TEAMSTERS CALIFORNIA STATE COUNCIL
OF CANNERY AND FOOD PROCESSING UNIONS

CALIFORNIA PROCESSORS
INCORPORATED

JOINT BENEFIT TRUST
ADMINISTRATOR
4160 Dublin Blvd., Suite 400
Dublin, California 94568-7756
PHONE: (925) 833-7306
FAX: (925) 833-7301

CHAIRMAN, Maria Ashley Alvarado
CO-CHAIRMAN, Stacey Cue

PLAN CHANGE NOTICE

Summary of Material Modifications

Employee Co-Contributions, Non-1400 Hour Plan Default, Anthem PPO Provider Agreements, Disability Benefit Claims Procedures, and Venue Selection

TO ALL ACTIVE 1400 HOUR AND NON 1400 HOUR PLAN PARTICIPANTS, DEPENDENTS and COBRA PARTICIPANTS:

EMPLOYEE CO-CONTRIBUTION

As provided in the CPI/Cannery Council Contract, the employee co-contribution changes October 1, 2018 (and in July of 2019 and 2020):

1400 Hour Plan

JBT Option	Current Employee Contribution	10/1/18 Employee Contribution	7/1/19 Employee Contribution	7/1/20 Employee Contribution
Blue Cross **"Prudent Buyer"** PPO (*Includes* Sutter hospitals and doctors)	$80/month	$100/month	$125/month	$150/month
Blue Cross **"Advantage"** PPO (*Excludes* Sutter hospitals and doctors)	$20/month	0	$10/month	$20/month
Kaiser	$80/month	$100/month	$125/month	$150/month

Non-1400 Hour Plan

JBT Option	Current Employee Contribution	10/1/18 Employee Contribution	7/1/19 Employee Contribution	7/1/20 Employee Contribution
Blue Cross **"Prudent Buyer"** PPO (*Includes* Sutter hospitals and doctors)	$48/month	$75/month	$100/month	$125/month
Blue Cross **"Advantage"** PPO (*Excludes* Sutter hospitals and doctors)	$30/month	0	$10/month	$20/month

Para espanol Ver al reverso

TEAMSTERS CALIFORNIA STATE COUNCIL
OF CANNERY AND FOOD PROCESSING UNIONS

CALIFORNIA PROCESSORS
INCORPORATED

JOINT BENEFIT TRUST
ADMINISTRATOR
4160 Dublin Blvd., Suite 400
Dublin, California 94568-7756
PHONE: (925) 833-7306
FAX: (925) 833-7301

CHAIRMAN, Maria Ashley Alvarado
CO-CHAIRMAN, Stacey Cue

AVISO DE CAMBIO DE PLAN

Resumen de Modificaciones Materiales

Co-Contribuciones del Empleado, Plan Predeterminado de No-1400 horas, Anthem PPO Acuerdos de Proveedores, Procedimientos de Reclamación para Beneficios por Incapacidad, y Selección de Lugar

PARA TODOS PARTICIPANTES ACTIVOS DE 1400 HORAS O NO-1400 HORAS, DEPENDIENTES Y PARTICIPANTES DE COBRA:

CO-CONTRIBUCIONES DEL EMPLEADO

Como se estipula en el Contrato de CPI/Cannery Council, la co-contribución del empleado cambia el 1 de Octubre, 2018 (y en Julio del 2019 y 2020):

Plan de 1400 horas

Opción de JBT	Contribución Actual del Empleado	Contribución del Empleado 1 de Octubre 2018	Contribución del Empleado 1 de Julio 2019	Contribución del Empleado 1 de Julio 2020
Blue Cross **"Prudent Buyer"** PPO (*Incluye* doctores y hospitales de Sutter)	$80/mes	$100/mes	$125/mes	$150/mes
Blue Cross **"Advantage"** PPO (*Excluye* doctores y hospitales de Sutter)	$20/mes	0	$10/mes	$20/mes
Kaiser	$80/mes	$100/mes	$125/mes	$150/mes

Plan de No-1400 horas

Opción de JBT	Contribución Actual del Empleado	Contribución del Empleado 1 de Octubre 2018	Contribución del Empleado 1 de Julio 2019	Contribución del Empleado 1 de Julio 2020
Blue Cross **"Prudent Buyer"** PPO (*Incluye* doctores y hospitales de Sutter)	$48/mes	$75/mes	$100/mes	$125/mes
Blue Cross **"Advantage"** PPO (*Excluye* doctores y hospitales de Sutter)	$30/mes	0	$10/mes	$20/mes

NON-1400 PLAN DEFAULT (effective 10/1/18)

Effective 10/1/18 the "default" option for Non-1400 Plan participants will change from the Prudent Buyer option (*includes* Sutter) to the Advantage option (*excludes* Sutter). Any Non-1400 Hour employees who do not choose between the Prudent Buyer and Advantage options during open enrollment will be defaulted to the Advantage Plan effective 10/1/2018. If you are currently in Prudent Buyer and want to stay in Prudent Buyer (and pay the higher monthly employee co-contribution) you must re-enroll in Prudent Buyer by turning in a "Plan Selection Form". If you do not turn in a Plan Selection Form you will be moved ("defaulted") into the Advantage Plan. Open enrollment materials will be mailed out during the month of August and all elections will be effective 10/1/18. Again, if JBT does not receive your 2018 Plan Selection Form electing the Prudent Buyer option you will be enrolled in the Advantage option effective 10/1/18. **The 1400 Hour Plan default option – Prudent Buyer -- is not changing.**

PLAN TERMS vs. PPO NETWORK AGREEMENT (effective 3/1/18)

If you are not enrolled in the Kaiser HMO, you are in the "self-insured" Plan and its "preferred provider organization" ("PPO") with Anthem Blue Cross. Effective 3/1/18, if any PPO Network Agreement to which the Trust is a signatory imposes coverage terms different from the terms of the Plan described in your Summary Plan Description, the PPO agreement will control how your Plan will cover, process, and pay the claim. This includes, but is not limited to, applicable time limits for processing claims and requirements regarding prior-authorization and utilization review. However, please note that the Board of Trustees reserves discretion to construe, interpret and apply the terms of the PPO Network Agreements as they relate to whether (and how) the Plan will cover, process, or pay a claim.

DISABILITY CLAIMS PROCEDURES (effective 4/1/18)

A disability claim is any claim where to decide if you are eligible for the benefit the Plan must first determine whether you are "disabled." The Fund Administrator determines if you are eligible for disability benefits and the Fund's procedures are described in the attached procedures entitled "How to File a Claim for Disability Benefits."

VENUE REQUIREMENT (effective 7/1/18)

As noted in a Summary of Material Modifications dated January 1, 2012, any lawsuit brought against the Joint Benefit Trust based on the denial of benefits or eligibility (or related matters) must be brought within one year of the date you are notified of the denial. **The only courts in which such lawsuits may be filed are the United States District Court for the Eastern District of California (which is located in Bakersfield, Fresno, Redding and Sacramento and Yosemite) or the United States District Court for the Northern District of California (which is located in Eureka, Oakland, San Francisco and San Jose).**

If you have questions regarding this Notice please contact:

JOINT BENEFIT TRUST
4160 DUBLIN BLVD, STE 400
DUBLIN, CA 94568
(800) 528-4357

In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

PLAN PARA EMPLEADOS SIN 1400 HOURS (efectivo 10/1/18)

A partir de 10/1/18 la opcion "predeterminada' para los participantes del Plan de Empleados SIN 1400 Horas, cambiara de la opcion de Prudent Buyer (incluye Sutter) a la opcion de Advantage (excluye Sutter). Cualquier empleado SIN 1400 Horas que no elija entre las opciones de Prudent Buyer o Advantage durante el periodo de la inscripcion abierta, sera colocado en el Plan de Advantage a partir de 10/1/18. Si actualmente esta en el Plan de Prudent Buyer y desea seguir con esta opcion (y pagar una contribucion mensual mas alta), debe re-inscribirse en el plan de Prudent Buyer, llenando el "Formulario de Seleccion del Plan". Si usted, no entrega el Formulario de Seleccion del Plan, lo trasladaran al Plan de Advantage (Predeterminado). Los materials de Inscripcion abierta se enviaran por correo durante el mes de Agosto y todas las elecciones entraran en vigencia el 10/1/18. Nuevamente, si JBT no recibe su Formulario de Seleccion de Plan 2018 donde elige Prudent Buyer Plan, se le inscribira en la opcion de Advantage a partir de 10/1/18. La opcion Predeterminada para los empleados de 1400 Hours no ha cambiado y seguira siendo Prudent Buyer.

TÉRMINOS DEL PLAN CONTRA EL ACUERDO DE LA RED PPO (efectivo 3/1/2018)

Si no está inscrito en Kaiser HMO, está en el plan "autoasegurado" y su "organización de proveedores preferidos" ("PPO") con Anthem Blue Cross. A partir del 3/1/2018, si cualquier acuerdo de la red PPO del cual el fideicomiso es signatario impone términos de cobertura diferentes a los términos del Plan descrito, el acuerdo PPO controlará cómo el plan cubrirá, procesará y pagará el reclamo. Esto incluye, entre otros, los límites de tiempo aplicables para procesar reclamaciones y requisitos con respecto a la autorización previa y la revisión de la utilización. Sin embargo, tenga en cuenta que la Junta de Fideicomisarios se reserva la discreción de interpretar y aplicar los términos de los Acuerdos de la Red PPO en lo que respecta a si (y cómo) cubrirá, procesará o pagará el plan

PROCEDIMIENTOS DE RECLAMOS POR INCAPACIDAD (Efectivo 04/01/18)

Una reclamación por incapacidad es cualquier reclamación donde decidir si usted es elegible para el beneficio el plan primero debe determinar si usted es "discapacitado." El administrador del fondo determina si usted reúne los requisitos para recibir beneficios por incapacidad y los procedimientos del fondo se describen en los procedimientos adjuntos titulados "Cómo presentar una reclamación por beneficios de incapacidad."

REQUISITO DE LUGAR (Efectivo 07/01/18)

Como se indicó en un resumen de las modificaciones materiales del 1 de Enero de 2012, cualquier demanda presentada contra el fideicomiso de beneficio común basado en la denegación de beneficios o elegibilidad (o asuntos relacionados) debe ser presentada dentro de un año de la fecha en que se le notifique la negación. **Los únicos tribunales en los que se pueden presentar tales demandas son el Tribunal de Distrito de los Estados Unidos para el Distrito Oriental de California (que se encuentra en Bakersfield, Fresno, Redding, Sacramento y Yosemite) o el Tribunal de Distrito de los Estados Unidos para el Norte Distrito de California (que se encuentra en Eureka, Oakland, San Francisco y San José).**

Si tiene alguna pregunta con respecto a este aviso, por favor contacte:

JOINT BENEFIT TRUST
4160 DUBLIN BLVD, STE 400
DUBLIN, CA 94568
(800) 528-4357

En conformidad con los requisites de informacion In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

PLEASE NOTE

This Notice is intended to amend your Summary Plan Description.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the *Summary Plan Description*. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

POR FAVOR TOME NOTA

Este aviso es para informarle de los cambios en la Descripcion del Resumen de su Plan

La intención de este aviso es para cambiar todos los documentos, anuncios y correspondencia de JBT, inclusive el Descripción del Plan de Beneficios. Este documento es un Resumen Material de Modificaciones con la intención de comunicar importantes cambios impactando su plan de beneficios. UD. debe de tomar tiempo en leer con cuidado este Resumen Material de Modificaciones (inclusive compartirlo con su familia) y manténgalo junto con su copia de la Descripción del Plan de Beneficios. Aunque muchos esfuerzos han sido tomados para proveer una descripción completa y precisa la verdad es no es posible incorporar aquí todos las condiciones y términos de su Plan de JBT. La Junta Directiva de JBT reserva el derecho completo de cambiar, enmendar, modificar, terminar e interpretar y decidir todo casos material bajo el Plan de JBT, inclusive cualquier beneficios bajo el Plan de JBT, en parte o en total, en cualquier momento y por cualquier razón.

Si usted necesita la información acerca de "como presentar un reclamo de incapacidad. Por favor de contactar la oficina de Administracion de Joint Benefit Trust al 1-800-528-4357.

JOINT BENEFIT TRUST

APRIL2018

HOW TO FILE A CLAIM FOR DISABILITY BENEFITS

A disability claim is any claim where to decide if you are eligible for the benefit the Plan must first determine whether you are "disabled." The following kinds of claims for "disability benefits" are subject to the new procedures described in this document:

- Extension of coverage for disabled employees for up to twelve months when employer-paid coverage ends because the participant is disabled ;
- Extension of coverage for a disabled dependent child age 26 and over who is unable to earn a living due to their disability or from doing the regular and customary activities for a person of the same age and family status, provided they were both eligible for JBT coverage and disabled before age 19.

To apply for a disability benefit you need to obtain a disability claim form from the Fund Administrator, complete the patient portion of the form, then give the form to your physician to complete the health care provider section. Return the completed disability claim form to the Fund Administrator (whose contact information is listed at the end of this document).

For Extension of Benefits, the Plan requires evidence when the first claim is submitted and the first claim must be submitted within a year of the onset of the disability. Disabled dependent children will not qualify absent submission of evidence (satisfactory to the Trust) of the onset of the disabling condition prior to reaching age 19.

The Fund Administrator will determine your disability benefits claim no later than 45 calendar days after receipt. You will be notified if you did not follow the disability claim process or if you need to submit additional information or records to prove a disability claim and you have up to 45 calendar days to obtain this additional information. This 45-day period may be extended for up to 30 calendar days provided the Fund Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period that additional time is needed to process the claim, the special circumstances for this extension, and the date by which it expects to render its determination.

If, prior to the end of this first 30-day extension, the Fund Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the expiration of the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. If the Fund Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the claim for disability benefits is approved, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

If the claim for disability benefits is denied in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to you in writing. This notice of initial denial will:

(a) Give the specific reason(s) for the denial of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(d) Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

(e) Provide an explanation of the Plan's appeal procedure along with time limits;

(f) Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) Describe any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(h) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(i) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(j) Include a statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Fund Administrator to find out if assistance is available.

APPEAL OF A DENIAL OF A DISABILITY CLAIM

If you disagree with a denial of a disability claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. You will be provided with:

(a) Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) Automatically and free of charge, provided any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

(e) Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date;

(f) If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

(g) A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and

(h) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

1) Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) Provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make an appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period.

You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) The specific reason(s) for the adverse appeal review decision of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented

by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(d) A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) A description of any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(f) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(g) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(h) A statement that if you are not proficient in English and have questions about disability benefits, filing a claim for disability benefits or about a claim denial, you should contact the Fund Administrator for assistance.

If you have questions contact:

JOINT BENEFIT TRUST
4160 DUBLIN BLVD, STE 400
DUBLIN, CA 94568
(800) 528-4357