician* before beginning treatment. Second opinions will be paid in full by *the Trust* if *the Trust* requests or authorizes the second opinion.

- ***Skilled nursing facility** services and supplies as indicated in a certificate of medical necessity signed by the attending *physician*, unless otherwise specified in the "Exclusions" section.

- **Sleep Apnea** – Office visit and study subject to co-pays and deductible. Reimbursement limited to $1,000 every 24 months on durable equipment

- **Sterilization** procedures including vasectomy and tubal ligation only. (Surgical reversal of sterilization procedures not covered. See exclusions)

- **Telemedical Services**. The Plan shall provide coverage of a telemedical health service if (a) The plan provides coverage of the health service when provided in person by the health professional; (b) The health

service is medically necessary; and (c) The health service does not duplicate or supplant a health service that is available to the patient in person.

"Telemedical" means delivered through a two-way video communication that allows a health professional to interact with a patient who is at an "originating site" such as a hospital, rural health clinic, doctor's office, community mental health center, etc.

This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan or to reimburse a health professional that is not a covered provider.

- **Tobacco Use Cessation Program**. The Plan will cover, without cost-sharing:

  (A) Screening for tobacco use; and

  (B) For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

    (1) Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and

    (2) All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

- **Transplants** - See complete description at the end of this section.

  Transplant Benefit. Benefits for services and supplies rendered in connection with a *transplant*, including pre-*transplant* procedures such as harvesting (donor costs), and post-operative care (including anti-rejection drug treatment) and chemotherapy given in conjunction with transplantation are covered as follows:

  Covered transplant means a **medically appropriate *transplant*** as in the judgment of *the Trust* of one of the following only and no others:

  - heart (but not when both a heart and lung are transplanted in the same operative session);
  - liver (but not for alcoholic cirrhosis or liver cancer);
  - kidney;
  - kidney and pancreas when transplanted together in the same operative session;
  - autologous bone marrow and/or peripheral stem cells and related chemotherapy and other services, but only if required in the treatment of
    - Hodgkins disease after first or subsequent relapse
    - Neuroblastoma
    - non-Hodgkins lymphoma
    - acute lymphocytic leukemia
    - acute non-lymphocytic leukemia;
  - Homogenic/allogenic bone marrow and/or peripheral stem cells, but only if required in the treatment of:

- aplastic anemia
- acute leukemia
- severe combined immunodeficiency
- chronic malignant osteoporosis
- chronic myelogenous leukemia
- lymphoma
- Wiskott-Aldrich Syndrome

"Donor costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- Harvesting
- preserving it; and
- transporting it to the site where the transplant is performed.

"Transplant" means a procedure or a series of procedures by which an organ, tissue, bone marrow or peripheral stem cell is either:

- removed from the body of one person (called a **donor**) and implanted in the body of another person (called a **recipient**); or
- removed from and replaced in the same person's body (called a **self-donor**).

In treatment of cancer, the term "**transplant**" includes any chemotherapy or related course of treatment which the *transplant* supports.

"Facility transplant services" means all medically necessary services and supplies (including inpatient anti-rejection drugs) provided by a **designated *transplant* facility** in connection with a **covered *transplant*** except **donor costs**;

"Medically appropriate" means the **recipient** or **self-donor** meets the criteria set forth herein and the treatment is for a covered ***transplant*** listed herein and is *medically necessary* and not *experimental* or *investigational*;

"Professional *provider transplant* services" means all ***medically necessary*** services and supplies provided by a professional *provider* in connection with a **covered *transplant*** except **donor costs** and anti-rejection drugs.

Benefits for donor costs. If the **donor** is enrolled under this **contract** and the **recipient** is not, **we** will not pay toward **donor costs**. Complications and unforeseen effects of the donation will be covered as any other *illness* under the terms of the **contract** or **self-donor** is covered under the **contract**.

Benefits for anti-rejection drugs. For *outpatient* anti-rejection drugs following the covered transplant, we will pay according to the benefits for *prescription drugs* under the contract.

Other expenses related to the transplant: *The Trust* will cover the travel costs for a member undergoing a transplant at a facility more than 500 miles from the member's home. Preauthorization for both the facility and planned travel is required.

Precertification Requirement. All ***transplant*** procedures must be precertified for type of *transplant*, be a covered *transplant*, and be *medically necessary* and not *experimental* or *investigational* as those terms are defined elsewhere in this document.

If a covered procedure takes place without precertification, *the Trust* will be responsible for not greater than 50% of the cost related to the transplantation even if *your calendar year out-of-pocket* maximum has been met.

Precertification Procedures. To precertify, the **enrolled member's** *physician* must contact the Precertification Coordinator of *the Trust* before the transplant admission. Precertification should be obtained as soon as possible after an **enrolled member** has been identified as a possible ***transplant*** candidate.

Mail: Precertification Coordinator
Western Grocers Employee Benefits Trust
PO Box 22166
Portland, OR 97269
Telephone: Toll-Free 1-800-777-3603

Only written approval from *the Trust* on a proposed transplant will constitute precertification.

Exclusions
In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, we will not pay the following:

- donation related services or supplies provided to an enrolled donor if the recipient is not enrolled under this contract and eligible for *transplant* benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue;

- services or supplies for any *transplant* not specifically named as covered including the transplant of animal organs or artificial organs; the *transplant* of liver for alcoholic cirrhosis or liver cancer; bone marrow transplant or peripheral stem cells and related chemotherapy for cancer for conditions other than those noted under the definition of a covered *transplant*.

- **Traumatic Brain Injury**. The Plan shall provide coverage of medically necessary therapy and services for the treatment of traumatic brain injury.

- **Travel Expenses**. Travel expenses are not covered under the Plan.

- **Well child exams and immunizations** are covered according to the following schedule:

Infancy:		Routine newborn care in the nursery plus six well-baby visits to a physician's office during the first year of life
Age 1:		Two office calls during the calendar year (January – December).
Age 2 through 11:		One exam every calendar year.
Age 6 through 11:		All immunizations required by the State educational board for grades K-5

Any services performed during the well *child* exam that are related to an injury or *illness* are subject to the plan co- pays and deductible provisions.

- **Wellness Health Screening** – annual physicals, periodic health screening, immunizations, cholesterol testing and hearing screening exams are covered with maximum of four office visits per year.

- **Breast Reconstruction/Prostheses**
The following coverage is available for reconstructive surgery after mastectomy:

- Reconstruction of the breast when a mastectomy has been performed;

- Surgery and reconstruction of the other breast "to produce a symmetrical appearance"; and

- Prostheses and physical complications including lymphedemas.

The Plan provides a single authorization process for all mastectomy-related services that are part of the *enrollee's* course or plan of treatment.

- **Women's Health Care Provider Access**—If a female *enrollee* has designated a primary care *provider* who is not a *Women's Health Care Provider* (see definition in definitions section), the *enrollee* may have direct access to a *Women's Health Care Provider*, without referral from her primary care *provider*, for:

  - One annual woman's health preventative examination (January through December).

  - *Medically necessary* follow-up visits resulting from a preventative woman's health examination. *The Trust* may require the *Women's Health Care Provider* to notify and consult with *enrollee's* primary care provider.

  - Pregnancy care.

  Women's Healthcare Screening -- The following covered services are not subject to regular plan deductible or coinsurance:

  - Well-woman visits (includes mammograms, pelvic exams, and pap smears performed as preventative care)

  - Screening for gestational diabetes for all pregnant women

  - Human papillomavirus DNA testing for all women 30 years and older

  - Annual sexually transmitted infection counseling for all sexually active women

  - Annual counseling and screening for HIV for all sexually active women

  - FDA-approved contraception methods, sterilization procedures and contraceptive counseling

  - Breastfeeding support, supplies, and counseling, including costs for renting breastfeeding equipment

  - Domestic violence screening and counseling

  - X-ray, radium and radioactive isotope therapy

If a procedure or service is not identified in the "Covered Expenses and Limitations" section, do not assume that it is covered.

2. Precertification

Your coverage includes defined benefits for services which are *medically necessary*. In order to be sure that proposed services are *medically necessary*, precertification is required for all non-emergency inpatient and outpatient procedures. Precertification allows the Trust to determine whether a procedure meets the Plan's requirement of medical necessity. It does NOT guarantee that the Plan will pay for the procedure. The procedure may still be subject to the Plan's exclusions or limitations.

If precertification for a service is required, but is not obtained, the reimbursement for that service is reduced by 20%. For example, if your policy normally reimburses the service at 90%, failure to preauthorize that service will result in

reimbursement at 70%; if your policy normally reimburses the service at 80%, failure to preauthorize that service will result in reimbursement at 60%; etc. The penalty applies even if you have met your yearly out-of-pocket maximum and the 20% reduction is calculated based on your policy's normal reimbursement level before you meet your out-of-pocket maximum.

Notification. Although precertification is not required for the following services, you or your provider should notify the Trust in advance of treatment:

- Proton Beam Radiation Therapy;
- Intensity Modulated Radiotherapy (IMRT) is also known as tomotherapy. IMRT is a type of stereotactic radiosurgery that delivers a highly conformal, three-dimensional (3D) distribution of radiation doses;
- Genetic testing;
- High Dose Chemotherapy with Stem Cell Transplant;
- Chemotherapy drugs, including injectable drugs, infusible drugs, and oral anticancer medication;
- Pain Centers; and
- Treatment for Pervasive Developmental Disorders.

Precertification is waived when:

Coverage is provided under your policy without precertification for emergency medical screening exams, stabilization of emergency medical conditions and emergency services of a non-participating *provider* using the prudent layperson standard. We will apply the same claim payment standards, including the prudent layperson's standard, to all ancillary emergency services including ambulance services.

Services provided for these types of conditions are subject to: Plan Deductibles, Co-Payments, Coinsurance limits, Plan Lifetime Maximum Co-Payment requirements for hospital confinements.

3. <u>Exclusions</u>

The following services or items are <u>not</u> covered under the medical benefits:

- Air conditioners, dehumidifiers, purifiers;
- Any condition arising out of or resulting from the commission of a criminal/illegal act;
- *Any loss due to self-inflicted injury unless injury came as a result of domestic violence or as a result of a medical (including both physical and mental health) condition;
- Any condition caused by, or arising out of, an act of *war*, armed invasion or aggression;
- Care in a rest, convalescent, nursing home, or any other *custodial care*;
- Experimental drugs, services or treatment as defined in the definitions section;
- Charges incurred as a result of a work-related *illness* or injury. No benefit is provided for treatment of any *illness* or injury that arises out of, or as the result of, any work for wage or profit, if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit, any policy of workers' compensation insurance; or according to any recognized legal remedy. This applies whether or not you claim the benefits or compensation or recover the losses from third party. This

exclusion does not apply if you are enrolled in the Plan's On-the-Job Accident Coverage Benefit available to owners exempt from state workers' compensation requirements;

- Charges that exceed *Usual & Customary* charges (and are not reasonable) , charges for services or supplies that are not *medically necessary* or that are not approved by the attending physician;

- Complications arising from excluded services. Unless expressly stated otherwise, the Plan will not cover services or supplies required as a result of a complication arising from a service that is not covered under the Plan.

- Cosmetic surgery or services (unless for reconstructive purposes related to an *illness* or injury) including but not limited to: surgery for sagging skin of the eyelids (blepharochalasis); face, neck, abdomen, hips, or extremities (meloplasty, rhytidectomy or lipectomy); breast enlargement or reduction or uplift procedures; reshaping the nose (rhinoplasty), liposuction, or complications of non-covered cosmetic surgery or services;

- Deluxe equipment such as motorized wheelchairs or beds and supplies or maintenance of *durable medical equipment*, including batteries & chargers;

- Dental work or treatment, unless the charges are in connection with accidental injury of sound natural teeth or oral surgery for treatment of a fractured jaw due to an injury while covered by the Plan;

- Dietary formulas, services or supplies for obesity or weight reduction, including medical or surgical treatment for obesity, even though other systemic disorders are present, related or unrelated;

- *Experimental* treatment/care/services still under clinical investigation by Health Providers and the Food and Drug Administration (FDA). *Experimental* drugs not fully approved by the FDA for other than clinical investigation purposes for the condition being treated or for the method or manner of delivery or use; and Experimental treatment, care or services as defined by the Plan (see Definitions).

- Eye refractions are not covered under the medical portion of the policy. (See Vision Plan, page 34 for coverage.);

- Foot orthotics, routine foot care, arch supports, corrective shoes, cast impressions, and all related services;

- Hearing aid batteries or cost of repair of hearing aid;

- Heating pads, whirlpool-type baths or equipment, enuresis training equipment, and exercise equipment;

- Home delivery of a child (services and supplies). However, the Plan will provide benefits related to at-home delivery of a child for services provided by an advanced practice registered nurse who is practicing as a certified nurse midwife in accordance with regulations adopted under Alaska Statute 08.68.100(a), if the services provide are within the scope of the midwife's certification;

- Homeopathic or Holistic treatments;

- Hospitalization for diagnostic purposes when the patient is not ill enough to be hospitalized, or confinement for diet or rest cure;

- Immunizations, except as covered under Well Child benefits, the US Preventative Task Force or the human papillomavirus vaccine for female beneficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years of age;

- Massage therapists;

- Nutritional counseling and nutritional supplements, including but not limited to, Ensure or Total Parenteral Nutrition, which consists of various nutritional items, such as minerals, vitamins, potassium, etc.;

- Organ, bone marrow, nonhuman or manufactured organs or other transplant expenses that are not specifically listed in "Covered Expenses and Limitations;"

- *Outpatient* Rehabilitation for recreational or education therapy or for non-medical self-help or training, this includes cardiac rehabilitation;

- Over-the-counter drugs or drugs not requiring a prescription; and prescriptions for non-medically necessary drugs;

- Personal services and charges, such as charges for radio, telephone, television and guest meals;

- Physicians or other professional services that are not deemed medically necessary and are not specifically listed may be excluded;

- Private nursing care that consists primarily of bathing, feeding, exercising, homemaking, moving the patient or acting as a companion;

- Private room charges exceeding the covered semi-private room rate (except when isolation is necessary to protect the patient or other patients' health);

- Radial keratotomies or other surgeries to correct eye refraction (except see covered expenses under Vision Plan, page 32);

- Replacement of prosthetic devices, unless the existing device cannot be repaired or when recommended by a physician due to the patient's condition;

- Routine physical examinations or other examinations or tests not connected with the treatment of an injury or illness, including screening procedures and examinations performed or recommended by a physician due to family history or age, except as provided for under the Wellness Health Screening, Pelvic exam and Pap smear, Mammogram wellness benefits, prostate screening or colorectal screening;

- Sales tax, mailing fees, records delivery, faxes;

- Services and supplies for or in connection with: (1) infertility treatment, except to the extent covered services are required to diagnose such a condition; (2) reversal of sterilization; and (3) assisted reproductive technology (ART) procedures.

- Services of a *provider* related to the patient by blood or marriage, or private nursing care or professional services from someone who resides in your home;

- Services or supplies for which government funding is legally available;

- Services or supplies ensuing from an accident resulting in injury where an insurance company or third party payer is responsible for paying benefits. (See "Third Party Liability-Subrogation" section, page 66, for more information);

- Services, supplies, treatment and procedures for reproductive and sexual disorders, dysfunctions, and defects, whether or not the consequence of illness, disease or injury, including but not limited to the following conditions or procedures: impotency; sexual prosthesis/implant; frigidity; infertility; sterility; surgical reversal of sterilization procedures; removal of devices; artificial insemination; in-vitro fertilization and sex transformation;

- Services relating to developmental (following birth) malformations including but not limited to: upper and lower jaw malformations (such as orthognathic surgery), malocclusions, temporomandibular joint dysfunction (TMJ), enamel hypoplasia (lack of development) and fluorosis services as pertaining to developmental delay. This exclusion does not apply to the treatment by a physician for a fractured jaw due to an injury while covered by this plan;

- Sleep clinics and treatment for diagnosed or undiagnosed sleep disorders, except for sleep apnea subject to the benefit limitations discussed above under covered expenses and limitations.

- Temporomandibular Joint (TMJ) dysfunction and cranial mandibular disorder, and other conditions of the joint linking the jaw bone and skull, the muscles, nerves and tissues relating to that joint;

- Vision therapy or eye exercises or any training to correct muscular imbalance of the eye (orthoptics) or pleoptics;

- Voluntary support groups, court-ordered services, services relating to deferred prosecution, deferred or suspended sentencing or to driving rights.

4. Utilization Review Requirements

You may request a written summary of information that we may consider in our utilization review of a particular condition to the extent that we maintain such criteria. In order to do so, call our Customer Service representatives at (503) 968-2360, or 1-800-777-3603.

Utilization review involves:

- Length of stay

- Location of care

- *Inpatient-outpatient* services

- Cost of services

- Long range care

A doctor of medicine (M.D.) or osteopathy (D.O.) shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

5. Changing Primary Care Physician

Subscribers and dependents enrolled in a plan which requires a Primary Care Physician (PCP) can change the PCP as often as they choose. Information regarding the PCP change can be taken over the phone or in writing.

6. Accident Benefits

If *you* are injured in an accident, the Plan pays 100% of *your* eligible medical expenses, up to the first $500 in expenses for each accident. The Plan will then pay benefits as any other eligible expense for expenses that exceed $500, after you satisfy the deductible. To receive the accident benefit, *you* must incur the eligible medical expenses within 90 days of the accident. Accident benefits do not include specifically limited benefits such as *outpatient* rehabilitation and chiropractic care expenses.

7. Case Management

The *Trust* may make case management services available to you when such services are appropriate. If you request it, and based upon the recommendation of the case manager, the *Trust* may agree to modify coverage provisions when such modification is cost effective and does not deprive the member of *medically necessary* services. The *Trust* may require you to agree in writing to such modified coverage for a specified period of time.

8. How to File a Medical Claim

To provide you with prompt and accurate processing of your covered medical expenses, please read this section carefully so you will be acquainted with the information and procedures necessary in handling your claims.

9. Hospital Claims

If you or a covered dependent are hospitalized, present your Identification Card to the hospital admitting clerk. When you are discharged, you may be expected to pay for any expenses not covered by the Plan.

10. All Other Medical Claims

You may be billed directly or at the time you receive the care. *You* should forward a copy of the bill, it must include:

- Name of the patient
- *Your* name
- Group and Identification Numbers
- Diagnosis
- Dates and description of services received and the expenses you incurred
- If an accident, the date and circumstances of the accident.

PAYMENT FOR COVERED EXPENSES WILL BE MADE TO THE PROVIDER UNLESS THE CLAIM STATES THAT IT HAS BEEN PAID BY THE PATIENT.

SEND YOUR MEDICAL CLAIMS TO:

Western Grocers Employee Benefits Trust
Attn: Health Claims
P.O. Box 22166
Portland, OR 97269

11. PRO Health Advisor Program

The Pro Health Advisor Program is a targeted disease management system designed to assist participants diagnosed with certain chronic diseases to medically manage their condition.

Eligibility: All members of *the Trust* who have complicated diabetes (poorly controlled or diabetes with hypertension and dyslipidemia), coronary artery disease or chronic renal disease are eligible for participation in the program. In order to be enrolled in the program and participate in the incentives members must agree to comply with the following rules:

- Provide full access to medical information about the above conditions
- Follow 100% of attending Physician's Treatment Plan (PTP)
- Attend all appointments
- Meet with the assigned Health Advisor monthly or as requested
- Provide requested self-treatment information and result
- Not make false statements

Participants in the program who comply with the foregoing are eligible for reduced co-pays for outpatient visits (excluding ER), prescription medication (generic), or durable medical equipment related to the diseases mentioned above. The member is responsible for initial payment of applicable co-pays and deductibles, and will be reimbursed by the Trust on a quarterly basis.

Members enrolled in the Health Advisor program may continue to participate in the foregoing incentives until they are unable to show further health improvement or violate the following standards:

- Not be available for a scheduled appointment two or more times with their Health Advisor or health care provider
- Not contact their Health Advisor for more than 30 day
- Not comply with their Physician's Treatment Plan (PTP)
- Decline to follow 2 or more Health Advisor recommendations

Disenrollment of members will be decided by the Health Advisor Board consisting of the program medical director, at least one health advisor and the trust administrator. Members will be provided with the opportunity to appeal a disenrollment decision. Exceptions to policy will be considered for extraordinary situations. Members will be notified by telephone and in writing.

To participate in this free benefit, enrollees should contact Pro Health at:

843-839-9088

Or by email at:

info@prohealthadvisor.com

Additional information can be found online at www.prohealthadvisor.com

12. Outpatient Dialysis Treatment

This Section describes the Plan's Dialysis Benefit Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

SCHEDULE OF MEDICAL BENEFITS			
		PPO Provider	**Non-PPO Provider**
Outpatient Dialysis Treatment		100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined in this Outpatient Dialysis Treatment Section, (ii) the PPO allowable charge after all applicable deductibles; or (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.	

Dialysis Program Components. The components of the Dialysis Program are as follows:

(a) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for payment or reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(b) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan for expenses incurred on or after October 1, 2016, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(c) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator or Dialysis Claims Advisor or "DCA" shall consider factors including:

i. Market concentration: The Plan Administrator or DCA shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan Administrator or DCA shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(d) In the event that the Plan Administrator or DCA's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the member, dialysis-related claims received prior to the cost

review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable for dialysis-related claims subject to the payment limitation shall be the Usual, Customary and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles. Provided, however, that the Plan Administrator may pay, reimburse, or approve charges greater than the Usual, Customary and Reasonable Charge based on factors concerning the nature and severity of the condition being treated, geographic and market considerations, and provider availability.

iii. Usual, Customary and Reasonable Charge. With respect to dialysis- related claims, the Plan Administrator or DCA shall determine the Usual, Customary and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the determination of the Usual, Customary and Reasonable Charge based upon factors concerning the nature and severity of the condition being treated.

iv. Additional Information related to Value of Dialysis-Related Services and Supplies. The member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

v. All charges must be billed by a provider in accordance with generally accepted industry standards.

(e) Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator, or the DCA if the Plan Administrator delegates the authority to do so to the DCA in writing, may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

(f) Medicare Coverage. Plan members may be eligible for Medicare if their kidneys no longer work, they need regular dialysis, or they have had a kidney transplant. Coverage under the Plan will not be reduced or terminated based on a member's eligibility for Medicare. Members actively enrolled in Medicare or any other health plan may have access to additional providers or benefits. Additional coverage will be subject to Coordination of Benefits. Information on Medicare and ESRD can be found at Medicare.gov.

(g) Member Responsibility. The Plan pays 100% of the lesser of the Usual, Customary and Reasonable Charge or the contracted/negotiated rate with the provider. This means that, after a Plan member's deductible has been met, members are not required to pay coinsurance regardless of whether the provider is a preferred provider. Members using a preferred provider will not be balance- billed for any amount remaining after the payment to the provider. Members using a non-network provider may be subject to balance-billing by the provider.

13. Participating Provider vs. Non-Participating Provider Benefit Level

Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered serves rendered by a Non-Participating Provider will be paid at the Non-Participating Provider benefit level. The Participating Provider benefit level will be paid for Non-Participating Provider serves when a:

- Covered Person has a Medical Emergency requiring immediate care
- Covered Person receives services by a Non-Participating Provider (e.g., anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Participating facility
- Participating Provider submits a specimen to a Non-Participating facility
- Covered Person receives services from a Participating surgeon who uses a Non-Participating Assistant Surgeon
- Referrals by a Participating Provider to a Non-Participating Provider
- Participating Provider is not available within a 10 mile radius of the Covered Person's residence (excludes Hospital/facility inpatient charges)
- When a Full-Time Student resides outside the PPO service area

However, all other limitations, requirements, and provisions of the Plan will apply including the Usual and Customary provision of the Plan. This exception does not apply in the event of consultations and other situations in which the Covered Person and/or the provider selected had the opportunity to select a Participating Provider, and exercised the right to receive services from a non-Participating Provider.

PRESCRIPTION DRUG BENEFITS

1. The Plan provides prescription drug benefits as part of the health plan.

Optum is the Trust's prescription benefit manager.

For 2019, the Trust has adopted a Comprehensive Step Therapy Program for treatment of certain conditions, including diabetes, Asthma/COPD and ADHD. Pursuant to this Program, drugs are grouped in categories, starting with medications (typically generic drugs) that have been proven safe, effective and affordable, with the possibility that the Trust will cover more costly drugs, if necessary, at a later step in the Program.

2. How to File a Prescription Drug Claim

If you use the *Prescription Drug* Card Program, *you* don't have to file a claim. Just show *your* prescription I.D. card to the pharmacist and everything is done electronically. For a full description of the plan, including prescription plan deductibles and co-pays, see your Prescription Drug Program brochure.

Advance notice to the Trust is required for (1) all anti-cancer or chemotherapy drugs, whether infusible, injectable, or taken orally; and (2) any self-injectable prescriptions and prescriptions in excess of $2,500.00.

3. Current List of Exclusions

Not all medications are covered by the plan. The following items are a current list of exclusions and are NOT covered by the Plan (though subscribers may get a discount on some of these items pursuant to the Plan's Enhanced Savings Program):

- Anorectics (any drug used for the purpose of weight loss). Exceptions: Amphetamine/Dextroamphetamine (Adderall) is covered for individuals through the age of 19 years
- Anti-wrinkle agents (e.g. Renova®)
- Dermatologicals, hair growth stimulants
- DESI Drugs: Drugs determined by the FDA as lacking substantial evidence of effectiveness
- Fluoride supplements
- Growth hormones
- Hematinics
- Immunization agents, blood or blood plasma
- Drugs used in the treatment of infertility
- Mineral and nutrient supplements
- Non-legend drugs other than those listed above
- Injectable drugs: Estadiol Valerate (Delestrogen), Glatiramer Acetate (Copaxone), Insulin, Interferon Beta-1B (Betaseron), Octreotide Acetate (Sandostatin) and Sumatriptan (Imitrex) are covered

Exclusions are not limited to the above mentioned list. Periodically the FDA approves additional prescription drugs that would be considered injectables by the Plan. Lost or stolen prescriptions are not covered.

Certain new-to-market drugs that have not yet been approved by the Trust, certain drugs that are similar to existing drugs and certain drugs that have little clinical value will not be covered.

If your physician prescribes any drug that may come under this provision, you should check with the *Trust* at: (503) 968-2360 or 1-800-777-3603 to determine whether it is covered.

If *you* go to a non-contracting pharmacy, or if *you* choose not to use your prescription drug card, *you* will pay the pharmacist directly and the *Trust* will process *your* claim under *your* major medical plan, which is subject to a deductible and reimbursement at 70%. Exclusions under the *prescription drug* coverage will also apply to prescriptions purchased from non-contracting pharmacies and submitted under *your* medical plan. Complete the Major Medical Drug Report Form, supply the requested information and attach the receipts to the claim form. Forms are available from your employer or from the Trust.

Send your *prescription drug* claims to:

Western Grocers Employee Benefits Trust
Attn: Prescription Claims
P.O. Box 22166
Portland, OR 97269

VISION PLAN (INCLUDED IN MEDICAL PLAN)

The Plan provides vision care coverage for you and your eligible dependents. Vision care expenses are payable under the Plan only for covered expenses incurred while you are a participant in the Plan. If covered expenses exceed the maximum allowed benefit you must pay the difference.

1. Covered Expenses/Maximum Benefits

The Plan pays covered expenses up to the following maximums:

Covered Expenses		Maximum Benefit (in 24 consecutive months) Covered individuals under age 17 will be covered for eye examination and hardware every 12 months
Comprehensive eye examination (including professional fees for fitting of contact lenses		Co-pay $25
Lenses, if necessary (all lenses are limited to two per person during the benefit period)* Single vision Bifocal Trifocal Lenticular Contacts Frames		The Plan will pay up to $300 toward vision hardware (frames, lenses, and/or contact lenses) once every 24 months. Individuals under 17 may be covered every 12 months
Vision Corrective Procedure		50% up to a $1,500 lifetime maximum

*Only covered at $150 per lens after cataract surgery or when a patient's visual acuity is not correctable to 20/70 or better by use of conventional lenses (lifetime maximum $400.00).

Note – there is no limit on pediatric vision services that are essential health benefits.

A separate charge for a contact lens fitting will be payable subject to the maximum benefit for vision hardware.

2. Exclusions

- Anti-reflective coatings or other lens treatment;
- Charges for services or supplies which are covered under any other benefits Plan provided by *your* employer;
- Expenses covered by Workers' Compensation or similar laws or treatment injuries arising out of employment;
- Eye examinations required by an employer as a condition of employment;
- Replacement for lost, stolen, broken glasses unless benefits are available;
- Services or supplies not listed as covered expenses;

- Special procedures, such as orthoptics or vision training;
- Special supplies, such as sunglasses (plan or prescription), subnormal vision aids or tinted glasses; or
- Visual analysis which does not include refraction.

Submitting a Claim

Participating providers will submit the claim on your behalf. If you use a non-participating provider, you may be asked to submit the claim yourself. In that case, please contact the Trust for a claim form:

Western Grocers Employee Benefits Trust
503-968-2360
Toll free: 800-777-3603

www.westerngrocerstrust.com/contact

Additional information can be found on page 54 (Claims Procedures).

DENTAL PLAN (OPTIONAL)

The dental plan is an optional coverage and not available to all employees. Check with your employer to verify if the dental option is included in your group benefits.

This Plan provides dental coverage for you and your eligible dependents. Dental expenses are payable under the Plan only for covered expenses incurred while you are a participant in the Plan. All covered expenses must be dentally necessary and performed by a licensed dentist in a dental office. To determine benefits based on only services that are dentally necessary, the Trust will review any relevant records of the patient.

There is a deductible to satisfy before dental benefits begin. Plan benefits will not cover expenses that exceed U&C charges – you are responsible for paying this difference. Dental coverage is not cumulative and cannot be carried over from one calendar year to the next.

Payment for Preventative and Diagnostic services (class I) is made at 100%. The deductible is waived for preventative and diagnostic services.

Payment for Basic and Restorative services (class II) is made at 80% after deductible.

Payment for Prosthodontic (class III) services is made at 50% after deductible.

1. Covered Expenses and Limitations

This Plan pays for four types of dental services:

- Preventive/Diagnostic services
- Basic/Restorative services
- Prosthodontic services (dentures, bridges and treatment of Temporal Mandibular Joint (TMJ) dysfunction), and
- Orthodontic services

2. Covered Preventative/Diagnostic Services and Limitations

- Bitewing x-rays (limited to once every six (6) months)
- Cleanings (or “scaling/polishing teeth”) are limited to once every six (6) months. This does not include periodontal scaling
- Complete full mouth x-rays (is a set of 4 Bitewings & 14 PA’s) or Panoramic/panorex x-rays (not both). Once every 36 months
- Diagnostic casts/study models except for TMJ or bruxism
- Emergency oral examination
- Fluoride treatments, if under age 19 (limited to once every six (6) months)
- Individual tooth x-rays and occlusal x-rays
- Initial oral examination. (Will count as a Routine Oral Examination)
- Routine oral examinations (limited to once every six (6) months)
- Sealants placed on natural tooth structure (molars only)

- Space maintainers. (Replace primary teeth only, in conjunction with loss of primary teeth only)
- **Arestin®**
- Pulp caps

3. <u>Covered Basic/Restorative Services and Limitations</u>

- Endodontic services (such as root canal treatment)
- Fillings
  - Amalgam fillings
  - Silicate fillings
  - Composite resin fillings
- Oral surgery (limited to minor surgical procedures)
  - Extractions
  - Root recovery
  - Incise and drainage of an abscess
- Periodontal treatment
  - Periodontal maintenance procedure, full mouth, limited to three times per calendar year but not in conjunction with additional charges for scaling and root planning, gingival curettage, osseous surgery or cleaning
  - Periodontal scaling and root planning per quadrant, limited to twice per calendar year but not in conjunction with gingival curettage or periodontal maintenance or cleaning
  - Gingival curettage per quadrant, limited to twice per calendar year but not in conjunction with periodontal scaling, root planning, periodontal maintenance or cleaning, gingivectomy, or osseous surgery

All claims submitted for benefits for periodontal treatment are subject to review and require that a dated current copy of the patient's periodontal chart be attached.

4. <u>Covered Prosthodontic Services and Limitations</u>

A pre-treatment estimate is recommended prior to major services. Benefits for crowns and bridges are based on date of placement/seating.

- Fixed prosthodontics
  - Gold inlay/onlay restorations
  - Crowns
  - Bridges
  - Repairs

- Replacement of inlays, crowns, bridges if more than five years old

- Removable prosthodontics
  - Dentures, including partial dentures
  - Adjustments, relines, repair of dentures or partials
- Implants, but no more than once for the same tooth position in a five (5) year period;

  (a) When needed to replace congenitally missing teeth; or

  (b) When needed to replace natural teeth that are lost while the person receiving such benefits was covered under this dental plan.
- Repair of implants, but not more than once in a 12-month period.
- Implant-supported prosthetics, but not more than once for the same tooth position in a five (5) year period.
- Treatment of Temporal Mandibular Joint (TMJ) dysfunction

5. <u>Covered Orthodontic Services</u>

Orthodontic benefits from this Plan will not exceed $1,000 in the lifetime of any covered individual for the $1,000 and $1,500 Plan. Similarly, orthodontic benefits from this Plan will not exceed $1,500 in the lifetime of any covered individual for the $2,500 Plan. The following orthodontic services are covered under this Plan:

- Services for a diagnosed malocclusion, if:
  - Provided to a covered dependent before age 19, and
  - The malocclusion is abnormal and correctable
- Includes consultations, models and photos
- Initial and subsequent installations of orthodontic appliances (but excluding repairs)
- Treatment related to the reduction or elimination of an existing malocclusion sequel through the correction of malposed teeth

The Trust reserves the right to review your dependent's dental records (including x-rays, photographs and models). The Trust will stop making any payments for orthodontics if you are no longer eligible for coverage under this Plan or if the patient stops receiving treatment.

6. <u>Exclusions</u>

The following services or items are not covered under the dental benefits:

- Accidental injury to natural teeth (See benefits under Medical)
- Appliances or restorations necessary to increase vertical dimensions
- Broken appointments
- Cosmetic services or supplies

- Claims submitted more than twelve (12) months after the date of service
- Dental services received from a department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar person or group
- Excess cost of materials or supplies selected when less expensive materials or supplies would provide appropriate results
- Excess cost of specialized or personalized prosthetics (covered expenses will be limited to the cost of standard devices)
- Gold restorations (such as gold foil) except for prosthodontic services (see "Covered Expenses and Limitations")
- Home fluorides or home dental aids
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized
- General anesthesia or nitrous oxide sedation, as a separate charge, except for oral surgery
- Periodontal splinting, including crowns or bridgework for splinting
- Prescribed drugs, premedication or analgesia (nitrous oxide)
- Repairs or replacements of an orthodontic appliance
- Replacement of necessary crowns, jackets, gold or cast restorations or any other covered prosthetic device, if less than five years old
- Separate charges for acid etch
- Services or appliances for restoring tooth structure lost from attrition (wear), for rebuilding or maintaining chewing surfaces due to teeth out of alignment, occlusion or for stabilizing the teeth (except as required for treatment of Temporomandibular Joint Dysfunction).
- Services of a dentist who is a relative of the patient by blood or marriage
- Services relating to developmental (following birth) malformations including but not limited to: upper and lower jaw malformations, malocclusions, enamel hypoplasia (lack of development) and fluorosis
- Services rendered by a dentist beyond the scope of his or her license, or
- Temporary crowns, bridges, partials or dentures as a separate charge.

7. <u>General Provisions</u>

- The *Trust* will not be liable for any claim or reimbursement for damages arising out of or relating to any injuries suffered by you or a covered dependent while under the care of a dental provider.
- You may choose any licensed dentist except those dentists you are related to be blood or marriage.

8. Submitting a Claim

Many dentists bill the Trust directly. However, if your dentist does not bill the Trust directly, you may send the claim yourself. Please contact the Trust for a claim form:

Western Grocers Employee Benefits Trust
503-968-2360
Toll free: 800-777-3603

www.westerngrocerstrust.com/contact

Additional information can be found on page 54 (Claim Procedures).

LIFE INSURANCE PLAN

The life insurance plan is optional coverage and may or may not be provided by your employer.

Life insurance benefits are available through a group policy issued by The Standard. If the Sponsoring Employer chooses to provide life insurance benefits to eligible employees, details of such coverage, including certificate of coverage, group policy, and summary plan description will be provided.

SHORT TERM DISABILITY (STD) PLAN

Your short term disability (STD) benefits protect part of your income if you are temporarily absent from work because of a non-work related disability. You are disabled if you are unable, as a result of sickness, accidental bodily injury, or pregnancy, to perform the duties of your occupation. STD benefits are payable on the employee only.

The Plan provides three levels of benefit. Your employer chooses which benefit is available to you.

Short-term disability coverage is administered and funded by Standard Insurance Company. Please see the Standard STD Summary Plan Description provided by your employer for details. You may also obtain a copy from the Trust by calling 503-968-2360 or 800-777-3603

Details of the three plans are as follows:

	Basic Plan	Standard Plan	Select Plan
Administered and Funded by	The Trust	The Trust	The Standard
Maximum Weekly Benefit	$100	$150	$200
Waiting Period Before Benefits Become Payable	7 days	7 days	7 days
Maximum Benefit Period	13 weeks	13 weeks	13 weeks
Other	Maximum benefit payable per year is $2,000	Maximum benefit payable per year is $2,000	

IF YOUR EMPLOYER CHOOSES TO PROVIDE COVERAGE THROUGH THE PLAN INSURED BY THE STANDARD, ADDITIONAL DETAILS OF THAT PLAN WILL BE PROVIDED TO YOU.

1. When Coverage Begins

If *you* are disabled on the day before *your* coverage would begin, *your* coverage will be delayed until the first day after *you* complete one full day of *active work.*

If *you* lose *your* coverage and become eligible again within 90 days, coverage begins immediately. If *you* lose *your* coverage and become eligible again **after** 90 days, coverage will begin on the first day of the month coinciding with or following the date you became eligible.

2. Short Term Disability Benefits

You must satisfy a seven (7)-day waiting period before benefits will be payable for your total disability. To receive benefits, *you* must be regularly seen and treated by a *physician* during this *waiting period*.

The amount of *your STD benefit* is a percent of *your weekly earnings*, subject to a *maximum benefit* selected by *your* employer's plan.

Your STD benefit will be based on *weekly earnings* in effect on the last full day of *active work* before *you* become *totally disabled*. Any change in the amount of weekly rate of earnings which is approved or becomes effective **after** that last full day of *active work* will not affect the amount of *your STD benefit* for that period of *total disability*.

As appropriate, benefits are issued once every two weeks following the waiting period.

3. Limitations

Short term disability benefits are only payable for the time loss authorized by *your physician*. The *maximum benefit period* will be the earliest of the following dates:

- Thirteen weeks from the day after the *waiting period*.
- The day you are no longer eligible due to termination, end of disability or your death.

Maximum benefit period means the longest period of time for which *STD benefits* are payable for any one period of continuous *total disability*, whether from one or more causes. *STD benefits* will stop at the end of the maximum benefit period even if you are still *totally disabled*.

4. Exclusions

The Short Term Disability Plan will not provide benefits for a disability that:

- Is not being treated by a *physician*;
- Arises out of, or in the course of, any employment for wage or profit;
- Is the result of an intentionally self-inflicted injury; or
- Is the result of a *war* or act of *war*.

If *you* are receiving benefits under any Workers' Compensation or occupational disease law, or paid sick leave from *your* employer, *you* will not be eligible to receive *STD benefits*. If a claim for those benefits is accepted, compromised or settled, *you* must reimburse *the Trust* for the full amount of the *STD benefits* paid.

5. If *you* Temporarily Recover

If *you* temporarily recover from your disability during the *maximum benefit period*, *you* should be aware of the following provision: If two periods of continuous *total disability* from the same cause(s) are separated by a period of recovery of less than 14 days, they will be added together and treated as one period of continuous *total disability*. As a result, a new *waiting period* is not required and the amount of *STD benefit* will not change. The *maximum benefit period* will be the balance of the *maximum benefit period* that was unused before the period of recovery.

6. When Coverage Ends

Your short term disability coverage will end on the date:

- *You* are no longer eligible (as defined in the "Eligibility" section);
- *You* become a full-time member of the armed forces of any country;
- This contract terminates; or
- *You* no longer *actively work* for the employer (including temporary layoffs, strikes, or lockouts).

You will still be eligible to receive *STD benefits* if *your* period of continuous disability begins, and then:

- This contract terminates.
- *Your* coverage ends while under this contract, or
- An amendment to this contract is approved.

7. How to File a Short Term Disability Claim

All *STD benefits* will be paid directly to *you*. A claim for *STD benefits* must be received within 120 days after the end of the *waiting period* or as soon as reasonably possible. Claims not filed within ten (10) months after the date on which disability is claimed to have begun will be denied and no *STD benefits* will be paid.

To file a claim under either the Basic or Standard plans, follow the steps below. To file a claim under the Select plan, follow instructions provided by Standard Insurance Company:

a. Obtain a claim form from *the Trust* by calling 503-968-2360 or 800-777-3603.

b. Complete the "Short Term Disability Claim Statement" and submit it to *the Trust*. This form includes:

- A completed claim statement signed by *you*.
- A completed claim statement signed by *your* employer.
- A completed claims statement signed by *your physician*.

c. Complete an "Authorization to Obtain Information" form which is a written statement from *you* authorizing *the Trust* to obtain the records and information needed to determine eligibility for *STD benefits*.

d. Any other information requested by *the Trust*.

e. *The Trust* may arrange to have *you* examined by *physicians* at *the Trust's* expense.

f. *You* will receive a written decision on the claim within a reasonable period of time after *the Trust* received the claim.

Send *your* claims to:

Western Grocers Employee Benefits Trust
Attn: STD Claims
P.O. Box 22166
Portland, OR 97269

STD benefits may be deferred or suspended until you have completed the steps above.

Manner and Content of Notification of Claims Decisions

The Claims Administrator will provide a claimant with written or electronic notification of the Plan's claims decision. In the case of an adverse denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit determination, the notification will include:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; and

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and

- A notice that any claimant may file a complaint with the director of the Oregon State Department of Consumer and Business Services.

Appeal of Adverse Benefit Determinations

Upon receipt of an adverse benefit determination, the claimant has up to 180 days to file an appeal with the Plan Administrator. The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits.

The appeal will be reviewed by a claims administrator who is neither the party who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such party. The decision on appeal of an adverse benefit determination will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether such information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse benefit determination.

Notification of Claims Decision on Review

The Plan Administrator will notify the claimant of the Plan's claims decision on review within a reasonable time period, not to exceed 45 days from the date the Plan receives the appeal, except for situations requiring an extension of time because of matters beyond the control of the Plan. If an extension is required, the Plan Administrator may have up to an additional 45 days to provide the claimant with notice of the decision. If an extension is needed, you will be notified before the expiration of the initial 45 day period.

Manner and Content of Notification of Claims Decision on Review

The Plan Administrator will provide claimants with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification must set forth:

- The specific reason(s) for the adverse determination;

- Reference to the specific Plan provisions on which the determination is based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits;

- A statement of the claimant's right to bring a civil action under ERISA Section 502(a);

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- 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."

A claimant must exhaust all of the internal administrative review options before applying for external review.

GENERAL INFORMATION

1. About the Plan

Any payment required of *the Trust* under this Plan will be made to the *Hospital*, *Skilled Nursing Facility*, Special Facility, *Physician* or other person or organization furnishing the service for which payment is provided or to the Subscriber.

If this Plan replaces an earlier Western Grocers Employee Benefits Trust Plan, benefits furnished under the earlier Plan shall apply against the benefit maximums of this Plan as though the benefits had been furnished under this Plan.

The Trust may require you to submit information concerning benefits you are entitled to receive under Medicare (U.S. Public Law 89-97) when such information is necessary to process claims. *The Trust* may also require that *you* authorize a *hospital*, *physician* or other *provider*, to furnish us any information we may request relating to any condition for which benefits are claimed under this Plan.

Your benefits are provided by a Multiple Employer Welfare Arrangement (MEWA) which is subject to less stringent solvency protection regulations than are insurance companies regulated by the State. In the event *the Trust* does not pay medical expenses, whether eligible for ineligible for payment, *you* and *your* dependents may be liable for payment of those expenses directly to the *providers.*

The Trust expects to continue this Plan in the future, but may terminate the Plan, or the benefits offered under the Plan, at any time by appropriate action of its Board of Trustees or other persons designated by the Board. If any of the Plan changes or stops, any changes in your coverage, participation or benefits will be in accordance with applicable law. The Trust will provide written notice of discontinuation of Plan benefits to Plan participants and beneficiaries at least 180 days before the change in coverage takes effect.

2. Family Medical Leave Act

To the extent employers provide Family Medical Leave, the Plan will permit coverage in compliance with FMLA. The determination for eligibility is made by the employer.

3. Michelle's Law

If a student suffers injury or serious illness and takes medically necessary leave of absence from school or changes to part-time status, he/she may qualify for extended coverage of up to one year provided the medical leave of absence has been certified by a physician and commenced while the student is covered under the Plan. The leave of absence or reduction in hours must be medically necessary and must commence while the eligible student is suffering from a serious illness or injury and would otherwise lose coverage under the plan. The student must have been enrolled in the group health plan before the first day of the leave. The coverage under Michelle's Law must be extended for at least one year; however, coverage may end earlier for certain reasons, such as the student aging out of the plan (e.g., exceeding the plans' normal dependent-eligibility age). Call your plan administrator (503) 968-2360 or 1-800-777-3603 for more information.

4. Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or to less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the 48 hours, or 96 hours as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

5. Representations

In the absence of fraud, all statements made by applicants, the policyholder or an insured shall be considered representations and not warranties. A statement made for the purpose of effecting insurance may not void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or an insured person, a copy of which has been furnished to the policyholder or to the insured person or the beneficiary of the insured person.

6. Women's Health and Cancer Rights Act of 1998 (WHCRA)

Under federal law employers are required to provide you with a notice of your rights under WHCRA when you enroll in this Plan (enrollment notice). Accordingly, upon enrollment you will be provided with a notice describing the benefits that WHCRA requires the Plan and its insurance companies or HMOs to cover. These benefits include coverage of all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. In addition, the enrollment notice will provide that for the covered employee or his/her family member who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, and describe any deductibles and coinsurance limitations that apply to the coverage specified under WHCRA. Deductibles and coinsurance limitations may be imposed only if they are consistent with those established for other benefits under the plan or coverage.

In addition, an annual notice will provide disclosure similar to the following: "Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?" Call your plan administrator (503) 968 -2360 or 1-800-777-3603 for more information.

7. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PRIVACY OF YOUR HEALTH INFORMATION

This section describes how your medical information may be used and disclosed and how you obtain access to this information. **Please read this section carefully.**

HIPAA grants you certain privacy rights with respect to your Health Information. In addition, HIPAA requires that this Plan comply with rules designed to protect this information from improper uses and disclosures. One of your rights under HIPAA is to know how this Plan handles your Protected Health Information. This section explains how this Plan uses and discloses your Protected Health Information, and what rights you have with respect to your Protected Health Information. The Plan may change this Privacy Notice in the future, but it must always follow the terms of the Privacy Notice in effect.

Who Sees Your Health Information? The Plan Administration and Employer must see Health Information that can be linked to an Individual ("Protected Health Information") in order to operate this Plan. Others who may see this information are employees of outside organizations that assist in the operation of this Plan. In order to access this information, an Individual must complete extensive training on privacy and security procedures. The law prohibits these individuals from using Protected Health Information for improper purposes. These individuals understand that a violation of this Plan's privacy and security procedures may result in disciplinary action.

Other Privacy Notices. Your doctors, nurses, hospitals and other health care providers may provide you with privacy notices required by HIPAA. These privacy notices differ from this one because these notices discuss how your health care providers use your Protected Health Information. This notice applies only to the Protected Health Information obtained and maintained by this Plan. It describes your rights with respect to your Protected Health Information maintained by this Plan, and how this Plan may use and disclose that Health Information.

How this Plan Uses and Discloses Your Health Information. This Plan can only use and disclose Protected Health Information in ways that are expressly permitted by HIPAA. The sections entitled Treatment, Payment and

Health Care Operations describe how this Plan uses and discloses the Health Information obtained about you (your "Health Information"). Some of these uses and disclosures are routine, and are necessary to operate this Plan, and to provide assistance to the health care providers who treat you. Others are not routine, but are required by law or necessary due to special circumstances. This Plan has developed procedures for all of these uses and disclosures.

Treatment. This Plan may use or disclose your Health Information to facilitate medical treatment or services by your health care providers such as doctors, nurses, technicians, medical students, other hospital personnel or pharmacists who are involved in treating you.

Payment. This Plan may use and disclose your Health Information in order to determine your eligibility for Plan benefits, to process claims for payment for your treatment, or to determine whether any other plan or party might be responsible for payment of your treatment.

Health Care Operations. This Plan may use and disclose your Health Information in order to conduct Plan operations. For example, the Plan may review your Health Information in order to:

1. Conduct quality assessment and improvement activities;

2. Perform underwriting, premium rating, and other activities relating to Plan coverage;

3. Submit claims for stop-loss (or excess loss) coverage;

4. Conduct or arrange for medical review, legal services, audit services, and fraud and abuse detection programs;

5. Learn about ways to manage costs; and

6. Manage the business of this Plan, to make sure it is administered properly and effectively.

Required By Law. This Plan will disclose your Health Information when required to do so by federal, state or local law.

To Prevent Serious Threats to Health or Safety. This Plan may use and disclose your Health Information in order to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure of this nature would only be made to a person who is able to help prevent the threat.

Special Situations

Organ and Tissue Donation. If you are an organ donor, this Plan may release your Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, in order to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces of the United States or any other country, this Plan may release your Health Information if the Contracts require this Plan to do so by the appropriate military command authorities.

Workers' Compensation. This Plan may release your Health Information if required to in order to comply with workers' compensation laws.

Health Oversight Activities. This Plan may disclose your Health Information to a Health Oversight Agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, this Plan may disclose your Health Information in response to a court or administrative order. The Plan may also disclose your Health Information in

response to a subpoena, discovery request, or other legal process by someone involved in the dispute, but only if efforts have been made to inform you of the request or to obtain an order protecting the information requested.

Law Enforcement. If requested to do so by a law enforcement official, this Plan may release your Health Information in response to a court order, subpoena, warrant, summons or similar process.

Coroners, Medical Examiners and Funeral Directors. This Plan may release your Health Information to a coroner or medical examiner. This may be necessary, for example, to identify you if you die or to determine the cause of your death. This Plan may also release your Health Information to funeral directors as necessary to carry out their duties.

Your Rights Regarding Health Information this Plan Maintains About You. You have the following rights regarding the Health Information this Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your Health Information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must request that information in writing and submit it to the Employer's HIPAA Compliance Director. If you request a copy of the information, you may be charged for the cost of copying, mailing and for any supplies associated with your request.

Right to Amend. If you feel this Plan has medical information about you that is incorrect or incomplete, you may ask this Plan to amend the information. You have the right to request an amendment for as long as the information is retained by or for this Plan.

To request an amendment, your request must be in writing submitted to the HIPAA Compliance Director. Your request for an amendment may be denied if you do not complete this Form. In addition, your request may be denied if you ask this Plan to amend information that:

1. Is not part of the medical information retained by or for this Plan;

2. Was not created by this Plan;

3. Is not part of the information which you would be permitted to inspect and copy; or

4. Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where disclosures were made for any purpose other than treatment, payment, or health care operations.

To request a list or accounting of disclosures, you must complete a written request for an accounting and submit that request to the HIPAA Compliance Director. Your request must state a period within which you are requesting an accounting of disclosures. This period may not be longer than 6 years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. If you request any additional lists, this Plan may charge you for the cost of providing the lists. You will be notified of the cost in advance and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information this Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information this Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could request that this Plan not use or disclose to your spouse information about a surgery you had.

To request restrictions, you must provide a written request restricting the disclosure of information to the HIPAA Compliance Director. You should understand that the HIPAA Compliance Director is not obligated to comply with your request.

Right to Request Confidential Communications. If you believe that the normal form of communications of benefit information could compromise you, you have the right to request that this Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can request that this Plan only contact you at work or by mail.

To request confidential communications, you must complete a request for confidential communications and submit it to the HIPAA Compliance Director. This Plan will not ask the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes to Privacy Notice. This Plan reserves the right to change this notice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with this Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with this Plan, contact the Plan's General Manager. All complaints must be submitted in writing.

Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this notice or any law that applies to this Plan will be made only with your Written Authorization (please see below for a description of the term). If you provide this Plan Written Authorization to use or disclose medical information about you, you may revoke that Written Authorization, in writing, at any time. If you revoke your Written Authorization, this Plan will no longer use or disclose medical information about you for the reasons covered by your Written Authorization. You understand that this Plan is unable to take back any disclosures already made prior to the date it has received a revocation of the Written Authorization. To request authorization for use or disclosure of your Protected Health Information, you should contact the HIPAA Compliance Director.

"Written Authorization" means a written consent that: (a) identifies you; (b) generally describes the type of information that may be disclosed; (c) describes the party (or parties) to whom the information may be provided; (d) is signed by you (or an individual legally empowered to grant authority for you); (e) states the length of time (not to exceed 24 months) that the written authorization is effective for; (f) includes a statement that you may revoke the authorization at any time along with a description of the steps to take to revoke the authorization; and (g) is retained by the Plan during the period for which it was granted and for a reasonable time after it has expired or been revoked.

INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

In accordance with disclosure requirements of HIPAA, a complete list of providers is available by calling (503) 968-2360 or 1-800-777-3603.

HIPAA also requires that we inform you of the Department of Labor address in Washington, D.C. Therefore, if you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, or write to Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Additional information regarding your ERISA rights is located in this booklet on page 53.

Breach Notification Rule

All HIPAA covered entities, including health plans, and their business associates must notify individuals and HHS when personal health information has been breached.

A breach is when individually identifiable health information is acquired, used, accessed, or disclosed to an unauthorized party, in a way that compromises its security or privacy. A "breach" does not include inadvertent disclosures among employees who are normally authorized to view protected health information. A breach also does not include exposure of encrypted personal health information.

When a breach occurs, the covered entity must notify victims and the Secretary of Human Services within 60 days of the discovery of the breach. The covered entity must notify the individual directly if possible and must also post a

notice on its website if the breach involves 10 or more victims who are not directly reachable. If the breach involves more than 500 residents of a single state, the covered entity must also notify statewide media.

Notice to Media. There is no uniform definition of a prominent local media outlet. Depending on circumstances, an appropriate media outlet may include a local newspaper or a major general interest newspaper with a daily circulation throughout an entire state. Notices to the media must supplement individual notices provided to the affected individuals. HHS expects that most notices to the media will take the form of a press release.

8. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits discrimination in group health plan coverage based on genetic information. GINA expands the genetic information protections included in HIPAA. HIPAA prevents a plan or issuer from imposing a preexisting condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

GINA provides that group health plans and health insurance issuers cannot base premiums for an employer or a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.) GINA also generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although the regulations make clear that the plan or issuer may request only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that a participant or beneficiary undergo a genetic test.

GINA also prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA). The regulations provide several examples illustrating GINA's application to HRAs. An exception is included for incidental collection, provided the information is not used for underwriting. However, the regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

9. Non-Contract Providers

The Trust will pay benefits at the out of network level for covered services provided by non-contracted health care providers if the non-contracted health care provider performs the services as part of a covered stay at a facility and the covered individual does not have or is not given a choice as to who performs the services.

10. Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under *ERISA*. Under *ERISA*, all Plan participants have a legal right to:

- Examine, without charge, at *the Trust* Administrator's office, all Plan documents and copies of all documents filed by the Plan with United States Department of Labor.

- Obtain copies, at a reasonable charge, of all Plan documents and other Plan information upon written request to *the Trust*.

- Receive at no charge a summary of the Plan's annual financial reports.

- Receive both a written explanation and reconsideration on any denied claims.

- Be protected from discharge or discrimination to prevent payment of benefits or for exercising any rights under law.

Under *ERISA*, certain entities who administer your plan may be fiduciaries. A fiduciary is a person or agent responsible for the Plan's operation.

Under *ERISA*, there are steps *you* can take to enforce *your* legal rights. For instance, if *you* make a written request for materials from *the Trust* 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 Trust* to provide the materials and pay you up to $110 a day until you receive the materials; unless they were not sent for reasons *the Trust* could not control.

If *you* have a claim for benefits that is denied, in whole or in part, *you* may file suit in a state or federal court after all rights under the Claims Appeal procedure have been exhausted.

If *the Trust* misuses 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 file suit in federal court. The Court will decide who should pay the court costs and legal fees. If *you* are successful, the Court may order the person *you* have sued to pay these costs and fees. If *you* lose, the Court may order *you* to pay these costs and fees; for example, if it finds *your* claim is frivolous.

If *you* have any questions about the Plan, contact *the Trust*. If *you* have any questions about the information above or about *your* legal rights, contact the nearest Area Office of the U.S. Labor Management Services Administration Department of Labor.

11. Claims Procedures

A claim for benefits is a request for a Plan benefit or benefits, made by a claimant or the claimant's representative that complies with the Plan's reasonable procedure for making benefit claim.

The Trust is the Plan Administrator and named fiduciary under the Plan and is responsible for making claims and appeal decisions. The Plan Administrator has the authority to interpret the Plan in order to make benefit decisions. The Plan Administrator also has the authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

A. Submitting a claim

Participating providers will submit the clam to the Trust on the enrollee's behalf. In the event a non-participating provider declines to submit the claim, the enrollee may obtain a claim form by contacting the Trust's customer service department at 503-968-2360 or toll-free at 800-777-3603.

Claims should be submitted to:

Western Grocers Employee Benefits Trust
PO Box 22166
Portland, OR 97269

Fax #: 503-968-2817

If claim forms are required and not furnished by the Trust within 15 days after the Trust receives notice of the claim, the enrollee shall be deemed to have complied with this requirement.

Authorized Representative. An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. As assignment for purposes of payment does not constitute appointment of an authorized representative under these claims procedures. Once an authorized representative is appointed and the Plan Administrator is notified, the Plan shall direct all information and notification regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise. *Any reference in these claims procedures to "claimant" is intended to include "authorized representative" as described in this section.*

B. Notification of Claims Decision

Incorrectly-Filed or Incomplete Claims. Any request for benefits that is not made in accordance with these claims procedures is called an incorrectly filed claim. These procedures do not apply to any request for benefits that is not made in accordance with these claims procedures except (a) in the case of an incorrectly-filed pre-service claim, the claimant shall be notified as soon as possible but not later than five days following receipt by the plan of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed urgent-care claim, the claimant shall be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly-filed claim. The claimant will be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information for the urgent-care claim. The Plan Administrator will notify the claimant of the plan's claim decision on the urgent-care claim as soon as possible, but no later than 48 hours after the earlier of: (1) the plan's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified information. For all requests for benefits other than urgent-care claims, the notice shall explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the claimant.

If a pre-service or post-service claim is incomplete, the Plan will notify the Claimant within 15 days. If the Plan takes an extension of time, the extension notice shall include a description of the missing information. Following the retrieval of additional necessary information, the Plan will decide the claim within 15 days after receipt of the information requested or within 30 days after receipt of the claim. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is not provided within the time specified, the claim may be decided without that information.

Urgent Care Claims. An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a pre-service claim, the Plan will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

The Plan Administrator will notify the claimant of the Plan's claims decision as soon as possible, but not later than 24 hours after receipt of the claim by the Plan.

C. Non-Urgent Care Claims

Concurrent Care. A concurrent care decision occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. If the Plan has approved a benefit or service to be provided for a specified or indefinite time period any reduction or termination of the benefit or service (other than by plan amendment or termination) before the end of such period constitutes an adverse benefit determination. The Plan Administrator will provide notice of the adverse benefit determination sufficiently in advance to allow the claimant (or the claimant's representative) to appeal and obtain a determination on appeal before the benefit is reduced or terminated. In addition, any urgent care claim requesting an extension of a course of treatment beyond the initially prescribed time period or number of treatments must be decided within not more than 24 hours of the request provided the claim is made at least 24 hours before the expiration of the initially prescribed period or number of treatments. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Pre-Service Claims. A claim is a pre-service claim if the SPD specifically conditions receipt of the benefits, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined in the Section entitled "Urgent Care Claims." Benefits under this Plan that require approval in advance are specifically noted in the SPD as being "subject to Pre-Service Authorization."

The Plan Administrator will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 5 working days after receipt of the claim by the Plan.

Post-Service Claims. "Post-service claims" are any group health plan claims that are not pre-service claims. The Plan Administrator will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 30 days after receipt of the claim by the plan.

A post-service claim shall be filed within 90 days following receipt of the medical service, treatment or product to which the claim relates, unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

D. Manner and Content of Notification of Claims Decisions

The Plan Administrator will provide a claimant with written or electronic notification of the Plan's claims decision. In the case of an adverse denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit determination, the notification will include:

- The specific reason(s) for the adverse determination;

- Reference to the specific Plan provisions on which the determination is based;

- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

- If an adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request;

- In the case of an adverse benefit determination concerning a claim involving urgent-care, a description of the expedited review process application to such claims;

- Information sufficient to identify the benefit request or claim involved, including, if applicable, the date of service, the health care provider, and, if applicable, the claim amount;

- A statement describing (1) the diagnosis code and the code's corresponding meaning; and (2) the treatment code and the code's corresponding meaning; and

- A statement explaining your right to (1) contact the Alaska Division of Insurance for assistance (including the Division's current mailing address, email address, and telephone number); and (2) after completing the Plan's grievance procedure, file a civil suit.

In the case of an adverse benefit determination involving an urgent care claim, the information may be provided to the claimant orally within the time frame prescribed, provided that a written or electronic notification is furnished to the claimant not later than three days after the oral notification.

E. Appeal of Adverse Benefit Determinations

Upon receipt of an adverse benefit determination, the claimant has up to 180 days to file an appeal with the plan administrator. The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. The claimant has the right to appear before the decision maker with or by his or her authorized representative.

The appeal will be reviewed by an appropriated named fiduciary of the Plan who is neither the party who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such party. The decision on appeal of an adverse benefit determination will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether such information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse benefit determination.

In deciding the appeal of any adverse benefit determination involving a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is *experimental*, *investigational*, or not *medically necessary* or appropriate, the reviewer will consult with a health care professional, who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will not be one who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In addition, the plan will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the claims decision.

Appeal of adverse benefit determination involving urgent-care claims are subject to an expedited review process. The request for appeal may be submitted orally or in writing by the claimant or the claimant's representative. All necessary information, including the plan's claim decision on review of an urgent care claim, will be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

F. Notification of Claims Decision on Review

The Plan Administrator will notify the claimant of the Plan's claims decision on review within a reasonable time period appropriate to the circumstances.

Urgent Care Claims. For urgent-care claims, the Plan Administrator will notify the claimant of the Plan's claims decision on review as soon as possible, but not later than 24 hours after receipt of the claimant's request for review of an adverse benefit determination.

Pre-Service Non-Urgent Care Claims. For pre-service claims, the Plan Administrator will notify the claimant of the Plan's claims decision on review not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

Post-Service Non-Urgent Care Claims. For post-service claims, the Plan Administrator will notify the claimant of the Plan's claims decision on review not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

G. Manner and Content of Notification of Claims Decision on Review

The Plan Administrator will provide claimants with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification must set forth:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits;

- A statement of the claimant's right to bring a civil action under ERISA Section 502(a);

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- 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."

H. Review of Adverse Appeal Determination

Claimants have the right to apply for external review by an independent review organization when the adverse benefit determination concerns whether the course of treatment is medically necessary, experimental or investigational or an active course of treatment for purposes of obtaining continuous care from an individual provider for a limited period of time after the medical services contract terminates.

If the Plan Administrator does not follow the decision of the independent review organization, the claimant may file suit against the Trust.

The request for external review must be made no later than 180 days following notice of the adverse benefit determination. A claimant must exhaust all of the internal administrative review options before applying for external review.

I. Filing a Grievance

If you have questions about or are dissatisfied with claims payment, handling or reimbursement; availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or matters pertaining to the contractual relationship between you and the Trust, we encourage you to contact our office. Many times, matters can be resolved with a phone call.

If you wish to file a grievance or appeal, please refer to the following:

Grievance Procedures
Level 1

"Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the following:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

- Claims payment, handling or reimbursement of health care services; or

- Matters pertaining to the contractual relationship between an enrollee and the Trust.

If you have a grievance, you may submit the grievance to the Trust and ask for a review. If you need any assistance to complete a written complaint, you may contact our Customer Service Department at 1-800-777-3603 and ask for assistance. We will acknowledge receipt of the written grievance in writing with seven (7) days of receipt of your grievance submission and conduct an investigation. The Trust will issue a written decision within thirty (30) days of

receiving the grievance submission. If a decision cannot be reached within thirty days, we will issue a Notice of Delay and complete the investigation no later than fifteen (15) days from the 30th day of receipt.

Appeal Procedures
Level 2

"Appeal" means the process by which you may receive a review of decisions made by the Plan or its delegates concerning services by a health care provider or a supplier. If you are not satisfied with this review, you may submit a written appeal for review within 30 days to the Plan Administrator, by filing a request for review under the procedure described below. The Plan Administrator will acknowledge receipt of your appeal within seven days.

- **FOR URGENT CARE CLAIMS:** The Plan Administrator will notify you of the decision on your request for review as soon as possible taking into account the medical urgency but not later than 24 hours after the plan receives your request for review unless the claimant fails to provide sufficient information to determine whether the benefits are covered or payable. If you requested an expedited appeal of this benefit denial, all necessary information, including the plan's decision following review, will be transmitted by telephone, fax, or other available, expedited methods. Claimant must provide sufficient information to determine whether the benefits are covered or payable.

- **FOR PRE-SERVICE CLAIMS:** The Plan Administrator will notify you in writing of the decision on your request for review within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after the plan receives your request for review.

- **FOR POST-SERVICE CLAIMS:** The Plan Administrator will notify you in writing of the decision on your request for review within a reasonable period of time but not later than 30 days after the Plan receives your request for review.

    1. For non-urgent care claims only: You must file your request for review within 180 days of the date you receive this Notice of Benefit Denial. You must file your appeal by submitting a written Request for Review form by hand or by first-class mail to:

        Western Grocers Employee Benefits Trust
        PO Box 22166
        Portland, OR 97269

    2. For urgent care claims only: You must file your appeal by submitting a written Request for Review:

        Western Grocers Employee Benefits Trust
        PO Box 22166
        Portland, OR 97269
        Fax#: 503-968-2817

In the alternative, you may make an oral request for an expedited appeal of this benefit denial by calling (800) 777-3603 and all necessary information, including the plan's decision following review, will be transmitted by telephone, fax, or other available methods. Your request for review must:

- be made in writing;
- state the reason(s) for disputing the denial (adverse benefit determination);
- include any pertinent material not already furnished to this Plan; and
- be submitted within 180 days from the date you receive the notice of denial.

Failure to file an appeal that meets all of the above will constitute a waiver of your right to a review of the denial (adverse benefit determination) of your claim.

12. Plan Review Procedures

When you file an appeal, as described above, the Plan Administrator will provide for a full and fair review of this benefit denial under the following procedures.

1. The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in this initial benefit denial. The review on appeal will be a "fresh" look at your claim without deference to this initial benefit denial. It will be conducted by a person who was not involved in this initial benefit denial, and who is not a subordinate of the individual involved in this initial benefit denial.

2. If your benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the denial decision, nor be a subordinate of the health care professional who was involved. If the plan has obtained or will obtain medical or vocational experts in connection with your claim, they will be identified, regardless of whether the plan relies on their advice in making any benefit determinations.

3. On request, and at no charge, you may obtain reasonable access to, and copies of, all documents, records and information relevant to your claim for benefits.

External Review
Level 3

If the Plan Administrator denies the appeal, you may appeal in writing for External Review through an Independent Review Organization within 180 days after receipt of the adverse benefit determination at no cost to yourself, provided the adverse benefit determination involves one of the following:

- Whether a course or plan of treatment is medically necessary;

- Whether a course or plan of treatment is experimental or investigational; or

- Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care.

If the Plan does not follow a decision of an independent review organization, the enrollee has the right to file suit against the Plan.

After exhausting all rights under the Claims Appeal Procedures (please see the Claims Appeal Procedures in the Summary Plan Description, page 56, for further information), you have the right to bring a civil action under ERISA §502(a) or any applicable State Court private right of action if you file an appeal and your request for coverage or benefits is denied following review.

You have the right to file a complaint or seek other assistance from the Department of Consumer and Business Services:

Telephone: 503-947-7984 or toll-free at 1-888-877-4894

Address: Department of Consumer and Business Services
Oregon Insurance Division – Consumer Protection Unit
PO Box 14480
Salem, OR 97309-0405

By email: cp.ins@state.or.us\

Online at: www.oregon.gov/DCBS/insurance/gethelp/pages/fileacomplaint.aspx

13. Additional information available on request.

The Trust will provide the following information to a Participating Employer upon request. An interested enrollee may obtain this information from his or her employer:

- Annual summary of grievance and appeals
- Annual summary of utilization review policies
- Annual summary of quality assessment activities
- Results of all publicly available accreditation surveys
- Annual summary of the health promotion and disease prevention activities
- Annual summary of scope of network and accessibility of services

14. Notices

Any notice by the *Trust* shall be deemed given if mailed to the Subscriber or group at the last address appearing on the records of the *Trust*.

Employers participating in this Plan are not and do not act as agents of the *Trust*, but act as agents of the Subscribers.

15. Refunds

The *Trust* has the right to request a refund for any payment made in error. The *Trust* will recover or attempt to recover overpayments or otherwise correct payments in the time period prescribed for an insured to appeal or submit a claim.

16. Continuation of Coverage (COBRA)

When an enrollee's coverage under this Plan ends, there are several alternatives to obtain continued coverage.

A. Federal COBRA Coverage

This section applies if your employer employs 20 or more employees (if your employer employs 19 or fewer employees, please refer to the Continuation of Coverage—State Continuation section after this section on page 64).

If your benefits under this Plan end, you and your covered dependents may be eligible to continue coverage under COBRA. Under specific circumstances, COBRA allows certain employees and their eligible dependents to separately purchase continued coverage when it would otherwise end. You pay for this extended coverage, which is 100% of the full cost of providing coverage plus a 2% administrative fee.

The following chart shows the qualifying events, who is eligible for COBRA coverage, and the length of time it will be available:

If *you* can no longer participate due to . . .		**These individuals may continue to participate. . .**		**For up to this length of time. . .**
Your termination of employment (for any reason except gross misconduct) or reduction in work hours		*You*, *your* covered *spouse* and dependent children		18 months

Your death*		*Your* covered *spouse* and dependent children		36 months
Your divorce* or legal separation*		*Your* covered *spouse* and dependent children		36 months
Your entitlement to Medicare*		*Your* covered *spouse* and dependent children		36 months
Your covered dependent child is no longer eligible for participation		*Your* covered dependent child		36 months

*If one of these reasons for continuation of coverage occurs during the 18-month period after termination of employment or reduction of hours, the total continuation period cannot exceed 36 months.

A retiree or retiree's spouse, surviving spouse, or dependent child can also elect continuation of coverage if coverage ends or is substantially eliminated within one year before or after the filing of a bankruptcy proceeding in a case under Title 11, United States Code, and retirement occurred before the substantial elimination of coverage.

Retirees who elect continued coverage under these conditions can receive benefits for their life and, in the case of their death, for up to 36 additional months for their surviving spouse and dependents. The surviving spouse of a retiree receiving benefits at the time of the event may also continue coverage for life.

Participation may continue up to another 11 months if you are (or a covered member of *your* family is) totally disabled when you terminate employment or your hours are reduced. Under these circumstances, your costs to continue coverage after the first 18 months will be 150% of the full cost of providing coverage. To be eligible for this extension, you or your dependent must:

- Receive a determination of disability from the Social Security Administration that you or a family member were disabled at any time during the first 60 days of continuation coverage, and

- Notify the Trust within 60 days of receiving the disability determination and before the original 18- month period ends.

B. Coverage for Spouse Age 55 or Older

If *your spouse* is age 55 or older and his or her coverage ends under the Plan because of your death, legal separation or dissolution of marriage the spouse and any dependent children may continue coverage under the Plan. The Spouse must give written notice to the Trust of the death, separation or dissolution of marriage

- Within 30 days of the date of your death, or

- Within 60 days of the date of legal separation or date of entry of the divorce decree.

Within 14 days after receipt of notice from the spouse, the Trust will notify the spouse that coverage under the Plan can be continued and provide an election form to the spouse. The election form must be returned to the Trust within 60 days after the Trust mails the form. If the form is not returned within 60 days, the right to continuation of coverage terminates. If the Trust fails to notify the spouse, premium shall be waived from the date notice was required until the date notice is received by the spouse.

Premium for continuation coverage for the spouse will be the same as would be charged for an individual covered by the Plan plus the premium for coverage of any dependent children. The initial premium payment must be paid to the trust within 45 days of the date of election. Following premium payments shall be made monthly and shall be paid by the spouse to the Trust within 30 days of the premium due date.

C. End of Continuation Coverage

Continuation coverage will end on the earliest of the following dates:

- The last day of the month for which premiums were paid if coverage terminates for non-payment of premium;
- The date, after the date of *your* COBRA election, upon which you become covered under another group health plan;
- The date, after the date of your COBRA election, on which you become eligible for federal Medicare coverage;
- The date on which the Plan terminates or on which the employer terminates coverage under the Plan.

Please note that continuation of coverage is not automatic. If you lose your coverage either you or your employer must take specific action to ensure continuation of coverage. If you or your employer fail to notify the Trust as described below you do not have the right to continue coverage.

Responsibility		**Action**		**Timing**
You must		Notify *the Trust* if *you* lose *your* coverage as a result of: • divorce • legal separation • a child losing dependent status		Within 60 days of the event
Your employer must		Notify *the Trust* if *you* lose *your* coverage as a result of *your*: • death • termination (other than by reason of gross misconduct) • reduction in hours • Medicare entitlement		Within 30 days of the event
The Trust will		Notify *you* if a termination of coverage entitles *you* to continued coverage under *COBRA*		Within 14 days after receiving notice of a qualifying event

Notice to *you* or *your spouse* constitutes notification to any beneficiary residing with *you* or *your spouse*. If *your spouse* or other covered family member has a different address, either *you* or *your spouse* must provide that address to *the Trust*.

You will receive a coverage election form, information about the cost to continue coverage and a description of how to make payments. Once *you* elect to continue participation, *you* will have 45 days to make the first premium payment. Premium payments are due monthly and must be are due no later than the first of each month. If any person covered under COBRA does not make payments on time, this benefit may be terminated.

A covered person's continuation of coverage under *COBRA* will stop before the end of the indicated time period if:

- Premium payments are not paid on time (the maximum grace period is 30 days after the payment is due)
- The covered person becomes, after electing COBRA, covered under another group Medical Plan (that does not contain any exclusion or limitation with respect to the covered person's pre-existing conditions)

- The covered person becomes, after electing COBRA, entitled to Medicare benefits, or

- *Your* employer no longer participates in this Plan (if *your* employer adopts another Plan, *your* participation will continue under that new Plan).

If *you* or *your spouse* elect continuation of coverage, and do not enroll dependents at that time, *you* or *your spouse* will be entitled to add dependents at the Plan's open enrollment period, or a special enrollment period (see "Eligibility" for more information on changes in family status, page 10).

Your rights to continue coverage are the same as required by federal law or applicable state insurance law if health plan benefits are insured. The Plan and summary do not grant *you* more rights than the law requires.

D. COBRA Summary Plan Description Disclosure

Covered employees and qualified beneficiaries are responsible for providing notice of certain qualifying events, disability and second qualifying events to the Plan Administrator. The notice must be provided within 60 days of the qualifying event or disability. Such notice must be provided in writing to the Plan Administrator, include a description of the qualifying event or disability and the date of the qualifying event or disability occurred.

E. Loss of Employment Through Layoff

If *your* employment is terminated because of layoff and *you* are rehired within 9 months of the layoff, *you* will not be subject to any *waiting period* otherwise required under *your* employer's group health plan or policy if *you* were eligible for coverage at the time of the layoff, regardless of whether *you* were covered at any time during the layoff.

F. State of Oregon Continuation of Coverage

This section applies if *your* employer is not subject to COBRA. (In general, employers that employed fewer than 20 employees on a typical business day during the preceding calendar year are not subject to COBRA.) If *your* employer is subject to COBRA, please refer to the Continuation of Coverage—COBRA section before this section on page 61).

If *you* would otherwise lose *your* coverage under the Plan because you lose *your* employment, *you* and *your eligible dependents* may be able to continue *your* coverage under the medical benefits portion of the Plan if the following conditions are met:

1. *You* must have been covered continuously under this Plan or a similar predecessor plan for a period of at least three consecutive months immediately prior to the termination of employment.

2. *You* are not eligible for continuation of coverage under the Plan if:

   a. *you* are eligible for coverage under federal Medicare, or

   b. *you* are eligible for coverage of *hospital* or medical expenses under another program that *you* were not covered under immediately prior to *your* termination of employment.

3. *You* must make written request to *the Trust* for continuation not later than 10 days after the later of the date on which *your* employment terminated and the date on which *your* employer notifies *you* of *your* right to continue coverage.

4. *You* must pay the premium for *your* continuation coverage monthly and in advance. Premium must be paid directly to *the Trust*. *Your* first premium payment must be made within 31 days after *your* coverage would have otherwise ended.

5. Continuation coverage ends upon the earliest of the following dates:

a. Nine months after *your* coverage under the Plan would have otherwise ended because of the termination of *your* employment.

b. If *you* should fail to make timely payment of premium, the end of the period for which *you* did last make timely payment.

c. The premium payment due date coinciding with or next following the date on which *you* become eligible for federal Medicare coverage.

d. The date on which the Plan terminates or the employer terminates participation under the Plan. However, if the employer replaces the coverage that is terminating with similar coverage under another group plan or policy, *you* may:

   i. Obtain coverage under the replacement group for the balance of the period for which *you* would have been covered under the replaced group policy.

   ii. The minimum level of benefits provided to *you* under the replacement group plan shall be the applicable level of benefits under this Plan minus any benefits still payable under that policy.

   iii. This Plan shall continue to provide benefits to *you* to the extent of the Plan's accrued liabilities and extensions of liability as if the replacement had not occurred.

The following chart shows the qualifying events, who is eligible for *State Continuation* coverage, and the length of time it will be available:

If *you* can no longer participate due to. . .	**These individuals may continue to participate. . .**	**For up to this length of time. . .**
Your termination of employment (for any reason except gross misconduct) or reduction in work hours	*You*, *your* covered *spouse* and dependent children	9 months
Your death	*Your* covered *spouse* and dependent children	9 months
Your divorce or legal separation	*Your* covered *spouse* and dependent children	9 months
Your entitlement to Medicare	*Your* covered *spouse* and dependent children	9 months
Your covered dependent child is no longer eligible for participation	*Your* covered dependent child	9 months

Coverage for Spouses Age 55 or Over

If *you* die or are divorced while covered under the Plan, *your* surviving or ex-*spouse* and dependent children, who would otherwise lose coverage under the Plan because of the death or divorce, may continue coverage under the Plan in the same manner that you would continue coverage under the Section immediately above. Premium payment must be made by the surviving or ex-*spouse* for the *spouse* and any dependent children. Premium must be paid monthly and in advance.

17. <u>Continuation of Benefits After Injury or Illness Covered by Workers' Compensation</u>

If *you* incur an injury or illness for which a workers' compensation claim is filed, medical benefits of the Plan will continue in effect upon timely payment by *you* of the premium due under the Plan, including the employer's

contribution portion and *your* individual contribution for *your* coverage. Such coverage shall continue until whichever of the following events occurs first:

a. You become employed full-time elsewhere, or

b. Six months from the date that *you* first make premium payment under this section.

18. The Federal Exchange Market

Under the Affordable Care Act, *you* are able to buy coverage through the Federal Exchange Marketplace (www.healthcare.gov). In the Marketplace, *you* could be eligible for a new kind of tax credit that lowers *your* monthly premiums, and *you* can see what *your* premium, deductibles, and out-of-pocket costs will be before *you* make a decision to enroll. Being eligible for COBRA or state continuation coverage does not limit *your* eligibility for coverage in the Marketplace.

19. Other Options

You may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

20. Leave of Absence

The policy on group health coverage for individuals granted an approved leave of absence is determined by *your* employer. A subscriber who is granted a temporary leave of absence may continue to be covered under this Agreement for up to three (3) consecutive months, or, in the case of total disability, for an additional three (3) months, or six (6) months in total if the monthly subscription charges are paid with the regular group payments.

To qualify an employee for the *total disability* extension, proof must be forwarded to and accepted by *the Trust*, that Subscriber is unable to work either at his job or any job, but is still considered an employee by the employer. Maternity, as well as other disabilities, is covered under this provision. Coverage may be continued for up to a maximum of three (3) months, with premium paid in advance.

21. Consent to Examination of Medical Records

By acceptance of benefits under this Plan, *you* and *your* covered dependents shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by the Trust or its designee.

22. Subrogation, Reimbursement and Third Party Payments

A. **Definitions.** For purposes of this Section 20, the following terms have these corresponding definitions:

Ailment – an Injury or Illness: (a) to a Covered Person that was caused or contributed to in whole or in part by, or results from the acts or omissions of the Covered Person and/or another person or entity; and (b) for which the Covered Person or the Covered Person's Beneficiaries may have or had a First or Third Party Claim.

Covered Person's Beneficiaries (or "CPBs") – a Covered Person's Spouse, Dependents, beneficiaries, estate, heirs, guardian, personal representative, and assigns.

First Party Claim – a Covered Person's and the CPBs' claims or rights to indemnification, damages or other payments from a First Party Provider. Examples of sources of First Party Claims include, but are not limited to, no-fault auto insurance policies, personal injury protection insurance policies, uninsured or under-insured motorist policies, and medical reimbursement coverage.

First Party Provider – any person or entity (except the Plan) who, under a contract (implied or express) or agreement with a Covered Person, is or may be obligated to compensate the Covered Person or the CPBs because of an Ailment.

Subrogation Instruments – documents (whether paper or electronic or otherwise) that serve to notify all First and Third Party Providers of a lien held in favor of the Plan. The lien prohibits all First and Third Party Providers from paying any amounts related to the Ailment prior to paying the Plan for all claims paid or payable by the Plan. The documents may contain a waiver and release allowing the First and Third Party Providers to pay the Plan directly to satisfy the lien.

Third Party – a person or entity who is not the Covered Person.

Third Party Claim – a Covered Person's or CPBs' claims or rights to indemnification, damages or other payments from a Third Party or Third Party Provider.

Third Party Provider – a Third Party's insurance company or any entity or person (including the Third Party personally) who is liable or may be liable for payments or compensation due to an Ailment.

B. The Plan, except as provided under this Section, does not provide benefits stemming from Ailments. The Plan may provide benefits stemming from an Ailment. The Plan Administrator may cease providing benefits at any time and for any reason, including, but not exclusively, a concern whether the Plan will be reimbursed to any extent from the proceeds of any First or Third Party Claims.

C. **Subrogation and Reimbursement Rights.** With regard to any benefit paid or payable due to an Ailment, the following shall apply:

1. The Covered Person or CPBs shall immediately notify the Plan of all information pertinent to the Ailment including:

    a. a statement regarding the circumstances that gave rise to the Ailment;

    b. the name and contact information of all persons or entities that contributed to or may have contributed to the Ailment;

    c. the names and contact information for all person or entities known to the Covered Person or CPBs to represent Third Parties that contributed to or may have contributed to the Ailment;

    d. the names and contact information for any First and Third Party Providers; and

    e. any other pertinent information requested by the Plan.

2. Upon presentation to the Covered Person or the CPBs, the Covered Person or CPBs shall immediately execute (or secure the execution) of all Subrogation Instruments. Subrogation Instruments are deemed to be presented to the Covered Person and CPBs upon delivery to the Covered Person's last known address (or P.O. Box) as per the Plan's records. The Plan may cease advancing any and all benefit payments upon presentation of the Subrogation Instruments. The Plan may pay benefits upon the delivery of all fully executed Subrogation Instruments to the Plan. Execution of the Subrogation Instruments shall be witnessed by a notary public. Delivery of the Subrogation Instruments shall be to the Plan's address via certified return receipt mail.

    The Plan's subrogation and reimbursement rights shall apply without regard to whether any acknowledgment of these rights is obtained by the Plan from the Covered Person or CPBs.

3. The Plan shall be subrogated to all rights of the Covered Person and CPBs to recover from any First or Third Party Provider.

The Plan shall have full subrogation and reimbursement rights in cases involving an Ailment regardless of the source of the rights or claims and regardless of whether the Covered Person and CPBs are made whole by the rights or claims or by any recovery made thereon. The Plan shall be entitled to recover 100% of benefits provided, without deduction for attorney's fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person and CPBs are fully compensated by the Covered Person's and CPBs' recovery from all sources;

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These provisions shall not limit any other remedies of the Plan provided by law. The Plan's subrogation and reimbursement rights shall apply without regard to the location of the event that led to or caused the applicable Ailment.

4. The Plan shall have an equitable lien on the Covered Person's and CPBs' First and Third Party Claims which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement.

   Any payment or compensation received by a Covered Person or CPBs from a First or Third Party Provider and arising out of an Ailment shall be placed in a constructive trust for the exclusive benefit of the Plan. The recipient shall be the Trustee of the constructive Trust. The Trustee will immediately and first reimburse the Plan, or cause the Plan to be reimbursed, for the full amount of all benefits payments made or owed under this Plan for treatment, service or loss of income with respect to the Ailment (or, if less, the full amount of the payment received from the First or Third Party Provider). The Plan shall have the first right of reimbursement out of the proceeds of any such recovery, and regardless of whether the Covered Person or the CPBs are made whole by the recovery. The Plan may agree to accept less than the full amount in reimbursement.

   The Plan's right of reimbursement extends to any amount paid with respect to, associated with, or stemming from an Ailment whether paid directly or indirectly to the Covered Person or the CPBs, or whether held in trust or constructive trust for the benefit of the Covered Person or the CPBs. The Plan shall be reimbursed regardless of whether the funds have been commingled with other assets, and the Plan shall have the right to recover from any available funds without the need to trace the source of the funds.

   The Plan shall have a first security interest and a lien on any payment made to or on behalf of a Covered Person or the CPBs from any First or Third Party Provider to the full extent of the benefits paid or owed under the Plan for any Ailment. The Plan's security interest and lien shall not be reduced by attorney fees or other costs related to the recovery, and shall be fully enforceable regardless of whether the Covered Person and CPBs are made whole by the recovery.

   If the Covered Person or CPBs fail to honor the Plan's right to subrogation and/or reimbursement (a) the Covered Person or CPBs shall be liable to the Plan for all costs of enforcement and collection, including attorney and paralegal fees through and including any appeals; and (b) the Plan may offset future Plan benefits otherwise payable under the Plan with respect to any Injury or Illness sustained by the Covered Person until such time as the Plan's rights have been fully satisfied by such offset or otherwise.

D. **Settlement Between Covered Person (or CPBs) and First or Third Party Provider.** If the Covered Person or CPBs obtain any settlement or recovery stemming from an Ailment that does not have written approval from the Plan and that bars the Covered Person or CPBs from further recovery with respect to the

First or Third Party Claim, the Plan shall not provide benefit payments for any continuing treatment or additional expenses incurred in connection with, or arising out of, the Ailment.

E. **Final Resolution of Claims and Offset of Plan Payments.** To the extent the Plan does not pay for benefits because of any unresolved First or Third Party Claims, the Plan will not be obligated to pay any remaining benefits until full and final resolution of all First and Third Party claims. The Plan may offset any remaining obligations to pay benefits by an amount that does not exceed the sum of all First and Third Party Claim proceeds not received by the Plan. The offset shall be on a first dollar basis, without reduction for attorneys' fees, taxes, amounts withheld for taxes, or other costs of recovery. Any Plan benefit obligations that are offset shall be the exclusive responsibility of the Covered Person, provided that the Plan has given notice of the offset to the Covered Person. Notice for this purpose is a written document explaining the offset that has been mailed to the Covered Person's last known address (or P.O. Box) as per the Plan's records.

23. Workers' Compensation Exclusion

No benefit is provided for treatment of any illness or injury that arises out of, or as the result of any work for wage or profit, if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit, any policy of workers' compensation insurance; or according to any recognized legal remedy. This applies whether or not you claim the benefits or compensation or recover the losses from third party.

24. Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

COB MANDATORY LANGUAGE

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB

provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person 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 the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent 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 plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of

the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(l) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. The Trust may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. The Trust need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Trust any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under this plan. If it does, the Trust 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 Trust will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Trust is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

NON-DUPLICATION OF MOTOR VEHICLE COVERAGE

State laws require many motor vehicle insurance policies to provide medical payments, including personal injury protection payments, up to a minimum amount set by law as primary coverage for the insured and members of his family residing in the same household. The Trust benefits will be excess coverage over and above the medical payments coverage of motor vehicle insurance policy. As to benefits furnished, the Trust shall be entitled to any reimbursement from any motor vehicle insurer required by said law. The Subscriber shall furnish information concerning medical payments insurance to the Trust upon request.

RIGHTS AND RESPONSIBILITIES

As a subscriber of the Trust, you have the right to:

- Be treated with dignity and respect;
- Impartial access to treatment and services without regard to race, religion, gender, national origin, or disability;
- Know the name of the physicians, nurses, or other health care professionals who are treating you;
- The medical care necessary to correctly diagnose and treat any covered illness or injury;
- Have your provider tell you about your diagnosis, the treatment ordered, the prognosis of your condition, and instructions required for follow-up care;
- Know why various tests, procedures or treatments are done, who the persons are who give them to you, and any risks you need to be aware of;
- Refuse to sign a consent form if you do not clearly understand its purpose, cross out any part of the form you don't want applied to your care, or change your mind about treatment you previously approved;

- Refuse treatment and be told what medical consequences might result from your refusal;
- Expect privacy about your care and confidentiality in all communications and in your medical records; and
- Expect clear explanations about benefits and exclusions.

PLAN ADMINISTRATION

Trust Plan Administrator:		Trustees Western Grocers Employee Benefits Trust c/o Ross Dwinell, General Manager 12901 SE 97th Avenue Clackamas, OR 97015 www.westerngrocerstrust.com/contact
Plan Year		January 1 – December 31
Trust's Identification Number:		93-0792758
Agent for Service of Process:		Western Grocers Employee Benefits Trust c/o Ross Dwinell, General Manager 12901 SE 97th Avenue Clackamas, OR 97015 Process also may be served on the Trust Plan Administrator.
Plan Funding:		Member employers contribute to the Western Grocers Employee Benefits Trust at a specified rate. All contributions are deposited in a trust fund. Participants may obtain from the Trust upon written request, whether a particular employer is a member of the Plan.