BENEFITS AND COVERAGE FOR RETIREES

OFFERED BY THE:

WF RETIREES' HEALTH TRUST

Plan Document and Summary Plan Description
(Original Plan Effective Date: January 1, 1992)
Version 4-2020
Updated Through January 1, 2021

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SECTION I — INTRODUCTION

Introduction and Purpose

The Plan Sponsor has established the WF Retirees' Health Trust (the "Plan") to provide Plan benefit coverage for those (a) who retired under the early, normal, and disability provisions of the Pension Plan for Hourly Employees of Wilson Foods Corporation, (b) who remained eligible for the WF Retirees' Health Trust on September 26, 1991, and (c) who elect to pay contributions continuously to the WF Retirees' Health Trust, in accordance with the terms and conditions described herein. The Plan is amended and restated in its entirety effective September 1, 2020.

The Plan provides a broad spectrum of benefit coverages— Medical Expense, Prescription Drug, Vision Care, Dental Care, Death Benefit, Hearing, Adult Custodial Care, Medicare Part B Refund, and Rx Reimbursement Coverage. This document was first written when the Plan was much simpler. As Coverages, within the Plan, have been added and terminated, the document has become more complex. The complexity has increased with the number of administrators as each applies their expertise to the varying coverages.

At this amendment and restatement, wording changes are being made to clarify the terms of the Plan. In general, each of the Coverage descriptions is intended to be self-sufficient within the Plan.

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **WF Retirees' Health Trust.**

Claims Administrators

HealthSmart Benefit Solutions, Inc. is the Claims Administrator for Medical Expense Coverage. HealthSmart will process claims (forms and documentation) and answer benefit and claim questions for the above listed coverages.

HealthSmart Benefit Solutions, Inc.
7725 W. Reno Ave., Suite 397
Oklahoma City, OK 73127
(844) 871-2353

HealthSmartRx, a separate Prescription Drug Coverage Administrator, processes prescription drugs.

The Adult Custodial Care Coverage, which was terminated 1/1/17, has its run out claims processed by Bodon, Inc. Further, effective January 1, 2020 Bodon, Inc. will administer the Dental Care, Vision Care, and Hearing Coverages.

The Health Trust administers the Medicare Part B Refunds, the Rx Reimbursement Coverage, and the Death Benefit Coverage.

The Claims Administrator's customer service representatives are available to answer any questions or concerns regarding this Plan.

Plan Document and Summary Plan Description

This document serves as both the written Plan Document required under ERISA, and the Summary Plan Description (SPD) required under ERISA. It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under this Plan. The document should be read in its entirety.

Cost of the Plan

Plan benefits are paid out of the WF Retirees' Health Trust Trust's current assets. Benefits are not guaranteed; they are limited by the WF Retirees' Health Trust's available assets.

The WF Retirees' Health Trust is responsible for funding Plan benefits on behalf of Covered Persons and will do so as required by law. To the extent permitted by law, the WF Retirees' Health Trust is free to determine the manner and means of funding the Plan. The amount of the Retiree's contribution will be determined from time to time by the WF Retirees' Health Trust, in its sole discretion. While the Health Trust retains its ability to collect retiree future contributions, effective 1/1/2019, the Health Trust has determined it will not collect retiree contributions.

Identification (ID) Card

The Identification Card for Medical Expense and Prescription Benefit Coverage that is issued to a Covered Person pursuant to this Plan is for identification purposes only. To be eligible for services or benefits under this Plan, the holder of the Identification Card must be a Covered Person and must present the Identification Card to the Medical Expense and/or Prescription Benefit Coverage Provider.

Medicare Advantage Plans (HMO)

Medicare Advantage Plans ("HMO's") are included as sponsored programs for Retirees and/or Dependents who are eligible for Medicare:

To be eligible to participate in an HMO, a Retiree and/or Dependent:

a) must be eligible for Medicare because they are disabled or are age 65 or older;

b) must live within the access area defined by Health Care Financing Administration (HCFA); and,

c) must not reside outside the service area for more than 90 consecutive days.

Retirees and/or eligible Dependents who meet the above eligibility requirements have been notified. Any Retiree and/or eligible Dependent who does not elect available HMO coverage is not eligible to continue participation in the Medical Expense Coverage of this Plan unless he/she waives rights to such medical HMO coverage, remains a member of the Medical Expense Coverage of this Plan and receives coverage for benefits ancillary to medical. If someone is covered under the HMO program, Medicare will not pay for care outside the HMO.

The benefits of the above HMO's are different than those of the Medical Expense Coverage of this Plan and are contained in the brochure provided by each HMO, which are incorporated in this Plan Document by reference.

SECTION II — MEDICAL EXPENSE COVERAGE

If a Retiree or a Retiree's Dependent(s) are entitled to enroll for Medicare Part B benefits under Social Security, the Retiree and Dependent(s) will be considered enrolled whether or not the Retiree and Dependent(s) have actually enrolled. Benefits available under such Act will be considered paid whether or not such benefits have been requested or received.

For Retirees and Dependents eligible for Medicare, Medicare is the Covered Person's primary medical coverage, processing all of your claims first as if there were no other plan involved. The Medical Expense Coverage of this Plan, as secondary payor, will coordinate with Medicare based on 100% of the amount allowed by Medicare for each expense. The benefit for these expenses will first be calculated at this medical Plan's normal Medical Expense Coverage level, after application of coinsurance and copayments required by the Medical Expense Coverage of this Plan and will pay the normal plan benefit or the balance remaining after Medicare's payment, whichever is less.

There are some illnesses and injuries your medical coverage under the WF Retirees' Health Trust does not cover. See the "Medical Expenses That Are Not Covered" Section for a list of these special situations/exclusions.

Medical Expense Coverage benefits are available under this Plan when Covered Expenses are Incurred by a Covered Person for care while the person is covered for these benefits under the Plan.

Covered Expenses are those Incurred for the following items of services and supplies when (1) Medically Necessary to diagnose or treat a Covered Person, or (2) specifically for preventive non-diagnostic. These charges are subject to the benefit limits, exclusions and other provisions of this Plan.

Schedule of Benefits

The applicable Schedule of Benefits provides a snapshot of the terms and conditions of the available covered Medical Expense Coverage benefits under this Plan. It is not intended to be comprehensive. Details regarding each of these items are in the later text.

The WF Retirees' Health Trust covers Medical Expense Coverage benefits on the basis of the following "Schedule of Benefits":

Maximum Out-of-Pocket

The maximum out-of-pocket applies to those Covered Persons who are under age 65. The maximum out-of-pocket expenses per Calendar Year for each family unit (consisting of the Retiree and eligible Dependents) is shown in the table below. The maximum out-of-pocket is the dollar amount of covered expenses incurred for which no benefit is payable under the Plan due to the application of copayments. The benefit percentage under the Plan will increase to 100% for the remainder of the Calendar Year after the satisfaction of this maximum is met.

Schedule of Benefits

MEDICAL EXPENSE COVERAGE	MEDICAL EXPENSE COVERAGE PAYS	
		NOTES
Maximum Out-of-Pocket (applies to Covered Persons under age 65 only)	$6,700 (for under age 65 only your maximum responsibility)	
Physician Services Primary Care Physician Specialist	 100% after $10 copayment 100% after $10 copayment	
Emergency Room Services	100% after $50 copayment	Copayment waived if admitted within 24 hours for same condition
Urgent Care Needed (other than primary care physician)	100% after $10 copayment	Copayment waived if admitted within 24 hours for same condition
Ambulance Services	100%	
Inpatient Hospital Care (including inpatient substance abuse)	100%	
Testing for the 2019 Novel Coronavirus (COVID-19)	100%	
Inpatient Mental Health in a Psychiatric Hospital	100%	
Skilled Nursing Facility Services	100%	Limited to 100 days per calendar year
Home Health Care	100%	
Hospice Services	100%	
Outpatient Hospital Services (includes observation, medical and surgical care)	100%	
Medical Nutrition Therapy	100%	
Outpatient X-ray Services	100%	
Clinical Laboratory Services	100%	
Blood and Administration	100%	
Bone Mass Measurements	100%	
Colorectal Screening Exam	100%	Limited to one per 12 month period
Annual Screening Mammogram	100%	Limited to one per 12 month period

MEDICAL EXPENSE COVERAGE	MEDICAL EXPENSE COVERAGE PAYS	
		NOTES
Pap Smears and Pelvic Exam	100%	Limited to one per 12 month period
Annual Prostate Cancer Screening Exams	100%	Limited to one per 12 month period
Cardiovascular Disease Testing	100%	
Physical Exams	100%	Limited to one per 12 month period
Immunizations (flu, pneumococcal, pneumonia, and Hepatitis B vaccines)	100%	
Diabetes—Self Management Training	100%	
Medical Nutrition Therapy and Counseling	100%	
Mental Health & Substance Abuse—Outpatient Services (individual visit and group visit)	100% after $10 copayment	
Mental Health & Substance Abuse—Partial Hospitalization	100% after $50 copayment Per day	
Rehabilitation Facility—Outpatient	100% after $10 copayment	
Occupational Therapy	100% after $10 copayment	
Physical and Speech Therapy	100% after $10 copayment	
Cardiac/Pulmonary Therapy	100% after $10 copayment	
Kidney Dialysis	100% after $10 copayment	
Chiropractic Visit	100% after $10 copayment	Limited to 12 visits per calendar year
Podiatry Visit	100% after $10 copayment	
Durable Medical Equipment & Medical Supplies	100%	
Smoking Cessation Visits (Medicare covered)	100%	Limited to 8 visits

For Care in a Hospital

If you or your Dependent(s) require hospitalization in a hospital for diagnosis or treatment of an injury or disease, including substance abuse care, the Medical Expense Coverage of this Plan will cover the following expenses:

- **Hospital Room And Board.** The medical coverage of this Plan pays benefits toward your room and board and general nursing services in a semi-private room. If you stay in a private room or suite, you are responsible for paying the difference between the daily cost of the private room or suite and the hospital's average charge for a semi-private room.

  In the event the hospital has only private accommodations, the average semi-private rate in the local area will be considered.

- **Hospital Special Care Unit.** Necessary confinements in special care units of a hospital such as intensive care units, cardiac care units, etc., are covered at the reasonable and customary rate.

- **Hospital Services.** The Medical Expense Coverage of this Plan covers the reasonable and customary charges made for all required hospital services and supplies, including pre-admission testing and special diets, operating room costs, bandages, casts, laboratory examinations and tests, x-rays, physical therapy, oxygen and its administration, anesthetics, the administration of blood and blood plasma, and intravenous feedings. The Medical Expense Coverage of this Plan does not cover personal items such as magazines and television rentals.

- **Physician Services.** The Medical Expense Coverage of this Plan covers the reasonable and customary charges for in-hospital visits by your primary care physician, visits by another physician for consultation purposes and any visits in connection with surgery, pregnancy, or to change dressings or administer medicines.

- **Hospitalization for dental work is not generally covered.** However, benefits are paid for repair or damage to the jaw and natural teeth as the direct result (and within 3 months) of an accident or in connection with the surgical removal of tumors and cysts in the mouth.

- **Hotel Expenses for Clinical Treatment.** If a covered individual stays in a hotel or motel while being treated in an approved clinic, the Medical Expense Coverage of this Plan will cover the daily cost of the room up to the cost of a semi-private room at the clinic/hospital in which treatment is being given, provided that there is a lack of bed space that prohibits the patient from being hospitalized and the clinic is more than 100 miles from the covered Retiree's residence. Approved clinics are the Mayo Clinic, the Cleveland Clinic or a clinic agreed to by the claims administrator in advance.

2019 Novel Coronavirus (COVID-19)

Covered Expenses associated with testing for COVID-19 include the following:

- **Diagnostic Tests.** The following items are covered at 100%, deductible waived, as provided in the Family First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Precertification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan.
    - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy one of the following conditions
        - ✦ that are approved, cleared, or authorized by the FDA;
        - ✦ for which the developer has requested or intends to request emergency use authorized under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe.
        - ✦ that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
        - ✦ that are deemed appropriate by the Secretary of Health and Human services.
    - Items and services furnished during an office visit, (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

- **Qualifying Coronavirus Preventive Services**. The following items are covered at 100%, deductible waived, and do not require Pre-Certification.
    - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, and
    - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

- **Inpatient Hospital Quarantines.** There may be times when Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medical Necessary requirements would not indicate a need for a private room.

- **Telehealth and Other Communication-Based Technology Services**. Participants can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.

- **Requests for Prescription Refills**. When considering whether to cover a greater than 30-day supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case basis, consider each request and make decisions based on the circumstances of the patient.

- **Non-Emergency Ambulance Transportation.** The Plan will cover limited Medically Necessary non-emergency ambulance transportation relating to COVID-19 Diagnosis.

The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Outpatient Treatment

The Medical Expense Coverage of this Plan covers outpatient treatment in a hospital for surgery, accidental injuries or other medical emergencies.

If you or a Dependent is treated on a physician's order as an outpatient in a hospital, the Medical Expense Coverage of this Plan will cover, in accordance with the "Schedule of Benefits", reasonable and customary charges related to:

- Accidental injury
- Outpatient surgery that does not require admission
- Medical emergencies
- Pre-admission testing

Reasonable physician's charges are covered as are the costs of any other required medical services and supplies such as:

- Operating and treatment rooms and equipment
- Drugs and medicines
- Oxygen and its administration and the administration of blood and blood plasma
- X-ray and laboratory examinations
- Dressings, splints and casts
- Intravenous injections and solutions

For an Operation

Reasonable and customary charges for surgery are covered, including the assistant surgeon's charges and second surgical opinions.

Should you or a covered Dependent need surgery, whether it is performed in a hospital, clinic or physician's office, the Medical Expense Coverage of this Plan covers reasonable and customary charges for the following:

- The surgeon's fee for performing the operation.
- The fee for anesthesia, given by a physician or anesthesiologist when the type of surgery requires this service.
- The fee for an assistant surgeon when the type of surgery requires such assistance.
- A second opinion on recommended surgery by another physician qualified to render an opinion. If necessary to resolve the first two opinions, a third opinion is covered.

Emergency Services

For accident: If a Covered Person sustains an injury and incurs expenses for emergency medical treatment, this Plan will pay for:

- The initial treatment in a hospital facility; and
- Any necessary diagnostic tests; provided that

- Initial treatment is received within 72 hours of the accident.

For illness: If a Covered Person requires medical treatment due to an emergency illness, this Plan will pay for:

- The initial treatment in a hospital or facility;
- Any necessary diagnostic tests.

If the patient is admitted to the hospital within 24 hours from the emergency room for the same condition, the copayment shown in the "Schedule of Benefits" table will be waived.

Maternity Care

Federal law protects the benefit rights of mothers and newborns related to hospital stays in connection with childbirth. In general, group health plans and health insurance issuers generally 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 less than 96 hours following a cesarean section. However, federal law generally 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 48 hours (or 96 hours as applicable).

- Require that a physician obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or surgical care of an illness, shown in the "Schedule of Benefits" and this section. Covered expenses will also include services provided in a birthing center, and for complications of a pregnancy.
Eligible Dependent children are not eligible for coverage for expenses in connection with pregnancy. Covered expenses do not include coverage for any expenses in connection with the newborn child of the Dependent children.

Other Covered Medical Expenses

The Medical Expense Coverage of this Plan will pay benefits toward the reasonable and customary charges for the following required services and supplies:

- Diagnostic laboratory tests and x-rays.

- The following preventive non-diagnostic services:

  a) Non-diagnostic mammograms, limited to one each 12 month period;

  b) Colorectal screening examination, limited to one each 12 month period;

c) Pap Smears and pelvic examination, limited to one each 12 month period;

d) Prostate cancer screening examination, limited to one each 12 month period;

e) Cardiovascular disease testing;

f) Physical examination, limited to one "welcome to Medicare" exam and one routine physical exam each 12 month period;

g) Immunizations (flu, pneumococcal, pneumonia, and Hepatitis B vaccines).

- Radiation therapy.

- Physician home and office visits, including injections

- Chiropractic care services including spinal manipulation and other related therapy treatments, and X-rays. Chiropractic care must be rendered for the active treatment of an illness or injury. Maintenance care is not covered.

- Necessary physical therapy by a licensed physical therapist who is not related to the patient.

- Necessary speech therapy for Covered Persons who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the illness or injury and which is ordered by the attending physician.

- Private duty nursing care by a registered nurse, licensed vocational nurse, or a licensed practical nurse when the care has been ordered by a physician and approved by the administrator. Care will not be approved if a more cost-effective means of treatment is available. The nurse may not be a family member of the Covered Person.

- Necessary local ambulance service.

- Diabetes self-management training when such education is designed to insure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets.

- Medical nutrition therapy.

- Artificial limbs or other prosthetic appliances, braces and crutches, including replacements as necessary.

- Rental charges (or purchase charge if more economical) for durable medical equipment such as a wheelchair, a hospital bed, an iron lung or other equipment to aid breathing and diabetes monitoring supplies.

- Qualified convalescent skilled nursing facility services and supplies as listed below, provided that the skilled nursing facility confinement commences while the Covered Person is eligible under this Medical Expense Coverage of this Plan. The following are skilled nursing facility services and supplies:

  a) room and board;
  b) routine nursing care, not including the services of a private-duty nurse or other private-duty attendant;
  c) physical therapy, occupational therapy and speech therapy provided the skilled nursing facility or by others under arrangements with the skilled nursing facility;
  d) medical social services;
  e) such biologicals, supplies, appliances, and equipment as are ordinarily provided by the skilled nursing facility for the care and treatment of its patients;
  f) diagnostic and therapeutic services furnished to inpatients of the skilled nursing facility by a hospital; and
  g) such other services necessary to the health of patients as are generally provided by skilled nursing facilities (excluding any item or service which would not be provided to a hospital patient).

- Covered Home Health Services (as defined below) received by a Covered Person while eligible under the Medical Expense Coverage of this Plan when furnished by a qualified Home Health Care Agency if treatment commences within 24 hours after discharge from a hospital or skilled nursing facility. Covered items and services, except as provided in paragraph (f) below, are also covered on a visiting basis at the patient's home.

  a) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse (R.N.);
  b) physical, occupational or speech therapy;
  c) medical social services, given under the direction of a physician, by a medical or psychiatric social worker who is a graduate of a school of social work accredited by the Council on Social Work Education and as had social work experience;
  d) part-time or intermittent services of a home health aide;
  e) medical supplies (other than drugs or biologicals), and the use of medical appliances;
  f) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the Home Health Care Agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as are prescribed for participation in the Medicare program under the Social Security Amendments of 1965, as amended, and

     i. the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available at the patient's home, or
     ii. which are furnished at such facility while the patient is there to receive any such item or service described in clause (i) above of this item;

but not including transportation of the individual in connection with any such item or service.

- Hospice care services for a terminally ill Covered Person when provided by a hospice care agency. The services must be provided through a formal, written hospice care treatment program and certified by the attending physician as medically necessary. The attending physician must certify that the Covered Person is expected to continue to live for six months or less in order to qualify for this benefit. If the Covered Person lives beyond six months, the Plan will approve additional hospice care benefits on receipt of satisfactory evidence of the continued medical necessity of the services. Benefits are provided for:

  a) Room and board for confinement in a licensed, accredited hospice facility;
  b) services and supplies furnished by the hospice while the patient is confined;
  c) part-time nursing care by or under the supervision of a registered nurse;
  d) nutrition services and/or special meals;
  e) respite services;
  f) counseling services by a licensed social worker or a licensed counselor.

- Outpatient mental health services include outpatient mental health care by a licensed psychologist, psychiatrist, masters of social work, licensed professional counselor or social worker, if the social worker services are under the direct supervision of a physician.

- Outpatient substance abuse services include outpatient substance abuse care by a licensed provider.

Medical Expenses That Are Not Covered

The following are not covered by the Medical Expense Coverage of the WF Retirees' Health Trust:

- Treatment that is not ordered by a physician.
- Treatment for a job-related illness or injury.
- Charges in excess of what is considered reasonable and customary.
- Cost of fitting and purchasing eyeglasses other than the vision care benefits described in the "Vision Care Benefits" section of this Plan.
- Custodial care or care to maintain an incurable patient, except as specifically covered under Hospice Care.
- Treatment of diseases or injuries resulting from war whether declared or not.
- Medical care for which you have no legal obligation to pay.
- Cosmetic surgery unless it corrects a birth defect (other than malformation of teeth) or treats an injury or disease (including breast reconstruction after radical mastectomy) that occurred while the patient was covered by the Medical Expense Coverage of this Plan. (Treatment must begin within three months after the illness or injury for medical benefits to be covered.)
- Charges incurred in connection with the pregnancy of a Dependent child.
- Diagnostic or therapeutic procedures not related to the condition being treated.
- Hospital confinement for treatment or testing if the confinement is not ordered by a physician.
- Medical expenses incurred during research studies or surveys.
- Experimental/investigative medical, surgical or other health care procedures.
- Care provided in a government operated hospital or at government expense.
- Hospitalization and surgical services for dental treatment other than dental surgery for accidents, jaw surgery, or removal of tumors or cysts from the mouth.
- For care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician, except for wigs following chemotherapy treatment.

- Any medical expenses incurred before January 1, 1992.

- Services performed and charges incurred outside of the United States.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition.

Filing A Medical Expense Claim

Certain claim services for the Medical Expense Coverage of this Plan are provided through a claims administrator. The claims administrator will process your medical bills for payment after it receives the necessary claim information.

The Medical Expense Coverage of this Plan is structured to make payments directly to the provider of service. However, if you pay the medical bills before you file the claim, the Medical Expense Coverage of this Plan will reimburse you. Be certain that the bills clearly indicate they have been paid before filing, if that is the case.

The hospital or physician will normally file the claim for you. Medical claims that you need to file yourself should be mailed to the claims administrator at the following address:

Claims Administrator:
HealthSmart Benefit Solutions, Inc.
P O Box 16327
Lubbock, TX 79490
(844) 871-2353

If a claim is denied, you may request further review. See the "If Benefits Are Denied" Section of this Plan Document for more information on the claim appeal procedure.

SECTION III — PRESCRIPTION DRUG COVERAGE

All Retirees and/or eligible Dependents will be eligible to participate in the Prescription Drug Card program. All Retirees and/or eligible Dependents are eligible to use the Maintenance Drug Program.

Prescription Drug Card

After you enroll in the Prescription Drug Coverage of this Plan, you will receive a prescription drug card. To purchase a prescription drug using your card, you present the card at a participating pharmacy and pay a $10.00 copayment for a 30-day supply, limited to the full cost of the drug. Payment for the remainder of the drug is then arranged between the WF Retirees' Health Trust and the pharmacy.

If the prescription has an alternative to the brand-name prescription, the Prescription Drug Coverage of this Plan will reimburse up to the average cost of the generic alternative. If your physician has indicated that the brand-name prescription is necessary to maintain your health, however, then you must pay only the $10.00 copayment and you will receive the brand name prescription.

If you purchase a drug at a non-participating pharmacy, you will be reimbursed the reasonable charge for the drug less the $10.00 copayment. Have the pharmacist fill out a form for each prescription or refill drug and mail it in accordance with the instructions on the form.

The Plan's Prescription Drug Card Program is administered by HealthSmartRx. HealthSmartRx has a network of pharmacies which can identify Covered Persons and the Plan's coverage provisions. To find out which pharmacies participate or to inquire about specific coverage for prescription drugs, call HealthSmartRx at 1-800-681-6912.

Mail Order Program

If you are taking maintenance prescriptions (medication taken on a regular basis such as for diabetes or high blood pressure) you may be interested in using the mail order drug program. Under this program, you are able to order up to a three-month supply of maintenance medication. You can realize substantial savings because you will pay a single, $5.00 copayment for each three-month supply of prescriptions dispensed by the mail order pharmacy.

SECTION IV — VISION CARE COVERAGE

The Vision Care Coverage, effective January 1, 2014, reimburses you for eye examinations, glasses, lenses and contacts as prescribed by an optometrist or ophthalmologist. It is not necessary to use network providers. Pre-authorization is neither required nor necessary.

Annual Vision Reimbursement Schedule		
Cumulative Cost of Procedures	**Reimbursement Percentage Prior to 12/31/2020**	**Reimbursement Percentage After 1/1/2021**
$0 - $500	100%	100%
$501 - $1,000	50%	100%
Maximum Benefit per Calendar Year	$750 per Covered Person	$1,000 per Covered Person

Sunglasses and eyeglasses purchased for cosmetic reasons are not covered. Eye disease and eye injury are covered by the Medical Expense Coverage of this Plan in the same way as any other injury or illness.

Filing a Vision Care Claim

The WF Retirees' Health Trust will reimburse you for your covered expenses through its Vision Care Coverage claims administrator. When you have vision expenses, you must pay your provider and receive a receipt for payment. Then request the provider give you an itemized invoice for services rendered. Finally, submit a completed claim form, receipt from the provider, and itemized invoice to the claims administrator for reimbursement. Assignment of Benefits is not allowed.

Mail Vision Care claims to:

Bodon, Inc
9101 E Chenango Ave,
Greenwood Village, CO 80111-1321
855 937-3847 Voice and Fax

If your claim is denied, you may request further review. See the "If Benefits Are Denied" Section of this Plan Document for more information on the claim appeal procedure.

SECTION V — DENTAL CARE COVERAGE

The Dental Care Coverage under the WF Retirees' Health Trust became effective January 1, 2011.

All dental procedures, with the exclusion of cosmetic treatment (bleaching, laminates and implants) and not otherwise covered under the Medical Expense Coverage of the WF Retirees' Health Trust, are covered Dental Care Coverage expenses if provided by, or under the direction of, a dentist licensed to practice by the state in which he or she practices. It is not necessary to use network providers. Pre-authorization is neither required nor necessary.

Annual Dental Reimbursement Schedule		
Cumulative Cost of Procedures	**Reimbursement Percentage From 1/1/2016 to 12/31/2020**	**Reimbursement Percentage After 1/1/2021**
$0 - $1,000	100%	100%
$1,001 - $5,000	80%	100%
$5,001 - $10,000	50%	100%
Maximum Benefit per Calendar Year	$6,700 per Covered Person	$10,000 per Covered Person

Filing a Dental Care Claim

The WF Retirees' Health Trust will reimburse you for your covered expenses through its Dental Care Coverage claims administrator. When you have dental expenses, you must pay your dentist and receive a receipt for payment. Then request the provider give you an itemized invoice for services rendered. Finally, submit a completed claim form, receipt from the dentist, and itemized invoice to the claims administrator for reimbursement. Assignment of Benefits is not allowed.

Mail Dental claims to:

Bodon, Inc
9101 E Chenango Ave,
Greenwood Village, CO 80111-1321
855 937-3847 Voice and Fax

If your claim is denied, you may request further review. See the "If Benefits Are Denied" Section of this Plan Document for more information on the claim appeal procedure.

SECTION VI — DEATH BENEFIT COVERAGE

The Death Benefit Coverage under the WF Retirees' Health Trust became effective January 1, 2012, was improved effective January 1, 2017, and January 1, 2019. It has been further improved effective January 1, 2021.

There is a $5,000 death benefit available for each eligible member deceased prior to January 1, 2017; $10,000 for those members deceased after December 31, 2016 through December 31, 2018; $20,000 for those members deceased after December 31, 2018 through December 31, 2020; and, $50,000 for those members deceased thereafter. This benefit will be paid directly to the estate of the deceased or the beneficiary if a beneficiary has been designated, provided a copy of the death certificate is submitted.

Who is Eligible?

A Death Benefit will only be paid for members who are eligible for WF Retirees' Health Trust benefits at the time of death.

Filing a Death Benefit Claim

A completed Death Benefit claim form must be submitted to the WF Retirees' Health Trust claims administrator with a copy of the death certificate. If a copy of the death certificate is not included, the claim will not be processed. The estate, or beneficiary, has one year from the date the Trustee sends the notification letter within which to complete the necessary form and request payment, after which the right to claim the benefit terminates.

Mail Death Benefit claims with the death certificate to:

WF Retirees' Health Trust
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201

SECTION VII — HEARING COVERAGE

The Hearing Coverage under the WF Retirees' Health Trust become effective January 1, 2012.

All hearing aids and routine examinations to fit them that are not otherwise covered under the Medical Expense Coverage of this WF Retirees' Health Trust are covered Hearing Coverage expenses if provided by and under the direction of an audiologist, otolaryngologist or an audioprosthologist who is licensed to practice by the state in which he or she practices. It is not necessary to use network providers. Pre-authorization is neither required nor necessary.

Annual Hearing Reimbursement Schedule		
Cumulative Cost of Procedures	**Reimbursement Percentage Prior to 12/31/2020**	**Reimbursement Percentage After 1/1/2021**
$0 - $4,000	100%	100%
$4,001 - $10,000	80%	100%
Maximum Benefit per Calendar Year	$8,800 per Covered Person	$10,000 per Covered Person

Filing a Hearing Claim

The WF Retirees' Health Trust will reimburse you for your covered expenses through its Hearing Coverage claims administrator. When you have hearing expenses, you must pay your provider and receive a receipt for payment. Then request the provider give you an itemized invoice for services rendered. Finally, submit a completed claim form, receipt from the provider, and itemized invoice to the claims administrator for reimbursement. Assignment of Benefits is not allowed.

Mail Hearing Coverage claims to:

Bodon, Inc
9101 E Chenango Ave,
Greenwood Village, CO 80111-1321
855 937-3847 Voice and Fax

If your claim is denied, you may request further review. See the "If Benefits Are Denied" Section of the Plan Document for more information on the claim appeal procedure.

SECTION VIII — ADULT CUSTODIAL CARE COVERAGE

The Adult Custodial Care Plan coverage is terminated effective January 1, 2017.

The plan provisions in effect on December 7, 2016 will continue in effect for those beneficiaries qualified for reimbursement prior to the termination. A beneficiary will be considered to be qualified if, on or before December 31, 2016, they have satisfied the qualification provisions of the WF Retirees' Health Trust Adult Custodial Care Plan Summary Plan Description and Plan Document as Restated Effective: January 1, 2014. Further, to be considered qualified, the beneficiary and their physician must submit the appropriate paperwork to the Adult Custodial Care Administrator by January 15, 2017.

Benefit Summary

The Adult Custodial Care Coverage ("ACC Coverage") under the WF Retirees' Health Trust is effective April 1, 2012. The benefits of the ACC Coverage reimbursement plan are different from those described in this document and are contained in a separate Summary Plan Description and Plan Document provided by the WF Retirees' Health Trust, which is incorporated in this Plan Document by reference.

Who is Eligible?

All members who are eligible for the WF Retirees' Health Trust benefits are eligible for ACC Coverage benefits.

Filing an Adult Custodial Care Claim

ACC Coverage benefits are payable to members who's doctor certifies to the ACC Coverage Claims Administrator that the member is (1) incapable of performing two of six Activities of Daily Living (as defined in the ACC Coverage Plan SPD) on their own and (2) the requested service is designed to safeguard or improve the member's health. A completed Adult Custodial Care claims form must be submitted to the ACC Coverage Claims administrator with a copy of receipts for the services rendered.

The member reimbursement for previously incurred costs is limited to a six month "look back" period. The look back ends in the month previous to the month the ACC Coverage Claims Administrator authorizes the member for benefits.

Mail Adult Custodial Care Coverage claims with the appropriate documentation to:

Bodon, Inc.
9101 E. Chenango Ave.
Greenwood Village, CO 80111
1-855-WFRetirees (1-855-937-3847) toll-free
www.WFRetirees.com

SECTION IX — MEDICARE PART B REFUND

Benefits Summary

The Medicare Part B Refund is annually determined by the W F Retirees' Health Trust Benefits Committee. If approved, eligible members are refunded some or all of their Medicare Part B premiums paid in the immediately prior Calendar Year.

Who is Eligible?

Members who paid Medicare Part B premiums and are in good standing as of January 1st of the year following approval are eligible.

Filing a Medicare Part B Refund Claim

The Trust Administrator of the WF Retirees' Health Trust mails a letter to eligible members following the end of the Calendar Year reminding the member to mail a copy of their SSA 1099 no later than July 1st of the following year to:

WF Retirees' Health Trust
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201

SECTION X — Rx REIMBURSEMENT COVERAGE

The Rx Reimbursement Coverage is effective January 1, 2019.

This new Coverage has no impact on the existing Prescription Drug Coverage. Members must not make any changes to their existing Prescription Drug Coverage due to this Rx Reimbursement Coverage.

Members are not required to submit claims or take any action due to this Rx Reimbursement Coverage.

Rx Reimbursement Coverage Description

1. Eligible members are those who are members in good standing at the beginning of the calendar year following cost Incurral.
2. The Rx Reimbursement Coverage intends to reimburse members for the qualified prescription drug out-of-pocket costs they incurred in the previous calendar year.
3. Rx Reimbursement Coverage will be based on the members' prior year qualified out-of-pocket cost as determined by Express Scripts data (or the then appropriate Administrative Services Organization) and calculated by the Trust Professionals.
4. The Data will be collected from the Administrative Services Organization after the last day in February of the year following the year of Incurral. Any Incurral data posted after the collection will not be considered in the reimbursement estimate.
5. The Trust Professionals' Rx Reimbursement Coverage estimate, once determined, is final.
6. The Rx Reimbursement Coverage is designed to minimize the administrative costs associated with the program while providing eligible members a benefit.
7. For example, for those members in good standing on January 1, 2019, the out-of-pocket cost incurred in calendar year 2018, will be documented by Express Scripts and summarized by the Trust Professionals. A single Rx Reimbursement Coverage check will be issued to each member in the amount of the estimated annual member out-of-pocket payments they made toward their prescription drugs. Some members, those who incurred no cost, will receive nothing. Other members, those who incurred substantial costs, may receive a Rx Reimbursement Coverage check of $1,000 or more. The professionals will use the resources available to provide a best estimate of the out-of-pocket prescription drug cost reasonably close to the previous year end.

SECTION XI — WHEN COVERAGES BEGIN

Coverages for you and your eligible Dependents under the WF Retirees' Health Trust began on January 1, 1992.

Eligible Dependents are those who were currently eligible on September 26, 1991, and:

If you retired prior to September 1, 1979:

- Your enrolled spouse at the time of retirement.

If you retired on or after September 1, 1979:

- Your enrolled spouse at the time of retirement;
- Your enrolled children (including adopted children) under the age of 26;
- Step-children and foster children who live with you in a normal parent/child relationship are covered in the same way as other children, with one difference – the Medical Expense Coverage of this Plan supplements the health care benefits provided by natural parents or by governmental or private agencies;
- A child who is an alternate recipient under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993.

Also, the Medical Expense Coverage of this Plan covers any physically or mentally handicapped child who is totally dependent upon the Retiree for support so long as the incapacity and dependency continue. Notification and proof of this condition must be reported to the administrators at least 2 months before the date on which coverage would be otherwise ceased.

Medicaid and State Child Health Insurance Programs

An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

An eligible Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

1. The eligible Employee or Dependent covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent terminated due to loss of eligibility for such coverage, and the eligible Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or State Child Health Insurance Program (CHIP) coverage terminated.

2. The eligible Employee or Dependent becomes eligible for assistance with payment of employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the eligible Employee or Dependent requests enrollment in this Plan within 60 days after the date the eligible Employee or Dependent is determined to be eligible for such assistance.

Note: If a Dependent becomes eligible to enroll under this provision and the eligible Employee is not then enrolled, the eligible Employee must enroll in order for the Dependent to enroll.

Coverage will become effective on the date of the occurrence.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child(ren) of a Participant who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child(ren) reside with the Participant, provided the Child or Child(ren) are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. The name of an issuing State child support enforcement agency;
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment;

3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

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

A National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage. If the Plan Administrator receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Plan Administrator will assume that all are designated;
3. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any); and
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

An NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall:

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

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

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

As required by Federal law, the Plan Administrator shall:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders; and
2. Administer the provision of benefits under such qualified orders. Such procedures shall:

    a. Be in writing;
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the Plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the Plan of the Medical Child Support Order; and
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

SECTION XII — CONTINUATION OF COVERAGE

The WF Retirees' Health Trust offers covered Retirees and Dependents the opportunity for a temporary extension of Coverages (called "continuation coverage") at $135 per month. This section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions. (If you are married, both you and your spouse should take time to read this section carefully).

Your spouse has the right to choose continuation coverage if coverage under the Medical Expense Coverage of this Plan is lost for any of the following reasons:

1. The death of the Retiree;
2. Divorce.

In the case of a Dependent child he or she has the right to continuation coverage if coverage under the Medical Expense Coverage of this Plan is lost for any of the following reasons:

1. The death of the Retiree;
2. Divorce; or
3. The Dependent ceases to be a "Dependent child" under the Medical Expense Coverage of this Plan.

The Retiree or a family member has the responsibility to inform the WF Retirees' Health Trust of a divorce, Retiree's death, or a child losing Dependent status under the Medical Expense Coverage of this Plan.

When the WF Retirees' Health Trust is notified that one of the preceding events has happened, surviving Dependent(s) will have the right to choose continuation coverage. They have 60 days from the date they would lose coverage to indicate they want continuation coverage. If they do not choose continuation coverage, the Medical Expense Coverage of this Plan coverage will end in accordance with the provisions as described below.

If they choose continuation coverage, the WF Retirees' Health Trust will provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Medical Expense Coverage of this Plan to similarly situated employees or other participants. They will be afforded the opportunity to maintain continuation coverage for up to 3 years. However, continuation coverage may be cut short for any of the following five reasons:

1. The WF Retirees' Health Trust no longer provides group health coverage to any of its Retirees;
2. The contribution for your continuation coverage is not paid;
3. They become an employee covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary;
4. They become eligible for Medicare; or
5. They remarry and may choose to be covered under their new spouse's group health plan.

Insurability does not have to be shown in order to choose continuation coverage. However, all of the contributions must be paid.

SECTION XIII — COVERAGE TERMINATION / SURVIVING SPOUSE OPTION

The WF Retirees' Health Trust provides the benefits described in this plan document/summary plan description effective January 1, 1992 to Retirees who have retired from the service of the Wilson Foods Corporation prior to September 27, 1991. Generally, all benefit coverage ceases on the last day of the month in which the Retiree dies. However, coverage for Dependent children will cease on the last day of the month in which they reach age 26.

In certain circumstances, coverage for eligible Dependents will continue in force upon the death of the Retiree. Those situations are as follows:

- If the retirement date was prior to September 1, 1979, and the Retiree signed up for the optional surviving spouse health care coverage continuation to age 65 and has made the necessary premium payments, then coverage continues for the surviving spouse until death or remarriage.

- If the retirement date was on or after September 1, 1979, and the Retiree selected the joint and survivor pension option at the time of retirement, and the spouse is receiving a survivor's benefit from the Pension Plan, then coverage for all eligible Dependents continues until the surviving spouse remarries or dies.

In all cases, the participants must have continuously paid monthly contributions to the WF Retirees' Health Trust in order to be eligible for future benefits.

SECTION XIV — COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Medical Expenses when two or more plans are paying. When a Retiree is covered by this Plan and another plan, or the Retiree's Dependent is covered by this Plan and by another plan or the Retiree's Dependents are covered under two or more plans, the plans will coordinate benefits when a Claim is received.

By coordinating the payment of benefits of those Covered Persons having coverage with one or more plans, this Plan coordinates with other similar plans so that the total benefits available from all plans will not exceed 100% of the total Allowable Expenses.

Note that when this Plan is secondary (i.e., it pays after another plan), it will pay the balance due up to 100% of the total Allowable Expenses for a single claim submission. This Plan's payment will not exceed the amount which would have otherwise been payable under the Medical Expense Coverage of this Plan.

For Retirees and Dependents eligible for Medicare, Medicare is the Covered Person's primary medical coverage, processing all of your claims first as if there were no other plan involved. The Medical Expense Coverage of this Plan, as secondary payor, will coordinate with Medicare based on 100% of the amount allowed by Medicare for each expense. The benefit for these expenses will first be calculated at this Plan's normal Medical Expense Coverage level, after application of coinsurance and copayments required by the Medical Expense Coverage of this Plan and will pay the normal plan benefit or the balance remaining after Medicare's payment, whichever is less.

Benefits Subject to This Provision

The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

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

"Allowable Expenses"

"Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

"Claim Determination Period"

"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits

A. Application to Benefit Determinations

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

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

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

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

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

B. Order of Benefit Determination

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

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses Claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom Claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child;

4. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, TRICARE, Medicaid, State child health benefits or other applicable State health benefits program; and
5. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses Claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay an amount pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

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

SECTION XV — THIRD PART RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Retirees, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' compensation or other liability insurance company; or
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

    the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claim in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien 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. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

3. 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 Participant(s), 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.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. The Participant will furthermore agree to cooperate on all occasions, in a timely manner, regardless of whether the right to subrogation or reimbursement is being exercised by the Plan;
    c. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information;
    d. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    e. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    f. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

2. If the Participant(s) and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

These provisions apply even if the Participant has terminated coverage.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

SECTION XVI — HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses the individual's personal health information. It also describes certain rights the individual has regarding this information. Additional copies of our Notice of Privacy Practices are available by calling: (888) 938-7878 (toll-free)

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

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

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

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

How Health Information May be Used and Disclosed

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

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a) Privacy Officer: Is an Employee, or class of Employees, or other persons under control of the Plan Sponsor, who shall be given access to the PHI to be disclosed. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

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

Disclosure of Summary Health Information to the Plan Sponsor

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

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

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

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of Food and Drug Administration (FDA)-regulated products or activities;
    c. Locate and notify persons of recalls of products they may be using; and
    d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;

3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes them to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing them would place them at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if they are, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities or armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

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

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

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

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

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

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by them who are involved in their care or payment for their care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that they receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;

4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of their PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about them in certain records maintained by the Plan. If the Participant requests copies, they may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of the individual's PHI transmitted directly to another designated person, they should contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend their PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if they do not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

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

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

Contact Information

Privacy Compliance Coordinator Contact Information:
WF Retirees' Health Trust Benefits Committee
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201
(888) 938-7878 (toll-free)

SECTION XVII — HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

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

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

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

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

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

    a. Written notice by first-class mail to the Participant (or next of kin) at the last known address or, if specified by the Participant, e-mail;
    b. If the Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form";
    c. If an urgent notice is required, the Plan may contact the Participant by telephone.

    The breach notification will have the following content:

    - Brief description of what happened, including date of breach and date discovered;
    - Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
    - Steps the Participant should take to protect from potential harm;
    - What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

SECTION XVIII — IF BENEFITS ARE DENIED; CLAIM PROCEDURES; PAYMENT OF CLAIMS

A claim is filed when the appropriate claims office receives a form for that purpose completed and signed by you. Claims administrator(s) have been retained to provide expert service in evaluating and processing of charges by health care providers you may use. They have the authority to withhold payment of benefits on services as the Coverages of this Plan provides.

When you feel that the wrong action has been taken, such as nonpayment of a charge, there are two steps you can consider. First, you should contact the claims administrator(s) directly for information and to give your point of view. It is expected that most questions can be handled to your satisfaction this way. Second, you may file a claim of appeal in writing with the Benefits Committee of the WF Retirees' Health Trust. You must follow the claims procedures shown below to file an appeal under the Coverages of this Plan:

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and you or your covered dependent(s) believes the claim has been denied wrongly, you or your covered dependent(s) may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you and your covered dependent(s) with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- You and your covered dependent(s) at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

- You and your covered dependent(s) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by you or your covered dependent(s) relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

- That you or your covered Dependent(s) will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to you or your covered Dependent(s) claim for benefits in possession of the Plan Administrator or the claims administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to you or your covered Dependent(s) medical circumstances.

Requirements for Appeal

You or your covered Dependent(s) must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, you or your covered Dependent(s) appeal must be addressed as follows and mailed as follows:

WF Retirees' Health Trust Benefits Committee
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201

It shall be the responsibility of you or your covered Dependent(s) to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of you or your covered Dependent(s);

- You or your covered Dependent(s) social security number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, you or your covered Dependent(s) will lose the right to raise factual arguments and theories which support this claim if you or your covered Dependent(s) fails to include them in the appeal**;

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that you or your covered Dependent(s) has which indicates that you or your covered Dependent(s) is entitled to benefits under the Plan.

If you or your covered Dependent(s) provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Benefits Committee of the WF Retirees' Health Trust shall notify you or your covered Dependent(s) of the Plan's benefit determination on review within the following timeframes:

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Benefits Committee of the WF Retirees' Health Trust shall provide you or your covered Dependent(s) with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- Information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare Provider, the Claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment Code and its corresponding meaning);

- Specific reason(s) for a denial, including the denial Code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim, and a discussion of the decision;

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar

criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request;

- A description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in bulleted items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

If, for any reason, you or your covered Dependent(s) does not receive a written response to the appeal within the appropriate time period set forth above, you or your covered Dependent(s) may assume that the appeal has been denied. The decision by the Benefits Committee of the WF Retirees' Health Trust will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 365 days after the Plan's claim review procedures have been exhausted.**

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

- Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
- A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

- Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

- Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    - The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    - The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    - The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations;

- The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

- Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate Claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

- Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the Claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

- Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
    - An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
    - A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an Admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

- Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth

above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

- Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the Claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal Claims and appeals process.

- Notice of final external review decision. The Plan's (or Claims Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Definitions

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"Claimant"
"Claimant" shall mean any plan Participant or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

"Final Internal Adverse Benefit Determination"

"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Plan Claims

Full and final authority to adjudicate Claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make Claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, Claims for benefits and questions regarding said Claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process Claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make Claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Claims Administrator. Although a Provider of medical services and/or supplies may submit such Claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the Claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting Claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "Claim," since an actual Claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the Claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the Claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The Claims procedures are intended to provide a full and fair review. This means, among other things, that Claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

SECTION XIX — PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Claims Administrator to provide certain Claims processing and other technical services. Subject to the Claims processing and other technical services delegated to the Claims Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

Discretionary Authority

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon

all persons claiming any interest under the Plan subject only to the Claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To adopt and implement procedures, including care management recommendations, in its sole discretion;
9. To appoint and supervise a Claims Administrator to pay Claims;
10. To perform all necessary reporting as required by ERISA;
11. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
12. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
13. To perform each and every function necessary for or related to the Plan's administration.

Plan Administration Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of Plans assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Participants, and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation.

- By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.
- In accordance with the Plan documents to the extent that they agree with ERISA.

Named Fiduciary

A "named fiduciary" is the fiduciary named in the Plan. A Named Fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the Named Fiduciary allocates its responsibility to other persons, the Named Fiduciary shall not be liable for any act or omission of such person unless either:

- The Named Fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- The Named Fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Participants with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding Claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered Participants in accordance with ERISA.

SECTION XX — PARTICIPANT'S RIGHTS

As a Participant in the Plan, the Participant entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan office of the Benefits Committee of the WF Retirees' Health Trust and at other specified locations, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Benefits Committee of the WF Retirees' Health Trust, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Benefits Committee of the WF Retirees' Health Trust may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Benefits Committee of the WF Retirees' Health Trust is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the plan participants if there is a loss of coverage under the Plan as a result of a Qualifying Event. The covered person may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Participant's rights under ERISA.

Enforce Participant's Rights

If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps the Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Benefits Committee of the WF Retirees' Health Trust and do not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Benefits Committee of the WF Retirees' Health Trust to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Benefits Committee of the WF Retirees' Health Trust. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a State or Federal court. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Assistance with Questions

If the Participant has any questions about the Plan, the Participant should contact the Administrator(s). If the Participant has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Benefits Committee of the WF Retirees' Health Trust, the Participant should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. The Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

As a Participant in this Plan, the Employee is entitled to certain rights. All Participants shall be entitled to:

1. Examine, without charge, at the office of the Benefits Committee of the WF Retirees' Health Trust, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of documents, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Benefits Committee of the WF Retirees' Health Trust. (The Benefits Committee of the WF Retirees' Health Trust may make a reasonable charge for the copies.)

If the Participant has any questions about this statement or about rights under HIPAA, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The Participant may also obtain certain publications about his or her rights and responsibilities under HIPAA by calling the publications hotline of the Employee Benefits Security Administration.

The Participants in this Plan have the sole right to select their own Providers of health care. The Plan will not choose a Provider for any Participant, or have any liability for any acts, omissions, or conduct of any Provider. The Plan's only obligation is to make payments according to the terms of this Plan Document. The payments that the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

A Participant will have the right to assign the payment of any benefits for which he is eligible under this Plan to any eligible Provider of services. If a Provider makes a representation to the Claims Administrator that a person covered under this Plan has made an Assignment of Benefit payments to the Provider, the Claims Administrator will make payment to the Provider based on that representation.

SECTION XXI — GENERAL PROVISIONS

Clerical Error/Delay

Any clerical error by the Benefits Committee of the WF Retirees' Health Trust or an agent of the Benefits Committee of the WF Retirees' Health Trust in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or Institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a Claim for or on behalf of a person who is not a Participant of the Plan; submits a Claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid Claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Word Usage

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

Titles for Reference

The titles used within this document are for reference purposes only. In the event of a discrepancy between a title and the content of a section, the content of a section shall control.

Misstatements

If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Trust and the amount to be contributed by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Plan's obligation with respect to such payments.

In the event that the Trust terminates the Plan, then as of the effective date of termination, the Trust and eligible Retirees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims Incurred after the termination date of the Plan.

Release of Medical Information

The Plan Administrator and Claims Administrator are entitled to receive information reasonably necessary to administer this Plan, subject to all applicable confidentiality requirements as defined in this Plan and as required by law, from any healthcare Provider of services to a Participant. By accepting coverage under this Plan, Participants agree to sign the necessary authorization directing any healthcare Provider that has attended or treated them, to release to the Plan Administrator and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Participant. If the Participant fails to sign the necessary authorization or otherwise inhibits the Plan Administrator and/or Claims Administrator from getting necessary information to pay Claims, this Plan has no obligation to pay Claims.

Non Discrimination Policy

This Plan will not discriminate against any Participant based on race, color, religion, national origin, disability, gender, sexual preference, or age. This Plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.

Severability

In the event that any provision of this Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Binding Arbitration

Note: The Retiree is enrolled in a plan provided by the Trust that is subject to ERISA, any dispute involving an Adverse Benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after the individual has completed an appeal under ERISA. If the individual has any other dispute which does not involve an Adverse Benefit decision, this Binding Arbitration provision applies.

SECTION XXII — DEFINITIONS

The following words and phrases shall have the following meanings when used in this Plan Document.

Note: There may be other terms defined in specific sections of this Plan Document that appear just in those sections. Those terms may not be defined in this section.

"Ambulance" shall mean a specially designed or equipped vehicle used only for transporting the critically ill or Injured to a healthcare facility. The Ambulance service must meet state and local requirements for providing transportation of the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

"Assignment of Benefits" shall mean an arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Medical Expense Coverage benefits, less Copayments and the Coinsurance percentage that is not paid by the Medical Expense Coverage of this Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive medical coverage benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Copayments and the Coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary. Note: Assignment of Benefits is not allowed under the Vision Care Coverage, Dental Care Coverage, or Hearing Coverage.

"Brand Name" and/or "Brand Name Drug" shall mean a trade name medication.

A ***"Business associate"*** shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this plan.

"Calendar Year" shall mean the 12 month period from January 1 through December 31 of each year.

"Cardiac Care Unit" shall have the same meaning set forth in the definition of "Intensive Care Unit."

"Claim" shall mean a submission to the WF Retirees Health Trust for payment made under the Plan in accordance with the Plan requirements.

"Claim Determination Period" shall mean each Calendar Year.

"Claims Administrator" shall mean a third party retained by the Plan Administrator and the Plan Sponsor or the Plan Administrator. The Claims Administrator's responsibilities typically consist of initially determining the validity of the Claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Plan Administrator, Plan Sponsor, and Claims Administrator.
"Close Relative" or **"Family Member**" is a spouse, mother, father, daughter, son, sister, brother or in-law.

"Coinsurance" shall mean the charge a health plan participant must pay for certain Covered Expenses after any applicable Deductibles and Copayments have been paid and until the Out-of-Pocket Maximum has been reached. Coinsurance is a percentage of the Covered Services.

"Copayment" (also referred to as "copay") shall mean the flat dollar amount for which the Participant is financially responsible, if applicable, and as outlined within the relevant Schedule of Benefits.

"Coverages" shall mean those benefits under the Plan that are available to Covered Persons under the WF Retirees' Health Trust. The benefits are: Medical Expense Coverage, Prescription Drug Coverage, Vision Care Coverage, Dental Care Coverage, Death Benefit Coverage, Hearing Coverage, Adult Custodial Care Coverage, Medicare Part B Refund, and Rx Reimbursement Coverage.

"Covered Medical Expense(s)" means a Reasonable and Customary Charge for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the relevant Schedule of Benefits and as determined elsewhere in this document.

"Covered Person" shall mean any Retiree or Dependent who is eligible for benefits under the Plan (also see definition of "Participant").

"Dental Service" shall mean a professional Dental Service rendered by a Dentist in the necessary treatment of Accidental Injury, dental Disease or defect. It shall also mean:

1. The scaling and cleaning of teeth by a licensed dental hygienist or dental assistant if performed under the supervision and direction of a Dentist and a charge is made for such service by the Dentist.
2. Laboratory services for preparation of dental restoration and dental Prosthetic devices if the Dentist includes the cost of such services or devices in the charges for these services.

"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice Dentistry within their applicable geographic venue.

"Dependent" shall mean one or more of the person(s) as defined within the When Your Health Coverage Begins section of this document.

"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the United States Pharmacopeia, National Formulary or AMA Drug Evaluations published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed Drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home

"Emergency" is the sudden and unexpected onset of a medical condition:

1. Which requires medical care; and
2. For which the Covered Person secures medical attention immediately after the onset or within 72 hours.

"Emergency Accident Care" means the initial treatment, including diagnostic services, of an accidental injury.

"Emergency Medical Care or Emergency Illness" means the initial treatment, including diagnostic services of a medical condition which is not accident related. Such illness is characterized by the sudden onset of acute symptoms, which in the absence of immediate medical attention may:

1. Permanently jeopardize the health of the Covered Person;
2. Cause serious medical problems;
3. Impair bodily functions; or
4. Cause dysfunction of any body organ or part.

"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Generic Drug" shall mean a prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HIPAA Rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Home Health Agency" is an organization that is primarily engaged in providing skilled medical services in a home setting and meets all Medicare requirements.

"Hospice Agency" shall mean 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 Services and Supplies" shall mean those provided through a Hospice Agency and under a Hospice Care Program and include Inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling.

"Hospital" is a legally licensed hospital. It must be primarily engaged in providing treatment for the sick and injured, and must have round-the-clock doctors and nursing care, and surgical and treatment facilities (except in the case of an accredited psychiatric hospital). The Medical Expense Coverage of this Plan will also pay benefits for treatment of tuberculosis in a sanatorium.

"Identification (ID) Card" shall mean an Identification Card issued in the covered Retiree's name identifying the membership number of the covered Retiree.

"Incurred" A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient" shall mean a Covered Person who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its Outpatient department, where a Room and Board is charged by the Hospital.

"Intensive Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "Cardiac Care Unit", "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

"Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician or Dentist exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, Diagnosis or treatment of that Covered Person'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 Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person'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 Covered Person's Sickness or Injury without adversely affecting the Covered Person's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. It must not be primarily custodial in nature;
3. The Plan reserves the right to incorporate the Centers for Medicare and Medicaid Services (CMS) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Nurse" shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

"Out-of-Pocket Maximum" shall mean the annual aggregate amount for which a Covered Person will be financially responsible for during the Calendar Year. If applicable, the Out-of-Pocket Maximums are listed in the applicable Schedule of Benefits.

"Outpatient" shall the treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Participant" shall mean any Retiree or Dependent who is eligible for benefits under the Plan (also see definition of "Covered Person").

"PHI" shall mean Protected Health Information, as enacted pursuant to HIPAA.

"Physician" is a person who is not a close relative or family member of the Covered Person but who is a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or in the case of treatment of a fractured jaw or surgical removal of tumors or cysts in the mouth, a duly licensed Doctor of Dental Surgery (D.D.S.). Vision care benefits will be paid for services by a licensed optometrist or optician working within the scope of his or her license.

"Plan" generally means any plan, fund, or program which is established by an employer or an employee organization, or by both, for the purpose of providing benefits to participants and their beneficiaries in the event of sickness, accident, disability, death, etc. Specifically, when the term **"Plan"** is used in this Plan Document, it means the benefit coverages established by the WF Retirees' Health Trust that are described in this Plan Document.

"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Prosthetic" shall mean a fixed or removable device that replaces all or part of an extremity or body part, including such devices as an artificial limb, intraocular lens or breast prosthesis.

"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant Provider type.

"Qualified Convalescent Skilled Nursing Facility" is a licensed institution engaged in providing skilled medical care or rehabilitation services. The term does not include an institution providing primarily custodial care.

"Reasonable and Customary Charge" is the usual charge made for services performed under the same circumstances in the same part of the country by doctors of similar background. Charges in excess of reasonable and customary charges are not paid by the Medical Expense Coverage of this Plan; you pay the difference. Therefore, when possible, you should determine how your physician's and hospital's fees compare with the norm in your part of the country before you make a final decision about where to obtain treatment.

"Rehabilitation Hospital" or "Rehabilitation Facility" shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training Institution.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and complete linen service;
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation;
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education; and
4. Other conditions of occupancy which are Medically Necessary.

"Security Standards" mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Substance Abuse"
"Substance Abuse" shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a 12-month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to

substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);

b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
c. Craving or a strong desire or urge to use a substance; or
d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

SECTION XXIII — PLAN INFORMATION

The following information about this Plan is important for Covered Persons to know, and much of it is required to be provided.

Name of Plan:
WF Retirees' Health Trust

Types of Coverages:
Medical Expense Coverage
Prescription Drug Coverage
Vision Care Coverage
Dental Care Coverage
Hearing Coverage
Death Benefit Coverage
Adult Custodial Care Coverage
Medicare Part B Refund Coverage
Rx Reimbursement Coverage

Plan Sponsor:
WF Retirees' Health Trust
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201
(888) 938-7878 (toll-free)

Plan Administrator:
(Named Fiduciary)
WF Retirees' Health Trust
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201
(888) 938-7878 (toll-free)

Plan Sponsor ID No. (EIN):
75-2396970

Source of Funding:
WF Retirees' Health Trust

Applicable Law:
ERISA

Plan Year:
January 1st through December 31st

Medical Expense Coverage Claims Administrator:

HealthSmart Benefit Solutions, Inc.
7725 W. Reno Ave., Suite 397
Oklahoma City, OK 73127
(844) 871-2353

Prescription Drug Coverage Administrator:

HealthSmartRx
Retail Drug Card and Mail Order
1-800-681-6912

HMOs:

The HMO contact information is shown in the HMO document

Adult Custodial Care Coverage, Vision Care Coverage, Dental Care Coverage, and Hearing Coverage Claims Administrator:

Bodon, Inc.
9101 E. Chenango Ave.
Greenwood Village, CO 80111
1-855-WFRetirees (1-855-937-3847) toll-free

Medicare Part B Refund, Death Benefit Coverage, and Rx Reimbursement Coverage:

WF Retirees' Health Trust
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201
(888) 938-7878 (toll-free)

Claims Appeals—Benefits Committee:

WF Retirees' Health Trust Benefits Committee
c/o Lain, Faulkner & Co., P.C.
400 N. St. Paul, Suite 600
Dallas, TX 75201
(888) 938-7878 (toll-free)

Agent for Service of Process:
Munsch Hardt Kopf & Harr, PC
Attn: Lee Morris & Chris DeMeo
3800 Lincoln Plaza
500 N. Akard Street
Dallas, TX 75201-6659

Discretionary Authority

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

ESTABLISHMENT OF THE PLAN;
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **WF Retirees' Health Trust** (the "Plan Sponsor") as of January 1, 2019, hereby sets forth the provisions of the WF Retirees' Health Trust (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

WF Retirees' Health Trust

By: _____

Name: Dennis Faulkner

Title: Trustee

Date: _____