JOINT BENEFIT TRUST

Health and Welfare Plan

For Eligible 1400 Hour Employees

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

January 1, 2007

Este libro contiene un resumen en inglés de los derechos y prestaciones que a usted le corresponden bajo los planes de 1400 Hour Seniority Employees ofrece a sus empleados. Si tiene dificultad en entender alguna parte de este libro, puede dirigirse a su representante de la Oficina Adminstrativa, quien le prestará la ayuda que usted necesite.

This document constitutes a Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). It has been prepared for 1400 Hour Employees (and their dependents) who meet the eligibility requirements on page 13 as of January 1, 2007. JBT also offers benefits to eligible Non-1400 Hour Employees and retired 1400 Hour Employees. For information on these benefits, please see the *Summary Plan Description for the Health and Welfare Plan for Non-1400 Hour Employees Who Became Eligible Prior to July 1, 2003,* the *Summary Plan Description for the Health and Welfare Plan for Non-1400 Hour Employees Who Became Eligible On or After July 1, 2003* and the *Summary Plan Description for the Health and Welfare Plan for Eligible 1400 Hour Retirees*.

This document is also the official Plan document for the Joint Benefit Trust Health and Welfare Plan for 1400 Hour Employees (the "Plan").

This document does not serve as a guarantee of continued employment or benefits. In addition, the Board of Trustees reserves the right to change or end the Plan by action at a regularly constituted Trustee meeting held according to the Trustees' established process. You will be notified if any material changes are made to the Plan or if the Plan is terminated.

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Important Phone Numbers

For:	Call:	At:
General eligibility and benefit coverage questions	Joint Benefit Trust	1-800-JBT-HELP (1-800-528-4357)
JBT Medical coverage hospital pre-admission review and medical questions	Blue Cross	1-800-274-7767
Kaiser HMO hospital pre-admission review and medical questions	Kaiser	1-800-464-4000
PacifiCare HMO hospital pre-admission review and medical questions	PacifiCare	1-800-624-8822
Health Net HMO Hospital pre-admission review and medical questions	Health Net	1-800-522-0088
Chronic disease support (provided by registered nurses and dieticians to all non-HMO participants who have diabetes, coronary artery disease, heart failure and/or asthma)	Healthways (formerly American Healthways)	1-877-743-6824
Confidential substance abuse treatment referral	Teamsters Alcohol/Drug Rehabilitation Program (TARP)	1-800-522-8277
Confidential mental health assessment and pre-authorization	Managed Health Network (MHN)	1-800-528-0646
Prescription Drug Program ID Cards and benefit questions	Caremark: Member services Mail order Pre-authorization for physicians	 1-888-685-7752 1-800-552-8159 1-800-294-5979
Chiropractic benefit questions	Landmark Healthcare	1-800-638-4557
Vision benefit questions	Vision Service Plan (VSP)	1-800-877-7195

Summary Plan Description and Plan Document

This document provides information about:

- Benefit eligibility
- Benefit coverage
- Claims and appeals procedures, and
- Administrative and legally required information about the Plan

HMO coverage and the claims and appeals procedures applicable to such coverage are described in separate *Evidences of Coverage* furnished by the HMO. HMO coverage is administered solely by the HMO. For further information about HMO coverage, see HMO Enrollment Requirements on page 21 and HMO Coverage beginning on page 43.

The benefits and claims and appeals procedures applicable to life and AD&D coverage are described in separate booklets/certificates of coverage. For further information about these coverages, see page 138.

Except as otherwise stated in this document, JBT's Administrative Office—Health Services Benefit Administrators—administers the Plan and provides information about the amount of benefits, eligibility and other provisions of the Plan. No Union employee, including Union officers and business agents, employer or employer representative, or any other organization except JBT's Administrative Office, is authorized to give information or commit the Trustees on any matter. As a convenience to you, JBT's Administrative Office will provide oral answers on an informal basis regarding coverage. However, no such oral communication is binding on the Board of Trustees. In all cases, the provisions of the official Plan documents will govern.

Important Notice Regarding Eligibility. Your eligibility for benefits under this Plan depends on the continued receipt of employer contributions on your behalf. If your employer stops making contributions to JBT, your eligibility for benefits will end according to JBT's Delinquency Control Procedures.

If you have any questions about your benefits coverage, contact JBT's Administrative Office at 1-800-JBT-HELP (1-800-528-4357).

BOARD OF TRUSTEES

Establishment and Purpose

The Joint Benefit Trust Health and Welfare Plan for 1400 Hour Employees ("Plan") was established effective January 1, 1974, to provide health care benefits to employees of Participating Employers of the Joint Benefit Trust. The Plan is intended to be maintained on an indefinite basis, but is subject to the amendment and termination provisions beginning on page 147. The Plan or any of its provisions may be amended or terminated at any time and at the sole discretion of the Board of Trustees. Eligible dependents may also receive health care benefits. The Plan is maintained for the exclusive benefit of employees and their dependents. The Plan was amended and restated as of April 1, 1990 and was further amended and restated as of January 1, 1996. The Plan is again amended and restated to read as set forth herein as of January 1, 2007.

Highlights of Your JBT Health and Welfare Plan

The following chart highlights the health benefits available under the JBT Health and Welfare Plan for Eligible 1400 Hour Employees. Please refer to the appropriate sections of this document for more details.

<table>
<tr><th colspan="2">HEALTH MAINTENANCE ORGANIZATION (HMO)</th><th>See page</th></tr>
<tr><td>What the HMOs Cover</td><td>The HMOs only cover expenses that are:
▪ Medically Necessary and not Experimental
▪ Prescribed by a licensed Doctor recognized by the HMO and operating within the scope of his or her license
▪ Within Reasonable and Customary charge limits
▪ Certified by the HMO when required; and
▪ Not excluded from coverage</td><td>44</td></tr>
<tr><td>What the HMOs Pay</td><td>The HMOs pay many expenses at 100% after you pay a fixed copay amount. But for certain expenses, some HMOs apply a deductible and compute the copay amount as a percentage of the cost of treatment.

For details, see your HMO's Evidence of Coverage.</td><td>44</td></tr>
</table>

JBT MEDICAL		See page
What JBT Medical Covers	JBT Medical only covers expenses that are: ▪ Medically Necessary and not Experimental ▪ Prescribed by a licensed Doctor and operating within the scope of his or her license ▪ Within Reasonable and Customary charge limits; ▪ Certified by Blue Cross when required ▪ Not excluded from coverage	46
What JBT Medical Pays	▪ For preferred physician visits, JBT Medical pays 100% after a $20 copayment for some in-office services and 80% after you meet your calendar year deductible for other in-office services. ▪ For non-preferred physician visits, JBT Medical pays 70% of the charges incurred, subject to your calendar year deductible and Reasonable and Customary limits. ▪ For all other services except hospitalization, JBT Medical pays 80% for preferred care, subject to your calendar year deductible, and 70% of Reasonable and Customary charges for non-preferred care, subject to your calendar year deductible.	56 51 53
If You Reach the Annual Out-of-Pocket Maximum	You pay the remaining share of expenses until the amount you have paid out of your pocket in a calendar year for Covered Expenses reaches $2,000 for preferred providers and $4,000 for non-preferred providers. Then, JBT Medical pays 100% of the remaining Covered Expenses for the rest of the calendar year, up to a $1 million maximum lifetime benefit (physical and mental health combined).	53
If You Use a Preferred Hospital	If you go to a preferred hospital, JBT Medical pays 100% of inpatient services, after you meet your calendar year deductible.	58
If You Do NOT Use a Preferred Hospital	If you go to a non-preferred hospital, JBT Medical pays 70% of the Reasonable and Customary charges for inpatient services, after you meet your calendar year deductible.	58
If You Do Not Obtain Pre-Authorization from Blue Cross	**If you do not obtain pre-authorization at least three working days before a non-emergency hospitalization, your benefits will be reduced by 50%.** For maternity hospitalization, call at least two months before your baby is due.	59

CHIROPRACTIC BENEFITS (through Landmark Healthcare)		See page
What the Chiropractic Benefit Covers	For JBT Medical participants, chiropractic coverage is provided through Landmark Healthcare. Chiropractic benefits are limited to expenses for Chiropractic Treatment that is provided, supervised, or directed by a licensed chiropractor and incurred while under the care of a chiropractor, even if prescribed by a Doctor of medicine and/or performed by a licensed physical therapist. If you are enrolled in an HMO, chiropractic coverage may be available through your HMO; you are not eligible for chiropractic benefits through Landmark Healthcare.	65
What the Chiropractic Benefit Pays	What the Chiropractic benefit pays depends on whether you use a Landmark Healthcare provider or a non-Landmark non-Blue Cross provider.	65
If You Use a Landmark Chiropractor	JBT has negotiated special guaranteed rates with Landmark Healthcare. If you use a Landmark chiropractor, the chiropractic benefit pays 100% of Covered Expenses, after a $20 copay, up to $50 per day until you reach the calendar-year chiropractic benefit limit of $680.	66
If You Do NOT Use a Landmark (or Blue Cross) Chiropractor	If you do not use a Landmark chiropractor, the Chiropractic benefit pays Covered Expenses at 70%, up to $50 per day, until you reach the calendar-year chiropractic benefit limit of $680.	66

MENTAL HEALTH BENEFITS (through Mental Health Network (MHN))		**See page**
What the Mental Health Benefit Covers	For JBT Medical, PacifiCare HMO and Health Net HMO participants, mental health coverage is provided through Mental Health Network (MHN), an independent company that will direct you to care and work with the provider to ensure that your treatment goes as planned. If you are enrolled in the Kaiser HMO, mental health coverage is available through Kaiser; you are not eligible for MHN mental health benefits.	73
If You Use MHN Providers	**Outpatient care** When treatment is pre-authorized by MHN, MHN pays 100% of eligible expenses for the first five private counseling sessions in a year. Then MHN pays: ▪ 100% after you pay $10 for sessions 6-10 ▪ 100% after you pay $20 for sessions 11-15 ▪ 100% after you pay $30 for sessions 16-50 There is no copayment for group counseling sessions. Benefits are limited to a combined total of 50 visits for private and group counseling. You do not need to file a claim form. **All treatment must be pre-authorized.** **Inpatient care** If you are admitted for inpatient treatment of Mental or Nervous Disorders at a facility that contracts with MHN, your treatment is covered at 100% to a lifetime maximum of $1 million, mental health and physical health care combined.	76 73 76 73 76
If You Do NOT Use MHN Providers	**Services received from non-MHN providers are not covered** under the Plan except for the first 24 hours of inpatient emergency treatment.	76
Pre-authorization	Pre-authorization is required for all psychiatric Hospital admissions. **If your inpatient treatment is not pre-authorized, no benefits will be paid. In an Emergency, MHN must be contacted within 24 hours of admission.** Pre-authorization is also required for outpatient treatment. **Without pre-authorization, no benefit will be paid.** **Call the Member Assistance Program (MAP) "Warm Line" at 1-800-528-0646 to request pre-authorization for both inpatient and outpatient treatment.**	76 76 75

PRESCRIPTION DRUG BENEFITS (through Caremark)		See page
What the Prescription Drug Benefit Covers	JBT Medical participants receive Prescription Drug benefits through Caremark. Prescription Drugs are covered only if they are: ▪ Available only by a Doctor's prescription (except insulin), and ▪ Not excluded from coverage. If you are enrolled in an HMO, prescription drug coverage is available through your HMO; you are not eligible for prescription drug benefits through Caremark.	84 158 84
What the Prescription Drug Benefit Pays When You Visit a Network Pharmacy (30-day supply)	When you visit a network pharmacy and use your ID card, the prescription drug benefit pays 100% for a **30-day supply** after you pay a $10 copayment for generic drugs and $20 for preferred brand-name drugs. You pay a $15 penalty (total copay $35) for non-preferred Drugs. In addition, if you choose a brand-name drug when a generic equivalent is available, you will also pay the difference in cost between the two drugs, as well as the copay.	86 84
What the Prescription Drug Benefit Pays When You Buy through the mail-order program (90-day supply)	When you order your long-term maintenance medication through the mail-order program, the prescription drug benefit pays 100% for a **90-day supply** after you pay a $20 copayment for generic drugs and $40 for preferred brand-name drugs. You pay a $30 penalty (total copay $70) for non-preferred drugs. In addition, if you choose a brand name drug when a generic equivalent is available, you will also pay the difference in cost between the two drugs, as well as the copay.	87 84

DENTAL BENEFITS		See page
What the Dental Benefit Covers	HMO and JBT Medical participants receive dental benefits. The dental benefit covers only expenses that are: ▪ Necessary to prevent or eliminate oral disease or to maintain or restore function ▪ Not Experimental or cosmetic ▪ Provided by a licensed Dentist recognized by the Plan and operating within the scope of his or her license (or licensed dental hygienist for teeth cleaning) ▪ Pre-authorized by JBT dental consultants when necessary ▪ Within cost levels shown on the JBT Dental Table of Allowances ▪ Not excluded from coverage	93
Pre-authorization	For treatment over $300, you should obtain prior approval from JBT's Administrative Office to learn if the treatment is covered. Pre-authorization is required for some procedures.	95
If You Use a Participating Dentist	If you use a participating dentist, the dentist will accept the amount in the Dental Table of Allowances as full payment after the deductible has been met.	94
If You Do NOT Use a Participating Dentist	If you use a non-participating dentist, the dentist may charge more than the amount in the Dental Table of Allowances. You must pay the extra cost.	94
What the Dental Benefit Pays	Each calendar year, you pay the first $50 for each individual ($100 for a family). Then the dental benefit pays up to the maximum amount listed in the Dental Table of Allowances for each service. The dental benefit pays up to $1,500 for each person in a calendar year.	94
What Services Are Covered	The dental benefit covers: ▪ Diagnostic care and preventive care (visits and consultations) including: • Oral examinations and cleaning every six months • Bitewing X-rays once every 12 months • Fluoride treatment once every six months for dependents under age 18 ▪ Full mouth X-rays once every five years	95

DENTAL BENEFITS (continued)		See page
What Services Are Covered (continued)	The dental benefit covers (continued): ▪ Restorative Dentistry, including fillings and crowns once every five years ▪ Prosthodontics, including fixed partial dentures and full dentures once every five years ▪ Oral surgery, including extractions and other oral surgery ▪ Endodontics, including pulpal therapy and root canal fillings ▪ Periodontics, including treatment of gum and tissues supporting the teeth	95
Exclusions	See What's Not Covered?	97

VISION BENEFITS		See page
What the Vision Benefit Covers	Vision benefits are provided through Vision Service Plan and cover: ▪ Vision examinations—once every 12 consecutive months ▪ Eyeglass lenses—only if needed, once every 24 consecutive months ▪ Frames—only if needed, once every 24 consecutive months up to a maximum retail allowance of $100 ▪ Contact lenses—In lieu of benefits for eyeglass lenses and frames, an allowance of up to $100 in a 24-consecutive-month period towards the cost of contact lenses and the associated fitting and evaluation exam	102
When You Use a VSP Provider	Your out-of-pocket cost is limited to a $10 deductible plus the additional cost (above the basic cost of allowed lenses and frames) for the following:	102
	▪ Blended, oversize, multifocal and UV-protected lenses ▪ The coating or laminating of lenses ▪ Cosmetic eyeglass lenses and optional cosmetic processes ▪ A frame that costs more than the VSP retail coverage allowance of $100 ▪ The cost of contact lenses in excess of the $100 coverage allowance	102
	No claim form is required. To find a VSP provider in your area log on to VSP.com or call VSP at 1-800-877-7195.	102
When You Use a Non-VSP Provider	Your benefit is limited to an allowance established by VSP for each covered service. The difference between this allowance and what your provider charges for all of the services you receive is your out-of-pocket cost. You must submit a claim form to VSP to receive the allowance.	103

ELIGIBILITY AND PARTICIPATION

Eligibility and Participation

Employee Eligibility and Participation

Who is Eligible?

You are eligible for coverage under this Plan in any month that you meet these four requirements:

- You are a 1400 Hour employee under the terms of the Collective Bargaining Agreement between your Union and your employer or have met an equivalent measure of full time work,
- You are on the seniority list as of the first day of the month,
- You worked at least 80 hours for a Participating Employer during the preceding month, and
- Your Participating Employer made the required contributions on your behalf.

When Employee Coverage Begins

If you meet the eligibility requirements described above before the 15th of the month, your coverage begins on the first day of that month. Otherwise, coverage starts on the first day of the following month.

Once you become eligible, you need to make some important decisions about your health plan coverage; for example, whether or not you want to join an HMO. You also need to enroll your dependents; otherwise, their claims will not be paid. For more information on how to enroll, see Enrollment beginning on page 21.

How Long Employer-Paid Coverage Continues

After you establish eligibility, your employer-paid coverage will continue so long as you are on the 1400 Hour seniority list as of the beginning of the month AND you worked 80 hours during the preceding month. After establishing eligibility, your employer-paid coverage will also continue for up to twelve months if you are unable to work due to illness, industrial injury or lay-off (12 month disability and lay-off protection) and up to 31 days if you take a leave of absence to serve in the armed forces.

Example: Lay-off—Assume that you work 80 hours in October 2003 and are then laid-off. You will be covered in November because of your October hours. If your lay-off continues, you will also be covered from December 2003 through November 2004 (twelve months of lay-off protection).

You may also be eligible for up to 12 weeks of employer-paid coverage if you take a leave of absence to care for a family member or your own health condition that prevents you from working. For more information, see Family and Medical Leave beginning on page 15.

When Employer-Paid Coverage Ends

Employer-paid coverage ends as follows:

Quit or Terminate—The end of the month in which you terminate employment and are therefore no longer on the 1400 Hour seniority list, regardless of the number of hours you worked. For example, assume that you worked 80 hours in March and quit on March 21st. Your employer-paid coverage ends March 31, even though you worked 80 hours in March.

Personal Leave—The end of the month after the last month you worked 80 hours. (For possible exceptions, see Family and Medical Leave beginning on page 15.) For example, assume that you worked 80 hours in March and then, starting March 21st took a personal leave. Your employer-paid coverage ends April 30th, the month after you last worked 80 hours.

Work-Related Disability—The end of the twelfth month following the month after the month you last worked 80 hours or the end of the month in which Workers' Compensation benefits cease, whichever is earlier. For example, assume that you worked 80 hours in October 2003 and then are injured on the job. Assuming Workers Compensation benefits do not end earlier, you will be covered during November 2003 (because of the hours you worked in October) and for the following twelve months (because of the 12 months disability protection). Your employer-paid coverage ends November 30, 2004.

Medical Leave—The end of the twelfth month following the month after the month you last worked 80 hours or when you are able to return to work, whichever is earlier.

Lay-off—The end of the twelfth month following the month after the month you last worked 80 hours. (See How Long Employer-Paid Coverage Continues beginning on page 13.)

Loss of 1400 Hour Seniority—The last day of the month in which you were on the 1400 Hour seniority status list, regardless of the number of hours you worked. Depending on how many years you have worked, you may be covered or have self-payment rights as a Non-1400 Hour employee. For example, assume that, despite working 80 hours in December, you lost 1400 Hour seniority protection on December 31, 2003. Your coverage under the 1400 Hour Plan ends December 31st. However, depending on your seniority date, you may have employer-paid coverage or self-payment rights under one of the plans offered to Non-1400 Hour employees.

Family and Medical Leave—See Family and Medical Leave beginning on page 15.

Military Service—The 31st day following the end of the month after the month you last worked 80 hours. For example, assume that after working 80 hours in March, you are called to active

duty on March 21st. You are covered in April because of hours worked in March and through May 31st because of military leave. Thereafter, employer-paid coverage ends.

Permanent Lay-off Due to Plant Closure—Employer-paid coverage ends as described above or on the last day of the month you are permanently laid-off, whichever occurs first.

Your employer-paid coverage will also end if your employer does not make contributions to JBT on your behalf. Coverage will also end on the date the Plan ends or is amended to eliminate or reduce your coverage.

Unless the Plan ends or is amended to eliminate your coverage, you generally have the right to continue your health coverage by making self-payments when employer-paid coverage ends. For information, see Self-Pay Options When Employer-Paid Coverage Ends beginning on page 24.

Family and Medical Leave

You may be eligible for up to 12 weeks of unpaid leave of absence under the Family and Medical Leave Act (FMLA) to take care of family matters such as birth and care of a newborn, newly adopted child, care of an ill parent, child or spouse, or your own serious health condition that keeps you from doing your job. You are eligible for an FMLA leave if you have been employed for at least 12 months at a worksite where your employer employs at least 50 employees (or employs at least a total of 50 employees within 75 miles of your worksite) and you have worked at least 1,250 hours during a 12-month period immediately preceding the start of your leave of absence.

If you take an unpaid leave pursuant to the federal Family and Medical Leave Act (FMLA) or the California Family Rights Act, your and your dependents' eligibility for coverage continues throughout your leave. This is because your employer continues to pay monthly contributions for your coverage. Your and your dependents' coverage will continue until the earliest date:

- Your leave period under FMLA ends,
- Your employer can show that you would have been laid-off and the employment relationship terminated,
- You provide your employer with notice that you do not intend to return to work, or
- You do not return to work.

At the end of your FMLA leave, you may be eligible for COBRA continuation of coverage for up to 18 months. Note: if you are on an approved leave of absence subject to the Family and Medical Leave Act (FMLA), only a failure to return to work at the end of the approved leave constitutes a COBRA qualifying event. For more information, see Self-Pay Options When Employer-Paid Coverage Ends beginning on page 24.

Because the family and medical leave laws do not apply to all employers or all employees, you may or may not qualify for this leave. For more information, contact your employer.

Military Leave

If you take a leave of absence because of voluntary or involuntary service in the uniformed services (for active duty or training), employer-paid coverage for you and your covered dependents continues during your military leave if your leave is less than 31 days. If your leave continues 31 days or more, you and your covered dependents can continue coverage under the Uniformed Services Employment and Reemployment Rights Acts (USERRA) by paying 102% of the cost of coverage. Coverage will end on the earlier of:

- The 24-month period (the 18-month period, for elections to continue coverage prior to December 10, 2004) beginning on the date your leave started, or
- The day after the date your leave ends and you fail to apply for or return to employment, whichever occurs first.

You and your covered dependents must elect this coverage; it is not automatic. To be eligible for this coverage, you must give your employer advance notice of the leave. The duration of this leave combined with all your previous periods of military leaves under the same employer must not exceed five years (unless extended by national emergency or similar circumstance). If it does, you may be able to continue benefits as described under Leave of Absence beginning on page 30.

For more information on your USERRA rights, contact your employer or union.

You may also choose to treat the military leave as a leave of absence and you may continue coverage under the Plan for up to 24 months by making self-payments or for up to 18 months by electing and paying for COBRA continuation coverage, as described under Leave of Absence beginning on page 30 and Continuing Coverage through COBRA on page 31. Unless you continue coverage under COBRA, you and your dependents will not be entitled to the 11-month disability extension of coverage or the 18-month extension of coverage as a result of a second qualifying event available under COBRA. For details, see Self-Pay Options When Employer-Paid Coverage Ends beginning on page 24.

If you elect to treat your continuation coverage as JBT Self-Pay coverage (instead of COBRA), you will lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your JBT Self-Pay coverage ends. For details, see Self-Pay Options When Employer-Paid Coverage Ends beginning on page 24.

If You Return From a Leave of Absence

If you return to work after an approved leave of absence, your employer-paid coverage will be reinstated on the first day of the calendar month following the month in which you work at least 80 hours in covered employment. If you return to work after a USERRA-protected military

leave, your employer-paid coverage will be reinstated without the application of any preexisting condition exclusions or waiting periods unless you have an injury or illness that the Veterans Administration (VA) has determined to have been incurred in, or aggravated during the performance of service in the uniformed service.

Reinstatement of Plan Coverage after Termination

If your employment was terminated when you were covered under the Health and Welfare Plan for 1400 Hour Employees, and you then return to non-seasonal covered employment within six months of your termination, and complete the normal 30-day trial period required to attain seniority, you will become eligible for coverage retroactive to the day you returned to work, provided you started between the 1st and 15th of the month. If you started work on or after the 16th day of the month, coverage will begin on the first day of the following month.

Dependent Eligibility and Participation

Who is Eligible?

The following dependents are eligible for coverage, unless otherwise indicated (for example, dependents are not eligible for hearing aid benefits, see Hearing Aid Benefits on page 66):

Your Spouse

Your lawful spouse is eligible for coverage. If you are legally separated or divorce proceedings have started, your spouse continues to be covered until the divorce is final.

Your Children

Your children are eligible for coverage if they:

- Are unmarried, and
- Are under age 19 and living in your home, OR are under age 25 if they are full-time students at an Accredited School or College, whether or not they are living in your home.

Definition of Children

“Children” means your natural children, stepchildren and adopted children who depend primarily on you for financial support and live with you in a regular parent-child relationship. Health care coverage for an adopted child can begin when you are legally obligated to support the child in anticipation of adoption, regardless of whether the adoption is final. Children also includes children for whom you are required to provide health coverage as the result of a Qualified Medical Child Support Order (QMCSO). For more information on QMCSOs, see Automatic Coverage Due to a QMCSO on page 19. Wards of the state and foster children are not considered eligible dependents.

Verification of Full-time Student Status

For full-time students, you must file a verification of student status with JBT's Administrative Office.

Eligibility for full-time students ages 19 through 24 will not continue beyond the last day of the month in which the student's full-time attendance ends. However, your child will remain eligible through the summer months if enrolled as a full-time student in the spring term or semester and enrolled for the following fall.

Disabled Children

Your unmarried Disabled children of any age who are unable to earn a living due to their Disability, provided they were eligible and Disabled before age 19, and you furnished proof of Disability before your Disabled child reaches age 19.

Note: In addition to meeting the requirements above, a dependent will be eligible for coverage only if: (1) he or she is a citizen or national of the United States, (2) he or she is a resident of the United States, Canada or Mexico, or (3) he or she is the child of an employee who is a citizen or national of the United States (such child must reside with the employee and be a member of the employee's household).

Domestic Partners

In addition to your lawful spouse and dependent children, the Plan will cover your Domestic Partner as a dependent. For purposes of Plan coverage, a Domestic Partner means a person with whom you have established a domestic partnership under California law for which you have received a *Certificate of Registration of Domestic Partnership* from the Office of the California Secretary of State. To obtain the *Certificate,* you and your Domestic Partner must meet the following requirements for domestic partnership under California law. You must:

- Share a common residence
- Be jointly responsible for each other's basic living expenses
- Not be married to another person (unless you and your Domestic Partner are of the same gender and married to each other in a jurisdiction recognizing same-sex marriage),
- Not be in another domestic partnership for which you have not filed a Termination of Domestic Partnership with the California Secretary of State
- Not be related by blood in a way that would prevent you from being married in California
- Both be over 18 years of age
- Be of sound mind sufficient to consent to enter into the domestic partnership

- File a *Declaration of Domestic Partnership* with California's Secretary of State and present a notarized copy of the declaration and proof of its filing to the JBT Administrative Office
- Be of the same sex: however, if one or both of you are age 62 or older and eligible for Social Security benefits, you can be members of the opposite sex yet still qualify as Domestic Partners under California law

Once you have furnished a copy of your *Certificate of Registration of Domestic Partnership* to the JBT Administrative Office, your Domestic Partner will be treated as a legal spouse under the Plan, to the extent permitted by law, **with the exception of COBRA coverage**. The children of your Domestic Partner will be treated the same as stepchildren under the Plan, **with the exception of COBRA coverage**. After establishing a Domestic Partnership, you and your Domestic Partner must notify the JBT Administrative Office if either of you terminate the Domestic Partnership, if either of you file a *Notice of Termination of a Domestic Partnership* with the Secretary of State, or if any of the criteria listed above to qualify as a Domestic Partner under California law are no longer met.

Domestic Partners and COBRA Continuation Coverage

Because JBT Medical Coverage (described beginning on page 46) is subject to **federal** law, Domestic Partners and their children are **not eligible for COBRA continuation coverage** as described beginning on page 31 when their group coverage ends. However, HMOs are subject to **state** COBRA continuation coverage laws, so if you are enrolled in one of the JBT HMOs when group coverage ends, your Domestic Partner and his/her dependents may be entitled to elect and pay for COBRA continuation coverage under California law.

Tax Consequences of Domestic Partner Eligibility

Federal tax laws require the Trust to determine how much of the monthly employer contribution to the JBT is attributable to the coverage of your domestic partner and to **report that amount as additional taxable income paid to you** unless you can show that for purposes of your federal income tax returns you have primary responsibility for your domestic partner's living expenses. In other words, if your Domestic Partner has a job or supports him or herself through work of his or her own, you will have to pay the employee payroll taxes each quarter on part of the monthly employer contribution paid on your behalf. This amount will vary from year to year but is likely to be at least 50% or more of the monthly employer contribution. So, as an example, if the monthly employer contribution rate for the 1400 Hour Plan is $850, then the "fair market value" of domestic partner coverage would be half that amount and the JBT would report that you have an additional $425 per month in federal taxable income. Each quarter, JBT will bill you for the federal employee payroll taxes on this the fair market value of domestic partner coverage. If you do not pay these taxes on time, your Domestic Partner's coverage will be terminated.

Automatic Coverage Due to a QMCSO

If a child support order is submitted to the Plan providing for the health coverage of a child as a dependent, it will be reviewed by the Plan Administrator, who will determine whether the order

satisfies the legal requirements for a QMCSO. If the Plan Administrator determines that the order is a QMCSO, the child will be enrolled as your dependent. If the order was issued in the form of a “National Medical Support Notice” and is subsequently determined to be qualified, you (and your child) will automatically be enrolled in the Plan if your child is not currently enrolled.

You may obtain detailed information on the procedures governing QMCSO determinations, without cost, by contacting JBT’s Administrative Office.

If You Claim Coverage for Someone Who Is Not Eligible

If you claim coverage for a dependent or other person who does not meet the Plan’s eligibility requirements, JBT reserves the right to take any legally permissible actions to recover any amounts wrongly paid, including withholding payment on future claims submitted by you and/or your eligible dependents. JBT will withhold benefit payments for Covered Expenses until it has fully recovered the amount paid for expenses incurred by ineligible dependents. Anyone who submits a claim for a person who is not eligible should be aware that insurance fraud is a crime subject to criminal prosecution.

When Dependent Coverage Begins

Coverage for your eligible dependents begins on the later of the date you become eligible or they become dependents, except, coverage for a dependent child who is eligible for participation due to a QMCSO begins on the date specified in the QMCSO.

Your dependents must be enrolled *before* benefits are paid. As part of enrollment, you must furnish a marriage certificate for your spouse and birth certificates, adoption papers or the equivalent applicable documents for your children. For more information, see Enrollment beginning on page 21.

When Dependent Coverage Ends

Your dependents’ coverage will end on the earlier of the following dates:

- The date your coverage ends
- The date your dependent no longer qualifies as a dependent

For your spouse, this means the date of divorce. For your dependent child, this means the end of the month of the child’s 19th birthday (25th birthday if a full-time student). If you and your spouse divorce, your stepchildren by your divorced spouse lose coverage on the date of the divorce. Participation of a dependent child who is covered as the result of a Qualified Medical Child Support Order (QMCSO) ends on the date he or she is no longer covered under the QMCSO.

If you die, your dependents will lose coverage at the end of the month in which your death occurs.

Enrollment

JBT Plan Enrollment Requirements

As soon as you are eligible for coverage, or whenever you move, add or drop dependents you must complete and file an enrollment form with JBT's Administrative Office. You will need to fill in your address, the names of your eligible dependents, and the name of your Beneficiary for your life insurance benefits. **Remember to update your enrollment form any time a change occurs**—for example, whenever you change your address or name, or if you add or drop a dependent. Payment of claims will be delayed if your form is not up to date.

- Spouse—To enroll your spouse, you must furnish a copy of the marriage certificate with the JBT enrollment form. If you and your spouse divorce, your spouse and any stepchildren by your divorced spouse lose coverage when the divorce is final. You must furnish a copy of the divorce decree with the revised enrollment form that excludes your former spouse.
- Dependent child—To enroll a dependent child you must furnish a copy of the birth certificate, adoption papers or the Qualified Medical Child Support Order, whichever applies.
- Student status—A dependent child loses coverage upon attaining age 19 unless enrolled as a full-time student. Students are covered while attending school. Students are also covered during the summer if they attended the previous spring and are registered for the following fall. To be covered, you must submit proof of full-time student status. This can usually be obtained from the registrar's office. The extension of coverage to students ends when your child reaches age 25.

These documentation requirements apply to **all** dependents, even dependents who were enrolled before this requirement took effect. Send the appropriate documentation to:

Joint Benefit Trust
P.O. Box 2479
Livermore, CA 94551

HMO Enrollment Requirements

Choosing a Medical Coverage Option

You and your eligible dependents will be automatically covered by the JBT Medical option described in this document unless you timely elect HMO coverage**. You must make an election to enroll in HMO coverage on a separate HMO enrollment form**. Send your completed HMO enrollment form to JBT's Administrative Office for processing. Do not send this enrollment form directly to the HMO. The election you make applies to your entire family. If

you do not choose HMO coverage at the time you first become eligible for coverage, you cannot enroll in HMO coverage until the next annual open enrollment period. During open enrollment, you can move from the JBT Medical option to an HMO or from an HMO to the JBT Medical option or switch from one HMO to another. **Again, if you elect HMO coverage, you must complete the HMO's enrollment form and mail it to JBT's Administrative Office for processing.**

NOTE: IF YOU ARE ENROLLED IN AN HMO AND CHANGE EMPLOYERS, YOU MUST RE-ENROLL IN THE HMO; otherwise, your coverage will be moved to the JBT Medical Plan.

Adding or Dropping Dependents

If you are enrolled in an HMO and want to add a new spouse or dependent child to your HMO coverage, you must notify the HMO directly (not just JBT's Administrative Office) within 31 days of the date of marriage or birth, adoption or placement for adoption. If you drop dependents because of divorce you must also notify the HMO directly. Notification to the HMO is in addition to the requirement that you complete a new JBT enrollment form and submit the required documentation.

Your Cost for Coverage

The cost of coverage under this Plan is determined annually by the Board of Trustees. Mid-year adjustments may be made by the Board. The Board of Trustees sets a monthly contribution rate designed to cover the cost of Plan benefits and maintain reserves. The Board may, at its sole discretion, set different rates for HMO and JBT Medical coverage, if the costs of providing these two types of coverage differ significantly.

The portion of the monthly contribution rate paid by your employer is determined by the terms of the Collective Bargaining Agreement under which you work. How the difference, if any, between the contribution rate established by the Board and the amount the employer is required to contribute under the Bargaining Agreement is funded, will be determined by the bargaining parties.

To the extent not expressly prohibited by the Bargaining Agreement, the Board can adjust benefits. The Board may, but is not required to, adjust benefits if, for example, the cost of coverage increases to a level such that the contribution rate needed to pay for it rises above the amount the Participating Employer is obligated to pay.

SELF-PAY OPTIONS WHEN EMPLOYER-PAID COVERAGE ENDS

Self-Pay Options When Employer-Paid Coverage Ends

When employer-paid coverage ends, you may continue coverage for a limited time by making self-payments according to:

- The rules for JBT Self-Pay Coverage ("JBT Self-Pay"), or
- Federal law, under the Consolidated Omnibus Budget and Reconciliation Act ("COBRA").

These two sets of rights are independent. JBT Self-Pay rights come from your Collective Bargaining Agreement. COBRA rights come from federal law. Therefore, if you lose coverage, YOU MUST CHOOSE BETWEEN JBT Self-Pay coverage or COBRA coverage. You cannot choose both.

Comparing JBT Self-Pay and COBRA Rules

Overview

Your continuation rights under JBT Self-Pay and COBRA differ. In some situations, such as when a dependent child loses coverage upon reaching age 19 or you and your family lose coverage because you are terminated, the only option available is COBRA coverage. In other situations, such as when you take an approved leave of absence or lose coverage because of a prolonged lay-off, you will have a choice. Which choice is right for you will depend on how long you want coverage, the type of coverage you need, coverage cost and when you make your election for continuation coverage. To help you decide, JBT Self-Pay rights and COBRA rights are compared below.

Note: If you elect JBT Self-Pay coverage instead of COBRA coverage (that is, you waive COBRA coverage) and your JBT Self-Pay coverage ends for any reason, you will not be entitled to elect COBRA coverage. Furthermore, by electing JBT Self-Pay coverage instead of COBRA coverage, you and your dependents will lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your JBT Self-Pay coverage ends. Therefore, you must carefully decide whether JBT Self-Pay coverage or COBRA coverage is right for you.

Duration of Continuation Coverage

When you lose employer-paid coverage, one of the most important considerations is how long you can continue coverage by making self payments. Both JBT Self-Pay coverage and COBRA

coverage impose limits, but they are different depending on why you lost group coverage. The chart below summarizes your JBT Self-Pay and COBRA rights. Unless otherwise stated, coverage applies to the entire family.

Reason Coverage Lost	JBT Self-Pay Coverage	COBRA Coverage
Lay-off	Up to 24 additional months (lay-off months 13-36) after employer-paid 12- month lay-off protection ends.	Up to 18 months less the number of months employer-paid coverage continued during lay-off.*
Work-related Disability or personal medical leave	Up to 24 additional months (disability months 13-36) after employer-paid 12-month disability protection ends.	Up to 18 months less the number of months employer-paid coverage continued during your Disability.* Under some circumstances, coverage can be extended an extra 11 months at a higher cost (see page 34).
Approved leave of absence	Up to 24 months.	Up to 18 months.*
Plant closure	Up to 12 months.	Up to 18 months less any months employer may have paid for coverage because you were on lay-off or disability when the plant closed.*
Retirement	No JBT Self-Pay rights. However, you may be eligible for coverage under the JBT 1400 Hour Retiree Plan if you are receiving a pension from the Western Conference of Teamsters Pension Trust or an alternate plan approved by the JBT Board of Trustees.	Up to 18 months*. If you elect COBRA coverage upon retirement, you cannot purchase JBT Self-Pay coverage under the JBT 1400 Hour Retiree Plan when your COBRA coverage ends (for example, when you become covered by Medicare). If you are on COBRA at the time you retire you can switch to a Self-Pay option under the Retiree Plan.
Termination	**No JBT Self-Pay rights.**	Up to 18 months.*

* The number of months you can continue coverage under COBRA is reduced by the number of months the employer continued paying for your coverage when you were not working. For example, if your employer paid for coverage while you were laid-off for 12 months, you can only pay for COBRA coverage for another six months. You and your dependents will be provided with your right to elect COBRA coverage or JBT Self-Pay coverage following the end of employer-paid coverage for lay-off, plant closure or disability.

Reason Coverage Lost	JBT Self-Pay Coverage	COBRA Coverage
Loss of 1400 Hour status	No JBT Self-Pay rights under the 1400 Hour Plan. However, you may be eligible for either JBT Self-Pay or employer-paid coverage under the Non-1400 Hour Plan. **The JBT Non-1400 Hour Plan does not cover your Spouse.** Children only have coverage while you are working or if you make self payments for such coverage.	Up to 18 months.*
Military service	**No JBT Self-Pay rights.**	Up to 18 months for you and your dependents if the military leave is treated as a leave of absence and you elect COBRA. Alternatively, coverage may be continued under USERRA for up to 24 months (see Military Leave beginning on page 16).
Divorce	**No JBT Self-Pay rights.**	Up to 36 months (spouse and children whose coverage is lost as a result of the divorce only).*
Children no longer qualify as dependents	**No JBT Self-Pay rights.**	Up to 36 months for child losing dependent status.*
You die	**No JBT Self-Pay rights.**	Up to 36 months for your spouse and children.*

* The number of months you can continue coverage under COBRA is reduced by the number of months the employer continued paying for your coverage when you were not working. For example, if your employer paid for coverage while you were laid-off for 12 months, you can only pay for COBRA coverage for another six months. You and your dependents will be provided with your right to elect COBRA coverage or JBT Self-Pay coverage following the end of employer-paid coverage for lay-off, plant closure or Disability.

Note: If you are enrolled in an HMO at the time federal COBRA coverage ends, you may be able to continue HMO coverage only (no dental or vision) for another 18 months (or possibly longer if you are at least 60 years old) by making premium payments directly to the HMO as mandated by California state law. See State Continuation Coverage Rights beginning on page 38.

Consequences If You Do Not Elect JBT Self-Pay or COBRA Coverage

In considering whether to elect continuation coverage (JBT Self-Pay coverage or COBRA coverage), you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may lose the right to avoid having pre-

existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of either JBT Self-Pay coverage or COBRA coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not maintain COBRA coverage for the maximum time available to you. This guaranteed right will only be preserved if you elect and exhaust COBRA coverage. You will lose the guaranteed right to purchase an individual health policy without pre-existing condition exclusions if you elect JBT Self-Pay coverage.

Finally, you should take into account that you have special enrollment rights under federal law. That is, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event giving rise to your right to elect continuation coverage (JBT Self-Pay coverage or COBRA coverage, as applicable). You will also have the same special enrollment right at the end of the maximum duration of continuation coverage (JBT Self-Pay coverage or COBRA coverage, as applicable) available to you.

It is extremely important that you inform your employer and JBT's Administrative Office whenever you or any of your dependents have a change of address, so that notices can be sent to the correct address.

Dependent Eligibility

No Independent Right to JBT Self-Pay Coverage

If you elect JBT Self-Pay coverage your family members will have JBT Self-Pay coverage as well. Your eligible dependents do not have an independent right to elect JBT Self-Pay coverage. If you elect COBRA coverage, your dependents cannot elect JBT Self-Pay coverage. Further, the loss of self-pay coverage is not a COBRA qualifying event. This means that if your family members lose JBT Self-Pay coverage because of your death, divorce or your dependents' loss of "dependent status" they will not be able to elect COBRA coverage or independently continue their JBT Self-Pay coverage.

Independent Right to COBRA Coverage

You and each eligible dependent do have an independent right to elect COBRA coverage. For example, you and your spouse may elect COBRA coverage, or you only may elect COBRA coverage. Or your dependents may elect COBRA coverage and you may elect JBT Self-Pay coverage in which case your dependents will have both COBRA and JBT Self-Pay coverage provided they continue to qualify as dependents. Parents may elect to continue COBRA coverage on behalf of their dependent children only.

Military Leaves of Absence
If you take a military leave, your spouse and children have separate continuation of coverage rights under another federal law, called USERRA. For information, see Military Leave on beginning on page 16.

Levels of Coverage and Cost

When you purchase COBRA coverage, you have the option of just paying for medical and prescription drug coverage, or for medical and prescription drug coverage plus dental and vision. When you purchase JBT Self-Pay coverage, you get the entire benefit package and must pay its full cost.

The premium rates for JBT Self-Pay coverage and the two coverage options under COBRA are set by the Board of Trustees. For the current rates, call JBT's Administrative Office.

Election Period and Payment of First Premium

JBT Self-Pay coverage must be elected and paid for by the sixth day of the month following the month employer-paid coverage is lost. COBRA coverage provides for a 60-day election period and a brief grace period thereafter in which to make the first payment.

The sections that follow describe the JBT Self-Pay rules and COBRA rules separately and in greater detail.

Continuing Coverage under JBT Self-Pay Rights (Instead of COBRA)

When JBT Self-Pay Coverage Begins and Ends

You are eligible for JBT Self-Pay coverage for up to 24 months (or 12 months in the event of a Plant Closure) under the Collective Bargaining Agreement when you are laid-off, have a medical condition or work-related Disability that keeps you from working, or take an approved leave of absence. These JBT Self-Pay coverage rights are an alternative to COBRA and are not affected by COBRA. COBRA coverage is federally-mandated continuation coverage that is independent of your collectively-bargained JBT Self-Pay rights. Therefore, if you lose coverage for one of the reasons described above, you may choose either COBRA coverage or the JBT Self-Pay coverage available under your Collective Bargaining Agreement, but not both. If you elect JBT Self-Pay coverage, you will lose your right to elect COBRA coverage.

Lay-off

If you do not work 80 hours in a month due to lack of work, your employer will continue to pay for your coverage for up to 12 consecutive months during your lay-off. After 12 months of lay-off, your employer-paid coverage ends. However, you may continue coverage under the JBT Self-Pay option for an additional 24 months by making self-payments. (Or you may elect COBRA coverage, which would generally be limited to six months—18 months less the 12 months already covered by employer under lay-off protection.) You must choose either the JBT Self-Pay option or COBRA if you wish to continue coverage. **If you elect JBT Self-Pay coverage, you waive the right to elect COBRA coverage.**

Disability

If you do not work at least 80 hours in a month because you are Disabled by an illness or injury, your coverage will continue while Disabled for up to 12 consecutive months, as follows:

- If you have a personal illness or non-work-related injury, your employer will continue to make payments on your behalf for coverage until you are able to return to work, or for up to 12 consecutive months after your disability began—whichever period is shorter.
- If you are injured on the job or suffer an illness as the result of your job, your employer will continue to make payments on your behalf until the date on which Workers' Compensation weekly benefits stop, or for up to 12 consecutive months after the injury occurred—whichever period is shorter.

After a maximum of 12 months of disability, your employer-paid coverage ends. However, you may continue your coverage by either electing JBT Self-Pay coverage for an additional 24 months or by electing COBRA coverage, (usually limited to six additional months—18 months

less the 12 months already covered by the employer under disability protection or 17 months if you are deemed Disabled by the Social Security Administration ("Social Security-Disabled")).

Example: You last worked 80 hours in October 2004. You are covered by your employer in November 2004 because of October work and, because of disability protection, from December 2004 until November 2005, when employer-paid coverage ends. Starting in December 2005, you have the right under the JBT Self-Pay rules to pay for an additional 24 months of coverage, or in this example, until November 2007.

Leave of Absence

If you do not work at least 80 hours in a month because you are on an approved leave of absence, your Plan coverage will stop. However, you may continue coverage by electing JBT Self-Pay coverage for up to 24 months by making self-payments. (Or, you may continue coverage by electing COBRA coverage, which would generally be limited to 18 months). You must choose one or the other of these options. You cannot choose both.

Example: For example, assume that you begin an approved leave in October 2004 after working 80 hours. Employer-paid coverage ends November 2004. Under Plan rules, you then have the right to JBT Self-Pay coverage until November 2006.

Plant Closure

If you are permanently laid-off because a processing or warehouse unit closes or because the entire plant closes, you may elect JBT Self-Pay coverage for up to 12 months. (The partial discontinuance of an operation or the discontinuance of particular products does not constitute a plant closure.) As an alternative to JBT Self-Pay coverage, you may have the option of electing COBRA coverage. COBRA coverage can be purchased for up to 18 months, reduced by the number of months of coverage, if any, that your employer paid for if you were disabled or laid-off when the plant closed. You must choose one or the other of these self-payment options. **If you elect JBT Self-Pay coverage, you lose your right to elect COBRA coverage.**

Payment of JBT Self-Pay Premiums

If you choose JBT Self-Pay coverage, you pay a monthly premium for you and your dependents. You must make your payments for continued coverage to your employer or to JBT's Administrative Office **no later than the sixth day of the calendar month for which you are purchasing coverage.** To make your payment easier to process, please write your Social Security Number or Plan ID number on your check. **There is no grace period for late payments**. Payments **must** start the month after employer-paid coverage ends and be continuous. If you miss a payment, your coverage ends and you will lose the right to purchase any future self-pay coverage until you return to work and re-qualify for employer-paid coverage.

JBT Self-Pay rates will be determined annually by the JBT Board of Trustees. For current JBT Self-Pay rates and general information on JBT Self-Pay coverage, consult your employer, union, or JBT's Administrative Office.

Continuing Coverage through COBRA (Instead of JBT Self-Pay Coverage)

When you and your eligible dependents experience a "qualifying event," you may elect COBRA coverage as an alternative to the JBT's Self-Pay coverage option. You must choose one or the other; you cannot choose both.

Qualifying Events

You, your spouse and dependent children are eligible for 18 months of COBRA coverage if coverage ends under the Plan because:

- Your active employment with your employer ends for any reason except gross misconduct
- You retire
- Your hours are reduced (this includes periods of lay-off, disability leave, medical or personal leave and plant closure)

In addition, your spouse and dependent children are eligible for 36 months of COBRA coverage if coverage ends under the Plan because:

- You become entitled to Medicare benefits
- You become divorced
- Your spouse or child is no longer considered a dependent under the Plan
- You die

Who Is Eligible for COBRA Coverage

COBRA coverage is offered to:

- You, your spouse and/or your dependent children who are covered under the Plan on the day before a qualifying event
- Children born to you or placed for adoption with you during the time you are on COBRA coverage
- Family members who become eligible to enroll for COBRA coverage due to special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) while you or your dependents are on COBRA coverage. However, such family

members are not COBRA "qualified beneficiaries" if they were not covered under the Plan on the day before the qualifying event.

COBRA Notification and Enrollment

If Plan coverage ends because of your death, termination, or reduced hours, your employer will send you or your dependents information on your COBRA coverage rights. **You will then have 60 days to elect COBRA coverage**.

If you or your dependents are Disabled on the date of your initial COBRA qualifying event of termination of employment or reduction of hours, or become Disabled within 60 days of your COBRA qualifying event and you want the 11-month extension (as described later in this section), **you must notify JBT's Administrative Office within 60 days after the date you receive your Social Security Disability determination, the date your employment ends, or the date your hours are reduced, whichever is latest**. If you or your dependents fail to provide timely notice of the Social Security Disability determination, you and your dependents will forfeit the right to the 11-month extension.

If Plan coverage ends because you divorce your spouse or a dependent is no longer eligible, you or the covered dependent are responsible for notifying JBT's Administrative Office within 60 days of the event. You must use the form prescribed by JBT to notify JBT of these qualifying events. If JBT is not notified within the 60-day period of the qualifying event, your dependent's COBRA rights will be lost. To receive a form, call JBT's Administrative Office at 1-800-JBT-HELP (1-800-528-4357).

Within 30 days of receiving timely notice of the occurrence of a qualifying event from an employee, dependent, or a Participating Employer, **JBT's Administrative Office will notify the "qualified beneficiary" of his or her COBRA rights**. Specific notice and administrative procedures have been adopted by the Joint Benefit Trust that are consistent with applicable federal law and regulation. **All "qualified beneficiaries" will then have 60 days to elect COBRA coverage**. All forms and notices must be mailed to JBT's Administrative Office at P.O. Box 2479, Livermore, CA 94551-2479

Remember, if you do not elect COBRA coverage within the 60-day election period and you do not have any other self-payment rights, your Plan coverage will end.

To help ensure that your COBRA coverage is properly administered, you must also notify JBT's Administrative Office of your or your dependent's enrollment in Medicare.

When COBRA Coverage Begins

If you choose COBRA coverage at any time during the 60-day election period, coverage will be retroactive to the date employer-paid coverage was lost due to the qualifying event. If you or your dependents decide to waive COBRA coverage, you may revoke the waiver at any time during the 60-day election period and elect COBRA coverage. You may not revoke your waiver and elect COBRA coverage if the 60-day election period has ended or if you waived COBRA and selected JBT Self-Pay coverage instead.

Duration of COBRA Coverage

Coverage may continue for at least 18 or 36 months, depending on the type of qualifying event, as shown in the table below:

Qualifying Event	Individuals Eligible for Coverage	Coverage Period from Initial Qualifying Event
Your employment ends	Employee, spouse, children	18 months
You retire	Employee, spouse, children	18 months
Your hours are reduced (lay-off, disability, or approved leave)	Employee, spouse, children	18 months
You get divorced	Spouse, children	36 months
Your dependent loses dependent status	Spouse, children	36 months
You die	Spouse, children	36 months

If you enrolled in Medicare less than 18 months before you became eligible for COBRA coverage due to your termination or reduction of hours, your eligible dependents will be entitled to 36 months of COBRA coverage measured from the date of your Medicare enrollment. In order for your dependents to be entitled to this 36-month coverage period, you or your dependents must notify JBT's Administrative Office of your enrollment in Medicare and provide information regarding the date your Medicare coverage became effective.

Employer-paid coverage after the qualifying event reduces the COBRA coverage period. For example, if you lose coverage after being laid-off 12 months, your COBRA coverage is limited to six months (the 18-month period less the 12 months already paid by the employer). The same rules apply if you receive employer-paid coverage while you are disabled.

Extensions for 18-month COBRA Coverage Periods

The 18-month coverage period may be extended under the following circumstances:

Disability Extension

If you or your covered dependent(s) were Disabled (as determined by the Social Security Administration) on the date of the qualifying event or at any time during the first 60 days after the date of your COBRA qualifying event, you and your dependents may continue coverage under COBRA **for up to 29 months** (11 months plus the regular 18 months of COBRA). For months 19 through 29, you pay a higher premium (150% of the total cost).

You must submit the Social Security Administration's determination of Disability to JBT's Administrative Office no later than 60 days after the loss of coverage or the date of the Social Security determination (whichever is later) and before the end of the initial 18-month period of COBRA coverage. The maximum 29-month COBRA period will also be reduced by any employer-paid coverage provided.

Example: After working 80 hours in October 2003, you are Disabled. You have employer-paid coverage in November 2003 (based on October work) and for the twelve-month period ending November 2004 (because of 12-month disability protection). If you elect COBRA coverage, you would pay the normal COBRA rates for the next six months (December 2004 through May 2005). At the end of this period, if you are still Disabled as determined by the Social Security Administration, you can continue your COBRA coverage for an additional 11 months (June 2005 through April 2006) by paying the higher disability extension rate.

Newborn and adopted children who are determined to be Disabled by the Social Security Administration within the first 60 days of birth or placement for adoption are treated as having been Disabled within the first 60 days of COBRA coverage.

You or your dependents are responsible for notifying JBT's Administrative Office within 60 days of receiving the Social Security Administration's determination of Disability and before the end of the initial 18-month period of COBRA coverage. Send your notice to:

Joint Benefit Trust Administrator
P.O. Box 2479
Livermore, CA 94551-2479

If you or your dependents were determined to be Disabled before COBRA coverage began, the extension is valid as long as the determination was still in effect on the first day of COBRA coverage.

If you or your dependents are on extended COBRA coverage because of a Disability, you must notify JBT's Administrative Office within 30 days of the date you or your dependent receive the Social Security Administration's determination that you or your dependent is no longer Disabled. The disability extension will end on the first day of the month that is more than 30 days after the date the Disability ends. You must send your notice to the above address.

Second Qualifying Event Extension

If your dependents are entitled to 18 months of COBRA coverage as a result of your termination of employment or reduction of hours, and they later experience a second qualifying event within this 18-month period that would have resulted in a loss of coverage if not for the COBRA coverage, coverage may be extended an additional 18 months, for a total COBRA coverage period of up to 36 months from the initial qualifying event.

The second qualifying event must be related to your death, divorce or a child losing dependent status. This extension applies only to your spouse and dependent children. For further information regarding your COBRA notice obligations, see COBRA Notification and Enrollment beginning on page 32.

Notice of Unavailability of COBRA

If, after receiving a notice relating to a qualifying event, second qualifying event or a determination of Disability by the Social Security Administration, the Plan Administrator determines that the individual who provided the notice is not entitled to COBRA coverage or extended COBRA coverage, the Plan Administrator will provide the individual with a notice explaining the reasons why COBRA coverage is not available. The notice will be provided not later than 30 days after the Plan Administrator's receipt of the individual's notice.

When COBRA Coverage Ends

COBRA coverage will end on the earliest of:

- The end of the 18-, 29-, or 36-month period
- The date a COBRA coverage payment is not received within 30 days of the due date
- The date the Plan ends
- The date you or your dependents become covered, after the COBRA election, under another group plan unless the new group plan contains any exclusions or limitations for pre-existing conditions that directly affect your or your dependents' coverage
- The date you or your dependents become covered, after the COBRA election, under Medicare Part A or Part B (COBRA coverage ends only for the person who becomes covered by Medicare)
- The first day of the month beginning more than 30 days after the date an individual on the 29-month disability extension described above is determined to be no longer Disabled according to the Social Security Administration
- The date determined by JBT that your Plan coverage will terminate due to fraud or misrepresentation or because you knowingly provided JBT or JBT's Administrative Office with false material information including, but not limited to, information relating to another

person's eligibility for coverage or status as a dependent. JBT has the right to rescind coverage back to the effective date of coverage.

If COBRA coverage ends prior to the 18-, 29- or 36-month coverage period, the Plan Administrator will provide a notice to the affected individuals as soon as practicable following the Plan Administrator's determination of the termination of COBRA coverage. The notice will explain the reason for the early termination, the date of the termination, and the availability of alternative group of individual coverage, if any.

Note: Your Domestic Partner and his or her children are not eligible for COBRA continuation coverage if they were enrolled in the JBT Medical Plan on the day before the qualifying event. However, if they were enrolled in an HMO on the day before the qualifying event, they may be eligible to elect and pay for California COBRA continuation coverage. For more information, see Special Continuation Rights If You Are Enrolled In an HMO When Your Coverage Ends on page 38.

Levels of Coverage

You may elect and pay for one of two levels of COBRA coverage:

- Medical coverage through an HMO or the JBT Medical option, prescription drug, mental health, chiropractic, and drug and alcohol rehabilitation coverage,
- The coverage described above plus vision and dental coverage

Your COBRA payments will be higher if you elect the option including vision and dental coverage.

Life and accidental death and dismemberment insurance are not available under COBRA.
If Plan coverage is changed for active employees while you or your dependents are on COBRA coverage, the same changes will apply to you and your dependents.

Paying for Coverage

If you elect COBRA continuation coverage, you pay the full cost of coverage for you and your dependents plus a 2% administration fee—in other words, 102% of the cost. If you are Disabled and qualify for the COBRA extension, the cost of COBRA continuation coverage for the additional 11 months (from the 19th to the 29th month) will be 150% of the cost. The cost is determined annually by the JBT Board of Trustees.

Your first COBRA payment can be sent in with the COBRA election form and will be considered late if not received by JBT's Administrative Office within 45 days of the date you elect COBRA coverage.

The first payment covers the cost of COBRA coverage retroactive to the date your employer-paid coverage ended. You are responsible for ensuring that the amount of your first payment is enough to cover this entire period. You may contact JBT's Administrative Office to confirm the

correct amount of your first payment. If the first payment is not received by the end of the 45-day period described above, COBRA coverage will be retroactively canceled, and you must pay any health care expenses incurred during that period. After you make the first payment, COBRA payments are due on the first of the month and are considered late if they are not received within 30 days of the due date. If any of your COBRA payments are late, you will lose all of your COBRA coverage rights.

COBRA Payment Shortfalls

If you or your dependent remits a timely monthly contribution to the Plan Administrator that is significantly less than the actual COBRA payment due for the month, your or your dependent's COBRA coverage will be terminated immediately. If you or your dependent remits a payment that is not significantly less than the actual COBRA payment due for the month, the payment will be deemed to satisfy the Plan's requirement for the amount that must be paid, unless the Plan Administrator notifies you or your dependent of the amount of the deficiency and permits you or your dependent to pay the deficiency within 30 days of the date of the notice of deficiency. You or your dependent are responsible for paying all deficiencies.

If you have any questions about COBRA or need additional forms, please call JBT's Administrative Office at 1-800-JBT-HELP (1-800-528-4357) or write to the address below. Send all payments to:

Joint Benefit Trust Administrator
P.O. Box 2479
Livermore, CA 94551-2479

Payment of Claims

Once you enroll in COBRA continuation coverage and pay the first premium, claims are payable from the effective date of COBRA coverage. The Plan will continue to pay claims for the length of your continuation coverage, provided you pay the monthly premiums on time.

If you or your dependents do not elect COBRA coverage or pay the premium, the Plan will not pay benefits for any expenses incurred by you or your dependents after the date coverage ended. Except as described under Major Medical Extension of Benefits (see page 71), this applies to conditions being treated before coverage ended.

Special COBRA Rights for Trade Displaced Employees

If you lost coverage under the Plan because your employer shut down its plant because of a shift of production to another country or because of an increase in imports, you may be eligible for a tax credit for your COBRA payments, provided you qualify for trade adjustment assistance or alternative trade adjustment assistance from the federal government and your state government. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under these tax provisions, eligible

individuals can take a tax credit on their tax returns of 65% of premiums paid for qualified health insurance, including COBRA coverage. Advance payments of the tax credit may also be available.

If you become eligible to receive trade adjustment assistance within six months of losing JBT Plan medical coverage and did not elect COBRA coverage when you were initially eligible, you may also be entitled to a second COBRA election period. To obtain this second COBRA election period, you must provide a copy of the certificate issued to you by your state workforce agency entitling you to federal trade adjustment assistance to JBT's Administrative Office. JBT's Administrative Office will provide you with a COBRA election notice. Your election to continue coverage must be made during the 60-day period that begins on the first day you become eligible for trade adjustment assistance, but no later than six months after you lost Plan medical coverage. If you elect COBRA during this period, COBRA will commence on the first day of the second election period. Your COBRA period, however, will be measured from the date you lost JBT Plan coverage. The second election period does not extend the COBRA period available to you.

If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Special Continuation Rights If You Are Enrolled In an HMO When Your Coverage Ends

State Continuation Coverage Rights

Many states, including California, require insured medical plans (including HMOs) to provide extended health coverage to participants after their group coverage ends. Because the JBT Medical option is not an insured medical plan, it is not subject to these state law requirements and, therefore, provides no continuation coverage rights other than those described herein. State law continuation coverage generally supplements federal COBRA or provides continuation coverage to those who are ineligible for federal COBRA coverage.

Because your decision to enroll in an HMO when you first become eligible or during the annual JBT open enrollment may be affected by the availability of state law COBRA, please review this section.

Cal-COBRA Extended Continuation Coverage Beyond 18 or 29 Months of Federal COBRA

If you are enrolled in an HMO when your federal COBRA coverage ends, California law requires that your HMO provide an additional period of continuation coverage, up to a total of 36 months from the date federal COBRA began. To take advantage of extended Cal-COBRA, you must be enrolled in an HMO immediately prior to losing federal COBRA coverage. Your

coverage for this Cal-COBRA period will be limited to the benefits provided by your HMO and will not include any benefits provided by JBT.

HMO Conversion Rights

If you are enrolled in an HMO, you may convert your HMO coverage to an individual medical policy offered by the HMO when your coverage under the 1400 Hour Plan ends. This "conversion" right is part of the HMO's group agreement with the Trust and is completely unrelated to Cal-COBRA rights described above. The HMO-sponsored individual medical policy will cost more and may provide fewer benefits than the HMO group medical plan. There are no conversion rights for JBT Medical, mental health coverage, prescription drug coverage, dental coverage, vision coverage, and drug and alcohol rehabilitation coverage described in this booklet. See your life insurance booklet/certificate of coverage for life insurance conversion privileges.

If you are Disabled and enrolled in the JBT Medical Plan when all coverage ends, you may be entitled to extended benefits. For information, see page 72.

Certification of Coverage

JBT does not exclude medical coverage for pre-existing conditions. However, if you become eligible for coverage in another plan, you should know that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) places limits on the restrictions your new plan can impose on your coverage for certain medical conditions. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period must be reduced by your prior health coverage, as long as there is no break in coverage between your prior coverage and coverage in your new group health plan of 63 or more consecutive days.

Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage. If you buy health insurance other than through an employer group plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. If you purchase individual health coverage, you must exercise your right to COBRA continuation coverage to the full extent available to take advantage of this certificate.

If your JBT coverage ends, a certificate of coverage will automatically be sent to you and your covered dependents at your last known address. If you elect COBRA continuation coverage, you will also receive a certificate after COBRA coverage ends. You and your covered dependents may also request a certificate within 24 months of losing coverage. To get a certificate or for additional information, contact JBT at 1-800-JBT-HELP (1-800-528-4357).

MEDICAL BENEFITS

Your Medical Benefit Options

Enrollment Options

JBT gives you a choice of medical coverage options. You may choose either:

- Coverage through a Health Maintenance Organization (HMO), if you live in a location where HMO coverage is available, or
- Coverage through the JBT Medical option.

HMO coverage is available only if you live in an HMO "service area." For more information on HMO coverage, see HMO Coverage beginning on page 43.

JBT Medical coverage is available to all eligible employees. For more information on JBT Medical coverage, see JBT Medical Coverage beginning on page 46.

There are important differences between medical coverage through an HMO and medical coverage through the JBT Medical option. The following chart highlights key differences:

	HMO	**JBT Medical Coverage**
Availability	Availability is based on your home ZIP code.	Available in all locations.
Choice of Doctors	Less choice. You must use your HMO's doctors and facilities to receive benefits.	More choice. You may use any licensed doctor, but benefits are higher when you use preferred doctors.
Your Out-of-Pocket Costs	Usually lower than the JBT Medical option. The services subject to a deductible and a copay based on a percentage of charges is limited. For many services the HMO pays expenses at 100% after you pay a fixed copay amount.	Usually higher than an HMO. You pay a deductible plus a percentage of your expenses.
Claims	You do not have to file claim forms.	You do not have to file claim forms when you use preferred providers. You must file claim forms when you use non-preferred providers.

When you are a newly eligible employee, you automatically receive JBT Medical coverage unless you specifically enroll in HMO coverage. Send your completed enrollment form to JBT's Administrative Office for processing. Do not send your enrollment form directly to the HMO. Your coverage election applies to your entire family.

If you do not enroll in an HMO when first eligible, you cannot enroll in an HMO until the next open enrollment period. Once a year, JBT holds "Open Enrollment." During this time, you can move from JBT Medical coverage to HMO coverage, from HMO coverage to JBT Medical coverage or switch from one HMO to another. **You may only change coverage during Open Enrollment.**

HMO Coverage

HMO coverage currently includes your choice of three HMOs—Health Net, Kaiser and PacifiCare. To enroll in an HMO, you must live in a location where that HMO operates—called the "service area." The service area is defined by home ZIP codes. Call JBT's Administrative Office to find out what HMOs are available to you.

How HMO Coverage Works

Overview

If you choose to participate in an HMO, your coverage includes the hospital, medical and prescription drug benefits expressly provided by the HMO under the terms and conditions of its contract with the Trust. Each HMO publishes a booklet describing the specific benefits and exclusions for its plan. That booklet, usually referred to as the "Evidence of Coverage," will be sent to you if you enroll in an HMO. The HMOs provide benefits through a contract with the Trust and are responsible for any claim or coverage decisions. When deciding whether or not to enroll in an HMO, you should consider the following factors:

Availability

Each HMO is licensed to operate only in specific areas, usually defined in terms of either counties or ZIP codes. Therefore, not every HMO the Trust offers will necessarily be available to you.

HMO service areas are not static. HMOs move in and out of geographic areas based on economic factors such as negotiations with doctors and medical groups. If an HMO moves out of the area where you live, you will be allowed to enroll in JBT Medical coverage.

Choice of Doctors

One of the distinguishing features of all HMOs is that you must use doctors, hospitals, facilities, and other service providers designated by the HMO. Each HMO publishes its own list of doctors and hospitals. Except in the case of a Medical Emergency, HMOs generally pay no benefits unless you use a provider on the HMO's list.

Some HMOs require you to select a primary care physician (PCP) when you enroll. A PCP is usually a doctor in general practice, internal medicine, or family practice. HMOs must allow female participants to designate an obstetrician/gynecologist as their PCP. If you need specialty care, your PCP must generally make the referral. Often, the HMO requires that a PCP refer participants to a specialist that practices in the same group as the PCP or to a specialist who is in some other way affiliated with the PCP.

Therefore, as you consider your HMO options, ask yourself:

- Does the HMO's list have a PCP I know or would be comfortable with?
- If my primary medical relationship is with a specialist, can the PCP I select refer me to this specialist? If not, am I willing to change specialists?

Remember, all of your care will be provided by doctors on the HMO's list.

Pre-authorization

In general, you need a referral from your PCP to see a specialist and the HMO's permission for non-emergency hospitalization and certain other specialized services.

Claims

With HMO coverage, you do not have to file any claim forms unless you receive emergency or urgent care from a non-HMO provider.

What's Covered?

The services covered by the HMO coverage may vary depending on which HMO you select—Health Net, Kaiser or PacifiCare—and may not be the same as the services covered by the JBT Medical option. For coverage details, refer to the specific HMO's *Evidence of Coverage*. The *Evidence of Coverage* is the binding document between the HMO and its members. For details on the benefit and claims review and claims determination procedures of your HMO, please refer to the HMO's *Evidence of Coverage*. You will receive an *Evidence of Coverage* and a provider directory listing the HMO participating doctors and hospitals from your HMO automatically and at no charge. To obtain a copy of the *Evidence of Coverage*, contact the HMO or JBT's Administrative Office. For HMO contact information, see Administration and Financing of Plan Benefits beginning on page 149 and Important Phone Numbers on page 1.

As you consider your HMO options, review the benefits each offers, especially if you have special treatment needs such as durable medical equipment, orthotics, mental health, or chiropractic care as HMO coverage often differs in these areas.

Medical Benefits

The HMO pays Covered Expenses for treatment and services prescribed or authorized and provided by the HMO provider. See the specific HMO's *Evidence of Coverage* for details. When

you receive care under an HMO, you pay a fee at the time of service, called a copayment. HMO copayments are based on the service provided and are often a fixed amount (such as $20 per office visit). However, under some HMO options, some services are subject to a deductible and a copayment based on a percentage of the charge. A chart showing the copayment each HMO charges, if any, for the major service categories is available from JBT's Administrative Office. (In contrast, under the JBT Medical option, you pay a calendar year deductible plus a percentage of what the provider charges on almost all services.)

Prescription Drug Benefits

Under HMO coverage, the HMO provides your prescription drug coverage. Many HMO plans restrict coverage to a formulary, which is a specific list of "preferred" drugs for each condition. Non-formulary or "non-preferred" drugs may not be covered. If you are taking particular drugs on a regular basis for a chronic condition, you should ask your HMO about the formulary. For more information about your drug benefits, refer to your HMO's *Evidence of Coverage*.

Other Health Care Benefits

HMO coverage provides benefits for eligible medical, prescription drug and in some cases, mental health, and chiropractic care. If you are enrolled in an HMO, you receive this coverage through your HMO and not through the JBT Plan. However, you do receive JBT Plan coverage for:

- Dental care
- Vision care
- Drug and alcohol rehabilitation

> ***SPECIAL NOTE:*** *JBT offers HMO plans, but does not necessarily recommend them, nor does JBT have any control over the HMO services. Furthermore, JBT has no financial obligation for any medical services provided to you while in the HMO other than the payment of premiums to the HMO.*

JBT Medical Coverage

JBT Medical coverage helps pay for the cost of covered medical care. To be covered, medical services and treatment must be:

- Medically Necessary
- Not Experimental
- Prescribed by a licensed Doctor or health care provider operating within the scope of his or her license
- Pre-certified when required
- Within Reasonable and Customary cost levels or a contracted rate, whichever is applicable
- Covered by the JBT Medical option

When you enroll in the JBT Medical option, you receive:

- Medical benefits using Blue Cross of California's Preferred Provider Organization
- Chiropractic coverage using the Landmark Healthcare Network of providers
- Mental health benefits through Managed Health Network (MHN)
- Prescription drug benefits through Caremark

JBT Medical Coverage at a Glance

The following chart provides an overview of JBT Medical coverage. The coverage amounts shown are for covered services and supplies that are Medically Necessary. Non-preferred services and supplies are subject to Reasonable and Customary limits. As you can see from the chart below, although **you can see any provider that you want for care, your benefits are much higher when you see preferred providers.**

JBT Medical Coverage		
	Preferred Provider	**Non-Preferred Provider**
How the JBT Medical Option Works	Use a preferred provider and receive higher benefits.	Use a non-preferred provider and receive lower benefits.
How Benefits Are Paid	The JBT Medical benefit pays a percentage of costs (100%, 80% or 70%), after you meet an annual deductible. The deductible does not apply to some preferred office visits, for which you pay only a $20 copayment. Preferred care is paid at a higher percentage than non-preferred care.	
Calendar Year Deductible	$200 per person $500 per family	$400 per person $1,000 per family
	You must satisfy a separate deductible for preferred and non-preferred care. The deductible does not apply to certain services. For details, see Calendar Year Deductible beginning on page 52.	
Annual Out-of-Pocket Maximum	$2,000 per person	$4,000 per person
	Preferred and non-preferred out-of-pocket maximums are not combined. For details, see Calendar Year Out-of-Pocket Maximum beginning on page 53.	
Lifetime Maximum Benefit	$1,000,000—preferred and non-preferred combined. Physical and mental health combined.	
Physician Office Visits (For a more complete list of routine and other services, see Physician Office Visits beginning on page 56.)		
Routine services (exam, intramuscular injections, in-office lab work)	100% after $20 copayment (no deductible)	70% after deductible
All other services (including surgery, diagnostic testing and chemotherapy)	80% after deductible	70% after deductible

JBT Medical Coverage		
	Preferred Provider	**Non-Preferred Provider**
Hospital		
Inpatient Hospital (Room and Board)	100% after deductible	70% after deductible
Inpatient Surgery and Anesthesia	80% after deductible	70% after deductible
Failure to Authorize Inpatient Hospital	**Coverage will be reduced by an additional 50% if you fail to call Blue Cross for pre-admission certification.**	
Outpatient Hospital and Ambulatory Surgical Centers	80% after deductible	70% after deductible **(Benefits reduced an additional 50% if you use a non-preferred facility for non-emergency surgery.)**
Skilled Nursing Facility	100% after deductible met **(pre-authorization required)**	70% after deductible met **(pre-authorization required)**
Emergency Care		
Emergency Room **Urgent Care Center**	Paid the same as inpatient hospital if you are admitted directly to a hospital, otherwise paid as any other outpatient hospital service.	Paid at preferred level if to treat a Medical Emergency. Otherwise, paid at non-preferred level. See Inpatient Hospital and Outpatient Hospital.
Ambulance	80% after deductible	70% after deductible for non-emergency transportation
Other Benefits		
Surgery and Anesthesia	80% after deductible	70% after deductible
Lab work—outside Doctor's Office	80% after deductible	70% after deductible
X-rays and Diagnostic Imaging	80% after deductible	70% after deductible
Home Health Care	80% after deductible Care must be pre-authorized	70% after deductible Care must be pre-authorized
Physical Therapy (when not part of Chiropractic Treatment)	80% after deductible	70% after deductible
Chemotherapy	80% after deductible	70% after deductible
Radiation Therapy	80% after deductible	70% after deductible
Hemodialysis	80% after deductible	70% after deductible

JBT Medical Coverage		
	Preferred Provider	**Non-Preferred Provider**
Durable Medical Equipment and Supplies/Prosthetic Devices	80% after deductible with prior approval	70% after deductible with prior approval
	Always contact JBT's Administrative Office for approval before renting or buying durable medical equipment.	
Hospice Care	100% at an Approved Hospice Care Program for those diagnosed with a life expectancy of six months or less	
Hearing Aids—see page 66		
Mammography (for women over 40 up to $75 at intervals recommended by American Cancer Society)—see page 66		
Chiropractic (through Landmark Healthcare)**—**see page 65		
Mental Health (through Managed Health Network (MHN))**—**see page 73		
Prescription Drugs (through Caremark)**—**see page 84		

How JBT Medical Coverage Works

Overview

With JBT Medical coverage, you have the option of seeing preferred or non-preferred providers; however, benefits are paid at a much higher level when you use preferred providers. A Blue Cross ID card and a booklet listing the preferred Blue Cross Doctors and facilities will be mailed to you when your coverage begins.

Using the Blue Cross Preferred Provider Network

The preferred provider network for the JBT Medical option is provided through Blue Cross of California, the State's largest hospital and physician network. If your doctor participates in the Blue Cross network, you will not need to do anything when you receive services except present your Blue Cross ID card.

Remember: when you use preferred providers, you receive a discount. So, do not pay your portion of a preferred provider's bill until you receive an Explanation of Benefits from JBT that shows you what you owe.

Using the Blue Cross Website to Locate a Provider Near You

To find a provider in the Blue Cross network, you can contact the Administrative Office at 1-800-528-4357 or log into the Blue Cross website at www.bluecrossca.com. If you log into Blue Cross's website, you may search by specific provider name or use the following steps to find a network provider:

1. In your browser, type in www.bluecrossca.com
2. Click on "Find a Doctor"
3. Click on Visitor Search then click on "Next"
4. In the Provider Finder window:
   - Under Plan Type, use the down arrow and select "Large Group"
   - Under Select a Plan, use the down arrow and select Blue Cross PPO
   - Under Provider Type, use the down arrow and select the type of provider you want to use: hospital, physician, etc. If you select a professional provider, you will also have the option of choosing a provider specialty such as cardiac, or gynecology, etc.
   - Then click "Next."
5. In the "Provider Finder" window, type in your address and select either the mileage or state and county. Selecting mileage will give you all the providers in the specialty you've chosen who practice within the distance you've chosen and the address you provided. Selecting state and county will give you all of the providers in your chosen specialty in the county you select. Then click on "Review results."
6. The results page will list all of the providers in the specialty you have chosen.

Using Non-Preferred Providers

You always have a choice of using non-preferred providers. However, when you use non-preferred providers, JBT Medical pays only 70% of the Reasonable and Customary charges for all covered medical expenses (including physician office visits and inpatient hospital services), and your deductible and out-of-pocket maximum is higher than when you use preferred providers. Also, non-preferred providers may charge more than what is Reasonable and Customary—if this happens, you are responsible for paying any amounts over the Reasonable and Customary charges.

If your doctor does not participate in the Blue Cross network, you should consider choosing a doctor who does.

It Pays To Use a Preferred Provider

The following example shows how your out-of-pocket costs are much higher when you do not use a preferred provider.

Description	Preferred Provider		Non-Preferred Provider	
	JBT Medical Pays	You Pay	JBT Medical Pays	You Pay
Total charge by surgeon	$11,500		$11,500	
Less JBT Medical discount*	(2,000)		-0-	
Amount owed to surgeon	9,500		11,500	
Less deductible	(200)	200	(400)	400
Balance	9,300		11,100	
Paid at:				
80% for preferred	7,440	1,860		
70% for non-preferred			7,770	3,330
Balance paid by JBT Medical/you before out-of-pocket adjustment	7,440	2,060	7,770	3,730
Adjustment because of out-of-pocket protection	60	(60)	-0-	-0-
Adjusted balance paid by JBT Medical/you	$7,500	$2,000	$7,770	$3,730

*For illustration only. Actual amount varies by provider.

In this example, you would pay almost twice as much if you used a non-preferred doctor, $3,730 instead of $2,000. By using a preferred provider you save four ways:

1. You get the benefit of the discount offered by the preferred provider
2. Your deductible is lower ($200 instead of $400)
3. A higher percentage of the bill is paid (80% instead of 70%)
4. Your out-of-pocket protection starts sooner (at $2,000 instead of $4,000)

Because of the discount offered by the provider, the Trust also saves money, preserving assets for future benefits.

Calendar Year Deductible

With the exception of certain services performed by a preferred provider in his or her office (see Physician Office Visits beginning on page 56), all medical charges will be subject to a calendar

year deductible. The amount of the deductible depends on whether you are treated by a preferred or non-preferred provider. The deductible amounts are:

Calendar Year Deductible*	Preferred Provider	Non-Preferred Provider
Individual	$200	$400
Family maximum	$500	$1,000

* The deductible is waived for approved Teamsters Alcohol/Drug Rehabilitation Program, Hospice Care and the mammography program.

The preferred and non-preferred calendar year deductibles are not combined. If you use both preferred and non-preferred providers, your deductible could be up to $600 for any one person in your family ($200 + $400) and up to $1,500 ($500 + $1,000) for your entire family.

Example: The first treatment you receive during the calendar year is from a preferred doctor. The charge is $300. JBT Medical pays $80 ($300 charge less the $200 deductible leaves $100 payable at 80%). You have now met your preferred provider deductible. Any other charges from preferred doctors during the year will be paid at 80% (100% once your annual out-of-pocket maximum is reached). However, if you go to a non-preferred provider, JBT Medical will deduct another $400 (the non-preferred provider deductible) before paying benefits at 70%.

Note: Any eligible expenses applied toward your deductible during the last three months of any calendar year will carry over and be applied toward your deductible requirements for the following calendar year. This rule applies to both the preferred and non-preferred deductibles.

What JBT Medical Coverage Pays

After you satisfy your calendar year deductible, JBT Medical pays its share of covered medical expenses as shown below up to the lifetime benefit limit. The amount JBT Medical pays depends on whether you use preferred providers.

- Preferred providers for:
  - Inpatient hospitalization 100%
  - All other services including outpatient hospital care 80%
- Non-preferred providers—all services 70%

What You Pay—Calendar Year Out-of-Pocket Maximum

Once JBT Medical pays its share of the medical charges, you pay the rest. When the amount you pay, including the deductible, reaches the calendar year out-of-pocket maximum, JBT Medical will pay 100% of Covered Expenses for the remainder of the year (not to exceed the $1 million

lifetime benefit maximum). Your calendar year out-of-pocket maximum will depend on whether you use a preferred or non-preferred provider.

Calendar Year Out-of-Pocket Maximum	
Preferred Provider	**Non-Preferred Provider**
$2,000	$4,000

The out-of-pocket maximums are not combined. If you use both preferred and non-preferred providers, your annual out-of-pocket costs could be up to $6,000. Also note: your $20 preferred provider office visit copayment continues to apply even after you have met your annual out-of-pocket maximum.

When you use non-preferred providers, JBT Medical covers only Reasonable and Customary charges. **If your non-preferred provider charges are higher than Reasonable and Customary charges, you will be responsible for the excess. The excess will not count toward your calendar year out-of-pocket maximum.**

JBT Medical Plan Lifetime Benefit Limit

JBT Medical payments are limited to a lifetime maximum of $1 million. This maximum benefit applies to both mental health and physical health care combined.

Pre-authorization

With the JBT Medical Plan, you must obtain pre-authorization for certain procedures. If you do not obtain the required pre-authorization, your benefits may be reduced or not paid at all. Pre-authorization is required for:

Non-emergency admissions—you must call Blue Cross at least three working days before any non-emergency Hospitalization. **If you do not do so, your benefits will be reduced by 50%.** While pre-authorization is not required for pregnancy, JBT recommends that you call Blue Cross at least two months before the due date.

Medical Emergency admissions—you or your doctor must call Blue Cross as soon as possible after you are admitted to a hospital for a Medical Emergency.

Foot surgery—you must call JBT's Administrative Office, even if the surgery is planned on an outpatient basis.

Home health care—when home health care follows a hospital admission (which is usually the case), it must be pre-authorized by Blue Cross. In all other cases, have your doctor contact JBT's Administrative Office.

For pre-authorization by Blue Cross call 1-800-274-7767

For pre-authorization by the JBT's Administrative Office call 1-800-528-4357

Claims
When you use preferred providers, you do not have any claim forms to file; the preferred provider will do this for you. Payment will be made directly to the provider. Do not pay your portion of the bill until you receive an Explanation of Benefits from JBT showing what you owe. If you use non-preferred providers, you must file your own claims. For claims filing information, see Claims and Appeals Procedures beginning on page 120.

If You Are Eligible for Medicaid
If you are eligible for medical assistance under a state Medicaid plan, benefits provided under the JBT Medical option will not be reduced or denied based on your eligibility for Medicaid coverage. JBT Medical will reimburse the state Medicaid plan for the cost of any Covered Expenses paid by Medicaid that would have been payable by JBT Medical.

What's Covered?

Physician Office Visits

When you see the Doctor, the benefits payable will depend on whether you use a preferred or non-preferred physician. When you visit a preferred physician's office, some of the services you receive will be subject to a $20 copayment and JBT Medical will pay the balance. Other services are payable at 80% after you meet your deductible and do not require a $20 copayment. The chart below shows which services qualify for the $20 copayment.

Office Visit—Preferred Physician		
Description of service	**$20 Copayment**	**Payable at 80%**
Examination or consultation	✓	
Lab work:		
▪ Done in Doctor's office, including draw fees/handling charges if specimen sent out for analysis	✓	
▪ Laboratory services not performed in the Doctor's office		✓
Specimen taken in Doctor's office, such as a Medically Necessary pap smear or tissue culture	✓	
Diagnostic tests such as X-rays (including chiropractic), nerve conduction studies, and allergy testing		✓
Injections:		
▪ Intramuscular injections such as antibiotics, allergy or pain	✓	
▪ Intravenous injections		✓
▪ Surgical injections into joint, bursa, trigger points		✓
Surgery including incisions, excisions, repairs and punctures		✓
Chiropractic Treatment charges for manipulations, procedures and physical therapy but only if rendered by or under the direction of a chiropractor	✓	
Physical therapy (not part of Chiropractic Treatment)—when prescribed by a Physician and rendered by a Registered Physical Therapist (RPT)		✓
Chemotherapy		✓
Radiation therapy		✓
Hemodialysis		✓
Durable medical equipment		✓

Note: services subject to the $20 copayment include related supplies.

The preferred physician office visit copayment is not subject to the deductible, but it will apply whenever you receive any of the services for which there is a checkmark under "$20 Copayment" in the chart above, even after you reach your annual out-of-pocket maximum. **You should not pay the $20 copayment at the time of the visit.** It will be deducted from your benefits when the claim is processed. Your Explanation of Benefits (EOB) will show the amount you owe your physician.

If you visit a non-preferred physician's office, the services you receive are payable at 70% of the Reasonable and Customary charges, which means benefits are paid at a much lower level.

A Physician office "visit" is a personal interview between the patient and the Doctor, or services billed as part of the Doctor's care. Visits do not include telephone calls or other situations where you are not personally examined by the Doctor or directly under the care of the Doctor.

Routine physical examinations are not covered.

Note: Mental health expenses are covered separately under the mental health benefits described starting on page 73

HEALTHSMART TIPS

- If you or a dependent needs to see a doctor, call the doctor's office to be sure a visit is necessary.
- Use preferred doctors whenever possible, and select a family or personal doctor who can get to know your medical history.
- If your favorite doctor is not a preferred doctor, ask your doctor if he or she is interested in being part of the Blue Cross preferred network.
- If your preferred doctor draws blood or takes a specimen during your visit to send to an outside laboratory for analysis, be sure to request that it be sent to a preferred laboratory. Also, be sure to use a preferred provider if your doctor refers you for further tests. Otherwise, benefits are payable at the non-preferred level.
- Use hospital emergency rooms only for Medical Emergencies. Using the emergency room for non-emergencies drives up JBT Medical costs.
- Call JBT's Administrative Office to find out about getting pre-authorization for podiatric procedures. Many podiatric procedures are for treatment of chronic foot conditions that are not covered by the JBT Medical option (for additional exclusions and limitations, see What's Not Covered? under JBT Medical beginning on page 69 and General Plan Exclusions and Limitations beginning on page 108) .

Hospital Benefits

Overview

- **Pre-authorization—Non-emergency admissions to a Hospital must be pre-authorized three days in advance or benefits will be reduced by 50%.**
- **Outpatient Surgery—Benefits for outpatient surgery at a non-preferred hospital will be reduced by 50%.**
- Preferred facilities—Use preferred hospitals listed in the Blue Cross directory. Except for Emergencies and some out-of-area care, benefits are lower if you do not use a preferred hospital
- Benefits

Inpatient	Preferred	100%
	Non-preferred	70%
Outpatient	Preferred	80%
	Non-preferred*	70%

*** An additional 50% penalty applies if you use a non-preferred facility for non-emergency outpatient surgery.**

Hospital Pre-Authorization

If you or a covered dependent will be admitted to a Hospital for any reason (except for mental health), YOU MUST CALL BLUE CROSS FOR PRE-AUTHORIZATION at 1-800-274-7767 within the following time periods:

- **Non-emergency admissions—call Blue Cross at least three working days before any non-emergency admission to a Hospital.**
- **Medical Emergency admissions**— you or your doctor must call Blue Cross as soon as possible after you are admitted to a Hospital for a Medical Emergency.
- **Pregnancy**—JBT recommends that you call Blue Cross at least two months before the due date.

The purpose of hospital pre-authorization is to ensure you are receiving care in the most appropriate setting. In some cases, a lower cost alternative to the treatment or service you are considering may be appropriate. For example, some routine surgical procedures can be safely performed on an outpatient basis—you may not need hospitalization for effective treatment.

Blue Cross does not certify your eligibility for JBT Medical coverage or determine your benefits. If you have questions about eligibility or coverage, call JBT's Administrative Office at 1-800-528-4357 (1-800-JBT-HELP).

You do not have to contact Blue Cross for outpatient lab tests, X-rays, or emergency room visits if you are not admitted to the Hospital. Do not call Blue Cross if you are enrolled in an HMO (in this case, call your HMO directly—for contact information, see Important Phone Numbers beginning on page 1).

How Hospital Pre-authorization Works

You or your Doctor must call Blue Cross at least three days before a scheduled admission. If you call, identify yourself as a Blue Cross member covered through Joint Benefit Trust and give:

- Your name and Social Security number or Blue Cross identification number
- The patient's name, address, and birth date
- The names, addresses, and telephone numbers of the doctor and the hospital
- The reason for hospitalization

If you have your doctor call, be sure to follow-up. **REMEMBER—IT IS YOUR RESPONSIBILITY** to make sure your admission is pre-authorized. You should receive a letter at the address you have supplied to JBT letting you know whether your admission has been authorized. If you do not receive such a letter, you can check on the status of your authorization by calling 1-800-274-7767. If Blue Cross requests that you get a second opinion, the cost for the second opinion will be paid for in full.

When Benefits May Be Reduced

If you do not contact Blue Cross at least three working days before a non-emergency hospital admission, your hospital benefits will be reduced by 50%, even if your treatment is Medically Necessary. In addition, the extra amount you pay because of the 50% reduction in benefits will not apply toward your calendar year (preferred or non-preferred) out-of-pocket maximum.

No benefits will be payable for a hospital stay that Blue Cross determines is not Medically Necessary, including days spent in the Hospital that are not certified as necessary.

Covered Hospital Charges

JBT Medical shall pay benefits for days in the Hospital certified by Blue Cross as Medically Necessary. In the case of a non-emergency admission, the stay must be pre-authorized (see above). Benefits are provided for semi-private accommodations, or, when Medically Necessary, in an Intensive Care Unit (ICU), a Cardiac Care Unit (CCU), a definitive care bed or a private room in a Hospital. If it is not Medically Necessary for the patient to be placed in an ICU, CCU, a definitive care bed or a private room, an allowance for the Hospital's highest rate for a room of two or more beds, or the preferred provider Contract Rate for same, whichever is less, will be provided for the private room or unit occupied. The excess will not be a Covered Expense.

Preferred and Non-Preferred Hospital Benefits Compared

If you are admitted to a Hospital, the benefits you receive will depend on whether you use a preferred or non-preferred hospital. If you are hospitalized at a preferred hospital, JBT Medical will pay 100% of covered charges after you satisfy the calendar year deductible. If you live in an area where a preferred hospital is available and you are admitted to a non-preferred Hospital for non-emergency treatment, you will pay more out of pocket for covered treatment and services than if you had used a preferred hospital. That's because, when you use non-preferred hospitals, after you meet the higher non-preferred deductible, JBT Medical pays only 70% of charges for covered inpatient treatment and services. There are some exceptions when treatment at a non-preferred hospital is paid on the same basis as at a preferred hospital.

- **Medical Emergency**—In the case of a Medical Emergency, you should always go to the nearest Hospital or medical facility. The benefit coverage for Medical Emergencies at non-preferred hospitals is the same as the benefit coverage at preferred hospitals. For more information on Medical Emergencies, see page 62.
- **Treatment Outside Preferred Provider Service Area—**If you live outside an area served by the preferred provider hospital network, you will be eligible for preferred provider level of benefits. If there is no preferred hospital serving your community, call JBT's Administrative Office or log on to the Blue Cross website at www.bluecrossca.com to determine if you live in a ZIP code area served by a preferred hospital. If you are traveling outside the service area and hospitalization cannot be delayed until you return without jeopardizing your health or potentially causing serious or permanent impairment, benefits will be paid at the preferred provider level.
- **Transfer to a Non-Preferred Hospital**—If you are transferred with Blue Cross' authorization from a preferred hospital to a non-preferred Hospital because you cannot get needed services at the preferred hospital, your benefit coverage will be at the preferred benefit level.

Here's an example of what you can save by going to a preferred Hospital. In this example, assume that you have not yet satisfied any of your annual deductible.

	Preferred Hospital	Non-Preferred Hospital
Hospitalization cost	$12,000	$12,000
Less preferred provider discount	(4,000)	-0-
Contracted amount (preferred) or billed charge (non-preferred)	$8,000	$12,000
JBT Medical pays	100% of contracted amount after you satisfy your annual in-network deductible ($200). So, JBT Medical pays $7,800 ($8,000 - $200 deductible = $7,800).	70% of billed charge after you satisfy the non-preferred deductible ($400). So, JBT Medical pays $8,120 ($12,000 - $400 = $11,600 at/70% = $8,120).
You pay	$200 deductible.	$400 deductible + 30% copayment (30% of $11,600 = $3,480). So, you pay $3,880.

In this example, you would save $3,680 by using a preferred Hospital!

HEALTHSMART TIPS

Use a preferred hospital whenever possible for non-emergency care (for a list of preferred hospitals, call JBT's Administrative Office).

Outpatient Care and Ambulatory Surgical Facilities

JBT Medical pays 80% of the covered charges made by a preferred hospital or ambulatory surgical facility. JBT Medical pays 70% of the covered charges billed by a non-preferred hospital or facility. **EXCEPTION: If you go to a non-preferred hospital or ambulatory surgical facility for a non-emergency surgical procedure your benefits will be further reduced by an additional 50%. The extra amount you pay because of this further 50% reduction in benefits will not apply toward your calendar year non-preferred out-of-pocket maximum.**

Maternity Hospitalization Benefits

Inpatient hospital stays for the mother or newborn child are covered for at least:

- 48 hours following a normal delivery
- 96 hours following a cesarean section

No authorization is needed from Blue Cross to be covered for these periods of time, but longer stays do require Blue Cross' authorization. The attending physician, after consulting with the mother, may discharge the mother and her newborn child earlier than 48 hours (or 96 hours, as applicable). You or your physician should notify Blue Cross prior to being admitted to the hospital or as soon after admission as possible.

If you have coverage provided through an HMO, state law minimum benefit requirements will also apply. For additional details, see your HMO materials.

Skilled Nursing Facility

JBT Medical covers admissions to a Skilled Nursing Facility on the same basis as an inpatient hospital admission so long as the stay:

- Is approved by Blue Cross as Medically Necessary
- Follows confinement as an inpatient at a Hospital
- Treats the same condition for which you were hospitalized

Medical Emergency Benefits

If you have a Medical Emergency, you should always seek immediate treatment at the nearest medical facility as quickly as possible. Benefit coverage for Medical Emergencies is the same for preferred and non-preferred doctors and hospitals.

- **Emergency Room/Urgent Care Center**—JBT Medical pays 80% of the covered cost of medical treatment in an emergency room or Urgent Care Center. Use the hospital emergency room only for Medical Emergencies. If you use the emergency room or Urgent Care Center for non-emergency treatment, JBT Medical will only pay 70% of the covered cost at a non-preferred facility.

  If you are admitted directly to the Hospital from the emergency room, benefits will be paid at the applicable inpatient hospital level.

- **Ambulance**—JBT Medical pays 80% of the covered cost of emergency ambulance transportation. Non-emergency ambulance transportation furnished by a non-preferred provider is covered at 70%.

HEALTHSMART TIPS

Use the hospital emergency room only for Medical Emergencies. If you need to see a Doctor for a non-emergency, schedule an appointment. Emergency room service is extremely expensive and drives up JBT Medical Plan costs.

Surgery Benefits

JBT Medical pays 80% of the covered fees charged by a preferred surgeon after you meet the deductible. Except in the case of a Medical Emergency, the benefit is reduced to 70% if a non-preferred surgeon is used. Separate charges for a surgeon's visit made in connection with or on the day of a surgical operation are not covered. (Such visits are considered as part of the allowance for the surgical procedure.) Other important JBT Medical rules affecting surgical benefits are:

- **Anesthesia—**Paid on the same basis as the surgeon
- **Assistant Surgeon—**Same basis as the principal surgeon except Covered Expenses are limited to 20% of the allowance for the principal surgeon
- **Cosmetic Surgery—NOT COVERED** unless required to repair or alleviate damage from an accident or injury and performed within a reasonable time after the accident or injury
- **Reconstructive Surgery after Mastectomy—**JBT Medical pays benefits for reconstructive breast surgery following a mastectomy on the same basis as any other surgical treatment. Covered treatment includes:
  - All stages of reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas
- **Foot Surgery**—**Call JBT's Administrative Office to pre-authorize podiatric (foot) surgery, even if planned on an outpatient basis.**
- **Second Opinion—**JBT Medical pays 100% of the covered expense for a second opinion, including x-ray and laboratory tests provided the second opinion is:
  - For a surgical procedure covered by JBT Medical, and
  - Obtained from a specialist who does not subsequently do the surgery.

HEALTHSMART TIPS

If your doctor tells you or a dependent that non-emergency surgery is required, you will get maximum benefits if you remember to:

- Make sure you are referred to a preferred surgeon.
- Use a preferred hospital or ambulatory surgical center for your surgery. All preferred doctors can admit you to a preferred hospital, but sometimes they may not. You need to make sure your preferred doctor has arranged to use a preferred hospital or a preferred ambulatory surgical facility. Some non-preferred doctors—including some surgeons and specialists—cannot practice at preferred hospitals. So if you go to a non-preferred doctor, there is a chance that he or she cannot admit you to a preferred hospital. If you use a non-preferred hospital, you will pay more of the hospital's charges. For more information, see Hospital Benefits beginning on page 58.
- Find out if your surgery can be done on an outpatient basis. Many non-emergency surgical procedures can be performed safely and conveniently for the patient without an overnight stay in the hospital. Because outpatient surgery is less expensive, it saves money for both you and JBT.
- If your doctor recommends inpatient hospitalization for surgery, **you or your doctor must call Blue Cross and have the stay pre-authorized.** Blue Cross will review your case with your doctor to determine if the surgery is necessary. **Otherwise, your hospital benefits will be reduced by 50%.** For more information, see Hospital Pre-Authorization, beginning on page 58.

Laboratory

JBT Medical pays 80% of covered charges incurred at a preferred laboratory and 70% of covered charges at a non-preferred laboratory. Make sure your doctor refers you to a preferred laboratory for tests and uses a preferred laboratory to evaluate a sample drawn in the office. Tests that are part of a routine physical examination are not covered.

X-rays and Diagnostic Imaging

JBT Medical pays 80% of covered charges for Medically Necessary X-rays and diagnostic imaging done by preferred providers and 70% of covered charges billed by non-preferred providers. When you need X-rays or other diagnostic imaging, make sure your doctor refers you to a preferred facility and specialist. **X-rays that are part of a routine physical examination are not covered.**

Home Health Care

Home health care typically involves either infusion therapy or post-operative care given at your home. **Home health care is covered only if it is pre-authorized. When this care follows a hospital admission, which is normally the case, it must be authorized by Blue Cross. In all other cases, have your doctor contact JBT's Administrative Office to obtain authorization.**

JBT Medical pays 80% of the covered cost of pre-authorized home health care furnished by a preferred provider and 70% of covered charges when such care is furnished by a non-preferred provider.

Chiropractic Treatment Benefit

The Chiropractic Treatment benefit is available to you and your eligible dependents through Landmark Healthcare (formerly Pacific Chiropractic Resources). "Chiropractic Treatment" refers to any treatment provided, supervised, or directed by a licensed chiropractor (including neuromuscular and physical medicine) incurred while under the care of a chiropractor, even if prescribed by a Doctor of medicine and/or performed by a licensed physical therapist.

If you are enrolled in an HMO, chiropractic coverage may be available through your HMO; you are not eligible for chiropractic benefits through Landmark Healthcare.

Chiropractic Treatment Benefit at a Glance

The following chart provides an overview of the Chiropractic Treatment benefit.

Chiropractic Treatment Benefits at a Glance		
	When You Use LANDMARK Chiropractors	**When You Use Non-LANDMARK or Non-Blue Cross Chiropractors**
Covered Expenses	Benefit pays up to $50 per day after you pay $20 office visit copayment	Benefit pays 70% up to $50 per day after the non-preferred deductible is met
Claim forms	You do not have to file claim forms	You must file claim forms
Benefit limits	$680 calendar year maximum benefit (Landmark and non-Landmark chiropractors combined)	

How the Chiropractic Treatment Benefit Works

Each time you need chiropractic care, you choose whether to visit a Landmark or a non-Landmark chiropractor. The benefit pays a maximum of $50 per day. Your total benefits are limited to $680 each calendar year for Landmark and non-Landmark chiropractors—you cannot receive $680 in Landmark chiropractic benefits and an additional $680 in non-Landmark chiropractic benefits.

If both you and your spouse are covered under the JBT Medical option as employees of a Participating Employer, your total calendar year Chiropractic Treatment benefit is $680 per person. If your spouse has employer-paid coverage outside of JBT and your spouse is enrolled in both his or her employer's plan and the JBT Medical option, your spouse will receive Chiropractic Treatment benefits through Landmark of up to a total of $680 per calendar year (totaling benefits received under both your spouse's employer's plan, if applicable, and Landmark).

Network Benefits

JBT has negotiated special guaranteed rates with Landmark Healthcare and other preferred chiropractors. Landmark chiropractors have agreed to provide services at discounted rates for JBT Medical participants. When you use Landmark chiropractors, your out-of-pocket expenses are likely to be lower than if you use non-preferred chiropractors and, since the cost of services is discounted, you can get more treatment done within the $680 annual limit. If you visit a Landmark chiropractor or a chiropractor who is part of the Blue Cross network, you pay the first $20 and the Plan pays 100% of the remaining Covered Expenses up to a maximum of $50 per day until you reach the calendar year Chiropractic Treatment benefit limit of $680.

For a list of preferred chiropractors in your area, contact JBT's Administrative Office.

Non-Network Benefits

If you visit a non-Landmark or non-Blue Cross chiropractor, the Chiropractic Treatment benefit pays 70% of Covered Expenses (after the higher non-preferred deductible is met), up to $50 per day until you reach the calendar year Chiropractic Treatment benefit limit of $680. You must file a claim form to be reimbursed.

For more information on filing claims, see Claims and Appeals Procedures beginning on page 120.

Hospice Benefits

If you or one of your dependents is terminally ill—in other words, diagnosed with a life expectancy of six months or less—JBT Medical provides coverage for Hospice care as an alternative to hospitalization. JBT Medical pays 100% of Covered Expenses incurred under an Approved Hospice Care Program, including family counseling.

Hearing Aid Benefits

The JBT Medical option covers:

- One hearing exam per ear every three years:
  - Includes testing, hearing aid evaluation and fitting
  - Covered up to the Reasonable and Customary cost
- One hearing aid device for each ear every three years, with a maximum benefit of $500 per ear during that three-year period

Note: The hearing exam and aid benefit is available for the covered employee only. Dependents are not eligible for hearing exam or hearing aid benefits.

Mammography Benefits

JBT Medical covers 100% of the cost up to a maximum of $75 for an annual screening mammogram for female employees and female spouses age 40 and over.

Chronic Disease Management Program

If you are enrolled in the JBT Medical option, JBT offers a Chronic Disease Management Program for:

- Diabetes
- Heart failure
- Coronary artery disease, and
- Asthma

If you or your covered dependents have been diagnosed by a physician as having one or more of these four diseases and you are enrolled in JBT Medical, you may be eligible for this program (HMO participants are not eligible). For information about the program, call 1-877-743-6824.

The program offers telephonic support and education by specially trained registered nurses to people with these chronic diseases. The program provides the tools and support to help you learn how to effectively manage your disease. The nurses are not a replacement for the care provided by the physician, but rather an additional support to you and your physician to assist you toward effective self-management. The program can help you improve your health, your quality of life and save you money in health care costs. The program services are paid for by the Trust. All other medical services that you receive for your disease are paid for according to your current covered benefits.

Other Covered Medical Expenses

Under the JBT Medical option, covered medical expenses may also include charges for:

- The services of a registered nurse (RN) or registered or licensed physical therapist, speech therapist, or occupational therapist not related to you or your dependents by blood or marriage. Services received from a massage therapist are not covered
- Professional ambulance service
- Drugs and medicines requiring a Doctor's prescription administered during Hospital confinement
- Anesthetics, oxygen, and other necessary medical supplies
- Blood serum and plasma
- The rental of an iron lung and other durable medical equipment that is Medically Necessary for therapeutic treatment
- Orthopedic repositioning appliances in lieu of surgery for correction of temporomandibular joint dysfunction (TMD)

- Initial artificial limbs or eyes replacing natural ones lost and one replacement of an artificial limb or eye (limited to one replacement every three years for children under age 18)
- Dental services and supplies needed to repair damage to natural teeth, provided the damage resulted from an accident that occurred at any time
- Dialysis treatment, radiation and chemotherapy treatment
- Allergy testing
- Reconstructive surgery to restore or improve bodily functions if necessary to maintain patient's health due to illness, injury, or medical condition
- Certain medical supplies prescribed by a Doctor and/or necessary for the treatment of covered illnesses or conditions. Supplies that are generally covered include oxygen, colostomy supplies, certain braces, cervical collars, catheters, etc. Many supplies are not covered—see What's Not Covered? for a list of some. Because of the complexity of this area, you should call JBT's Administrative Office before you purchase any supply not specifically listed above

What's Not Covered?

JBT Medical does not cover treatment and services that fail to meet the criteria defined as a Covered Expense. In addition, JBT Medical specifically excludes:

1. Surgeon's visits made in connection with, or on the day of, a surgical operation, or charges made by an assistant surgeon that exceed 20% of the Covered Expenses from the primary surgeon
2. Private hospital rooms, unless isolation is certified as Medically Necessary by a Doctor
3. Hospital stays beyond those approved by a Doctor or any stay that is solely for the convenience of the patient
4. Weekend hospital admission, except in the case of a Medical Emergency
5. Any hospital stay that Blue Cross determines is not Medically Necessary
6. Any hospital or medical service furnished without charge by a Hospital or facility operated by the United States government or any authorized agency of it, or furnished at the expense of the U.S. government or its agency
7. Custodial Care
8. Routine physical examinations
9. Preventive care
10. Well-baby care
11. Routine eye examinations and eyeglasses (covered separately under vision benefits)
12. Tests and X-rays used for purposes other than diagnosing illness or injury
13. Dental X-rays unless performed because of an accidental injury (covered separately under dental benefits)
14. Alcohol and drug rehabilitation (benefits provided separately under JBT drug and alcohol rehabilitation coverage)
15. Treatment for Mental or Nervous Disorders except as described under Mental Health Benefits, starting on page 73
16. Drugs and medicines not administered during hospital confinement (outpatient Prescription Drugs are covered under separate prescription drug benefits—see Prescription Drug Benefits, starting on page 84)
17. Vitamins
18. Routine nursery care

19. Expenses in connection with a dependent child's pregnancy
20. Expenses in connection with artificial insemination, in-vitro fertilization, or any form of assisted reproductive technology
21. Routine foot care such as callus or corn paring, toenail trimming, or for the diagnosis or treatment of weak, strained, unstable, or flat feet or for any tarsalgia, metatarsalgia or bunion (except for operations that involve the exposure of bones, tendons or ligaments) or for orthotic devices used in connection with the treatment of such chronic foot conditions
22. Cosmetic surgery except if it is required to repair or alleviate damage that is the result of an accident or injury, and is performed within a reasonable time after the accident or injury
23. Environmental equipment
24. A condition for which the eligible person is not under a Doctor's care
25. Charges for treatment of illness or injury that exceed Reasonable and Customary charges, or, when applicable, preferred provider Contract Rates, and charges in excess of those that would have been made in the absence of JBT Medical benefits
26. Expenses that the participant is not obligated to pay, such as expenses incurred under HMO coverage for which no charge would otherwise be made to the patient
27. Any Experimental medical or surgical treatment (see definition of "Experimental" on page 158)
28. Radial keratotomy or any surgical treatment to correct nearsightedness or farsightedness
29. Treatment related to change of gender
30. Smoking cessation programs
31. Expenses related to diet control, weight loss or physical conditioning, even if prescribed by a Doctor
32. Expenses related to total parenteral nutrition
33. Purchase of durable medical equipment, unless in the sole determination of JBT's Administrative Office, purchase is less expensive than rental
34. Services of a Licensed Vocational Nurse (LVN), except when provided as part of an approved program of Home Health Care Services
35. Home Health Care Services, unless pre-authorized by Blue Cross or JBT's Administrative Office

36. Any medical supplies and/or equipment that are not prescribed by a Doctor, and any medical supplies and/or equipment that are ordinary household medical supplies or that have a value to the patient in the absence of an illness, injury or condition, whether or not prescribed by a Doctor, including supplies such as bandages (other than Ace-type), bed pans, heat lamps, orthopedic mattresses and many other items (because of the complexity of this area, you should call JBT's Administrative Office before purchasing supplies)

For additional general exclusions and limitations that apply to all types of JBT Health and Welfare coverage, see General Exclusions and Limitations beginning on page 108

If You Are Disabled and Enrolled in the JBT Medical Option When Coverage Ends (Major Medical Extension of Benefits)

If you are Disabled and under the treatment of a Doctor on the day that all coverage under the Plan would otherwise terminate, the benefits provided under the JBT Medical option shall be extended for the treatment of the condition, illness or injury causing the Disability, but for no other condition, illness or injury, until the earliest to occur of the following:

- A maximum of 12 consecutive months
- You become covered with no limitations on the disabling condition under any other group plan
- The Disability ceases
- A period of no more than 90 days after the Plan itself is terminated or the JBT Medical benefits under the Plan are terminated

This extension of benefits for the disabling condition does not apply if you are enrolled in an HMO.

Note: If you are on leave for illness or Disability, your leave may be subject to the requirements of federal and/or California family and medical leave laws. For more information about the application of family and medical leave see page 15 and contact your employer or union.

***SPECIAL NOTE:** The JBT Medical Plan pays for a portion of the cost of your medical bills, but does not recommend a course of treatment based on what the JBT Medical Plan provides by way of coverage. Treatment decisions are made by you and your medical providers.*

MENTAL HEALTH BENEFITS

Mental Health Benefits

JBT provides mental health coverage for you and your covered family members through Managed Health Network (MHN), an independent company. MHN works through its network of Mental Health Practitioners, private practice clinics, day or evening hospitals, intensive outpatient or therapeutic care facilities, and inpatient hospitals to ensure that your treatment goes as planned. **NOTE: if you are enrolled in Kaiser, you are not eligible for MHN mental health benefits. Instead, your mental health coverage is provided directly by Kaiser.**

The description that follows provides general information about your mental health benefit. A complete description of the benefit is contained in the Evidence of Coverage (EOC) issued by MHN and the related Group Agreement between MHN and the JBT. These documents may be obtained by contacting MHN at 1-800-JBT-0646 or JBT's Administrative Office at 1-800-JBT-HELP. The EOC and Group Agreement, which may be amended from time to time, are the binding documents between MHN and covered participants. If there is a difference between these documents and the general information provided below, the EOC and Group Agreement will prevail.

Mental Health Benefits at a Glance

The following chart shows how outpatient mental health benefits are paid:

Outpatient Mental Health Benefits	
Pre-authorization	REQUIRED for all outpatient services
Private Counseling Sessions:	
1-5 visits	100%
6-10 visits	100% after you pay $10
11-15 visits	100% after you pay $20
16-50 visits	100% after you pay $30
Group Counseling Sessions	100%
Calendar Year Benefit Limit	Benefits are limited to a combined total of 50 visits for private and group counseling per calendar year.
Out-of-Network Benefits	None

Inpatient Mental Health Benefits	
Calendar Year Deductible	None required
Inpatient Pre-Authorization	Required. **If you do not call MHN, no benefit will be payable except for emergency admissions and then only when MHN is notified within 24 hours of the admission. If MHN determines that hospitalization was not Medically Necessary, no benefit will be paid.**
Inpatient Psychiatric Care	100%
Physician Visit to Hospital	100%
Claim Forms	You do not have to file claim forms for Network Providers.
Out-of-Network Benefits	None, unless emergency treatment is authorized by MHN at a non-network provider.
Participants Enrolled in PacifiCare or Health Net	
Benefits for Treatment of a Child with: Severe Mental Illness Serious Emotional Disturbances	If you are enrolled in PacifiCare or Health Net, the benefits for the treatment of Severe Mental Illness or the Serious Emotional Disturbances of a Child shall be as described above or equal to your benefits under your HMO medical coverage, whichever is more favorable. Benefits for the treatment of other Mental Disorders or problems coping with life issues will be the same as for non-HMO participants.

Note: prior to September 1, 2004, limited benefits were paid for certain out-of-network treatment. For details, please contact JBT's Administrative Office.

How Your Mental Health Benefits Work

Overview

Mental health benefits provide coverage for the treatment of a Mental Disorder as well as help in coping with problems on the job, at school and in the home. These problems can include:

- Balancing work and family responsibilities
- Experiencing a loss
- Feeling depressed
- Stress and anxiety

How to Contact MHN

When you or a covered family member is experiencing a life problem that requires confidential, professional assistance, contact the Member Assistance Program (MAP) "Warm Line" at 1-800-JBT-0646 for treatment referral. MHN's trained staff will obtain some preliminary information, discuss the nature of your problem with you, and outline a plan of action for you to consider. This plan may include a referral to a Mental Health Practitioner in your area for further assessment and/or treatment. The telephone assessment is **strictly confidential** and cannot be shared with anyone without your written consent.

Claims

No claim forms are required for authorized treatment from an MHN network provider.

Claims for Approved Non-Network Emergency Services

To receive reimbursement for Emergency Services by a non-network facility, you must arrange for a copy of the report of the emergency (including clinical chart and notes), the itemized bill, and the receipt for the eligible participant's payment to be sent to the MHN Claims Department. For address information, see Claims Administrator Addresses beginning on page 135.

Claims Appeals

When you enroll in JBT Medical, PacifiCare HMO or Health Net HMO, you will receive a copy of MHN's appeals procedures automatically and at no charge. You may also request a copy of MHN's appeals procedures in writing or by calling MHN at 1-800-528-0646 (for address information, see Claims Administrator Addresses beginning on page 135). Grievance and Appeals procedures can also be found online at www.mhn.com under the Member Services section.

General Claims Filing Information

For general claims and appeals information, including claims filing addresses, see Claims and Appeals Procedures, beginning on page 120, or access information online at www.mhn.com under the Member Services section.

What's Covered?

Outpatient Benefits

If you or a covered family member needs outpatient counseling or treatment, you can receive a combined total of up to 50 private and group counseling sessions each calendar year, provided the treatment is determined by MHN to be Medically Necessary. **PLEASE NOTE: All treatment must be pre-authorized by MHN and delivered through an MHN-contracted provider to be considered eligible for coverage**. Consult the chart beginning on page 73 for the schedule of copayments for outpatient services. Be sure to call the MAP "Warm Line" at 1-800-JBT-0646 before seeking treatment. That way your treatment will be pre-authorized and you will be directed to an MHN network provider.

Inpatient Benefits

Pre-authorizations

You must call MHN at 800-JBT-0646 to obtain pre-authorization for all mental health inpatient or alternate care hospital/facility admissions. No benefits will be paid if you fail to obtain this pre-authorization. When you call, there will be a preliminary assessment and, if appropriate, you will be referred to a network clinician who, in conjunction with MHN will determine the need for hospitalization. If hospitalization is required you will be admitted to a network facility for your treatment. Consult the chart beginning on page 73 for the schedule of benefits for inpatient services. Remember, there are no benefits for out-of-network treatment.

Emergency Services

If you are experiencing severe symptoms and are impaired in your functioning to the extent that you present an immediate danger to yourself or others, it is an Emergency. If you are in crisis and need immediate assistance, call the 911 emergency response system or go to the nearest emergency room. MHN's counselors also are available 24 hours a day, 365 days a year for immediate telephone intervention. In an emergency, pre-authorization for treatment is not required during the first 24 hours.

However, to be covered for treatment after the first 24 hours, you, your provider or a family member must contact MHN immediately so that the Medical Necessity and clinical appropriateness of the current level of care can be evaluated. MHN may limit coverage to services and supplies rendered by MHN network providers if MHN determines that transfer to such a provider is medically appropriate.

Health Net and PacifiCare Participants—Benefits for Severe Mental Illness and Serious Emotional Disturbances of a Child

Whenever this Plan covers the diagnosis and treatment of Medically Necessary services for Severe Mental Illness of a person of any age and Serious Emotional Disturbances of a Child, your copayments, deductibles, and annual and lifetime maximums will be the more favorable of:

- The benefits as described above, or
- The benefits provided by Health Net or PacifiCare for the treatment of a physical condition, provided that the treatment is done by a MHN-participating Mental Health Practitioner.

The benefits for other Mental Disorders and for coping with life issues are as described above.

What's Not Covered?

This section describes the services and treatments MHN does not cover. This list is not exhaustive; other limitations and exclusions may apply. Please read these limitations and exclusions carefully before seeking any counseling or treatment through MHN. Please note that some of the services and treatments not covered by MHN may be covered by JBT Medical, an HMO and/or the Teamsters Alcohol Rehabilitation Program (TARP).

MHN does not provide benefits for:

- Treatment of detoxification in newborns
- Treatment of congenital and/or organic disorders. This includes, without limitation, Alzheimer's Disease, Mental Retardation (other than the initial diagnosis), Organic Brain Disease, Delirium, Dementia, Amnesic Disorders and Other Cognitive Disorders as defined in the DSM
- Treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders
- Treatment of obesity and eating disorders unless otherwise required by law (this does not include the diagnosis of anorexia and bulimia nervosa as defined in DSM)
- Court-ordered testing and treatment
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN is obtained
- Ancillary services such as:
  - Vocational rehabilitation
  - Behavioral training
  - Speech or occupational therapy

- Sleep therapy and employment counseling
- Training or educational therapy for reading or learning disabilities
- Other education services;

- Testing, screening or treatment for:
  - Learning Disorders, Expressive Language Disorders, Mathematics Disorder, Phonological Disorder and Communication Disorder NOS
  - Motor Skills Disorders and Developmental Coordination Disorder
  - Disorders resulting from general medical conditions, including but not limited to Catatonic Disorder Due to General Medical Condition, Personality Change Due to General Medical Disorder, Narcolepsy, Stuttering, Stereotypic Movement Disorders, Sleep Disorders, TIC Disorders, Elimination Disorders, Sexual Dysfunctions, Primary Insomnia
  - Personality Disorders
  - Pedophilia
  - Primary Sleep Disorders, Primary Hypersomnia, and Dyssomnia NOS
  - Age-Related Cognitive Decline;
- Treatment of conditions that are medical in nature, even when such conditions may have been caused by a Mental Disorder
- Treatment by providers other than those within licensing categories then recognized by MHN as providing Medically Necessary Services according to applicable medical community standards
- Treatment rendered for conditions not listed as an Axis I disorder (V Code diagnoses listed as an Axis I disorder are also excluded unless otherwise specified in the Plan)
- Services in excess of those with respect to which authorization by MHN is obtained
- Psychological testing except as authorized by MHN and conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports
- Missed appointments. MHN will consider one of the participant's counseling sessions used if the participant fails to cancel with the provider at least 24 hours in advance, unless the appointment is missed because of a Medical Emergency or circumstances beyond the participant's control.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a psychiatrist in connection with inpatient treatment

- Medication management or other pharmacological services rendered by a non-psychiatrist provider
- Inpatient services, treatment, or supplies rendered without authorization, except in the event of services and care for Emergencies
- Healthcare services, treatment, or supplies rendered in a non-Emergency by a provider who is not a participating provider, unless authorization by MHN has been received or as otherwise provided by the Plan
- Damage to a Hospital or facility caused by the participant
- Healthcare services, treatment or supplies determined to be Experimental by MHN according to accepted mental health standards, except as otherwise required by law
- Healthcare services, treatment or supplies:
  - Provided as a result of any Workers' Compensation law or similar legislation
  - Obtained through, or required by, any governmental agency or program
  - Caused by the conduct or omission of a third party for which the participant has a claim for damages or relief
- Healthcare services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental healthcare programs
- Treatment for biofeedback, acupuncture or hypnotherapy
- Healthcare services, treatment, or supplies rendered to the participant that are not Medically Necessary services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or domiciliary care as determined by MHN.
- Services received before the participant's effective date, or services received after the participant's coverage ended, except as specifically stated herein
- Services:
  - That the person is not legally obligated to pay
  - For which no charge is made to the person
  - For which no charge is made to the person in the absence of insurance coverage
  - That are provided without cost to the person by a local, state or federal government agency
- Services in connection with conditions caused by an act of war
- Conditions caused by release of nuclear energy, whether or not the result of war
- Emergency room services not provided by a psychiatrist directly related to the treatment of a Mental Disorder in accordance with the limitations listed above

- Professional services received from a person who lives in the participant's home or who is related to the participant by blood or marriage
- Any services or supplies to the extent they are covered under Parts A or B of Medicare if either:
  - The participant is enrolled in Part A of Medicare, whether or not the participant is enrolled in Part B of Medicare, or
  - The participant is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System, whether or not the participant has actually enrolled in Medicare or claimed Medicare benefits
- Services performed in any emergency room that are not directly related to the treatment of a Mental Disorder
- Electro-Convulsive Therapy (ECT) except when authorized by MHN according to MHN policies and procedures
- All other services, confinements, treatment or supplies not provided primarily for the treatment of specific covered benefits outlined above

Definitions

As used to describe your mental health benefits, the terms below have the following meaning:

Severe Mental Illness includes the following diagnoses: schizophrenia; schizoaffective disorder; bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa.

Serious Emotional Disturbances of a Child is defined as a child who:

1. Has one or more mental disorders as defined by the DSM, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
2. Is under the age of eighteen years old; and
3. Meets one or more of the following criteria:
    A. As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: (i) the child is at risk of removal from the home or has already been removed from the home; (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
    B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
    C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code).

Mental Disorder is a disorder that meets all of the following conditions:

1. It is a clinically significant behavioral or psychological syndrome or pattern
2. It is associated with a serious symptom such as distress
3. It impairs a patient's ability to function in one or more major life activities
4. It is a condition listed as an Axis I Disorder (except for V-codes) of the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and is not solely a character disorder (Axis II) or for personal exploration, desire for self-fulfillment or forensic evaluation

Mental Health Practitioner means a psychiatrist (Medical Doctor); a clinical psychologist; a marriage, family or child counselor; a certified social worker or such other person as may be designated by MHN, if such Mental Health Practitioners are licensed by the proper authorities of the state in which they practice; and they are practicing within the scope of their license.

For the definition of other capitalized terms, see the group agreement between MHN and the Trust.

PRESCRIPTION DRUG BENEFITS

Your JBT Prescription Drug Coverage

The Prescription drug program is administered by JBT's Pharmacy Benefits Manager, Caremark (formerly known as AdvancePCS), and is available to employees and their eligible dependents who are enrolled in the JBT Medical option.

Note: If you are enrolled in Kaiser, Health Net or PacifiCare, your prescription drug coverage will be provided through your HMO. HMO participants are not eligible for prescription drug benefits through Caremark. See the specific HMO's Evidence of Coverage for information on HMO prescription drug coverage.

Prescription Drug Benefits at a Glance

Prescription drug benefits are paid at 100% after you pay the copayment shown below. Note: If you receive a brand-name Drug for which a generic equivalent exists, you must pay the difference in cost in addition to the brand-name copayment. You must also pay a $15 penalty for non-preferred Drugs. The following chart summarizes what you pay.

Drug Type	**Retail** **(up to 30-day supply)**	**Mail-Order** **(up to 90-day supply)**
Generic	$10 copayment	$20 copayment
Preferred Brand-Name	$20 copayment	$40 copay
Non-Preferred Brand-Name	$20 copay + $15 penalty	$40 copay + $30 penalty
Note: If you receive a brand-name Drug (whether preferred or not) for which a generic equivalent exists, you must pay the difference in cost between the two Drugs, in addition to the applicable brand-name copayment.		

How the Prescription Drug Program Works

Overview

You may obtain Prescription Drugs:

- At a participating retail pharmacy using your Prescription Drug Program ID card
- Through the mail, using the mail-order program

When you use the mail-order program, you receive a higher level of benefits because the copayment applies to a full 90-day supply as compared to the 30-day supply covered at the retail pharmacy. Whether you fill your prescription at a retail pharmacy or through the mail-order program, the amount you pay depends on whether the Drug is preferred or non-preferred, generic or brand-name.

Preferred Drugs

JBT's list of preferred drugs is called a "formulary." The Drugs on this list have been selected by Caremark for safety, clinical effectiveness, and cost. When you receive your Prescription Drug ID Program Card (see below) you will also receive a list of "Commonly Prescribed Medications." All of the medications on this list are preferred. Check the list. While not every preferred drug is listed, the commonly prescribed ones are. IF YOU ARE TAKING A DRUG THAT IS NOT ON THE LIST, talk to your doctor to find out if one of the Drugs that is on the list is appropriate for you. You will save money if you use preferred drugs.

The list of preferred drugs changes from time to time based on the introduction of new Drugs and other developments in the prescription drug market. You may contact the Administrative Office or Caremark Member Services at 1-888-685-7752 to find out whether a particular Drug is on the JBT/Caremark formulary or to get an updated list of preferred drugs. If you are not satisfied with their determination, you can appeal to Caremark by following the appeals procedures, beginning on page 121. Your appeal should address why the Drug in question should be included in the JBT formulary or covered by an exception to the formulary.

Non-Preferred Drugs

A "non-preferred" drug is a Drug that is not on the preferred drug list. Non-preferred drugs are usually newer Drugs and can be more costly than preferred drugs. Since there are usually preferred drugs that are just as effective as their non-preferred counterparts, you pay a higher copayment when you choose a non-preferred drug. **When you fill a prescription for a non-preferred drug, you also pay a $15 penalty ($30 penalty if you receive a 90-day supply through mail-order program) in addition to your regular copayment.**

If you are taking a Drug that is not on the preferred list, you should ask your doctor if it is appropriate to change to a preferred alternative. If your doctor prescribes a non-preferred drug, your pharmacist may ask you if you are willing to switch to a preferred drug with your doctor's permission. If you agree, the pharmacist will contact your physician for approval to dispense a preferred alternative.

If your doctor believes that it is Medically Necessary for you to take a non-preferred drug, your doctor should get approval in advance by contacting Caremark at 1-800-294-5979 and filing an appeal. The appeal must include the medical justification for the non-preferred drug. If you are not satisfied with the initial determination made by Caremark, you can request reconsideration in accordance with Caremark's established appeals process. For details, see page 121.

Unless a non-preferred drug is pre-authorized by Caremark, you will pay the extra $15 retail or $30 mail order for the fill.

Generic Drugs and Generic Substitution

After the patent on a brand-name drug expires, other manufacturers may begin selling the Drug under its chemical or "generic" name. Generally, generic drugs cost less because they can be sold by more than one manufacturer. By buying the generic drug, you are saving money for both you and JBT and doing your part to help keep down the rising cost of health care.

If a brand-name drug is shown on the prescription, the pharmacist will automatically dispense a generic equivalent if one is available. At the time of purchase, if you request a brand-name drug when a generic equivalent is available, you must pay the difference in cost **in addition to your regular copayment. This applies whether you fill your prescription at a retail pharmacy or through the mail-order program.**

If no generic equivalent is available on the market, the benefit pays 100% of the cost for the brand-name drug after you pay your copayment.

Retail Pharmacy Benefit

Pharmacy Network

You can obtain Prescription Drugs from a network of participating pharmacies contracted through Caremark. The pharmacy network is nationwide and includes most major chains and many independents. To find the participating pharmacy nearest your home or work, call Caremark at 1-888-685-7752 or contact JBT's Administrative Office.

Supply Limits

Drugs purchased at a local pharmacy are limited to a 30-day supply. If you take maintenance medication and order through the mail-order program, you can receive up to a 90-day supply.

ID Cards

When you enroll in the JBT Medical option, you receive a Prescription Drug Identification Card ("Drug ID card") with your name and those of your dependents. **Participants are required to use their Drug ID card at the time of purchase. Drugs purchased without using the Drug ID card will not be covered.*** If you do not have a Drug ID card or if you need a mail-order form, contact JBT's Administrative Office at 1-800-528-4357.

* If you have other coverage and JBT is the secondary carrier, JBT will cover your prescription copayment
required under the primary plan.

Copayments

Participants are required to make the copayment at the time of purchase. For copayment amounts, see Prescription Drug Benefits at a Glance on page 84.

Claims

After you pay your copayment, the pharmacy will file a claim electronically using the information from your Drug ID card. If you do not use your Drug ID card, there is no benefit unless you are:

- A new participant and have not yet received your Drug ID card
- Traveling outside the country and do not have access to Caremark pharmacies
- Covered by other group insurance and are submitting a claim for secondary benefits

In these situations, file a claim with the JBT Administrative Office and include your drug receipt. Your benefit will be equal to 150% of the average wholesale cost of the prescription drug, plus $1.65 fill fee, or the actual charge made by the pharmacy or the amount not covered by the primary carrier, whichever is less.

For general claims and appeals information, including claims filing addresses, see Claims and Appeals procedures, beginning on page 120

Mail-Order Benefit

If you or your covered dependents use maintenance drugs (prescriptions used on an ongoing or long-term basis), the mail-order program saves time and money.

Supply Limits

You can order up to a 90-day supply for your maintenance drug through the mail-order program.

How to Fill a Prescription Through the Mail-Order Program

Using the mail-order program is simple. When you receive your Prescription Drug ID card, you will also get a supply of mail-order forms and envelopes. Just fill out the order form and enclose it with your prescription in one of the pre-addressed envelopes. If you run out of envelopes, simply mail or fax your order form and prescription to Caremark. You must complete the brief profile on the back of the order form so that your medication can be checked for possible drug interactions or allergic reactions.

Ordering Refills

With all mail-order prescriptions, you receive a refill notice that tells you how many refills are left on your prescription, if any. To order a refill, simply send your refill order no later than the date marked on the notice or call Caremark at 1-888-685-7752. Please allow 10 to 14 days for delivery.

There are important advantages to using the mail-order program to fill your prescriptions:

- The ease of delivery by mail
- The convenience of a 90-day supply
- The cost savings (you get a 90-day supply for the cost of a 60-day retail supply)

What's Covered?

The prescription drug benefit covers the following Medically Necessary Prescription Drugs and related Covered Expenses:

- Charges by a Licensed Pharmacist for Drugs prescribed by a licensed medical Doctor (other than a chiropractor or clinical psychologist) or Dentist
- Charges by a Doctor for any Drugs, insulin, or insulin injection kits supplied to the patient in the Doctor's office, and for which a charge is made separately from the charge for any other item of expense
- Charges for the following Drugs and preparations when prescribed by a Doctor for a condition that is covered under the Plan:

  Accutane

  Adhesive (for colostomy)

  Autoclix device (with letter from Doctor)

  Autoclix lancets

  Autolet kits

  AZT

  B-G chemstrips

  Benedict's solution or equivalent

  Betadine solution

  Colostomy bags (to include any ostomy-type bag)

  Compounded dermatological preparations, including ointments and lotions prepared by a pharmacist

  Culturette tube

  Diastix

Covered Drugs and preparations (continued)

Diabetic supplies, including insulin syringes, needles, sugar test tablets, sugar test tape, acetone test tape, acetone tablets, and glucometers,if Medically Necessary

Gloves

Glucagon (injectable

Insulin

K-Y jelly

Kerlix roll or similar products

Keto-Diastix

Retin-A—up to age 25 and by special authorization for age 25 and older

Skin preps (for colostomy, to include alcohol pads, adhesive remover, and other appropriate items)

Specimen container (to include jar-type containers and collection pouches for ostomies)

Sandimmune

Tes-Tape

Charges for any other Medically Necessary supplies

What Requires Pre-Authorization?

Because of their cost, possible side effects and potential for abuse, some Drugs will not be covered unless their use has been authorized by Caremark. To apply for authorization, your Doctor must contact Caremark at 1-800-294-5979. Caremark will review your case with your Doctor and determine whether the Drug should be authorized. The list of Drugs requiring pre-authorization may change from time to time. To obtain the most up-to-date list contact JBT's Administrative Office. Drugs currently requiring pre-authorization include:

Alprostadil
Aranesp
Arava
Avonex
Betaseron
Celebrex
Copaxone
Differin
Diflucan
Enbrel
Epogen
Geref Diagnostic
Growth Hormone
Intron A
Kineret
Lamisil
Leukine
Neulasta
Neupogen
Peg-Intron (peginterferon alfa-2b)
Procrit
Raptiva
Rebetol
Rebetron
Rebif (interferon beta-1a)
Remicade
Retinoids (Retin A, Avita Altinac, Tretinoin)
Serostim
Sporanox
Stadol
Tazorac
Wellbutrin
Xolair

In addition, coverage for Cialis, Levitra and Viagra is limited to a supply of 12 per month.

What's Not Covered?

The prescription drug benefit pays no benefits for the following:

1. Drugs that can be obtained without a Doctor's prescription, other than as listed above
2. Drugs taken or administered while a patient is in a Hospital (these Drugs are covered as a hospital expense under the JBT Medical option)
3. Blood and blood plasma (these items are covered under the JBT Medical option)
4. Biological serum Drugs
5. Appetite suppressants
6. Appliances, devices, bandages, heat lamps, braces, splints, and medical supplies other than those already listed
7. Contraceptives (prescription and non-prescription), including diaphragm
8. Drugs furnished or payable under any plan or law of any government agency or organization, Workers' Compensation law, or similar program
9. Drugs for which no charge is made
10. Drugs which are lost or stolen
11. Drugs prescribed for accidental bodily injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans Affairs to be service-connected
12. Drugs or medicines purchased and received subsequent to the enrollee's termination or prior to his/her enrollment
13. Therapeutic-devices or appliances, including hypodermic needles, syringes, support garments, and other non-medical substances (except insulin syringes)
14. Therapeutic and prenatal vitamins
15. Hair treatment prescriptions, including Rogaine and Minoxidil
16. Lancet devices
17. Cosmetic, health, or beauty aids
18. Prescription nicotine products, including Nicorette gum
19. Immunizing agents, biological sera, blood or blood plasma, or medication prescribed for parenteral use or administration, except insulin
20. Any Drug labeled "Caution: Limited by federal law to investigational use," or similar labeling, or any Experimental Drug, even though a charge is made

21. Abdec drops, Adeflor, Adipex-P, Aquasol A, Brevicon, Calinate FA, Cefol, Eldec, En-Cebrin F, Fenoprofen, Fergon Plus, Fero-Folic, Filibon FA, Filibon Forte, Flura-Drops, folic acid, Genora, Heptuna Plus, Iberet, Ircon FA, Larobec, Livitamin, Luride, Materna, Minoxidil, Mulvidren F, Natabec, Natafort, Natalins, Nicorette, Niferex, Pediaflor, Perihemin, Phos-Flur, Poly-Vi-Flor, Pramet, Pramilet FA, Pronemia, Rogaine, Rubramin PC, Stuartnatal, Supplical, Synkayvite, Tabron, Thera-Flur, Theragran Hematinic, Tri-Hemic 600, Tri-Immunol, Tri-Vi-Flor, Vicon Forte, Vi-Daylin (all forms), Viobec Forte, Vi-Penta F, vitamins, Zenate
22. Fertility Drugs
23. Drugs prescribed for conditions or treatments not covered under the JBT Medical option

For additional general exclusions and limitations that apply to all types of JBT Health and Welfare coverage, see General Plan Exclusions and Limitations beginning on page 108.

DENTAL BENEFITS

Your JBT Dental Coverage

Whether you enroll in HMO or JBT Medical coverage, you are eligible for the JBT dental coverage described in this section. JBT dental coverage provides limited benefits for procedures listed in the JBT Dental Table of Allowances. You will receive the Table of Allowances by mail at your last known address. You may also obtain the Table from JBT's Administrative Office or your Union, free of charge.

JBT Dental Coverage at a Glance

The following chart summarizes how JBT dental coverage works:

JBT Dental Coverage at a Glance	
Calendar Year Deductible	$50 for each covered individual No more than $100 for a covered family
Covered Expenses	Benefit pays 100% of scheduled amount for covered treatment and services that are: ▪ Necessary to prevent or eliminate oral disease or to maintain or restore function; ▪ Not Experimental or cosmetic; ▪ Provided by a licensed Dentist recognized by the Plan and operating within the scope of his or her license (or licensed dental hygienist for teeth cleaning); ▪ Pre-authorized by JBT dental consultants when necessary; ▪ Within cost levels shown on the JBT Dental Table of Allowances; and ▪ Not excluded from coverage.
Pre-authorization	Recommended for all treatment expected to cost $300 or more (see page 95).
Calendar Year Benefit Limit	$1,500 per covered individual.
Claim Forms	You or your Dentist must file claim forms. See pages 122 and 125.

HEALTHSMART TIPS

To receive maximum benefits provided under JBT dental coverage, use a Dentist who has agreed to participate in the JBT/Arrin dental network. Participating Dentists have signed contracts with Arrin agreeing to charge no more than the amount shown on the JBT Dental Table of Allowances for treatment and service. You will receive a directory of participating Dentists by mail at your last known address. You may also contact JBT's Administrative Office for a list of participating Dentists in your area.

If you use a non-participating Dentist, show your Dentist the JBT Dental Table of Allowances and discuss any additional amounts you have to pay. Non-participating Dentists have not agreed to accept the fees allowed under the JBT Dental Table of Allowances as full payment. They may charge you more than the full benefit amounts payable under JBT dental coverage. In this case, you pay the difference.

How JBT Dental Coverage Works

Overview

Covered dental expenses are limited to procedures that are necessary to prevent and eliminate oral disease or to maintain and restore function. All dental expenses are subject to review and determination by the Trust's dental consultants, and are allowable only where need can be demonstrated.

Calendar Year Deductible

Before any benefits are payable, you must first satisfy a $50 calendar year deductible (no more than $100 for a covered family). In some cases, you may require services under a single treatment plan that continues from one calendar year to the next. You must again satisfy the $50 calendar year deductible in the second year of treatment before benefits are payable. The deductible applies each calendar year. The deductible will not carry over to the following calendar year.

What JBT Dental Coverage Pays

If you or a covered dependent gets a dental checkup or receives dental treatment performed by a licensed Dentist, then after the deductible is met, JBT dental coverage will pay up to 100% of the amount shown on the JBT Dental Table of Allowances for each item—up to a maximum benefit of $1,500 per person each calendar year.

Any dental expenses above those amounts shown on the JBT Dental Table of Allowances or procedures not listed in the JBT Dental Table of Allowances are not covered. Also note that many dental services are not covered at all (for a list of exclusions, see What's Not Covered? beginning on page 97).

What You Pay

In addition to the deductible, you are responsible for paying for any services that are not listed in the JBT Dental Table of Allowances, any charges above the scheduled amounts shown on the Dental Table of Allowances, and any charges that exceed the calendar year maximum benefit of $1,500 per person.

Pre-Authorization of Treatment

If the treatment plan outlined by your Dentist—including the examination and necessary X-rays—will cost $300 or more, you should get prior approval (called "pre-authorization") from JBT's Administrative Office to make sure that all procedures are covered. Even if your Dentist recommends them, many procedures are not covered (see What's Not Covered? beginning on page 97) or are only covered under limited circumstances (see Procedures Only Covered Under Special Circumstances—Approval Required beginning on page 96). With pre-authorization, you can be certain of how much JBT dental coverage will pay for recommended treatment. If your treatment is not pre-authorized, JBT dental coverage may not pay any benefits for your treatment.

To obtain pre-authorization, you must complete your portion of a dental claim form and take it to your Dentist's office. Your Dentist will submit the proposed treatment plan to JBT's Administrative Office for written approval. The JBT dental consultants will review the treatment plan to make sure that the proposed services are both covered and necessary to eliminate oral disease and maintain or restore dental function. Having your treatment plan pre-authorized expedites payment when a claim is submitted for these services. If you do not have treatment pre-authorized and JBT's dental consultants cannot determine after the treatment was performed whether it was necessary, benefits may be denied. The required documentation for treatment plans and claims is described under Claims that Require Additional Information, beginning on page 125.

What's Covered?

- Diagnostic care (visits and consultations)—including full mouth X-rays once every five years, bitewing X-rays once every 12 months and oral examinations and cleaning once every six months. The benefit payment for multiple X-rays or for a panographic X-ray when combined with other X-rays shall not exceed the allowance for a full mouth X-ray. The allowance for study models is included in the benefit payment for a fixed or removable prosthesis.
- Preventive care—including fluoride treatment once every six months for covered dependents under age 18. Tooth sealants for permanent posterior teeth are covered only for dependent children under age 16. Where a bilateral space maintainer is required in the same arch, a bilateral space maintainer with molar bands connected by an arch wire is the covered benefit. An allowance will be made for a bilateral space maintainer, not two unilateral space maintainers.

- Restorative Dentistry—including fillings of amalgam and composite. Crowns are also covered, but not more than once in five years for each procedure. Proximal restorations in anterior teeth are not to exceed three tooth surfaces. Occlusal and buccal "spot" or lingual groove restorations in the same tooth are payable as a single two-surface filling. Amalgam or composite resin build-ups, including pins, are considered part of the preparation for the completed restoration, except in special circumstances and by report. Correction of occlusion is considered part of the completed restoration involving occlusal surfaces.
- Prosthodontics—including fixed partial dentures (bridges) and removable dentures (partial and full) not more than once in five years for each procedure. The fee allowed for a removable partial denture includes all teeth and clasps. Correction of occlusion is considered part of the completed prosthodontics involving occlusal surfaces.
- Oral surgery—including extractions and other oral surgery. Biopsy is considered with a pathology report.
- Endodontics—including pulpal therapy and root canal fillings. The benefit allowance for endodontic therapy by the same Dentist includes the initial treatment, interim and final X-rays, temporary fillings and cultures.
- Periodontics—including treatment of gums and tissues supporting the teeth. Mucogingival or osseous surgery and soft tissue grafts are considered when required for restoration of form and function. Periodontal procedures utilized for cosmetic purposes and procedures associated with implants are not covered.

Procedures Only Covered Under Special Circumstances—Approval Required

After you satisfy the calendar year deductible, JBT dental coverage may pay benefits for the following procedures. Before you undergo treatment, be sure to seek pre-authorization from JBT's Administrative Office. **No benefits will be payable for treatment not approved by JBT dental consultants.**

- Removable spacers, where a fixed space maintainer can be placed
- Inlays, onlays, and retainers for fixed partial dentures (bridges)
- Veneers, crowns and porcelain to metal pontics posterior to the first maxillary molar and second mandibular bicuspid (allowance will be made for full metal crown and/or gold pontics)
- Unilateral removable partial dentures
- Distal extension posterior cantilevered pontics
- A fixed partial denture (bridge) in the same arch as a removable partial denture

- Fixed prostheses where a large number of teeth are missing in the same arch and/or advanced periodontal bone loss is evident radiographically
- Replacement of second molars unless as part of a fixed partial denture (bridge) restoring other teeth
- Root canals and crowns on third molars
- Periodontal surgical procedures only when need can be demonstrated and when the participant has maintained good oral hygiene for approximately one year following scaling
- More than four quadrants of root planing and/or subgingival curettage within a 24-month period
- Any treatment for bruxism
- The use of chemotherapeutic agents exceeding five teeth on any date of service, not to exceed twice in a 12-month period per tooth

What's Not Covered?

The following treatment and services are specifically excluded from dental coverage:

1. Any service not needed to prevent and eliminate oral disease or to maintain or restore function
2. Any treatment performed by someone other than a licensed Dentist, except for charges for dental prophylaxis (cleaning and scaling) performed by a licensed dental hygienist
3. Full mouth rehabilitation or reconstruction
4. Orthopedic repositioning appliance for correction of temporomandibular joint dysfunction (TMD) (this is a covered expense under the JBT Medical option if the appliance is used instead of surgery)
5. Cosmetic procedures, orthodontic treatment, or implant and implant-related procedures
6. Experimental procedures
7. Appliances or restorations to increase vertical dimension
8. Premedication, prophylactic therapy, relative analgesia (nitrous oxide), and intravenous sedation except for documented disabled or uncontrollable patients or pre-existing medical or dental conditions
9. Charges for services provided by any person, dentist or organization, which normally makes no charges in the absence of dental benefits
10. Treatment as a result of congenital malformation to the extent allowed by federal law

11. Any treatment on primary teeth that are exfoliating or are soon to exfoliate
12. Procedures where the prognosis is poor
13. Charges for completion of claim forms or for broken appointments
14. Charges for crowns, fixed partial dentures (bridges), removable partial and full dentures when the impression was taken in an ineligible month, even if the service was completed in an eligible month
15. Charges for crowns, fixed partial dentures, removable partial and full dentures that are not delivered, even if the impression has been taken
16. Charges for crowns and fixed or removable partial dentures on teeth where X-rays or periodontal charting indicate the need for periodontal work
17. Crowns and fixed or removable partial dentures in the presence of gross residual calculus
18. Allowances for individual X-rays that exceed the allowance for a full mouth X-ray
19. Cleanings where gross residual calculus remains
20. X-rays that are diagnostically unacceptable
21. Sealants on previously restored teeth unless the restoration was to the lingual or buccal surfaces only
22. Fluoride treatment for individuals age 18 or older—and fluoride treatment more than once every six months for a covered dependent under age 18
23. Dietary planning for control of dental caries
24. Separate instruction in oral hygiene and "plaque control"
25. Space maintainers where first permanent and second deciduous molars are in occlusion
26. Spacers when spaces have closed or the crowns of erupting teeth have penetrated alveolar bone
27. Replacement of lost or broken crowns, fixed partial dentures, and removable prosthetic appliances (dentures, full and partial) within five years of restoration
28. Cast restorations when the tooth can be restored with an amalgam or with a composite resin restoration
29. Composite resin restorations on lingual surfaces
30. Composite resin restorations on molars
31. Dowels, posts, and pins unless insufficient coronal structure remains to retain the crown restoration

32. Any porcelain cast metal crown or porcelain fused to metal crown for patients under age 16 (allowance will be made for acrylic or stainless steel crown)
33. Two restorations on a single tooth surface during one visit
34. Permanent restorations performed within two months of remineralization (recalcification)
35. Allowance for multiple restorations on one tooth that exceed the cost of a covered crown
36. Pulp capping unless the pulp is exposed or nearly exposed
37. Fillings and crowns where large overhangs are present
38. Crowns with defective margins
39. Grossly under-filled or over-filled root canal fillings
40. Endodontic therapy using the “Sargenti Method”
41. Interim partial dentures (stayplates) except (a) to replace extracted anterior teeth for adults during healing period; (b) as an anterior space maintainer for children; or (c) as a temporary alternative to a permanent prosthesis in the presence of progressive periodontal disease likely to lead to further tooth loss
42. Gingivectomy in conjunction with crown preparation
43. Splinting of teeth for periodontal support
44. Endosseus implants
45. Surgical correction by grafts for denture retention purposes
46. Removal of remaining crown of an exfoliating deciduous tooth where the roots are essentially reabsorbed
47. Removal of essential and strategic teeth that can be retained with endodontic therapy
48. Removal of teeth that can be retained to avoid unnecessary conversion of a patient to edentulism (partial or complete)
49. General anesthesia except for surgical or operative procedures as approved by JBT’s dental consultant or where an allergy to local anesthesia is confirmed (must be administered under direct supervision of a state Dental Board-certified or Board-eligible oral surgeon, anesthesiologist or a Dentist with JBT-approved qualifications)
50. Premedication, prophylactic therapy, relative analgesia (nitrous oxide), and I.V. sedation except for documented handicapped or uncontrollable patients or pre-existing medical/dental conditions

51. Specialized techniques for treatment of full or partial (fixed or removable) dentures
52. Precision attachments or stress breakers for partial dentures and associated appliances
53. Personalization and characterization of full or partial dentures
54. Gnathologic recording (for removable or fixed prosthesis)
55. Procedures associated with overlays (overdentures) and implants
56. Removable cast partial or full dentures for patients under age 16
57. Full dentures when partial removable dentures can be placed
58. Relines only after six months from initial placement and no more than once a year thereafter. In the case of immediate dentures, a reline will be allowed following the healing period and once a year thereafter
59. Fixed partial dentures (bridges) for patients under age 16
60. Replacement of missing posterior teeth where the space is largely closed and neither of the proximal teeth otherwise require crown restoration
61. Replacement of missing teeth where the individual has at least 12 posterior teeth in occlusion

For additional general exclusions and limitations that apply to all types of JBT Health and Welfare coverage, see General Plan Exclusions and Limitations beginning on page 108.

Extension of JBT Dental Coverage

If you are undergoing JBT-approved dental treatment at the time your JBT dental coverage ends, JBT dental coverage continues to pay for any of the approved covered dental treatment completed within 90 days after the date your coverage ends. Treatment is considered to “start” at the time of the initial examination that resulted in the treatment or series of treatments.

VISION CARE BENEFITS

Your JBT Vision Coverage

JBT provides vision care benefits for you and your eligible dependents through Vision Service Plan (VSP). JBT vision coverage pays benefits for periodic vision examinations and the purchase of lenses and frames for you and your eligible dependents, within VSP limits.

How JBT Vision Coverage Works

Overview

VSP offers a panel of licensed eye Doctors who have agreed to provide vision care at reduced rates. Under VSP, you can go to any licensed eye Doctor you choose, but the benefits are higher when you use a participating VSP eye care professional. Licensed eye Doctors include ophthalmologists, optometrists, and dispensing opticians.

Using VSP Providers

To locate a VSP provider in your area:

- Log on to VSP.com, or
- Call VSP at 1-800-877-7195, or
- Call JBT's Administrative Office at 1-800-528-4357.

If you choose to obtain services from a VSP provider, be sure to inform him or her that you are a JBT Plan participant when you make an appointment. The doctor's office will contact VSP to make sure you are eligible for VSP benefits.

What You Pay When You Use VSP Providers

When you see a VSP provider, you pay a $10 copayment directly to that provider for covered services and the cost for any additional services that are not covered. For a list of the additional services that are not covered, see Limits on Vision Coverage beginning on page 103 and What's Not Covered? beginning on page 104.

Claims

When you see a VSP provider, you do not have to file any claim forms. The VSP provider will do this for you.

If You Use a Non-VSP Provider

If you use a non-VSP provider, you should still check with VSP first to make sure you are eligible for services on the expected treatment date. Then, make an appointment with your eye doctor.

What You Pay When You Use Non-VSP Providers

When you see a non-VSP provider, you will be required to pay the full bill at the time of service, and then submit a reimbursement claim form to VSP. Provided you are eligible for benefits, VSP will pay a limited allowance for each covered service. This allowance usually does not cover the full cost of treatment. Call VSP at 1-800-877-7195 to find out the current allowance for any procedure.

Claims

To receive benefits for non-VSP services, you must submit an itemized receipt along with your benefit form to VSP within 180 days of the date you incurred the expense. Benefit forms and claims should be sent to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

What's Covered?

The following expenses are covered whether you use VSP providers or non-VSP providers:

- Vision examinations—once every 12 consecutive months
- Eyeglass lenses—only if needed, once every 24 consecutive months
- Frames—only if needed, once every 24 consecutive months, subject to a retail allowance of $100
- A second pair of eyeglasses—you pay the retail cost less a discount of 20%
- Contact lenses—VSP pays up to $100 in a 24-consecutive-month period towards the cost of contact lenses and the associated fitting and evaluation examination. The fitting and evaluation exam is in addition to your routine vision examination and is done to ensure the proper fit of contacts. This allowance replaces the benefit for lenses and frames and applies regardless of whether the contact lenses are cosmetic or Medically Necessary or furnished by a VSP or non-VSP provider.

Limits on Vision Coverage

JBT vision coverage is designed to cover visual needs rather than cosmetic materials. You will be required to pay extra for the following items (VSP pays the basic cost of the allowed frames and lenses, and you pay the additional laboratory cost plus a modest fee unless you have prior authorization):

- Blended lenses
- Oversize lenses
- Progressive multifocal lenses

- The coating or laminating of lenses
- Cosmetic eyeglass lenses and optional cosmetic processes
- A frame that costs more than the VSP coverage allowance of $100 at retail
- UV-protected lenses
- Contact lenses ($100 allowance; you pay the balance)

What's Not Covered?

No benefits will be paid for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental plano (non-prescription) lenses
- New eyeglasses when there is no prescription change
- Medical or surgical treatment of the eyes (benefits may be provided separately through JBT Medical or HMO coverage)
- Any eye examination or corrective eye wear required by an employer as a condition of employment

In addition, lenses and frames provided under this program that are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

For additional general exclusions and limitations that apply to all types of JBT Health and Welfare coverage, see General Exclusions and Limitations beginning on page 108.

DRUG AND ALCOHOL REHABILITATION BENEFITS

Your Drug and Alcohol Rehabilitation Benefits

Drug and alcohol dependency treatment is available to you and your dependents through the Teamsters Alcohol Rehabilitation Program (TARP). If you or one of your covered dependents has a dependency problem with alcohol or drugs, JBT urges you to contact TARP at 1-800-522-8277. Early treatment can help save your health.

How TARP Works

Overview

When you call TARP at 1-800-522-8277, you or your dependent will be directed to an appropriate program that may include:

- Community resources
- Outpatient treatment
- Inpatient treatment

TARP has negotiated discounted rates with many of the treatment facilities it recommends. No benefits are payable for treatment from a facility not approved by TARP.

HEALTHSMART TIPS

Be sure to call TARP (1-800-522-8277) before seeking rehabilitation treatment. TARP will recommend a facility that meets your treatment needs. If you use a facility not approved by TARP, no benefits will be payable.

What TARP Pays

TARP pays for rehabilitation treatment for alcoholism and/or drug abuse. For adults, the Plan pays 100% of the cost of treatment up to a maximum benefit of $6,000 per course of treatment—limit, two courses of treatment per lifetime separated by at least 36 months. For dependent children under the age of 18, the coverage is limited to one course of treatment with a maximum benefit of $7,500.

A “course of treatment” is an alcohol or drug rehabilitation that begins on the day the individual enrolls in the treatment center or program and ends on the earliest of the following:

- The date the facility or program providing treatment discharges the patient as having fulfilled the course of treatment, or
- The date the individual ends the course of treatment without authorization from TARP, whether fulfilled or not.

However, if you contact TARP (1-800-522-8277) before enrolling in a course of treatment, and TARP advises you to go from one treatment center or program to another, this change of treatment centers or programs will not be considered a new “course of treatment.”

Detoxification provided as part of the rehabilitation treatment is considered a component of the “course of treatment” and included within the TARP benefit. Detoxification provided on an Emergency basis (at a hospital emergency room, for example) is covered as a medical expense.

Claims and Appeals Information

For general claims and appeals information, including claims filing addresses, see Drug and Alcohol Claims and Appeals Procedures, beginning on page 122.

What’s Covered?

The TARP benefit includes:

- Room and board
- Doctor visits and counseling
- Professional services
- Detoxification when provided as part of rehabilitation

What’s Not Covered?

- Any course of treatment that begins within 36 months of a prior course of treatment
- A third or succeeding course of treatment for an adult (second or succeeding treatment for a dependent child under age 18).
- Treatment received from a facility not approved by TARP, or a plan of treatment not approved by TARP

For additional general exclusions and limitations that apply to all types of JBT Health and Welfare coverage, see General Plan Exclusions and Limitations beginning on page 108.

General Plan Exclusions and Limitations

In addition to the exclusions already discussed in each benefit section, the Plan pays no benefits for the following:

1. Treatment that is not Medically Necessary
2. Any accidental bodily injury caused by or occurring in the course of the eligible person's employment, or in connection with illness or disease for which the person is entitled to benefits from Workers' Compensation or similar law
3. To the extent permitted by federal or state law, any condition for which care or treatment is obtained from a federal government agency or from any state or political subdivision where this care is available without cost to the individual. To the extent permitted by federal law, any period of confinement in, or any medical care and treatment received from a Veteran Administration Hospital. In addition, any confinement or care in a hospital owned or operated by a state or political subdivision is excluded from coverage, unless there is an unconditional requirement to pay for this care or confinement without regard to the rights of others, contractual or otherwise.
4. Any medical or dental services or supplies provided by or paid for by any governmental program (national, state, county, district or municipal)
5. Charges for treatment of accidental bodily injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans Affairs to be service connected
6. Charges for treatment of illness or injury or for dental services or supplies that are not reasonably necessary for medical or dental health
7. Charges for treatment of illness or injury that are in excess of Reasonable and Customary charges or are in excess of charges that would have been made for this care and treatment in the absence of benefits provided by the Plan. The Plan will not pay any expenses the participant is not obligated to pay, such as expenses incurred under HMO coverage for which no charge would otherwise be made to the patient.
8. Injuries or conditions caused by or resulting from your commission of an illegal act or an act of personal aggression. Provided, however, that this exclusion will not apply if the injury or condition resulted from an act of domestic violence or a mental health condition, to the extent that treatment for the injury or condition would otherwise be covered.
9. Services or supplies provided without charge, or for which the individual does not have to pay

10. Professional services provided by a person who lives in the covered individual's home or is related to the individual by blood or marriage
11. Any service, supply, or treatment (including days in the Hospital) that was rendered or furnished before the patient became covered by the Plan or after the individual is no longer eligible to receive benefits under the Plan
12. Services or supplies furnished for the treatment of a condition for which the Plan participant is not under the care of a Doctor

COORDINATION OF BENEFITS

Coordination of Benefits

How Coordination of Benefits Works

If you or a dependent is covered for benefits under another group medical plan (such as your spouse's plan at work) or by Medicare, the Plan coordinates the benefits it pays with benefits paid by Medicare or provided by the other group plan. The plan that pays first is the "primary" plan and the plan that pays second is "secondary." When the Plan is secondary, it will pay the lesser of the difference between the amount paid by the primary plan and:

- The Reasonable and Customary allowance for the service, or
- The lesser of the PPO contract amount (or other agreed amount) as negotiated on behalf of either the primary or secondary plan.

The Plan will never pay more than the Plan maximum. (When coordinating dental coverage, the secondary benefit will not exceed the amount the Plan would have paid, without regard to the dental deductible, had there been no primary coverage). These are examples of how benefits may be coordinated. Coordination will vary depending on the terms of the primary and secondary plans.

If the Patient Is:	Amount of Expense:	What JBT Would Have Paid if It Were Primary:	Primary Plan Payment:	Amount Plan Actually Pays:
Your spouse **(when spouse's plan is primary)**	$280	$200 ($250 is the maximum "Reasonable and Customary" charge; JBT would have paid 80%)	$250 (Spouse's employer's plan)	$0 (Because the Primary plan paid the Reasonable and Customary amount, it has paid as much as the Plan would have allowed if it were primary.)
Your child **(when spouse's plan is primary)**	$2,000 (illness requiring hospitalization)	$1,500 (PPO Contract Rate is $1,500; JBT would have paid 100%)	$1,400 (Primary plan of spouse pays 70%)	$100

If you or your dependents are covered under any other group plan or by Medicare, you must inform JBT's Administrative Office. If you do not notify JBT's Administrative Office of your other coverage, benefits may be overpaid in error. The Plan will require you to repay any overpayments and will withhold future benefits if you fail to do so.

Because the benefit paid by the secondary plan is reduced by the amount paid by the primary plan, the benefit under the secondary plan cannot be determined until the

primary plan pays. Therefore, always submit your claim to the primary plan first. When the primary plan has paid, attach a copy of the Explanation of Benefits when you submit your claim to the secondary plan.

Determining Which Plan Is Primary (Pays First)

If You or Your Dependent Is Enrolled in Another Group Health Plan

The following rules are used to determine which plan is "primary" if you or any of your dependents are covered by another "group health plan" (such as your spouse's plan at work). The rules are applied in the following order:

1. A Plan Without a Coordination of Benefits Provision or with a provision that bars coordination with the Plan will be primary.
2. Another plan that covers you as an employee is primary before a plan that covers you as a dependent.
3. A plan that covers your spouse as an employee is primary before a plan that covers your spouse as a dependent.
4. For a child covered under both parents' plans, the primary plan is determined by the "birthday rule." The plan covering the parent whose birthday occurs earlier in the year is the primary plan. The plan of the parent whose birthday occurs later in the year is the secondary plan. If both you and your spouse share the same birthday, then the primary plan will be the one that has covered one parent the longest.
5. If a child's parents are divorced or separated, the birthday rule does not apply. Instead, claims are processed in this order:
    - A. The plan of the parent to whom the court specifically assigned financial responsibility for health care expenses (for instance, through a Qualified Medical Child Support Order).
    - B. The plan of the parent who has custody.
    - C. The plan of the stepparent married to the parent who has custody.
    - D. The plan of the parent who does not have custody.
    - E. The plan of the stepparent married to the parent who does not have custody.
6. A plan that covers you as an employee or dependent of an employee will be primary before a plan that covers you as a laid-off or retired employee, a dependent of a laid-off or retired employee, or a COBRA participant.

7. If none of these rules applies, then the plan that has covered the individual the longest will process claims first.

If none of the above rules determines which plan is primary, the allowable expenses shall be shared equally between plans. When applying this rule, the Plan will not pay any more than it would have paid had it been primary.

All other provisions notwithstanding, if you or your dependents are covered under your spouse's HMO, the HMO will always be primary and the Plan will always be secondary.

HEALTHSMART TIPS

To help speed payment of benefits, be sure to submit your claim first to the plan that is considered "primary"—in other words, the plan that pays benefits first. The secondary plan cannot process a claim without knowing how much the primary plan has paid.

REMINDER—HMOs ARE PRIMARY

The Plan considers all HMO coverage to be primary. If you are enrolled as a dependent in your spouse's HMO coverage, the Plan considers your spouse's HMO coverage to be primary. Similarly, if your spouse or child is enrolled in the Plan and your spouse's HMO, your spouse's HMO coverage is always primary.

If You or Your Dependent Is Enrolled in Medicare

Employees Covered by Plan and Medicare

If you are an active employee enrolled in a JBT Plan and are also eligible for Medicare coverage—whether or not you apply for Medicare benefits—the following rules apply:

- The Plan is primary—and you file claims with the Plan first—if:
  - You are covered under the Plan because of your current employment status, or
  - You are eligible for Medicare benefits because you have end-stage renal disease (ESRD) **unless** you became eligible for Medicare benefits due to age or Disability prior to becoming eligible for Medicare benefits due to ESRD, and the Plan is already permissibly paying secondary because you are not covered on the basis of your current employment status.

  In general, the Plan remains primary for the first 30 months if either (1) ESRD is the first reason for Medicare-eligibility, or (2) Medicare eligibility is first due to age or Disability and the Plan has already been paying on a primary basis because coverage is provided by virtue of current employment status. At the end of the 30-month period, Medicare will be primary.

- Medicare is the primary payer—and you file claims with Medicare first—if you do not have ESRD and you are not in "current employment status." "Current employment status" means an individual is actively working—or is not actively working and:
  - Is receiving employer-provided disability benefits that are subject to FICA taxation (i.e., the first six months of disability benefits)—or
  - Retains employment rights in the industry (for example, as a seasonal employee), has not had membership in an employee organization terminated, has group health plan coverage other than COBRA coverage, is not receiving Social Security Disability benefits, and has not received disability benefits from an employer for more than six months.
- If you are age 65 or older, you may elect Medicare as the primary plan; if you do, benefits under the Plan will end.

JBT does not pay Medicare Part B premium reimbursements for active or retired employees. Contact your local Social Security office for more information.

Dependents Covered by Plan and Medicare

If your dependent is eligible to receive Medicare benefits—whether or not he or she has actually applied for Medicare benefits—the following rules apply:

- The Plan is primary if:
  - Your dependent is covered under the Plan because of your current employment status, or
  - Your dependent is eligible for Medicare benefits due to ESRD, **unless** your dependent became eligible for Medicare benefits due to age or Disability before becoming eligible for Medicare benefits due to ESRD, and the Plan is already permissibly paying secondary because your dependent is not covered on the basis of your current employment status.

    The Plan is primary payer for the first 30 months your dependent is eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.
  - Your dependent is Disabled and eligible for Medicare—and you are covered under the Plan because of your current employment status.
- Medicare is the primary payor—and you file claims with Medicare first—if your dependent does not have ESRD and you are not in current employment status.
- If your dependent is age 65 or older, he or she may elect Medicare as the primary plan; if he or she does, benefits under the Plan will end.

COVERAGE WHEN YOU ARE INJURED AT WORK OR BY A THIRD PARTY

(WORKERS COMPENSATION AND THIRD PARTY LIABILITY)

Coverage When You Are Injured At Work Or By a Third Party

Workers' Compensation Insurance

The JBT Health and Welfare Plan for 1400 Hour Employees **does not replace** or affect any requirement for coverage by workers' compensation insurance. **The Plan will not pay benefits for any accidental bodily injury caused by or occurring in the course of the eligible person's employment, or in connection with illness or disease for which the person is entitled to benefits from workers' compensation or similar law.** However, JBT may provide provisional coverage subject to a lien against any workers' compensation benefits ultimately awarded. In the event that you or a covered dependent sustain a work-related injury and file any claims with JBT related to that injury, JBT conditions any payment of such claims on its right to recover any monies it has paid for these claims from any workers' compensation judgment, award, or settlement of any kind as described under Right of Reimbursement under Third Party Liability.

Third Party Liability

Right of Reimbursement

The Joint Benefit Trust reserves the right to recover claim payments made under the Plan on behalf of an employee or dependent where the claim results from or is related to an injury or illness that is the responsibility of a third party. You are obligated to reimburse JBT in full for any claims paid relating to such injury or illness. If you recover any amount from a third party and fail to repay the JBT for the claims it has paid, the Plan will deduct the amount paid from any of your future benefit claims as a set off. What is a third party and when are they responsible for your injuries or illness? Here are some examples:

- If you are in an auto accident and the other driver is at fault, the third party is the other driver and his/her insurance company.
- If you are in an auto accident and the other driver is uninsured, your auto insurance policy's "uninsured motorist's" provision is a third party for this purpose.
- If you are injured in an auto accident and covered under a "no fault" provision of your own insurance policy, your policy is the third party.
- If you are injured on the job, your employer's Workers' Compensation policy is the third party.
- If you fall in a store because there was a spill near a shelf that no one bothered to clean up, the store is the third party.

Your Obligations To The Plan When Plan Pays Claims for Which A Third Party Is (Or May Be) Responsible

THE PLAN WILL PAY CLAIMS FOR EXPENSES INCURRED BECAUSE OF AN ILLNESS OR INJURY FOR WHICH A THIRD PARTY IS (OR MAY BE) RESPONSIBLE, BUT BY SUBMITTING THE CLAIM FOR PAYMENT BY THE PLAN, YOU (AND A COVERED DEPENDENT IF HE OR SHE SUFFERS THE ILLNESS OR INJURY) ARE DEEMED TO HAVE AGREED TO EACH OF THE FOLLOWING CONDITIONS:

- That JBT has established a lien on any recovery received by you (or your dependent, legal representative or agent)
- To notify any third party responsible for your illness or injury of the Plan's right to reimbursement for any claims related to your illness or injury
- To hold any reimbursement or recovery received by you (or your dependent, legal representative or agent) in trust on behalf of JBT to cover all benefits paid by the Plan with respect to such illness or injury and to reimburse JBT promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss
- That JBT has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that JBT's claim has first priority over all other claims and rights
- To reimburse JBT in full up to the total amount of all benefits paid by the Plan in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the JBT as reimbursement up to the full amount of the benefits paid.
- That JBT's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise
- That, in the event that you elect not to pursue your claim(s) against a third party, JBT shall be equitably subrogated to your right of recovery and may pursue your claims
- To assign, upon JBT's request, any right or cause of action to JBT
- Not to take or omit to take any action to prejudice JBT's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist JBT in obtaining reimbursement
- To cooperate in doing what is necessary to assist JBT to recover the benefits paid or in pursuing any recovery;
- To forward any recovery to JBT within ten days of disbursement by the third party or to notify JBT as to why you are unable to do so

- To the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to JBT's attorneys' fees and costs

If you or your dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

If you or your dependents fail or refuse to assist JBT in recovering damages from a third party, then JBT may:

- Offset what is paid on your and/or your dependents' future benefits claims until JBT is completely reimbursed for the cost of claims submitted as a result of the injury or illness caused by the third party, including but not limited to costs incurred in collection; and
- File a lawsuit against you or your dependents to fully recover the amount JBT should have been reimbursed; and/or
- Take any other action deemed appropriate by the Board of Trustees.

If you or your dependents do not receive payments from a third party to reimburse JBT for an illness or injury caused by the third party, you do not have to pay JBT back for any benefits properly paid to you or your dependents. If you do receive payment from the third party, you do not have to pay JBT more than the amount the third party paid to you or your dependents.

If you have questions about how to comply with these third party liability rules, contact JBT's Administrative Office.

CLAIMS AND APPEALS PROCEDURES

Claims and Appeals Procedures

This section describes:

- What claims require pre-authorization before you receive treatment
- How to file an initial claim for benefits under each benefit option
- The rules that you must follow to appeal the denial of a claim under the Plan
- The rules that the Plan must follow when making decisions on claims or appeals

The rules described here apply to the filing of claims and appeals for the following Plan benefits:

- JBT Medical benefits
- Chiropractic benefits (Landmark Chiropractic)
- Mental health benefits (Managed Health Network: initial claims only)
- Prescription drug benefits (Caremark)
- Dental benefits
- Vision benefits (Vision Service Plan)
- Drug and alcohol rehabilitation benefits (TARP)

For rules concerning the appeals procedures for mental health benefits, see the separate appeals procedure provided by Managed Health Network (MHN). (You should receive a copy of MHN's appeals procedures automatically and at no charge.)

If you are enrolled in an HMO, the HMO procedures for claims and appeals described in the HMO's *Evidence of Coverage* will apply. (If covered under an HMO, you will receive a copy of your HMO's *Evidence of Coverage* automatically from your HMO at no charge.)

You may also obtain a copy of either MHN's appeals procedures or your HMO's *Evidence of Coverage* by contacting MHN, your HMO or JBT's Administrative Office. For contact information, see Important Phone Numbers beginning on page 1.

Claims That Require Pre-Authorization

JBT Medical Claims

For JBT Medical benefits, you must obtain pre-authorization for certain procedures. If you do not obtain the required pre-authorization, your benefits may be reduced or not paid at all. Pre-authorization is required for:

Non-Emergency Hospital Admissions

Blue Cross, the Plan's utilization review organization, must approve any hospital admission—except Urgent Pre-Service admissions—**before** you go to the Hospital.

For pre-authorization of non-emergency hospital admissions, you (or your doctor) must call Blue Cross at 1-800-274-7767 at least three working days before any non-emergency hospitalization. **If you do not do so, your benefits will be reduced by 50%.**

If you are out of state or out of the country and need to be hospitalized, contact Health Care Evaluation (HCE) at 1-800-333-3018. HCE is the Plan's utilization review organization for out-of-country treatment.

Medical Emergency Admissions

You or your doctor must call Blue Cross as soon as possible after you are admitted to a Hospital for a Medical Emergency.

Foot Surgery

You must call JBT's Administrative Office for all foot surgery, before the surgery is performed, even if the surgery is planned on an outpatient basis.

Skilled Nursing Facilities, Home Health Care

Sometimes when you are discharged from the hospital, you require continuing care either at home or at a Skilled Nursing Facility. To be covered, an admission to a Skilled Nursing Facility and Home Health Care must be pre-authorized. Normally this will be done as part of discharge planning by Blue Cross. Check with your doctor to make sure this treatment has been authorized. Have your doctor contact JBT's Administrative Office for authorization if he or she prescribes a course of Home Health Care that is not follow-up treatment to a hospitalization.

Mental Health Claims

For psychiatric care, you must contact MHN at 1-800-528-0646 for authorization before services (inpatient or outpatient) are received. No benefits are payable unless you receive approval **before** treatment.

Prescription Drug Claims

Because of their cost, possible side effects and potential for abuse, some Drugs will not be covered unless their use has been authorized by Caremark. See What Requires Pre-Authorization on page 89. The list of drugs requiring pre-authorization may change from time to time. To obtain the most up-to-date list contact JBT's Administrative Office.

To apply for authorization, your doctor must contact Caremark at 1-800-294-5979. Caremark will review your case with your doctor and determine whether the Drug will be authorized.

Dental Claims

If the treatment plan outlined by your Dentist—including the examination and necessary X-rays—is anticipated to cost $300 or more, you should obtain pre-authorization from JBT's Administrative Office to determine whether the procedures will be covered. Many procedures are not covered or are only covered under limited circumstances even if your Dentist recommends them. With pre-authorization, you can be certain of how much JBT dental coverage will pay for recommended treatment. If your treatment is not pre-authorized, JBT dental coverage may not pay any benefits for your treatment.

To obtain pre-authorization, you must complete your portion of a dental claim form and take it to your Dentist's office. Your Dentist will submit the proposed treatment plan to JBT's Administrative Office for review. The JBT dental consultants will review the treatment plan to make sure that the proposed services are both covered and necessary to eliminate oral disease and maintain or restore dental function. Having your treatment plan pre-authorized expedites payment when you submit a claim for these services. If you do not have treatment pre-authorized and JBT's dental consultants cannot determine after the treatment was performed whether it was necessary, benefits may be denied. The required documentation for treatment plans and claims is described under Claims that Require Additional Information, beginning on page 125.

Drug and Alcohol Rehabilitation Claims

The Teamsters Alcohol/Drug Rehabilitation Program (TARP) must pre-authorize any claim for treatment of alcohol or chemical dependency. No benefits are payable unless you have received approval **before** treatment. For pre-authorization, call TARP at 1-800-522-8277.

Filing an Initial Claim for Benefits

Unless the service you receive requires pre-authorization, most of your claims will be filed after you receive the service. The procedure for filing these claims depends on the type of service you receive and whether you use network or non-network providers.

When you obtain services from a provider that participates in a network that has contracted with JBT (Blue Cross for JBT Medical, VSP for vision, Landmark for chiropractic, MHN for mental health, Caremark for prescription drugs and TARP for drug and alcohol rehabilitation benefits), you generally do not need to file a claim for benefits. The network providers are responsible for billing the appropriate claims administrator. If, however, you receive a bill that requires payment of more than your normal copayment or coinsurance amount, you may file a claim with the applicable claims administrator (for address information, see Claims Administrator Addresses, beginning on page 135).

When you obtain services (JBT Medical, vision, chiropractic or mental health) from a provider that does not participate in a network that has contracted with JBT or obtain

dental services, you must file a claim with the appropriate claims administrator (for address information, see Claims Administrator Addresses, beginning on page 135).

Note: No benefits are payable if you receive mental health services, drug and alcohol rehabilitation services or prescription drug services from a non-network provider or a provider that has not otherwise been approved by MHN, TARP or Caremark, respectively.

How To File an Initial Claim for Benefits—General Requirements and Procedures

Generally, preferred providers will bill JBT directly. Should you need to file a claim (for example, for a non-preferred provider) for JBT Medical benefits, prescription drug benefits (Caremark), vision benefits (Vision Service Plan), Chiropractic Treatment benefits (Landmark Chiropractic), mental health benefits (Managed Health Network: initial claims only), or dental benefits:

- Obtain the appropriate claim form from your local union, employer, or JBT's Administrative Office. Separate claim forms are required for medical, mental health, prescription drug, dental, vision, and chiropractic benefits (you do not have to file claims for drug and alcohol rehabilitation benefits).
- Be sure to fully complete and sign the claim form.
- Have the person providing services complete the rest of the form or provide an itemized bill that contains all of the information requested on the form.
- Keep a copy for your records and then submit the claim to the claims administrator within the applicable time frame. For mailing addresses, see Claims Administrator Addresses, beginning on page 135.
  - Submit medical, mental health, vision, chiropractic, and dental claims within 90 days of the first date of the service, if possible, but no later than 12 months (180 days for vision claims from non-VSP providers) after the first date of the service. No medical, mental health, vision, chiropractic, or dental benefits will be paid for claims filed after the applicable deadline (180 days for vision; 12 months for all others).
  - No benefits for prescription drugs will be paid for a claim submitted more than 90 days after the prescription is filled.
- When the claims administrator receives your claim form, the form will be reviewed to see if it is complete. If your claim form is incomplete, the claims administrator will request any missing information from you or the health care provider. Your claim will not be paid until the information is received. When complete, the claim form is processed by the claims administrator. Benefit payment is then made directly to the provider, if it is a preferred provider. If the provider is not a preferred provider and

the benefit is less than $250, payment will be made to you unless you have assigned the benefits to the provider.

- If payment is made to the provider, you will receive a statement (called an Explanation of Benefits, or "EOB") notifying you of the payment. If benefits are denied, you will also receive an EOB statement. If you do not receive payment or an EOB statement within three months of the date you (or the provider on your behalf) filed a claim, call JBT's Administrative Office. Preferred providers should bill JBT directly for their services. However, they do not always do so. If you have not received an EOB within three months after receiving services from a preferred provider, contact JBT's Administrative Office to make sure JBT received the preferred provider's bill.

Remember, if you are:

- A dependent child over age 19 who is either Disabled or a full-time student (see page 17); or
- A Disabled participant applying for benefits under Major Medical Extension (see page 71).

Proof of your status must be on file with JBT's Administrative Office before any claims will be paid. For the necessary forms, contact JBT's Administrative Office.

You may appeal any denied claim. For information on appealing a denied claim, see Appeals Procedures beginning on page 126.

HMO Claims

If you are enrolled in an HMO, the HMO procedures for claims and appeals described in the HMO's *Evidence of Coverage* will apply. (If covered under an HMO, you will receive a copy of your HMO's *Evidence of Coverage* automatically from your HMO at no charge).

Mental Health Claims

For information on filing mental health claims and appeals, see the separate appeals procedure provided by Managed Health Network (MHN). (You should receive a copy of MHN's appeals procedures automatically and at no charge).

HEALTHSMART TIPS

If you use a network provider, you should not pay for services received until after the Plan has been billed and has issued an Explanation of Benefits (EOB) statement. The EOB will indicate the amount of the preferred provider's write-off (the discounted amount for which you are not responsible).

When you receive your EOB statement, review it carefully to be sure you received the services for which you are being billed **and that you are not being billed for preferred provider write-offs**.

Claims that Require Additional Information

Dental Claims

When you or your dentist files a claim for dental work or requests pre-authorization to perform dental work, the claim or pre-authorization request must include:

- Member's name and social security number
- Patient's name
- A description of the services performed or proposed to be performed, together with the appropriate American Dental Association (ADA) code,
- The charge for each service
- The date the service was performed (if done)

In addition, before any benefit is paid, the Plan may require:

- A comprehensive treatment plan
- Acceptable diagnostic X-rays that demonstrate the need for the proposed treatment
- Complete pocket charting and/or X-rays to demonstrate medical necessity (for periodontal work), and/or
- Post treatment X-rays to verify that dental work was of acceptable quality

International Claims

For all claims from abroad, the provider must be able to supply the Plan, upon request, with documentation of services performed. Requests may include providing copies of the history and physical report taken at the time of examination, laboratory and X-ray reports, X-rays, operative reports or treatment notes. The provider must be able to supply the Trust, upon request, with documentation of services performed. If requested by JBT's Administrative Office, the participant must furnish a translation of the claim and all related documentation before payment will be made.

International Medical, Hospital, Lab, X-Ray and Dental Claims

For international medical, hospital and dental claims, each bill must be fully itemized and contain:

- Member's name and social security number
- Patient's name
- Date of service for each service billed
- A description of the service rendered, listing each date of service and charge
- The amount charged for each service billed

International Prescription Drug Claims

For international prescription drug claims, the Pharmacist must provide:

- Member's name and social security number
- Patient's name
- Date of purchase
- Description of medication (and English equivalent, if known)
- Quantity purchased and days supplied
- Strength of medication
- Type of medication (tablet, suspension (liquid), ampule (injection))
- The amount charged for each prescription

Claims Incurred in Mexico

In addition to the above requirements, for claims incurred in Mexico, each bill must be accompanied by an original Federal Registration of Services Receipt that contains a unique invoice number and the Mexican government's Seal of Registration authorizing the provider to render professional services, or the Pharmacist to supply medication.

Global Fees

For claims from abroad containing global fees (a single billed amount for all services rendered) or bundling of services in a single billed amount, the provider must list each service performed, the date of the service and the charge for each service.

Appeals Procedures

Health claims are divided into four categories: Pre-Service Claims, Urgent Care Claims, Concurrent Care Decisions, and Post-Service Claims. Different rules and time frames apply to each type of claim, as described below.

Definitions

Claim is any request for Plan benefits made according to the Plan's claims filing procedures, including any request for a service that must be pre-approved.

Pre-Service Claim is a claim that will not be covered or for which benefits will be reduced by the Plan unless you have asked for and received the Plan's approval **before** you receive treatment or care of any kind.

Urgent Care Claim is a Pre-Service Claim for medical care or treatment that, if processed according to the ordinary time limits for Pre-Service Claims, (1) could seriously jeopardize your life, your health or your ability to regain maximum function, or (2) in the opinion of the Doctor who has knowledge of your medical condition, would

subject you to severe pain that cannot be adequately managed without the care or treatment described in your claim.

Concurrent Care Claim is a claim for a benefit regarding an ongoing course of treatment that was previously approved by the Plan for a specific period of time or number of treatments.

Post-Service Claim is any claim other than a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim.

Adverse Decision or Adverse Decision on Appeal is a denial, reduction, termination of or a failure to provide or make payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on (i) an individual's being ineligible to participate in the Plan; (ii) utilization review; (iii) a service being characterized as Experimental or Investigational or not Medically Necessary or appropriate; and (iv) a concurrent care decision.

Authorized Representative is a person you have authorized, in writing, to act on your behalf. An individual will also be recognized as your authorized representative if a court order gives such individual authority to submit claims on your behalf. In the case of Urgent Care Claims, a health care professional with knowledge of your condition may always act as your authorized representative.

Insufficient Claims

Improperly Filed Pre-Service Claims

If a Pre-Service Claim is not filed according to the Plan's claim procedures, you will be notified as soon as possible, but no later than five days after the Plan receives the claim. If the claim is an Urgent Care Claim, you will be notified within 24 hours of receipt. Notice of an improperly filed pre-service claim may be provided orally—or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim.

In order to receive notice of an improperly filed Pre-Service Claim, you or your authorized representative must have provided a communication regarding the claim to the person or organizational unit that customarily handles benefit matters for the Plan. The communication **must** include:

- The identity of the claimant
- A specific medical condition or symptom
- A request for approval for a specific treatment, service or product

Incomplete Urgent Pre-Service Claims

If a properly filed Urgent Care Claim is missing information needed for a coverage decision, you will be notified by the Plan as soon as possible, but no later than 24 hours after the Plan receives the claim. You will be notified of the specific information

necessary to complete the claim. You will have a reasonable amount of time considering the circumstances, but not less than 48 hours, to provide the specific information. The Plan will then provide notice of the claim decision as soon as possible, but no later than 48 hours after the earlier of:

- The date the Plan receives the specified information, or
- The end of the additional time period given for providing the information.

Notice of Benefit Determination

After your initial claim is reviewed by the Plan, you will receive a notice of benefit determination within the time frames specified in the chart beginning on page 131. For Urgent Care and Pre-Service Claims, you will receive a notice of benefit determination whether or not the Plan makes an adverse decision on your claim. For Post-Service and Concurrent Care Claims, you are entitled to receive a notice of benefit determination if the Plan makes an adverse decision on your claim

The time frames for providing notice of a benefit determination generally start when the Plan receives a written claim for benefits. Notice of a benefit determination may be provided in writing by hand delivery, mail, or electronic delivery. However, for some Urgent Care Claims, you may first be provided notice orally, which will be followed by written or electronic notice within three calendar (not business) days. The time frames for providing a notice of benefit determination are shown in the chart beginning on page 131

Appeal of Adverse Decision

If you disagree with the decision on your initial claim, you may file a written appeal within 180 days after your receipt of the notice of adverse decision. Depending on the benefit and the reason for the denial, your appeal should be directed as follows:

Nature of Appeal	Appeals Administrator
Eligibility, including: ▪ Employer's obligation to make contributions ▪ Your rights to self pay for coverage ▪ Dependent coverage	Board of Trustees
Medical benefits (including Chiropractic Treatment):	
▪ JBT Medical:	
▪ Pre-authorization of Hospital admission	Blue Cross
▪ All other coverage issues	Board of Trustees
▪ HMO coverage	Your HMO
Mental health benefits (all plans except Kaiser)	MHN. See page 75.

Nature of Appeal	Appeals Administrator
Prescription drug benefits ▪ JBT Medical ▪ Classification of drugs (i.e., preferred or non-preferred) and coverage for specific drugs ▪ Out of country coverage, other issues ▪ HMO coverage, all issues	 Caremark Board of Trustees Your HMO
Dental benefits, all issues	Board of Trustees
Vision benefits, all issues except eligibility	Vision Service Plan
Drug and Alcohol Rehabilitation Benefits ▪ Treatment authorization (before and during care) ▪ Benefits and other issues	 TARP Board of Trustees

For contact information, see Important Phone Numbers on page 1 and Claims Administrators Addresses on page 135.

Your appeal should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

The appeals administrator will make the decision on appeal. The appeals administrator will not defer to the initial adverse benefit determination and will consider all comments, documents, and records and other information you submit, even if they were not submitted or considered during the initial claim decision. Their decision on your appeal will be made on the basis of the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of Medical Necessity or the use of an Experimental or Investigational treatment), the appeals administrator will consult a health care professional with training and experience applicable to the relevant field of medicine. Upon request, you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board did not rely on this advice in making its decision).

You will receive notice of the decision on your appeal within the time frames listed in the chart beginning on page 131. Decisions on appeals of Post-Service Claims filed with the Board of Trustees will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within 30 days of the next regularly scheduled Board meeting, your appeal will be decided at the second regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the third regularly scheduled Board meeting following receipt of your appeal. You will be notified

in writing if an extension is necessary. You will be notified of the decision on your appeal as soon as possible but no later than five days after a decision on your appeal is reached.

A Notice of an Adverse Decision (or adverse decision on appeal) will be provided in writing and include the following:

- The specific reason(s) for the adverse decision
- Reference to the specific Plan provision(s) on which the adverse decision is based
- A statement about your rights to bring a civil action under ERISA following an adverse benefit decision on an appeal or the denial of your claim
- A description of any additional material or information needed to make a full and complete claim, and the reason why it is needed
- A statement that you may receive, upon request and free of charge, reasonable access to and copies of any documents in the Plan's possession that are relevant to your appeal
- A statement that a copy of any internal rule, guideline or protocol that was relied on to decide your claim is available upon request at no charge
- An explanation of the Plan's appeal procedures and time limits
- For adverse decisions based on the absence of Medical Necessity or the use of Experimental or Investigational treatment (or any similar reason), an explanation of the scientific or clinical judgment for the determination as applied to the Plan and your claim (or a statement that this explanation is available upon request)

Time Frames for Filing Claims and Appeals

The charts on the following pages set forth the time frames by which you and the Plan must take action with respect to filing and appealing urgent, pre-service, concurrent care decisions and post-service claims.

Time Frame for Initial Claims Decisions

Time frames generally start when the claims administrator receives your claim (see the special rule for “concurrent care” decisions to limit previously-approved treatments). Notices of benefit determinations will generally be provided by mail or sent by electronic delivery before the period expires, though oral notices may be provided in limited cases. Any reference to “days” in the following chart means calendar days.

Claim Type	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Decision to Reduce Benefits
Applies To	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**
Time frame Plan to Provide Notice	Notice of determination (whether adverse or not) will be provided as soon as possible considering Medical Necessity (no later than 72 hours). If you request in advance to extend ongoing treatments, a notice of determination will be provided as soon as possible taking into account medical exigencies (no later than 24 hours).	Notice of determination (whether adverse or not) will be provided within a reasonable period of time appropriate to the medical circumstances (no later than 15 days).	Notice of adverse determination will be provided within a reasonable period of time (no later than 30 days).	Notice of adverse determination will be provided sufficiently in advance to give you an opportunity to appeal and obtain decision before benefit is reduced or terminated. [1]

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[1] If your Concurrent Care Claim is also an Urgent Care Claim to extend a previously approved ongoing course of treatment provided over a period of time or number of treatments, Blue Cross, TARP, HMC, or JBT’s Administrative Office will provide you or your authorized representative with its determination within twenty-four (24) hours after receipt of your claim, provided that the claim was made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If your or your doctor’s request for extended treatment is not made at least twenty-four (24) hours prior to the end of the prescribed period of time or number of treatments, the request will be treated as an Urgent Care Claim.

Claim Type	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Decision to Reduce Benefits
Applies To	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, MHN Mental Health, VSP Vision, Dental**
Plan Extensions	Up to 48 hours (subject to decision being made as soon as possible) for missing claim information; period measured from when information is received or extension period expires.	Up to 15 days if necessary due to matters beyond the claims administrator's control. You will be provided an extension notice before period ends.*	Up to 15 days if necessary due to matters beyond the claims administrator's control. You will be provided an extension notice before period ends.*	N/A
Other Related Notices	Notice that claim is improperly filed or missing information will be provided as soon as possible (no later than 24 hours).	Notice that claim is improperly filed will be provided as soon as possible (no later than 5 days).	N/A	N/A
Period for You to Complete Claim	You will have a reasonable period of time to provide missing information (no less than 48 hours).	You will have at least 45 days to provide any missing information.	You will have at least 45 days to provide any missing information.	N/A
Time frame for Plan decision after receipt of additional information	48 hours after receipt.	15 days after receipt.	15 days after receipt.	N/A

*15-day or 30-day extension period (whichever is applicable) is "tolled" until you respond to the notice.

Time Frame for Appeal Process

Time frames for filing an appeal start when you receive written notice of the adverse benefit determination or EOB. The time frames for providing a notice of the appeal decision (a “notice of benefit determination on review”) start when the appeal is filed with the appeals administrator. The notice of appeals decision will generally be provided by mail or sent by electronic delivery before the period expires, though urgent care decisions may have to be delivered by telephone, facsimile or other available expeditious method. Any reference to “days” in the following chart means calendar days. An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an Urgent Pre-Service, Non-Urgent Pre-Service or Post-Service Claim, depending on the situation.

Claim Type	Urgent Care Claims	Pre-Service Claims	Post-Service Claims
Applies To	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, VSP Vision, Dental**	**JBT Medical, Caremark Prescription Drugs, Landmark Chiropractic, TARP Drug and Alcohol Rehabilitation, VSP Vision, Dental**
Period for Filing Appeal	At least 180 days.	At least 180 days.	At least 180 days.
Time frame for Providing Notice	You will receive a notice of benefit determination on review as soon as possible taking into account medical exigencies (no later than 72 hours).	You will receive a notice of benefit determination on review within a reasonable period of time appropriate to medical circumstances (no later than 30 days).	You will receive notice of benefit determination on review five days after a decision is rendered by the Board of Trustees.*
Extensions	None	None	None

* Appeals of Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within 30 days of the next regularly scheduled Board meeting, your appeal will be decided at the second regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the third regularly scheduled Board meeting following receipt of your appeal. You will be notified in writing if an extension is necessary.

Additional Claims Provisions

Right to Sue

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- You have appealed the denial of your claim,
- The time period for filing an appeal has expired, or
- While your appeal is still pending.

Your ERISA Rights, beginning on page 140, provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

Benefit Payments

All benefits shall be paid by the Trust to the participant as soon as reasonably practicable after receipt of written proof satisfactory to the Plan covering the occurrence, character and extent of the event for which the claim is made.

Benefits Not Subject to Alienation

Plan benefits shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person; however, a participant may direct that his or her benefits may be paid to a hospital, any provider of medical, dental or hospital services or supplies in consideration for medical, dental or hospital services rendered or to be rendered, or supplies furnished or to be furnished, or to any other person or agency that may have provided or paid for, or agreed to provide or pay for, any Plan benefits.

Right to Examine

The Plan, at its own expense, shall have the right and opportunity to examine the person of any participant when and as often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Board of Trustees.

Payments Made in Error

In the event the Plan erroneously makes benefit payments to a participant in excess of the amounts provided for by this Plan, or erroneously makes benefit payments to a participant for expenses for which benefits are not payable under this Plan, or erroneously makes benefit payments to an individual who fraudulently participates in the Plan based on a misrepresentation of facts, the erroneous amounts so paid shall be repaid to the Trust by the participant or individual. If such amounts are not repaid by the participant or individual, the Plan may deduct

the amount erroneously paid from any future benefit payments due the participant or the Trustees may file suit to recover any amounts due.

Claims Administrator Addresses

For JBT Medical Claims

Health Services Benefit Administrators
P.O. Box 2109
Livermore, California 94551

For Prescription Drug Claims

Caremark
Account Services
9501 E. Shea Blvd.
Mail Code 128
Scottsdale, Arizona 85260

For Dental Claims

Health Services Benefit Administrators
P.O. Box 2069
Livermore, California 94551

For Vision Claims (non-preferred)

Vision Service Plan
P.O. Box 997105
Sacramento, California 95899-7105
For status of any claim go to www.VSP.com

For Chiropractic Claims

Health Services Benefit Administrators
P.O. Box 2109
Livermore, California 94551

For Mental Health Claims

(Claims)

Managed Health Network (MHN)
P.O. Box 14621
Lexington, Kentucky 40512-4621

(Appeals)

Managed Health Network (MHN)
Member Appeals Department
503 Canal Blvd
Point Richmond, CA 94804

For Drug and Alcohol Rehabilitation Claims (TARP)

Health Services Benefit Administrators
P.O. Box 2109
Livermore, California 94551

LIFE INSURANCE BENEFITS

Life Insurance Benefits

The following Plan benefits are guaranteed under a contract or policy of insurance, as identified:

- Life Insurance

  Prudential Life Insurance Company of America
  Group Life Claims Division
  P.O. Box 8517
  Philadelphia, PA 19101

- Accidental Death & Dismemberment Insurance

  Prudential Life Insurance Company of America
  Life Claims Division
  P.O. Box 8517
  Philadelphia, PA 19101

A booklet/certificate of coverage that describes the life insurance benefit and accidental death & dismemberment insurance ("AD&D") benefit, including the applicable claims and appeals procedures, provided under the Plan by Prudential Life Insurance Company of America ("Prudential") is provided as a separate document by Prudential at no charge. A copy will be mailed to your home address on file with JBT. You may also contact JBT's Administrative Office to obtain a copy of Prudential's booklet/certificate of coverage.

Prudential is responsible for determining all claims and appeals for life insurance and AD&D insurance benefits. To file a claim, you must use Prudential's claim form and follow Prudential's claims procedure. To obtain life insurance and AD&D insurance claim forms, contact your local union office or JBT's Administrative Office.

ERISA AND OTHER FEDERAL RIGHTS

ERISA and Other Federal Rights

Your ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information about Your Plan and Benefits

- You can examine, without charge, at JBT's Administrative Office and at other specified locations (such as worksites and local unions) all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Trust with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain, upon written request to the JBT Board of Trustees or JBT's Administrative Office, copies of all documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. (A reasonable charge may be made for the copies. The Summary Plan Description is provided at no charge).
- You should receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide a copy of this summary annual report to each Plan participant.

Continue Group Health Plan Coverage

You can continue health care coverage for you and/or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and/or your dependents may have to pay for such coverage. For details, review the COBRA information beginning on page 24.

Reduce or Eliminate Exclusionary Periods

If you have creditable coverage from another plan, you're entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan. Your group health plan or health insurance issuer should provide a certificate of creditable coverage, free of charge, in the following instances:

- When you lose coverage under the Plan
- When you become entitled to elect COBRA continuation coverage,
- When your COBRA continuation coverage ceases
- If you request it before losing coverage
- If you request it up to 24 months after losing coverage

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. These people, called "fiduciaries" of the Plan, have a duty to operate your Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your participating employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare (or pension) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right (within certain time schedules) to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive your copies within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

You may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court if Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542.

Newborns' and Mothers' Health Protection Act of 1996

Group plans and health insurance issuers generally may not, under federal law, 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). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer to prescribe a length of stay not in excess of 48 hours (or 96 hours).

Privacy of Your Health Information

The Joint Benefit Trust has long protected the privacy of its members' health information and has undertaken efforts to comply with all laws and regulations intended to protect the privacy of such information. As set forth below, effective April 14, 2003, the Plan was amended to comply with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996, as amended. If you have any questions regarding the Plan's privacy policies and procedures, please call JBT's Administrative Office or refer to the Notice of Privacy Practices provided to you by JBT. If you need another copy of the Notice, please call JBT's Administrative Office at 1-800-JBT-HELP (1-800-528-4357).

Group Health Plan Amendment to the Joint Benefit Trust Health & Welfare Plan

WHEREAS, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), impose privacy obligations on group health plans that restrict the use and disclosure of protected health information ("PHI");

WHEREAS, the Board of Trustees of the Joint Benefit Trust sponsors and maintains the The Joint Benefit Trust Health & Welfare, which is subject to the HIPAA regulations;

WHEREAS, the Board of Trustees and agents intend to receive PHI from the Plan and all those Covered Entities participating in the Organized Health Care Arrangement that includes the Plan, its health insurance issuers and HMOs from time to time;

WHEREAS, the HIPAA regulations require the Board of Trustees to amend the Plan document to incorporate provisions specified in 45 CFR 164.504(f)(2) prior to the receipt of such PHI; and

WHEREAS, the Trust Agreement and the Plan document authorize the Board of Trustees to adopt Amendments to the Plan;

NOW, THEREFORE, the Plan is hereby amended, as set forth below, to implement appropriate protections required under the HIPAA regulations.

1. **Effective Date.** This Amendment is effective as of April 14, 2003.

2. **Uses and Disclosures of PHI**. The Plan may disclose a Participant's PHI to the Board of Trustees for the purpose of performing Plan administration functions as described in 45 CFR 164.504(a), to the extent permitted under the HIPAA regulations. Such Plan administration functions may include, but are not limited to, hearing appeals of denied claims, arranging for legal services, and handling the financial activities of the Plan. The Board of Trustees will not use or further disclose PHI other than as permitted or required according to this stated purpose or as required by applicable law.

3. **Restriction on Plan disclosure to the Board of Trustees.** Neither the Plan nor any of its business associates, health insurance issuers, or HMOs, will disclose PHI to the Board of Trustees except upon the Plan's receipt of the Board's certification that the Plan document has been amended to incorporate the agreements of the Board under paragraph 4, except as otherwise permitted or required by law.

4. **Privacy Agreements of the Board of Trustees.** As a condition for obtaining PHI from the Plan and other insurers and HMOs participating in the Organized Healthcare Arrangement the Board agrees it will:

a) Not use or further disclose such PHI other than as permitted by paragraph 2 of this Amendment, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

b) Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Board with respect to such information;

c) Not use or disclose the PHI for employment-related actions of an entity appointing a member of the Board of Trustees, e.g., Union, employer or employer association; or in connection with any other benefit or benefit plan sponsored by the Board or an entity appointing a member of the Board of Trustees e.g., union, employer, or employer association;

d) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Board of Trustees becomes aware;

e) Make the PHI of a particular Participant available for purposes of the Participant's requests for inspection or copying, according to HIPAA regulation 45 CFR 164.524;

f) Make the PHI of a particular Participant available for purposes of the Participant's requests to amend PHI and incorporate any amendment to PHI according to 45 CFR 164.526;

g) Make the PHI of a particular Participant available for purposes of required accounting of disclosures by the Plan pursuant to the Participant's request for such an accounting according to HIPAA regulation 45 CFR §164.528;

h) 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 for purposes of determining compliance by the Plan with the HIPAA regulations;

i) If feasible, return or destroy all PHI maintained in any form and retain no copies of such information 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 information infeasible.

5. **Definitions.** All capitalized terms within this Amendment not otherwise defined by the provisions of this Amendment shall have the meaning given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under the HIPAA regulations.

6. **Adequate Separation.** The Board of Trustees will ensure that there is adequate separation between the Plan and the Board of Trustees as required by the HIPAA regulations in the event the Board of Trustees retains any employees who will assist it the performance of Plan administration functions.

7. **Miscellaneous.**

a) **Rights.** This Amendment shall not be construed to establish requirements or obligations beyond those required by the HIPAA regulations. Any portion of this Amendment that appears to grant any additional rights not required by the HIPAA regulations shall not be binding upon the Board.

b) **Amendment.** The Board reserves the right to amend or terminate any and all provisions set forth in this Amendment at any time to the extent permitted under the HIPAA regulations.

c) **Delegation.** The Board may delegate or allocate any authority or responsibility with respect to this Amendment. The Board (or its delegate) has discretion to construe and interpret the terms, provisions and requirements of this Amendment. All decisions of the Board (or its delegate) with respect to this Amendment will be given the maximum deference permitted by law.

d) **Document Retention.** If a communication under this amendment is required by the HIPAA regulations to be in writing, the Board will maintain such writing, or electronic copy, as documentation. If an action, activity, or designation is required by the HIPAA regulations to be documented, the Board will maintain a written or electronic record of such action, activity or designation. The Board will retain the required documentation for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

ADMINISTRATIVE INFORMATION

Administrative Information

Name of Plan

The full name of this Plan is the Joint Benefit Trust Health and Welfare Plan for 1400 Hour Employees.

Type of Plan

This is a welfare plan that provides medical benefits, surgical and hospital benefits, dental benefits, vision care benefits, prescription drug benefits, and group life and accidental death and dismemberment insurance.

Collective Bargaining

This Plan is maintained pursuant to the labor agreement between the California Processors, Inc. and the Teamsters California State Council of Cannery and Food Processing Unions and other Collective Bargaining Agreements, copies of which are available for examination during normal business hours by Plan participants and Beneficiaries at JBT's Administrative Office. Copies will be provided to Plan participants and Beneficiaries upon written request to JBT's Administrative Office.

Plan Numbers

JBT Employer Identification Number: 94-6284253

Plan Identification Number: 501

Plan Year

The Plan Year starts on May 1 and ends on April 30.

Plan Funding

The Plan is funded by monthly contributions from Participating Employers, paid on behalf of eligible employees and their eligible dependents. A list of Participating Employers is available from JBT's Administrative Office. The amount of the contribution is determined by the Board of Trustees of the Joint Benefit Trust acting under the authority of the Collective Bargaining Agreements. In some cases, as described beginning on page 24, employees may be able to self-pay for a period of time when they are not covered by employer contributions. Assets of the Plan are held in trust, and benefits are funded through the Joint Benefit Trust. Eligibility for benefits under the Plan (except in circumstances where you are entitled to extended coverage or coverage

through self-payment as described beginning on page 24) depends on continued receipt of employer contributions on your behalf. If your employer stops making contributions to the JBT you lose your eligibility for benefits. In addition, the Trust's obligation to provide benefits is limited to the extent the Bargaining Agreements provide for funding of the Trust sufficient to provide benefits.

- JBT Medical, prescription drug, dental, Chiropractic Treatment, and alcohol & chemical dependency coverages are funded directly by the JBT. These benefits are not insured by any contract of insurance and there is no liability on the Trustees or any other individual or entity to provide payment over and beyond the amounts in the Joint Benefit Trust collected and available for such purpose.
- HMO coverage, mental health benefits provided by MHN, vision care benefits, and life insurance and AD&D benefits are funded through contracts between, respectively, the HMOs, MHN, VSP, and Prudential Insurance. Under these contracts, these providers assume the risk for payment of claims.

Future of the Plan

Amendment

The Plan was established and is maintained through collective bargaining. The Trustees anticipate that the Plan will continue as long as the Collective Bargaining Agreements so provide or until the bargaining parties elect to discontinue the Plan. The Trustees reserve the right, to the extent not explicitly reserved for the bargaining parties, to change or modify the Plan at any time for any reason without specific approval of any person. Such modification to the Plan shall be enacted through a formally approved resolution at a regularly constituted Trustees meeting held according to the established process of the Trustees. A change or modification of the Plan shall not affect a claim incurred by a participant before such change or modification is adopted.

Termination

This Plan shall, except as modified below, continue in full force and effect for the duration of the Collective Bargaining Agreement and any amendments, extensions, or renewals thereof by which it is required that a Participating Employer make payments into the Trust for the purpose hereinbefore set forth. If the Trust Agreement and Plan are not voluntarily extended by the Participating Employers and the Union, the Trust shall be applied and disbursed by the Trustees so as to:

- Pay any and all outstanding debts and obligations of the Trust and the benefits established hereunder, including this Plan, then
- Apply any remaining surplus in a manner best able to effectuate the purposes contemplated by the Trust Agreement, and then upon disbursement of the entire Trust, the Joint Benefit Trust and the Plan shall terminate. However, if prior to the disbursement of the entire Trust, a new Collective Bargaining Agreement is entered into between the Participating Employers and Unions that provides for contributions to a benefit trust, and the Board of Trustees

concludes that continuation of the Trust is actuarially sound, the Trust Agreement and the Plan shall continue in full force and effect, and there shall be no further action taken toward termination of the Joint Benefit Trust or the Plan. Thereafter, all disbursements shall be made only as provided for by the Trust Agreement and the Plan. In no event shall Plan termination result in a reversion of assets to any Participating Employer. A termination of the Plan shall be enacted through a formally approved resolution at a regularly constituted Trustees meeting held according to the established process of the Trustees.

Trust Agreement and Collective Bargaining Agreement Controls

The benefits of this Plan are subject to and controlled by the provisions of the Cannery Council/CPI Collective Bargaining Agreement and the JBT Trust Agreement, and in the event of any conflict between the provisions of this Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail. In the event of any conflict between this Plan and the Collective Bargaining Agreement, the Cannery Council/CPI Collective Bargaining Agreement shall prevail.

Administration Responsibilities

The Trustees shall be the named fiduciaries with the absolute discretionary authority to control and manage the operation and administration of the Plan and to interpret or construe all provisions of the Plan, including the discretionary authority to determine eligibility for benefits. These fiduciaries shall be deemed to have properly exercised their authority unless they have abused their discretion hereunder by acting arbitrarily or capriciously. The Trustees shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Trustees may deem appropriate. The rules, interpretations, computations and actions of the Trustees shall be binding and conclusive on all persons. In administering the Plan, the Trustees shall at all times discharge their duties with respect to the Plan according to the standards set forth in section 404(a)(1) of ERISA.

Performance of Duties and Responsibilities

The Trustees may engage such attorneys, actuaries, accountants, consultants or other persons to render advice or to perform services with regard to any of its responsibilities under the Plan as it shall determine to be necessary or appropriate. The Trustees may designate by written instrument (signed by both parties) one or more actuaries, accountants, administrative service organizations or consultants as fiduciaries to carry out, where appropriate, fiduciary responsibilities of the Trustees. The Trustees may rely on the actions of an administrative service organization or the written opinion or advice of counsel or any actuary prudently retained by the Trustees.

Record Keeping and Authorization of Benefit Payments

The Trustees shall cause to be kept full and accurate accounts of receipts and disbursements of the Plan.

Administrative Office

The Administrative Office shall be appointed by the Trustees to administer claims under the Plan, provided, however, that JBT's Administrative Office, to the extent required by ERISA, acknowledges in writing that it is a fiduciary with respect to the Plan. The Trustees shall periodically review the performance and methods of the Administrative Office and may appoint, remove or replace JBT's Administrative Office at any time for any reason. JBT's Administrative Office shall make a determination as to the right of any participant to a benefit and shall afford any participant dissatisfied with such determination the right to a review.

Payment of Plan Expenses

The expenses of administering the Plan, including (1) the fees and expenses of JBT's Administrative Office, (2) the expenses incurred by the Trustees in the performance of duties under the Plan (including reasonable compensation for legal counsel, certified public accountants, actuaries, consultants, and agents, and the cost of other services rendered with respect to the Plan), and (3) all other proper charges and disbursements by the Trustees (including settlements of claims or legal actions approved by counsel to the Plan) will be paid from the general assets of the Trust. In estimating costs under the Plan, administrative costs may be anticipated.

Administration and Financing of Plan Benefits

This Plan is administered by the Board of Trustees of the Joint Benefit Trust, which contracts for administrative services for medical, surgical, hospital, dental, chiropractic benefits, treatment for alcohol and chemical dependency and prescription drug benefits with:

Health Services Benefit Administrators (HSBA)
160 Airway Boulevard
Livermore, California 94551
925-449-7070 or 1-800-528-4357 (toll-free in California)

Correspondence may be addressed to:

Joint Benefit Trust Administrator
P.O. Box 2479
Livermore, California 94551

The Plan benefits described above are not guaranteed under a contract or policy of insurance. Appeal of claims filed with and processed by Health Services Benefit Administrators should be addressed to the JBT Board of Trustees, care of Health Services Benefit Administrators.

JBT has also contracted with certain Health Maintenance Organizations ("HMOs") to provide medical benefits to Plan participants who choose HMO coverage. HMO premiums are paid out of Trust assets. The HMOs are solely responsible for the financing and administration of their program of benefits. The HMOs include:

Kaiser Permanente
1800 Harrison Street
Oakland, CA 94612

Health Net of California, Inc.
21281 Burbank Blvd.
Woodland Hills, CA 91367-6607

PacifiCare
5701 Katella Avenue
Cypress, CA 90630-5028
or
PO Box 6006
Cypress, CA 90630

JBT has contracted with Managed Health Network (MHN) on a capitated basis, to provide mental health benefits for those participants covered by the JBT Medical option and, as of June 1, 1998, to provide mental health benefits for those participants in the Health Net and PacifiCare HMOs. MHN can be reached at:

Managed Health Network (MHN)
PO Box 47049
Los Angeles, CA 90047-0259
1-800-528-0646

MHN is responsible for determining what services are appropriate and necessary for participants. MHN is solely responsible for the financing and administration of its program of benefits.

The following Plan benefits are provided under a contract or policy of insurance, as identified:

Vision Plan
Vision Service Plan
P.O. Box 997100
Sacramento, California 95899-7001

Life Insurance Plan
Prudential Life Insurance Company of America
Group Life Claims Division
P.O. Box 8517
Philadelphia, PA 19101

Accidental Death & Dismemberment Plan
Prudential Life Insurance Company of America
Group Life Claims Division
P.O. Box 8517
Philadelphia, PA 19101

Board of Trustees

Union Trustees

Crescencio Diaz
Vice President
General Teamsters Union Local 890
207 North Sanborn Road
Salinas, CA 93905

John Hailstone
Teamsters Local 948 Teamsters
Cannery Workers, Food Processors
& Helpers Union General Jurisdiction
In Tulare and King Counties and
Cannery and Food Processing
Jurisdiction in Fresno, Merced and
Stanislaus Counties, California
1222 I Street
Modesto, CA 95354

Lucio Reyes
Secretary-Treasurer
Cannery Workers, Processors,
Warehousemen and Helpers
Union Local 601
745 E. Miner Avenue
Stockton, CA 95203

Sam Martinez
Secretary-Treasurer
Teamsters Local 948. Teamsters
Cannery Workers, Food Processors
& Helpers Union General Jurisdiction
In Tulare and King Counties and
Cannery and Food Processing
Jurisdiction in Fresno, Merced and
Stanislaus Counties, California
1222 I Street
Modesto, CA 95354

Employer Trustees

Richard Ehrler
Vice President of Human Resources
Pacific Coast Producers
631 N. Cluff Avenue
P.O. Box 1600
Lodi, CA 95241-1600

John Hurley
President
California Processors, Inc.
Harvey Milk Plaza
425 Military East, Suite J
Benicia, CA 94510

Richard Muto
Vice President
Personnel U.S./International Operations
Del Monte U.S.A.
Steuart Street Tower, 6th Floor
San Francisco, CA 94105

Tom Nett
Vice President of Human Resources
Seneca Foods, L.L.C.
2801 Finch Road
Modesto, CA 95354

Agent for Service of Legal Process

The Plan's agent for service of legal process is:

David Haumesser
Health Services Benefit Administrators
160 Airway Boulevard
Livermore, CA 94551
Telephone: (925) 449-7070

Legal process may also be served on any Plan Trustee.

Participating Employers

A complete list of Participating Employers who sponsor the Plan may be obtained by participants and beneficiaries from the Plan Administrator upon written request to JBT's Administrative Office. The list is also available for examination by participants and beneficiaries at JBT's Administrative Office during normal business hours.

DEFINITIONS

Definitions

Accredited School or College

Accredited School or College means any accredited high school, college, university, or other bona fide educational institution that provides a curriculum for full-time students such as a nursing school or trade school. Correspondence schools, night schools, or other institutions requiring less than full-time attendance are not acceptable.

Administrative Office

Administrative Office means an insurance company or a company having trust powers appointed by the Trustees to perform the day-to-day administration of the Trust and its benefit plans and regularly engages in the business of providing claims administration, adjustment and payment and claims review services to employee welfare benefit plans.

Approved Hospice Care Program

Approved Hospice Care Program means a Hospice Care Program that is accredited by the National Hospice Organization and is approved by the JBT Board of Trustees.

Bargaining Agreement see **Collective Bargaining Agreement**.

Beneficiary

Beneficiary means the person or persons you have designated to receive the Plan benefits payable if you die.

Board of Trustees see **Trustees**.

California Processors, Inc.

California Processors, Inc. (“CPI”) is an association of employers engaged in the processing of fruits and vegetables.

Cannery Council/CPI Collective Bargaining Agreement

Cannery Council/CPI Collective Bargaining Agreement means the most recent Collective Bargaining Agreement between California Processors, Inc. (“CPI”) and the Teamsters California State Council of Cannery and Food Processing Unions, International Brotherhood of Teamsters (“Cannery Council” or “Union”).

Chiropractic Treatment

Chiropractic Treatment means any treatment provided, supervised, or directed by a licensed chiropractor (including neuromuscular physical medicine) and incurred while under the care of a chiropractor, even if prescribed by a Doctor of medicine and/or performed by a physical therapist.

Collective Bargaining Agreement or Bargaining Agreement

Collective Bargaining Agreement means the most recent Collective Bargaining Agreement between a Participating Employer and Teamsters California State Council of Cannery and Food Processing Unions, International Brotherhood of Teamsters, and/or an affiliated local Union that has been approved for participation in the JBT by the Trustees and provides for contributions to the Trust.

Contract Rate

Contract Rate means a specially negotiated fee for health care services and supplies provided by facilities and providers with whom JBT (and/or its preferred provider organization) has a preferred provider contract.

Covered Expenses

Covered Expenses means expenses covered by the Plan that are:

- Medically Necessary and not Experimental or Investigational,
- Prescribed by a licensed Doctor,
- Within Reasonable and Customary (R&C) charge limits,
- Certified by the Plan's utilization review organization—Blue Cross of California at the time this SPD/plan document was published—when the Plan requires certification,
- Not excluded from coverage, and
- Within Contracted Rates negotiated with preferred providers.

Custodial Care

Custodial Care means care provided primarily for maintenance or to assist a covered individual in meeting activities of daily living. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision of medications not requiring constant attention of trained medical personnel.

Dental Table of Allowances

Dental Table of Allowances means the description of dental procedures and the amounts payable for each, which may be amended from time to time. **You will receive the Dental Table of Allowances by mail at your last known address.**

Delinquency Control Procedures

Delinquency Control Procedures means the procedures adopted by the JBT Board of Trustees to control delinquent contributions.

Dentist

Dentist means a Doctor of Dental Science or Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.) licensed to practice Dentistry in the state, country or other jurisdiction in which he or she renders treatment.

Disability or Disabled

Disability or Disabled means a physical or mental condition that fully prevents:

- An employee from performing the tasks required for employment under the Collective Bargaining Agreement or for working for wage or profit in any occupation, or
- A dependent from doing the regular and customary activities for a person of the same age and family status.
- For purposes of COBRA extended disability coverage and Medicare benefits due to disability, the terms refer to the Social Security Administration's determination of Disability.

Doctor or Physician

Doctor or Physician means a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.) or a Dentist licensed to practice medicine or Dentistry in all its branches, prescribe and dispense all Drugs, and perform all surgery under applicable laws of the place where treatment is rendered. To the extent that benefits are provided while the individual is practicing within the scope of his license, Doctor or Physician includes a podiatrist, chiropractor, psychologist, optometrist, and dispensing optician.

Domestic Partner

Domestic Partner means an individual who meets the conditions and requirements set forth under Domestic Partners, beginning on page 18.

Drug or Prescription Drug

Drug or Prescription Drug means that the article may be lawfully dispensed, as provided under the federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a Dentist or Physician (other than a podiatrist, psychologist or chiropractor) licensed by law to administer such an article.

Emergency see **Medical Emergency**.

Experimental or Experimental and Investigational

Experimental or Experimental and Investigational means any accommodations, services, supplies, or other items or combination of the foregoing that are determined by the Administrative Office to be a medical or health care procedure or treatment:

- That is not recognized as conforming to safe and accepted medical or health practice,
- In which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness established, or
- For which the required approval of a governmental agency has not been granted at the time the services are rendered.

JBT's Administrative Office will make such determination. To determine whether a particular accommodation, service, supply, or other item is Experimental, the Administrative Office may review established utilization review procedures, and refer to the current applicable literature and federal and state laws and regulations, and consider any other information it deems relevant or appropriate. Such determination will be conclusive and binding with respect to all concerned parties.

Home Health Care Services

Home Health Care Services means the following services provided in the home:

- Home Infusion Therapy
- Therapy services provided by a physical therapist, speech therapist, occupational therapist, home health aide services, and nursing care provided by a registered graduate nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.)
- Services that are Medically Necessary for treatment of an illness, injury or condition and ordered by the attending Physician and approved by the Trust's utilization review organization—Blue Cross of California at the time this SPD/plan document was published.

Home Health Care Services does **not** mean:

- Custodial Care or homemaker services
- Services that are provided by a nurse, home health aide or therapist who resides in the home or who is a member of the participant's family

Home Infusion Therapy

Home Infusion Therapy means medicine taken at home through a pump or IV that can be maintained by the patient after specific instruction by a registered nurse.

Hospice

Hospice means an alternate type of treatment for terminally ill patients. A Hospice facility or program focuses on trying to make death less painful, less stressful, and less fearful for the patient and his or her family. Hospices provide both home and inpatient care, including, but not limited to:

- Physician services
- Home Health Care Services
- Physical therapy
- Rental of hospital beds, wheelchairs, and other equipment
- Homemaker services
- Pain control
- Bereavement and emotional support services for the patients' family

Hospital

Hospital means an institution that meets all of the following requirements:

- It maintains permanent and full-time facilities for bed care of five or more resident patients;
- It has a Doctor in regular attendance;
- It continuously provides 24-hour nursing service by registered nurses;
- It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, convalescent home, or place for the aged, alcoholics, or drug addicts, provided, however, the above shall be waived if the institution is licensed by the State of California as an Acute Psychiatric Hospital, and
- It is operated lawfully in the jurisdiction where it is located.

Rest homes and convalescent homes are **not** Hospitals.

JBT Medical

JBT Medical means the indemnity medical benefit option that uses the Blue Cross of California's Preferred Provider Organization network of providers.

Joint Benefit Trust

Joint Benefit Trust means the trust established to provide employees with benefits pursuant to the Collective Bargaining Agreement and Trust Agreement.

Licensed Pharmacist or Pharmacist

Licensed Pharmacist or Pharmacist means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Medical Emergency or Medical Emergencies

Medical Emergency means a sudden onset of a medical condition that, in the absence of medical attention, could reasonably place the individual's health in jeopardy, cause serious medical consequences, serious impairment to bodily functions, or serious and permanent dysfunctions of any bodily organ or part.

In the context of a Mental Disorder, an Emergency exists if you are experiencing severe symptoms and are impaired in your functioning to the extent that you present an immediate danger to yourself or others.

Medically Necessary

Medically Necessary means services and supplies that are:

- Appropriate for the symptoms and diagnosis or treatment of the illness, injury, or condition
- Provided for the diagnosis or direct care and treatment of the illness, injury, or condition
- According to the standards of good medical practice
- Not primarily for the convenience of the person or the person's Physician or other provider
- The most appropriate supply or level of service that can be safely provided. When applied to Hospitalization, this further means that acute care as a bed patient is required due to the nature of the services received or the nature of the illness, injury, or condition when safe and adequate care cannot be received as an outpatient

Medically Necessary services must be covered by the Plan and provided by a licensed Doctor or recognized practitioner operating within the scope of his or her license. The fact that a Physician or other practitioner may prescribe, order, recommend, or approve a service or supply does not necessarily mean it is Medically Necessary.

Medicare

Medicare means the benefits provided under Title XVIII of the Social Security Act and all amendments to the Act, as amended.

Mental Health Terms

For definitions of specialized mental health terms, see Definitions beginning on page 81.

Participating Employer

Participating Employer means any employer or successor in interest to such employer that subscribes to the Trust Agreement and becomes obligated to contribute to the Plan, and is accepted for Plan participation by the JBT Board of Trustees.

Physician see **Doctor**.

Plan

Plan means the Joint Benefit Trust Health and Welfare Plan for 1400 Hour Employees, as amended and restated.

Plan Administrator

Plan Administrator means Health Services Benefit Administrators, Inc ("HSBA").

Plan Without a Coordination of Benefits Provision

Plan Without a Coordination of Benefits Provision means a plan or sub-plan with a coordination provision that the JBT Trustees deem intended as a means to restrict or limit benefits because of the existence of the JBT 1400 Hour Employee Plan.

Plan Year

Plan Year means the twelve-month period beginning each May 1 and ending April 30 of the succeeding year.

Pharmacist see **Licensed Pharmacist**.

Prescription Drug see **Drug**.

Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Order (QMCSO) means a medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan participant is eligible. The Plan Administrator must determine that the order is qualified under the terms of ERISA and applicable state law.

Reasonable and Customary

Reasonable and Customary means an amount charged by a provider of services or supplies that does not exceed the fair and reasonable value of the service or supply. When determining whether a charge is Reasonable and Customary, the following criteria apply:

- "Customary" means the charge is within the range of prevailing fees charged by providers of similar training or experience, within the same geographic area, for the performance of a specific service or procedure, and
- "Reasonable" means the fees are Customary and justified considering medical complications or special circumstances requiring additional time, skill or experience in connection with the performed service or procedure.

Skilled Nursing Facility

Skilled Nursing Facility means a facility or a distinct part of an institution that is approved as a Skilled Nursing Facility under Medicare or is established and operated according to the applicable state laws and regulations and meets the following conditions:

- It provides skilled nursing and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis, and
- It provides 24-hour inpatient care and, at a minimum, includes Physician, skilled nursing, dietary, pharmaceutical services, and an activity program.

A Skilled Nursing Facility is **not** an institution that is used primarily as a rest facility or a facility for the aged, drug addicts, alcoholics, the mentally retarded, custodial or educational care, or for care of mental disorders. A Skilled Nursing Facility is not a Hospice, as defined earlier in this section.

Trust

Trust means the Joint Benefit Trust ("JBT").

Trustees or Board of Trustees

Trustees or Board of Trustees means the Board of Trustees of the Joint Benefit Trust established by the Trust Agreement.

Trust Agreement

Trust Agreement means the Agreement and Declaration of Trust establishing the Joint Benefit Trust and any modification, amendment, extension or renewal thereof.

Union

Union means the Teamsters California State Council of Cannery and Food Processing Unions, International Brotherhood of Teamsters, and its affiliated local Unions.