SUMMARY PLAN DESCRIPTION

JOINT BENEFIT TRUST

HEALTH & WELFARE BENEFITS FOR ELIGIBLE PARTICIPANTS UNDER THE

SEASONAL MEDICAL BENEFITS PLAN

(Pre 7/1/2003 Three-Years Seniority)

EFFECTIVE JANUARY 2022

JOINT BENEFIT TRUST (JBT)
HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION (SPD)/PLAN DOCUMENT

Describing the Medical, Dental and Vision Benefits for Eligible Participants under the Seasonal Medical Benefits Plan Who Attained Three-Years Seniority by June 30, 2003

Amended, restated and effective **January 1, 2022**

Please note, the words 'Seasonal' and 'Full-Time' as used in the new Plan names are descriptive terms used in the cannery industry. The use of these words in the new Plan names or in this document is not intended to limit or modify in any way the seniority provisions or job classifications contained in any collective bargaining agreement which provides for participation in the Joint Benefit Trust.

Este libro contiene un resumen en inglés de los derechos y prestaciones que a usted le corresponden bajo los planes de el plan de beneficios médicos temporales que se ofrece a los empleados. Si tiene dificultad en entender alguna parte de este libro, puede dirigirse a su representante de la Oficina administrativa, quien le brindará la ayuda que necesite.

TABLE OF CONTENTS

MESSAGE FROM THE BOARD OF TRUSTEES

This document describes the self-funded Medical, Dental and Vision Benefits of the Joint Benefit Trust Health and Welfare Seasonal Medical Benefits Plan available to employees **who achieved 3-Years seniority status before July 1, 2003 (hereinafter referred to as the employees of the Seasonal Medical Benefits Plan)**. This is a closed group: No new employees may become eligible for coverage under this plan if they did not achieve 3-Years seniority status before July 1, 2003. The document constitutes a Summary Plan Description (SPD) and Plan Document/Plan Rules, as required by the Employee Retirement Income Security Act of 1974 (ERISA). This document provides information for the Seasonal Medical Benefits Plan related to:

- Benefits eligibility;
- Benefits coverage, exclusions, networks and Preauthorization;
- Claim filing and claim appeal procedures, and
- Administrative and legally required information about the Plan.

The Eligibility chapter describes the rules for who is eligible for coverage and when that coverage can begin for employees under the Seasonal Medical Benefits Plan who achieved 3-Years seniority status on or before July 1, 2003, and their eligible dependents.

JBT also offers benefits to eligible Full-Time Employees, retired Full-Time Employees, and Seasonal Employees who achieve 3-Years seniority status on or after July 1, 2003. Information on these benefits is not described in this document and is instead, described in the separate Summary Plan Descriptions of these respective plans.

The JBT Board of Trustees is the fiduciary responsible for the Plan and has delegated certain responsibilities as described in this document. Except as otherwise stated in this document, the Administrative Office provides administrative services under 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 the Administrative Office, is authorized to give information or commit the Trustees on any matter. As a convenience to you, the Administrative Office may 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 SPD/Plan Document will govern.

Important Notice.

- 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.
- This document does not serve as a guarantee of continued employment or benefits. No individual shall have accrued or vested rights to benefits under this Plan. Vested rights refer to benefits that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.
- As your Trustees, we make every effort to administer the Plan carefully making changes to your Plan as the JBT's financial condition changes and as mandated by law. Eligibility provisions may be modified in accordance with law, and benefits may be increased or decreased (amended) from time to time. You will be notified if there are material changes made to the Plan, or if the Plan is terminated.

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

Sincerely,

BOARD OF TRUSTEES

CHAPTER 1: INTRODUCTION

Establishment and Purpose

The Joint Benefit Trust Health and Welfare Plan for employees under the Seasonal Medical Benefits Plan ("Plan") was established effective January 1, 1974, to provide health care benefits to employees of Participating Employers of the Joint Benefit Trust. The Trustees intend to maintain the Plan on an indefinite basis, but the Plan is subject to the amendment and termination provisions discussed in Chapter 14: General Provisions And Information Required By ERISA. An explanation of the funding of the benefits mentioned in this document is also outlined in the General Provisions chapter.

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 as outlined in Chapter 3: Eligibility and Participation. The Plan is maintained for the exclusive benefit of employees and their eligible dependents. The Plan is amended and restated to read as set forth herein as of **January 1, 2021**. The Plan described in this document replaces and supersedes all other plan document/summary plan descriptions and related summaries of material modifications previously provided to you.

What This Document Tells You

This document will help you understand and use the benefits provided by the Joint Benefit Trust Health and Welfare Plan. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read Chapter 11: General Plan Exclusions and Chapter 15: Definitions.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in Chapter 2.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding any change of name or address, marriage, divorce or legal separation, death of any covered family member, birth, adoption, placement for adoption, legal guardianship or change in status or disability of a Dependent Child, Medicare enrollment or disenrollment, a previously covered dependent no longer qualifies as a dependent, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Administrative Office preferably within 31 days, but no later than 60 days, after the occurrence of any of the above noted events.

Failure to give the Administrative Office a timely notice of the above noted events may:

a. cause you, and/or your Dependent(s) to lose the right to elect and obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent to end when it otherwise might continue because of a disability,
c. cause claim payments to be delayed until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid on behalf of an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical dental, or vision benefits or take any other action to recover any overpayment of benefits.

CHAPTER 2: QUICK REFERENCE CHART

For Help or Information

When you need information, please check this document first. If you need further help, call the individuals listed in the following Quick Reference Chart:

Quick Reference Chart	
Information Needed:	**Contact:**
Administrative Office • Claim Forms (Medical and Dental) • Dental Table of Allowances • File Medical, Chiropractic, Substance Abuse and Dental Claims and Appeals • Eligibility Questions (including eligibility for medical, dental, vision) • Plan Benefit Information • Medicare Part D Notice of Creditable Coverage • Request Preauthorization of Certain Services • Request Preauthorization of Dental Services • Summary of Benefits and Coverage (SBC) • COBRA Administration — Information about COBRA coverage — Adding or dropping Dependents — Cost of COBRA Continuation Coverage — COBRA premium payments — Second qualifying event and disability notification — COBRA Election Form	**Health Services & Benefit Administrators (HS&BA)** 1-800-JBT-HELP (1-800-528-4357) www.jointbenefittrust.com Mailing Address: Health Services & Benefit Administrators 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756 *Mailing address for submitting COBRA election forms, required notices, and premium payments:* Joint Benefit Trust COBRA Administrator c/o Health Services & Benefit Administrators 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756
Medical Benefit Networks • Medical Network Provider Directory • Additions/Deletions of Network Providers * See below for provider network for substance abuse treatment	**Anthem Blue Cross** 1-844-699-8811 www.anthem.com/ca **BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** **To access the free provider directory**, you'll need to register. Simply enter the information requested on the website (including your member ID) and begin your search. **You can also call** **The JBT Doctor Facility Help Line at** **1-833-346-3365**

Quick Reference Chart	
Information Needed:	**Contact:**
Medical Benefit Networks (cont.) • To access Anthem's **Advantage or Prudent Buyer Provider Network**: **You can also call** **The JBT Doctor Facility Help Line at** **1-833-346-3365**	1. Log in to anthem.com (Note: If you log in as a member, your personal information will be shown including physicians and facilities within your chosen network). 2. If you do not have your user information or log in as a member on the anthem.com homepage, go to *Useful Tools* on the right, and select ***Find a Doctor***. 3. Choose search as a guest. 4. Under what type of plan select Medical (Employer-Sponsored) 5. Under select a plan/network choose either Advantage or Blue Cross Prudent Buyer—Large Group 6. Then choose type of provider, i.e., hospital, doctor and within doctor specialty. 7. Finally choose your location and how far you are willing to travel. Press search and either a list of providers will populate on the screen for you to choose from or your specific choice will be shown as in or out-of-network. 8. Either a list of providers will populate on the screen for you to choose from or your specific choice will be shown as in or out of the network.
Utilization Management (UM) Company • Preauthorization of certain Medical Benefit services (but not for Substance Abuse treatment). See Chapter 5: Utilization Management for a list of services that require Preauthorization and other information. • Appeal of UM decisions	**Anthem Blue Cross** 1-800-274-7767 www.anthem.com/ca Mailing Address: P.O. Box 60007 Los Angeles, CA 90060-0007
Pharmacy Benefit Manager • ID Cards • Retail Network Pharmacies • Prescription Drug Information • Formulary of Preferred Drugs • Specialty Guideline Management • Preauthorization of Certain Drugs	**CVS/Caremark** Member services: 1-800-294-5979 Preauthorization for Physicians: 1-800-294-5979 www.caremark.com Mailing Address: CVS/Caremark PO Box 659541 San Antonio, TX 78265-9541
Mammography Center Network (MCN) • Network of preventive care mammography Providers	**Health Services & Benefit Administrators (HS&BA)** 1-800-JBT-HELP (1-800-528-4357) www.jointbenefittrust.com

Quick Reference Chart	
Information Needed:	**Contact:**
Chiropractic Network • Chiropractic benefit questions • California Network of Chiropractic Providers	**Landmark Healthcare** 1-800-298-4875 www.LHP-ca.com Mailing Address for claims: Health Services & Benefit Administrators 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756
Substance Abuse Treatment Program • Call for confidential substance abuse treatment or to locate a network provider • Substance Abuse Treatment Network Provider Directory (No benefit will be provided for any care provided by a non-network provider.) • Preauthorization of certain Substance Abuse Treatment (See Chapter 5: Utilization Management for Preauthorization information and Chapter 8: Substance Abuse Treatment Benefits for more information) • Appeal of Substance Abuse Preauthorization decision • Administrative Office pays substance abuse claims	**Teamsters Alcohol/Drug Rehabilitation Program (TARP)** 1-800-522-8277 (Normal business hours are M-F 8:30am to 5:00pm PST, closed federal holidays) After normal TARP business hours you may leave a confidential message, or if you feel you need urgent medical assistance dial 911 or go to your nearest emergency room. Mailing Address for claims: Health Services & Benefit Administrators 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756
Dental Benefit • Dental benefit questions • Dental Network and Provider Directory • Administrative Office pays these claims • Dental claims and appeals	**Health Services Benefit Administrators (HS&BA)** 1-800-JBT-HELP (1-800-528-4357) Mailing Address for dental claims: Health Services & Benefit Administrators 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756
Vision Benefit • Vision benefit questions • Vision network and Provider Directory • Vision claims and appeals	**Vision Service Plan (VSP)** 1-800-877-7195 Website to locate a network provider: www.vsp.com Mailing Address for Out-of-Network Claims: VSP P.O. Box 997105 Sacramento, CA 95899-7105 Mailing Address for Claim Appeals: VSP Member Appeals 333 Quality Drive Rancho Cordova, CA 95670

Quick Reference Chart	
Information Needed:	**Contact:**
HIPAA Privacy Officer and Security Officer • HIPAA Notice of Privacy Practices	**Privacy Officer** **Health Services Benefit Administrators (HSBA)** 1-800-JBT-HELP (1-800-528-4357) Mailing Address: HSBA Privacy Officer or HSBA Security Officer 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756

CHAPTER 3: ELIGIBILITY AND PARTICIPATION

Employee Eligibility and Participation

In order to receive benefits a participant must be both eligible (you have met the work and other requirements set forth below) AND enrolled (you have submitted a complete enrollment form).

Who is Eligible?

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

a. You achieved 3-Years seniority status before July 1, 2003 under the terms of the Collective Bargaining Agreement between your Union and your employer;

b. You are on the seniority list as of the first day of the month;

c. You worked at least 80 hours for a Participating Employer during the preceding month; and

d. Your Participating Employer made the required contributions on your behalf.

When Employee Coverage Begins

Coverage begins on the first day of the month these four conditions are met and ends on the first day of any month you no longer meet all four requirements, unless you make self-payments under COBRA (see Chapter 4: COBRA Continuation Coverage).

For more information on how to enroll, see the Enrollment section of this chapter.

How Long Employer-Paid Coverage Continues

Your employer-paid coverage ends on the first day of any month you do not meet all four of the requirements listed above and will not resume until you meet all four requirements again.

Examples

Example 1: Your 3-Years seniority date is June 27, 2003. You return from layoff and work 60 hours in July 2019 and 150 hours in August. You are not covered in August, because you did not work 80 hours in July. You ***are*** covered in September because you worked 80 hours in August and were on the seniority list on September 1, 2019.

Example 2: Your 3-Years seniority date is June 27, 2003. In August 2019, you work 150 hours. In September, you work just 70 hours and are then laid off. You are covered through the end of September because you worked 80 hours in August. You are not covered in October because you worked fewer than 80 hours in September. Your employer-paid coverage will not resume until the month after you return from layoff and work at least 80 hours.

Example 3: Your 3-Years seniority date is June 27, 2003. You work 150 hours in August 2019. In September, you also work 150 hours but instead of being laid off, you quit or are terminated. You are covered in September because you worked 80 hours in August. Even though you worked more than 80 hours in September, you are not covered in October because, having quit or been terminated, you were not on the seniority list on October 1, 2019.

When Employee Coverage Ends

Employee coverage ends on the earliest of the last day of the month in which:

- your employment ends with a contributing employer to the JBT; or
- you enter the Armed Forces (the military) on full-time active duty; or
- you are no longer eligible to participate in the Plan; or
- your employer ceases to make contributions required for your coverage; or
- the date of your death; or
- the date the Plan is discontinued.

There is no opportunity to convert to an individual health plan after coverage ends under this Plan.

Retroactive Cancellation of Coverage

In accordance with the requirements in the Affordable Care Act, the JBT will not retroactively cancel coverage **except** in cases of fraud or intentional misrepresentation of a material fact.

If your coverage is terminated in cases of fraud or intentional misrepresentation of a material fact, it may be terminated, after 30 days' written notice, retroactively to the date that you or your covered Dependent performed or permitted the acts described above. Keeping an ineligible dependent enrolled under the Plan (for example, a Dependent Child is age 26 or older, or is otherwise ineligible) is considered fraud.

Employee Enrollment

In addition to the requirements described above, an employee must be enrolled in order to receive benefits. To enroll, the employee must complete the enrollment form and send it to the Administrative Office. You can call the Administrative Office to obtain a form. Once the form is received, any claims incurred after the initial date of eligibility, including claims incurred before enrollment was completed will be paid in accordance with plan rules.

Example: As an employee you are first eligible in June, lose eligibility in July and regain it in August. You submit claims for treatment in June, July and August but do not submit your enrollment form until September 5. Before September 5, claims for treatment will be denied. After September 5, claims for treatment in June and August will be paid because you are both eligible and enrolled. Claims for July treatment will continue to be denied because while enrolled, you were not eligible.

Dependent Child Eligibility and Enrollment

As is the case with an employee, to receive benefits a dependent child must be both eligible and enrolled. A child must also qualify as a Dependent Child. Dependent Children are eligible for medical, Prescription Drug, dental and substance abuse benefits but not vision benefits. There is no option to decline coverage. Spouses and Domestic Partners are NOT eligible for coverage, only your dependent children are.

A Dependent may not be enrolled for coverage unless the employee is also enrolled. Specific documentation to substantiate Dependent status is required by the Plan (see Dependent Child Defined and Enrollment Documents, below).

Dependent Child Eligibility

Dependent child eligibility begins on the later of the date the employee is first eligible or the date the dependent child meets the definition of a dependent child.

Dependent coverage ends on the earliest of the last day of the month in which:

- the Employee's coverage ends;
- your covered Dependent Child(ren) no longer meet the definition of Dependent Child(ren) as defined in this document;
- the date of the Dependent's death; or
- the date the Plan is discontinued.

There is no opportunity to convert to an individual health plan after coverage ends under this Plan.

Dependent Child Defined and Enrollment Documents

Relationship	*Documents Needed for Enrollment*
Biological child (son or daughter) of employee	Birth certificate showing biologic child of employee
Stepchild	Birth certificate, marriage certificate, registration of domestic partnership, proof of adoption as applicable
Adopted child, child placed for adoption	Proof of adoption or placement for adoption. Placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of such child in anticipation of adoption. Court appointed placement/adoption documents and certified birth certificate.
Alternate recipient under QMCSO	A Qualified Medical Child Support Order naming the child as an alternate recipient signed by a judge or a National Medical Support notice. See Appendix A for more information.
Legal guardianship child	Proof of court appointed guardianship and age will be required.

The following are not considered dependent children**:** foster children, a spouse of a Dependent Child (e.g., employee's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g., employee's grandchild unless the employee has been appointed the grandchild's legal guardian), a spouse, or a Domestic Partner.

No individual may be covered under this Plan both as an employee and as a Dependent. A Dependent Child may be the covered Dependent of more than one employee, however, coverage will not be coordinated for that Dependent Child.

Age limit — Upon reaching age 26, a child no longer qualifies as a dependent child eligible for benefits unless the child is Disabled.

Disabled Child — To qualify for benefits at age 26 or older the dependent child must:

- be unmarried;
- have been eligible for and enrolled in this Plan during the season immediately preceding his/her 26th birthday;
- be permanently and totally disabled (for example, the disability has lasted 12 months or is expected to last 12 months or result in death);
- the disability existed prior to the child's 26th birthday; and
- rely chiefly upon the employee for support or maintenance.

Note: If the child does not qualify as a tax dependent under IRC §152 (or where the state law definition of a dependent does not match with the federal law definition), your employer must include in your income the fair market value of the coverage provided to the adult child.

A child whose coverage has terminated due to reaching the age limit and who then becomes disabled cannot re-enroll as a disabled adult dependent child.

To enroll a disabled child, you will have to provide initial and continuing proof of disability. You will have 31 days from the date of request to furnish such proof or your disabled child will lose coverage.

Dependent Child Enrollment

The effective date of a dependent child's enrollment is the later of the date you are eligible or the first day of the month during which all required enrollment documents have been submitted. See table above. No benefits will be paid until your dependent child is enrolled. You must also be enrolled in order to enroll a dependent.

Example: As an employee you are first eligible in June and July, lose eligibility in August and regain it for September and October. You submit your enrollment form in July. On August 5 you marry and acquire stepchildren. You submit a marriage certificate and new enrollment form on September 10. On October 25, you submit the stepchildren's birth certificates. Claims are submitted for these children for treatment in August, September and October. The August claims will be denied both because you are not eligible and because the children are not enrolled. The September claims will be denied because while you are eligible, birth certificates have not been submitted and therefore the enrollment process is incomplete for your dependent children. October claims, even those for services done between the 1st and 24th will be processed because you are eligible and the dependent children's enrollment is effective October 1st, the first day of the month enrollment was completed.

Newborns including children adopted or placed for adoption within 31 days of date of birth*

Newborns are your biologic children, newborn biologic children of your spouse or domestic partner, or newborn children placed with you for adoption. To enroll your newborn child, you must fill out an enrollment form and submit the birth certificate. However, unlike all other dependent children, two special rules apply. First, once enrollment is completed, coverage is retroactive back to the date of birth. Second, treatment during the first 30 days after the date of birth will be covered provided you are eligible and the Administrative Office has received some evidence of your child's birth—typically a copy of the bill for delivery. See also required documents for adoption and placement for adoption.

* Includes legal guardianship.

Enrollment While On COBRA

COBRA is a federal law that under certain circumstances allows a participant or dependent child who has lost employer-paid coverage to continue coverage by making self-payments. COBRA rules are described in the following chapter. One such rule is that only participants enrolled when coverage is lost are eligible for COBRA. Unlike the enrollment rules described above, this means that an otherwise eligible dependent child who was not enrolled when coverage was lost cannot be enrolled now that you

are on COBRA until the next annual open enrollment period. If your unenrolled child has a Special Enrollment event, this child may be enrolled even if you are on COBRA. The deadline for such enrollment is generally 30 days from the date of the special enrollment event (60 days for certain Medicaid/CHIP events). Special enrollment events include marriage or loss of other coverage (30 days), or changes to eligibility for Medicaid/CHIP or Medicaid premium subsidy (60 days). Please see Chapter 4: COBRA Continuation Coverage or Appendix B for more information.

Example: As an employee you are first eligible in June and send in your enrollment form in July 2020. You list your dependent child but neglect to send in a birth certificate. The annual open enrollment period is the month of August. You lose coverage in October 2020 and elect COBRA. Because your dependent child is not enrolled (missing birth certificate) s/he cannot be enrolled until August 2021—the next annual open enrollment period.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Annual Open Enrollment

Open Enrolment Period is the period of time each year designated by the Board of Trustees during which eligible employees may elect one of two Blue Cross health plan networks, Prudent Buyer network which includes Sutter and the Advantage network which does not. While the benefits are the same, the co-contribution for the Prudent Buyer network is much higher. If no election is made, last year's election continues. If no prior election was made, the default is the Advantage Network. Because there are no out-of-network medical benefits, if you elect or are defaulted to the Advantage network and use a Sutter facility, no benefits will be paid except in the case of an Emergency. You can only change networks during the Open Enrollment period. Any election applies to both the employee and dependents. They cannot make separate elections. Elections are effective on the first day of the second month following the Open Enrollment period or on the date announced in the Open Enrollment notice.

If you are on COBRA during the Open Enrollment period, you may also enroll a dependent child. If you are not on COBRA, you may also enroll a dependent child although you do not need to wait for the annual open enrollment period to do so.

Other Information Concerning Coverage and Enrollment

Family and Medical Leave

You may be eligible for up to 12 weeks of unpaid leave of absence (in some cases, up to 26 weeks) under the federal Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) to take care of family matters such as birth and care of a newborn, newly adopted child, child placed for foster care, care of an ill parent, child or spouse, or your own serious health condition that makes you unable to perform your job. You are eligible for an FMLA or CFRA leave if you have been employed for at least 12 months at a worksite where your employer employs at least 50 employees (FMLA) or employs at least 20 employees (CFRA) 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 FMLA or the CFRA, 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 end of the month your employer stops making contributions because:

- Your FMLA/CFRA leave entitlement ends;
- Your employer can show that you would have been laid-off or the employment relationship terminated,
- You notify your employer that you do not intend to return to work;
- You do not return to work at the end of your leave, or
- You no longer satisfy the conditions for FMLA/CFRA leave;

whichever occurs first.

At the end of your FMLA/CFRA 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 FMLA or the CFRA, only the failure to return to work at the end of the approved leave constitutes a COBRA qualifying event.

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. JBT does not determine whether you are eligible for FMLA leave. For more information about leave available under the FMLA and CFRA, how the laws interact, and the terms on which you may be entitled to leave, contact your employer or Union.

Military Leave and USERRA

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because you have been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

Your coverage under this Plan will terminate when you enter active duty in the uniformed services.

- If you elect USERRA temporary continuation coverage, you (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the date the leave started.

- If you go into active military service for **up to 31 days**, you (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if you continue to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer you USERRA continuation coverage only after JBT has been notified by you in writing that you have been called to active duty in the uniformed services. You must notify your employer or Union soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage:

- Once your employer or Union receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for you (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if you do not elect USERRA for the dependents, those dependents cannot elect USERRA separately.
- Additionally, you (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively.
- Contact your employer or the Administrative Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Administrative Office in the same timeframes as is permitted under COBRA. (COBRA Continuation Coverage is described in Chapter 4).

Paying for USERRA Coverage:

- If you go into active military service for up to **31 days**, you (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if you continue to pay the appropriate contributions for that coverage during the period of that leave.
- If you elect USERRA temporary continuation coverage, you (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date the leave started.
- USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See Chapter 4: COBRA Continuation Coverage for more details.

In addition to USERRA or COBRA coverage, your eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When you are discharged from military service (not less than honorably), your employer paid coverage will be reinstated on the day you return to work provided you return to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- The first day of the calendar month following the month in which you work at least 80 hours in covered employment, if your period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

You must notify your Employer in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

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

Options When Employer-Paid Coverage Is Lost

Medical Extension of Benefits for Disability

If you are Disabled and under the treatment of a Physician on the day that all coverage under the Plan would otherwise terminate, the benefits provided under the Medical Benefit 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; or
- A period of no more than 90 days after the Plan itself is terminated or the JBT benefits under the Plan are terminated.

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, contact your employer or Union.

COBRA

If you and your dependents lose coverage because of loss of hours (e.g., seasonal layoff), termination or retirement, you may continue your coverage by making self-payments. If your dependent child loses coverage because of your death, the child reaches the age limit, or because of your divorce (stepchildren), or because the child otherwise ceases to meet the plan's definition of dependent child, your child may continue coverage by making self-payments. There are election deadlines and other rules. See chapter 4 for details.

Health Insurance Marketplace (Covered California) and/or Medi-Cal

When you lose employer paid coverage you will generally be eligible to purchase coverage through the Health Insurance Marketplace commonly referred to as "Covered California." Based on your family income, you may be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. For more information visit www.coveredca.com. You may be directed to Medi-Cal if the information you provide demonstrates you and your family may qualify, and you may apply

through the same website. If you do not live in California during the off-season see your state Health Insurance Marketplace or www.healthcare.gov.

Other Group Coverage

You may qualify for special enrollment under your spouse's or some other group health plan for which you are eligible, even if that other plan does not accept late enrollees. Please see your spouse's or the other group health plan's special enrollment provisions for more information and deadlines, but generally enrollment must be requested WITHIN 30 DAYS of losing coverage under this Plan.

Medicare

If you are 65 or older you may be eligible to enroll in Medicare. There are numerous options. Contact the Social Security Administration for information.

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 Allowable Charges 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.

Keep the Plan Updated

Remember to update your enrollment information with the Administrative Office 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 enrollment information is not up to date. Contact information for the Administrative Office is listed on the Quick Reference Chart in the front of this document.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 60 days, after the occurrence of any of the above noted events.

Failure to give the Administrative Office a timely notice of the above noted events may:

a. cause you and/or your Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid on behalf of an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical dental, or vision benefits.

CHAPTER 4: COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (a federal law commonly called COBRA) the Plan must offer employees and their covered Dependent Children (called Qualified Beneficiaries) the opportunity to temporarily extend coverage at group rates when coverage would otherwise end because of certain events (called Qualifying Events). Evidence of your good health is not required. However, you must pay for the coverage you elect. The Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

For information on the JBT's Medical Extension of Benefits for Disability, please see page 15.

Procedure for Notifying the Plan (Very Important Information)

To have the opportunity to elect COBRA Continuation Coverage after loss of coverage due to a divorce or legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.** (More information on this, as well as a definition of Qualifying Event, are provided below.)

That written notice should be sent to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Administrative Office within the 60-day period, you will not be entitled to choose COBRA Continuation Coverage.

Who Is Eligible for COBRA Coverage

Employees may be eligible for COBRA Continuation Coverage when they lose coverage because their:

- Hours of employment are reduced below the 80 hours per month required for employer-paid coverage. The reduction may be because of lay-off, disability, industrial injury, approved leave, or any other reason.
- Termination.
- Retirement.

Dependent Children may be eligible for COBRA Continuation Coverage when they lose coverage because:

- The employee lost coverage;
- The employee died;
- The Child no longer qualifies as a dependent because the child is over age 26 or the employee becomes divorced or legally separated and this causes the child to lose coverage (i.e., the Dependent Child was a stepchild of the employee).

COBRA Administrator

The COBRA Administrator is the Administrative Office. The name, address and telephone number of the Administrative Office is shown in the Quick Reference Chart in the front of this document.

Electing COBRA Coverage

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment (as applicable).

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any **Employee or the Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs**, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.
2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e.g.*, employee continues working even though entitled to Medicare) then COBRA is not available. **FOR THIS PURPOSE, YOUR LAYOFF AND LOSS OF EMPLOYER-PAID COVERAGE AT THE END OF THE SEASON IS A "QUALIFYING EVENT."**

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]	
	Employee	Dependent Child(ren)
Employee terminates including retirement.	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage) – for example, the end of the season.	18 months	18 months
Employee dies.	N/A	36 months
Employee becomes divorced or legally separated (if this causes Dependent Child to lose eligibility for coverage).	N/A	36 months
Dependent Child ceases to have Dependent status.	N/A	36 months

[1]: *When a covered employee's Qualifying Event (e.g., termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's*

covered Dependent Children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

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 coverage was lost due to the qualifying event. If you or your dependents decide to waive COBRA coverage, you do not need to notify the Administrative Office or complete any forms to waive COBRA. You will simply not submit a COBRA election form within the 60-day election period. Remember, you may not elect COBRA coverage after the 60-day election period ends.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, which, under this Plan, is measured from the date coverage was lost on account of the Qualifying Event. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in the section of this chapter regarding extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Notice of Early Termination of COBRA" that appears on page 27 of this chapter.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to obtain coverage under COBRA there are notice requirements, election periods and payment deadlines that must be met. These are summarized below, based on the "Qualifying Event" that resulted in your right to elect COBRA coverage in the first place.

Loss of coverage because of termination, retirement or loss of hours due to lay-off, approved leave or disability:

Notice	You will receive a notice from the JBT notifying you of your loss of coverage and explaining your COBRA rights and giving you an "election form."
Election period	60 days. You have 60 days from the date of the notice or the date coverage is lost, whichever is later, to elect COBRA. If you do not meet this deadline, you lose the right to purchase COBRA coverage.
Payment deadline	The first payment must be made no later than 45 days after COBRA coverage is elected. The payment must cover the premium from the date employer-paid coverage was lost. Subsequent payments are due on the first of the month and are considered late if not received within 30 days of the due date. If your payment is late, coverage is canceled back to the original due date.
Duration	18 months plus an additional 11 if you or your Dependent Child are disabled.
Coverage	Core (medical and Prescription Drug) or full (core plus dental and for the employee only vision). The Plan offers two networks, Advantage and Prudent Buyer. The cost is less if you are in the Advantage network.

Death of employee	Dependent Child loses coverage because employee dies.
Notice	Same as above, you will receive a notice from the JBT explaining your COBRA rights.
Election period	60 days from the date of the notice or the date coverage is lost, whichever is later.
Payment deadline	Same as above, first payment 45 days after election, subsequent payments due on the first of the month and late if not paid within 30 days of due date.
Duration	Up to 36 months
Coverage	As described above, except full coverage does not include vision.

Dependent Child loses coverage because reached age 26 or because there was a divorce and the Dependent Child was a stepchild of the employee:

Notice	DIFFERENT THAN ABOVE. The JBT will NOT send you a notice. You must notify the JBT within 60 days of the events described above. If your notice is late, you lose the right to purchase COBRA coverage. Once a timely notice has been received, the JBT will send you a letter explaining your COBRA rights and providing you with an election form.
Election period	60 days from the date of the notice or the date coverage is lost, whichever is later.
Payment deadline	Same as above, first payment 45 days after election, subsequent payments due on the first of the month and late if not paid within 30 days of due date.
Duration	Up to 36 months
Coverage	As described above, except full coverage does not include vision.

Notices and payments should be sent to the Administrative Office at the address provided in the Quick Reference Chart.

Each of the topics noted above is described in greater detail below. In addition, this chapter discusses what happens if there is a second qualifying event while you are on COBRA and the impact Medicare eligibility may have on your COBRA rights.

To elect COBRA Continuation Coverage after loss of coverage due to a child ceasing to be a "Dependent Child" under the Plan **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Administrative Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Your employer should notify the Administrative Office within 31 days of these events: an employee's death, termination of employment including retirement, reduction in hours making the employee ineligible for coverage, or entitlement to Medicare (if it causes the employee to be ineligible for coverage). However, **you or your family should also promptly notify the Administrative Office in**

writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When the Administrative Office is notified of a Qualifying Event**,** the Administrative Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.** Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not elect COBRA coverage within 60 days after receiving notice, you and/or they will have no coverage from this Plan after the date coverage ends.

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

If the Administrative Office is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation describing why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

COBRA Continuation Coverage Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you or your Dependent are required to pay monthly for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Levels of Coverage

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

Medical and prescription drug coverage alone, or

Medical and prescription drug coverage plus vision and dental coverage.

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

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 of COBRA coverage) will be 150% of the cost. The cost of COBRA is determined annually by the JBT Board of Trustees.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

The **first payment for COBRA Continuation Coverage** is due to the Administrative Office (address at page 3) **no later than 45 days** after COBRA Continuation Coverage is elected (if mailed, the date the Election Form is postmarked). If this payment is not made when due, COBRA Continuation Coverage will not take effect. 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 the 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 grace period after COBRA is elected, your COBRA coverage will not take effect and you must pay any health care expenses incurred during that period.

After you make the first payment, **subsequent COBRA payments** are due on the first day of each month. Payments are considered late if they are not received within 30 days of the due date (a 30-day grace period). If any of your COBRA payments are late, COBRA Continuation Coverage will be canceled as of the due date and you will lose all of your COBRA coverage rights. Payment is considered made when it is postmarked.

IMPORTANT

There will be no invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Administrative Office.

COBRA Payment Shortfalls

Significant Shortfall in Payment: If you or your dependent sends a timely monthly contribution to the Administrative Office that is **significantly less** than the actual COBRA payment due for the month, your or your dependent's COBRA coverage will be terminated immediately. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

Not Significant Shortfall in Payment: If the shortfall is not significant, the Administrative Office will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. You or your dependent are responsible for paying all deficiencies.

- If the **shortfall is paid** in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the **shortfall is not paid** in the 30-day time period, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made. Your short payment will be refunded to you.

If you have any questions about COBRA or need additional forms, please call the Administrative Office at their phone number on page 3.

Payment of Claims

Once you enroll in COBRA continuation coverage and pay the first premium payment, claims are payable from the effective date of COBRA coverage. The Plan will continue to pay claims for the length of your COBRA continuation coverage, provided you pay the monthly premiums on time without a significant shortfall.

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 the Medical Extension of Benefits, this applies to disabling conditions being treated before coverage ended.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you or your Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the initial grace period is still in effect **or** you or your Dependent(s) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) or the surviving family members of such individuals. Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019 and extended again through 2020. For more information, visit www.irs.gov/HCTC.

Addition of Newly Acquired Dependents

If, while you are enrolled in COBRA Continuation Coverage (meaning timely elected and premium paid), you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage provided you do so within 31 days after the birth, adoption, or placement for adoption. The child will be entitled to coverage during the remaining duration of COBRA. Contact the Administrative Office to add a dependent.

Loss of Other Group Health Plan Coverage

If your dependent loses coverage under another group health plan while you have COBRA Continuation Coverage, you may enroll the dependent for coverage for the balance of the period of COBRA Continuation Coverage. The dependent must have been eligible but not enrolled in coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the dependent within 31 days after the termination of the other coverage.

Loss of coverage also includes a dependent who loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). Enrollment in COBRA must be requested within 60 days after the Medicaid or CHIP coverage ends.

To request enrollment in COBRA for an eligible dependent under Special Enrollment, the Qualified Beneficiary must, request enrollment within 30 days (60 days for CHIP) after the date on which the dependent first becomes eligible for Special Enrollment, by contacting the Administrative Office and completing and submitting an enrollment form.

Extensions for 18-month COBRA Coverage Periods

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

Second Qualifying Event Extension

If your dependents are entitled to 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.

Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

To extend COBRA when a second Qualifying Event occurs, you or your Qualified Beneficiary must notify the Administrative Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice must include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event.

This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or Placed for Adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described below). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case will COBRA Continuation Coverage be extended for more than a total of 36 months.

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). This extension is available only if the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and** the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

You must submit written notification of the Social Security determination of Disability to the Administrative Office no later than 60 days after the loss of coverage or the date you or your dependent received the Social Security determination (whichever is later). Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice must

include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation. The notice must be received by the Administrative Office before the end of the 18-month COBRA Continuation period.

Example: After working 80 hours in October 2019, you are Disabled. You have employer-paid coverage in November 2019 (based on October work). If you elect COBRA coverage, you pay the normal COBRA rates for the next eighteen months (December 2019 through May 2021). 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 2021 through April 2022) by paying the higher disability extension COBRA premium 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 the 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. Contact information for the Administrative Office is listed on the Quick Reference Chart in the front of this document:

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 the Administrative Office within 30 days of the date you or your dependent receive the Social Security Administration's determination that you or your dependent are no longer Disabled. The disability extension will end on the first day of the month that is more than 30 days after the Disability ends. You must send your notice to the Administrative Office.

When COBRA Coverage Ends

COBRA coverage **will end on the earliest** of:

a. The end of the 18, 29, or 36-month period;

b. The date a COBRA coverage payment is not **paid in full and on time**;

c. The date the Qualified Beneficiary becomes covered, after the COBRA election, under another group plan;

d. The date the Qualified Beneficiary becomes covered, after the COBRA election, under Medicare Part A or Part B (COBRA coverage ends only for the person who becomes covered by Medicare);

e. 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;

f. The date determined by JBT that your Plan coverage will terminate due to fraud or intentional misrepresentation, or because you knowingly provided JBT or 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, after providing 30 days advance written notice, to rescind coverage back to the effective date of coverage.

g. The date the JBT no longer provides group health coverage to any Participants.

Notice of Early Termination of COBRA

If COBRA coverage ends prior to the 18, 29 or 36-month coverage period, the Administrative Office will provide a notice to the affected individuals as soon as practicable following the Administrative Office'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 or individual coverage, if any.

If you are Disabled when all coverage ends under Medical Benefit, you may be entitled to extended benefits. For information, see Chapter 3: Eligibility and Participation.

Marketplace Coverage and COBRA

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or the birth of a child through something called a "special enrollment period." But be careful – if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Medicare and COBRA

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period[1] to sign up, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan will terminate your continuation coverage.

However, if Medicare Part A or B is effective on or before your COBRA effective date, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after your COBRA effective date.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods. These rules are different for people with End Stage Renal Disease (ESRD).

COBRA Questions

For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

Once COBRA coverage terminates early it cannot be reinstated. There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

CHAPTER 5: UTILIZATION MANAGEMENT

Preauthorization Is Required in Certain Situations

Preauthorization Review is a procedure, administered by various review organizations under contract to the JBT (noted in the Preauthorization Requirements chart below), to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, surgery, and other health care services are Medically Necessary. During the Preauthorization process the review company can also provide guidance on the location for In-Network providers.

Preauthorization is also referred to as predetermination, pre-service review, prior authorization, precert, precertification, prior auth, pre-admission review or preapproval.

To avoid a financial penalty, the following services must be preauthorized (pre-approved) BEFORE the services are provided. **Financial penalties for failure to preauthorize services do not accumulate to meet your annual Out-of-Pocket limit**. The contact information for each Appropriate Review Organization is listed on the Quick Reference Chart in the front of this document.

PREAUTHORIZATION REQUIREMENTS OF THE PLAN		
Service Needing Preauthorization	**Appropriate Review Organization to Contact for Preauthorization**	**Penalty for Failure to Preauthorize the Service**
1. All Elective (non-emergency) Hospital admissions for medical or surgical care. (*Note: for pregnant women, Preauthorization for a delivery is required only for Hospital stays that last, or are expected to last, longer than 48 hours for a vaginal delivery and 96 hours for a C-section.)* *While Preauthorization is not required for pregnancy, it is recommended that you call Anthem at least two months before the delivery date.*	Anthem Blue Cross	If you do not contact Anthem at least three working days before a non-emergency Hospital admission, your Hospital benefits will be reduced by 50%. No benefits will be payable for a Hospital stay that Anthem determines is not Medically Necessary, including days spent in the Hospital that are not certified as necessary.
2. All Elective (non-emergency) Hospital admissions and residential treatment program admissions for Mental Health care.	Anthem Blue Cross	Benefits payable by the Plan will be reduced by 50%. If the admission is determined to be not medically necessary, no benefit will be provided.
3. All Elective (non-emergency) Hospital admissions and residential treatment program admissions for substance abuse care.	Teamsters Alcohol Rehabilitation Program (TARP)	Treatment must be approved by TARP, for benefits to be paid.
4. All Elective (non-emergency) admissions to a Skilled Nursing Facility, Subacute Facility or Long-Term Acute Care Facility.	Anthem Blue Cross	Benefits payable by the Plan will be reduced by 50%. If the admission is determined to be not medically necessary, no benefit will be provided.
5. All admissions to any type of Health Care Facility for inpatient rehabilitation.	Anthem Blue Cross	Benefits payable by the Plan will be reduced by 50%. If the admission is determined to be not medically necessary, no benefit will be provided.
Preauthorization does not mean benefits are payable in all cases. Plan coverage depends on the services that are actually provided, your eligibility status at the time the service is provided, and any applicable benefit limitations.		

PREAUTHORIZATION REQUIREMENTS OF THE PLAN		
Service Needing Preauthorization	**Appropriate Review Organization to Contact for Preauthorization**	**Penalty for Failure to Preauthorize the Service**
6. Durable Medical Equipment (DME) over $1,000, such as bone growth stimulator, insulin pump, pneumatic compression devices, wheelchairs, heating/cooling devices, plus Corrective Appliances including Prosthetic Appliances, and Orthotic devices.	Administrative Office	No Penalty Currently In Effect. If the supply is determined to be not medically necessary, no benefit will be provided.
7. Any physical therapy, occupational therapy, or speech therapy visits after the 20th therapy visit per year and any acupuncture services after the 20th visit per year.	Administrative Office	No Penalty Currently In Effect. If the service is determined to be not medically necessary, no benefit will be provided.
8. All Home Health Care and all Home Infusion Services needed after a Hospital admission.	Anthem Blue Cross	No Penalty Currently In Effect. If the service or supply is determined to be not medically necessary, no benefit will be provided.
9. Your participation in a clinical trial. Preauthorization allows the Plan to understand which routine costs will be payable and associated with an "Approved Clinical Trial" related to cancer or other life-threatening Illnesses.	Anthem Blue Cross and Administrative Office	No Penalty Currently In Effect. If the service or supply is determined to be not medically necessary, no benefit will be provided.
10. Certain outpatient Prescription Drugs obtained at retail. The list of drugs requiring Preauthorization may change from time to time. To obtain the most up-to-date list contact the Pharmacy Benefit Manager. See Chapter 7: Outpatient Prescription Drug Benefits for more details.	Pharmacy Benefit Manager	Non-payment of drug
Preauthorization does not always mean benefits are payable. Plan coverage depends on the services that are actually provided, your eligibility status at the time the service is provided, and any limitations on benefits.		

PREAUTHORIZATION REQUIREMENTS OF THE PLAN		
Service Needing Preauthorization	**Appropriate Review Organization to Contact for Preauthorization**	**Penalty for Failure to Preauthorize the Service**
11. Human Organ, Bone Marrow, and/or Stem Cell Transplants.	Anthem Blue Cross	No Penalty Currently In Effect. If the service or supply is determined to be not medically necessary, no benefit will be provided. Many of these procedures involve hospitalization for which preauthorization is required and if not obtained benefits for the facility charges are subject to a 50% penalty. Given the complexity and expense of these procedures, even those performed on an outpatient basis should be preauthorized to avoid a later determination that they were not medically necessary and therefore not covered.
12. Certain diagnostic services such as rupture of membranes test, MRI/CT/PET/ECHO/ SPECT tests, certain genetic testing.	Anthem Blue Cross	No Penalty Currently In Effect. If the service or supply is determined to be not medically necessary, no benefit will be provided.
13. Certain outpatient treatments and ambulatory surgical procedures, including enteral and parenteral nutrition	Anthem Blue Cross	No Penalty Currently In Effect. If the service or supply is determined to be not medically necessary, no benefit will be provided.
14. Dental Benefit services anticipated to cost $500 or more. If the treatment plan outlined by your Dentist, including examination and X-rays, is anticipated to cost $500 or more, you should obtain Preauthorization from the Administrative Office to determine whether the procedures will be covered. See Predetermination of Dental Benefits on page 87 for more details.	Administrative Office	If the service or supply is determined to be not medically necessary, no benefit will be provided.
Preauthorization does not always mean benefits are payable. Plan coverage depends on the services that are actually provided, your eligibility status at the time the service is provided, and any limitations on benefits.		

The various review organizations noted in the Preauthorization chart do not certify your eligibility for coverage or determine your benefits. If you have questions about eligibility or coverage, call the Administrative Office at 1-800-528-4357 (1-800-JBT-HELP).

How Preauthorization Works

You and/or your Provider must call the appropriate review organization (see the Preauthorization Requirement chart above) **at least 7-10 days before** (and at least three working days before any elective non-emergency hospitalization) **a scheduled admission or service needing Preauthorization**. If you are making the call to the appropriate review organization, identify yourself as a member of Joint Benefit Trust (JBT) and give:

- Your name and Social Security number or member identification number;
- The patient's name, address, and birth date;
- The names, addresses, and telephone numbers of the Provider and/or the Hospital or health care facility;
- The reason for proposed hospitalization or health care service;
- The date of the proposed hospitalization or health care service.

If additional information is needed, such as medical records, the appropriate review organization will advise the caller.

The appropriate review organization will review the information provided, and will let you, your Health Care Provider and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed admission or health care services have been preauthorized. The appropriate review organization will usually respond to your treating Health Care Provider by telephone within 3 working days (but no later than 15 calendar days) after it receives the request for Preauthorization. Any adverse review determination will be communicated to you and your Health Care Provider in writing.

If you do not receive the preauthorized service within 60 days of the date the service was preauthorized, or if the nature of the service that was preauthorized has changed, a new Preauthorization must be obtained.

If the appropriate review organization requests that you get a second opinion, the cost for the second opinion will be paid for in full by the Plan.

If you have your Provider call to preauthorize, be sure to follow-up to assure Preauthorization was completed.

REMEMBER— IT IS YOUR RESPONSIBILITY TO MAKE SURE your proposed admission or other health care service is preauthorized.

Note that Preauthorization does not guarantee payment of benefits for a variety of reasons such as: the information submitted during Preauthorization varies from the actual services performed, the service actually performed is not a covered benefit, and/or you are ineligible for benefits on the date the service occurred.

If your admission or health care service is denied during the Preauthorization process, you and your Health Care Provider will be given written confirmation and information on how to appeal that pre-service determination. See also Chapter 13: Claims and Appeals Procedures regarding appealing a denied pre-service claim.

The purpose of Hospital Preauthorization 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.

Emergency Hospitalization

If an emergency requires hospitalization, there may be no time to contact the appropriate review organization before you are admitted. If this happens, **the appropriate review organization must be notified of the Hospital admission within 48 hours after the admission**. You, your Health Care Provider, the Hospital, a family member or friend can make that phone call to the appropriate review organization. This will enable the review organization to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Health Care Providers of the various In-Network support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

There is no requirement to preauthorize the use of a Hospital-based emergency room (ER) visit.

Pregnancies *(Preauthorization is not required)*

Pregnant women should notify Anthem as soon as possible once they know they are pregnant (and at least two months before the delivery date). This enables the review organization to work with the treating Health Care Provider to monitor for high-risk pregnancy factors and to assist the pregnant woman in completing the steps to help assure that plan benefits will be available for the newborn child.

Concurrent (Continued Stay) Review

How concurrent (continued stay) review works:

1. When you are receiving medical services in a Hospital or other inpatient health care facility, the appropriate review organization will monitor your stay by contacting your Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.
2. Concurrent review may include coordinating Home Health Care Services or the provision of Durable Medical Equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Health Care Providers of various options and alternatives for your medical care available under this Plan.
3. If at any point your stay or services are found NOT to be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Health Care Provider will be notified. This does not mean that you must leave the Hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your Hospital stay or services were not Medically Necessary, no benefits will be paid on any related Hospital, medical or surgical expense.

Case Management

How Case Management Works: Case Management is a voluntary process, administered by the appropriate review organization. Its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrators and Administrative Office to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the appropriate review organization at the telephone number shown on the Quick Reference Chart in the front of this document. However, in most cases, the appropriate review organization will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the appropriate review organization will work directly with your Health Care Provider, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Non-Network Health Care Providers as needed. From time to time, the Case Manager may confer with your Health Care Providers and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Health Care Provider may call the Case Manager of the appropriate review organization at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

Appealing a UM Determination (Appeals Process):

You may appeal any adverse review decision made during the Preauthorization, concurrent review, or Case Management processes described in this chapter. To appeal a denied preservice, urgent, concurrent care or post-service claim/bill, see Chapter 13: Claims and Appeals Procedures of this document.

Restrictions and Limitations of Preauthorization

1. The fact that your Health Care Provider recommends outpatient or inpatient treatment or that your Health Care Provider proposes or provides any other health care services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Plan.
2. Preauthorization is not intended to diagnose or treat health conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The review organization's certification that a service is Medically Necessary does not mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Health Care Provider. You should follow whatever course of treatment you and your Health Care Provider believe to be the most appropriate, even if the review organization does not certify the proposed treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the review organization.
4. With respect to the administration of this Plan, the Board of Trustees and the applicable review organization are <u>not</u> engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by a review organization as Medically Necessary, or for the results if the patient chooses not to receive services that have not been certified as Medically Necessary.
5. Again, **Preauthorization of a treatment/service does not guarantee that the Plan will pay benefits for that service** because other factors, such as ineligibility for coverage on the actual date of service, the information submitted during Preauthorization varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

CHAPTER 6: MEDICAL BENEFITS

Choice of Plan Networks

During the Open Enrollment you may choose from one of two Anthem Blue Cross network options

- **Prudent Buyer** – the network that includes Sutter Health physicians, Hospitals and outpatient providers.
- **Advantage** – the network ***does not include*** Sutter Health affiliated physicians, Hospitals and outpatient providers.

The benefits are the same only the networks are different. However, because the "Prudent Buyer" Network includes Sutter clinics, Doctors, Hospitals and labs that generally charge more than other providers, your co-contribution will be **higher** if you enroll in the Prudent Buyer option. **If you do not make a network election you will be automatically enrolled in the Advantage Network and, except for emergencies, you will not receive any benefit if you use a provider such as Sutter that is not in the Advantage network.**

If you receive services or supplies from a provider that is not a part of your chosen Network, there will be **no coverage** through this Plan, except in a Medical Emergency. Some providers are not in either Blue Cross network. If you use one of these providers there will be no benefits, even if you elected the more inclusive Prudent Buyer option.

If you are considering switching from one of the Plans to the other or want to confirm which network your provider is in, **call the JBT Doctor Facility Help Line at 1-833-346-3365 for more information.**

How can I be a wise consumer of health care and get the most value out of my JBT Medical Benefit?

- ✓ **BE SURE TO USE A PROVIDER THAT IS IN YOUR NETWORK**.
- ✓ **Choose Generic drugs when possible.** Ask your Doctor if a generic drug is appropriate for you. Without preauthorization, brand drugs are not covered if an appropriate generic is available.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range) and to stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your In-Network Doctor's office for help. Or, use an In-Network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Preauthorize** your elective Hospital admission, as well as certain other services as explained in Chapter 5, to help avoid a financial penalty.

These five tips will help you make the most of your Medical Benefits.

Mammography Network

The Plan has established a separate network, called the Mammography Center Network (MCN) to provide screening mammograms. A list of facilities may be obtained by calling 1 (800) 528-4357. As long as you use a center on the list there is no copay or deductible. However, if you use a facility that is not on the list, even though it may be in the Advantage or Prudent Buyer network, your benefit will be limited and your out-of-pocket cost may be significant.

Schedule of Medical Benefits

A schedule of the Plan's medical benefits appears on the following pages in a chart format so that you can more easily see the way the Plan reimburses coverage. Each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column.

In the Schedule of Medical Benefits Deductibles, Out-of-Pocket Limits, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services **are listed in the first few rows** because these categories of benefits apply to most (but not all) health care services covered by the Plan. These rows are followed by descriptions, appearing in **alphabetical** order, of the other covered medical benefits along with any limitations and exclusions to those covered benefits. Unless there is a specific statement in the Schedule of Medical Benefits, all benefits shown are subject to the Medical Benefit's annual Deductible.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Medical Benefit Exclusions section of this chapter and Chapter 11: General Plan Exclusions to see if they are excluded.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All Medical Benefit claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period.

See Chapter 13: Claims and Appeals Procedures for more information.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Deductible • The annual Deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. • Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. • Copayments do not accumulate to meet the Deductible. • The Deductible applies to all covered services except where otherwise noted in this Schedule of Medical Benefits.	• **Deductible Carryover Provision:** This plan administers a Deductible carryover provision where eligible expenses applied toward your Deductible in the last three (3) months of any calendar year will carryover to be applied toward your Deductible requirements for the new calendar year.	$300 per person $750 per family Expenses for Non-Network providers do not accumulate to meet the calendar year Deductible, except for Emergency Services performed in an emergency room or if you are admitted directly to the Hospital from the emergency room.	
Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one-year period (the calendar year) before your Medical Benefit starts to pay 100% for covered essential health benefits received from In-Network providers. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • Covered Emergency Services performed in a Non-Network Emergency Room will accumulate to meet the In-Network Out-of-Pocket Limit. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person in a family" annual out-of-pocket limit. • Covered outpatient drug expenses accumulate to a **separate Out-of-Pocket limit for outpatient drugs.** See Chapter 7 for information on the outpatient Prescription Drug benefits for individuals enrolled in the Medical Benefit.	**The Medical Benefit Out-of-Pocket Limit does not include or accumulate:** a) Premiums and/or contributions for coverage, b) Expenses for medical services or supplies that are not covered by the Plan; c) Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for Non-Network providers; d) Penalties for non-compliance with the Preauthorization requirements of the Plan; e) Expenses for the use of Non-Network providers, except covered Emergency Services performed in a Non-Network Emergency Room and Non-Network provider services that are preauthorized; f) Charges in excess of the Medical Benefit's maximum benefits; g) Expenses for Dental Benefit and Vision Benefit services; h) Outpatient drugs, (which do not accumulate to meet the Medical Benefit Out-of-Pocket Limit, and instead accumulate to meet a separate calendar year Out-of-Pocket Limit for Outpatient Drugs, explained in the Drugs row of this Schedule and in Chapter 7).	**Medical Benefit** $3,000 per person $6,000 per family **Outpatient Drugs** $3,600 per person, $7,200 per family Expenses for Non-Network providers do not accumulate to meet the calendar year Medical Out-of-Pocket Limit, except for Emergency Services performed in an emergency room or services provided in a Medical Emergency.	

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the Hospital (e.g., intensive care unit, cardiac care unit). • Lab/X-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care. See also the Maternity services row in this Schedule.	• **Elective Hospitalization requires Preauthorization (to avoid a 50% financial penalty).** See the Preauthorization section of Chapter 5 for more information. • Private room is covered only if Medically Necessary (such as if the patient is in isolation) or if the facility does not provide semi-private rooms. • Specialty care hospitals, also called long term acute care (LTAC) hospitals, are discussed under the Skilled Nursing Facility row in this Schedule. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee. See the "Physician" row of this Schedule below for how payments to Physicians for services performed in a Hospital are applied. • See the Eligibility chapter for how to properly enroll Newborns so coverage can be considered. • 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 an Allowable Charge and will not apply toward your calendar year out-of-pocket maximum. • Total hip and knee replacements are subject to the MAC (Maximum Allowable Charges). See the rows of this chart titled Routine Total Hip and Knee Replacement	Inpatient Facility: Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, Hospital, urgent care facility, outpatient/ambulatory surgery center or other covered health care facility location.
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon
  • Assistant surgeon (if Medically Necessary)
  • Anesthesia provided by Physicians and Certified Registered Nurse Anesthetists (CRNA)
  • Pathologist, Radiologist
  • Podiatrist (DPM)
  • Physician Assistant (PA); Nurse Practitioner (NP); Certified Nurse Midwife (CNM)
• See also the Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from In-Network providers.
• See also the Emergency Services row for payment of providers in an emergency room.
• An office "visit" is a personal interview between the patient and the provider, or services billed as part of the provider's care. Visits do not include telephone calls or other situations where you are not personally examined by the provider or directly under the care of the provider.
	• **Podiatric foot Surgery performed (in any location) requires Preauthorization. Elective Hospitalization requires Preauthorization (to avoid a financial penalty)**. See the Preauthorization section of Chapter 5 for more information.
	• See also the definition of Physician, Health Care Practitioner and Surgery in the Definitions chapter.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Definitions chapter.
	• **Assistant Surgeon fees** will be reimbursed only for Medically Necessary services to a **maximum** of 20% of the eligible expenses allowed for the primary surgeon.
	• Under this Plan, there is no requirement to select a Primary Care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• 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.)
	• **Routine Foot Care Benefit**: Routine foot care administered by a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
	• The Plan pays 100% of the Allowed Charge for a second opinion, including X-ray and laboratory tests as long as the second opinion is for a surgical procedure covered by JBT, and the opinion is obtained from a specialist who does not subsequently do the Surgery/treatment.
	• Newborn circumcision is covered.
		Coverage of 80% of In-Network Allowed Charges after Deductible met
		
		See also the Wellness (Preventive) box below for information on preventive services payable by the Plan at no charge.
		
		Second opinion consultation: No charge
		
		LiveHealth Online: Coverage of 100% of In-Network Allowed Charges, no Copay or Deductible applies
			No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Acupuncture Services	• The Plan pays up to 20 visits per person per calendar year, without Preauthorization. **If additional acupuncture visits beyond 20/calendar year are needed, then Preauthorization is required.** See the Preauthorization section of Chapter 5 for more information.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.		Testing, Allergy Shots and Antigen: Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

Ambulance Services and Non-Emergency Medical Transport Services
• **Ground vehicle emergency transportation:**
  • to the nearest appropriate facility as Medically Necessary for treatment of a Medical Emergency or acute illness.
  • for Medically Necessary inter-health care facility transfer (e.g., transfer from one Hospital to another Hospital or trip to and from one Hospital to another in order to obtain a special test/procedure not available at the primary facility).
• **Air/sea emergency transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.
• **Non-emergency medical transport** is payable, according to the provisions outlined to the right.
	• Expenses for ambulance services are covered only when those services are for an Emergency as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-facility transport.
	• **Non-emergency medical transportation** refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. Non-emergency medical transportation services are payable by this Plan when Medically Necessary. The Plan pays toward the least expensive and appropriate method of transportation that meets the physical and medical circumstances of the individual and the Plan reserves the right to limit its payment of transportation to the nearest appropriate location (such as the nearest provider of medical services when it has made a determination that traveling farther provides no medical benefit to the individual).
		Ambulance for Medical Emergency: Coverage of 80% of In-Network Allowed Charges after Deductible met	Ambulance for Medical Emergency: 80% after Deductible met

Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.		
Birthing Center/Facility	• See the Maternity Services row of this Schedule.		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician. • Expenses related to autologous blood donation (patient's own blood) are covered.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Covered only when ordered by a Physician.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Chiropractic Treatment Services • 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 and/or performed by a Physician or physical therapist. • **Covered only when you use the services of a Landmark network chiropractic provider** or a Chiropractor in the Anthem/Blue Cross network in which you are enrolled. See the Chiropractic Program row of the Quick Reference Chart (at the front of this document) to find a network provider.	• **Benefit When You use a Landmark chiropractor: 100% of covered charges up to a maximum of $50 per day. No deductible applies.** • **Chiropractic Treatment is payable to a maximum of $680 per person per calendar year (for care received from Landmark and Anthem chiropractors combined).** • Because JBT has negotiated special guaranteed discounted rates with Landmark Healthcare your benefit dollars will go further when you use a Landmark Healthcare provider.	**Landmark** 100% of covered charges up to $50/day. Deductible does not apply.	No coverage
	• **Benefit When You use Anthem/Blue Cross chiropractor**: 80% of covered charges up to a maximum of $50 per day after the deductible is met. • **Chiropractic Treatment is payable to a maximum of $680 per person per calendar year (for care received from Landmark and Anthem chiropractors combined).** Example ($300 deductible not met) Charge $200 Daily maximum 50 Deductible applied (50) Benefit paid $-0- Remaining deductible is $250. If only chiropractic charges are incurred, there will be no benefit for the next five visits (i.e., until the deductible is consumed). Example ($20 of the $300 deductible is not yet met). Charge $200 Daily maximum 50 Deductible applied (20) Remaining allowed charge 30 Benefit paid (80%) $24 Once the deductible is met, the maximum daily benefit is $40 or 80% of the daily allowed charge of $50	**Anthem** After the deductible is met, 80% of the daily maximum allowed charge of $50/day	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)
• Coverage is provided for Medically Necessary Prosthetic and Orthotic Devices as follows:
  • rental (but only up to the allowed purchase price of the device).
  • purchase of standard model. Rental or purchase determined by the Administrative Office.
  • repair, adjustment or servicing of the device when Medically Necessary.
  • replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired.
• Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner.
• Medically Necessary colostomy, ostomy and/or urinary catheter supplies are covered.
• See also the Hearing Services row in this Schedule.
	• **Corrective Appliance including Prosthetic Appliances and Orthotic Devices require Preauthorization.** See the Preauthorization section of Chapter 5 for more information.
	• See the exclusions related to Corrective Appliances in the Medical Benefit Exclusions section of this Chapter 6. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter.
	• **Prosthetics are** devices to replace a missing body part. **Prosthetic Devices:** an initial Prosthetic Device is payable and one replacement (per lifetime) is payable for individuals age 18 and older. The Plan pays for one prosthetic replacement every three years for children under age 18. An implantable hearing device, such as cochlear implant, is payable as a Prosthetic Device when preauthorized.
	• **Orthotics** are devices to support a weakened body part.
	  • **Non-Foot Orthotics,** such as a back brace or knee brace, are payable when Medically Necessary, including necessary supplies, repair and servicing.
	  • **Foot Orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) are payable up to one pair every 12 months for adults with diabetes and venous insufficiency.
		Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

Diabetes Education	• Coverage is payable for a formal diabetes education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes Association. A diabetes education program is payable when a covered person is initially diagnosed with diabetes. A refresher course is payable once each year.	Coverage of 100% of In-Network Allowed Charges, no Copay or Deductible applies	No coverage

SCHEDULE OF MEDICAL BENEFITS

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• **It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. • See also the Coordination of Benefits (COB) chapter that discusses what this Plan pays when you are also Medicare eligible.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage except for covered services in a Medical Emergency.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Drugs (Outpatient Medicines)
• Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Contact the Pharmacy Benefit Manager (whose phone number is listed on the Quick Reference Chart in the front of this document) for information on the following:
  • The list of drugs on the **Preferred Drug formulary**.
  • Information on **drugs needing prior authorization** (pre-approval) by the clinical staff of the Prescription Benefit Manager (PBM).
  • Information on which **drugs have a limit to the quantity** payable by this Plan.
  • The Specialty Guideline Management program, where preauthorization will be required for certain drug therapies and drugs for certain conditions.
• Drugs not yet approved by the FDA are not covered**. New FDA-approved drugs** will be covered by the Plan according with plan terms, see Chapter 7.
• In accordance with Affordable Care Act regulations, certain drugs including but not limited to FSA approved female contraceptives, tobacco cessation drugs and OTC drugs are payable by this non-grandfathered Medical Benefit, as explained in Chapter 7: Outpatient Prescription Drug Benefits.
	Benefits for outpatient Prescription Drugs are provided through the Plan's Pharmacy Benefit Manager, whose name is listed on the Quick Reference Chart in the front of this document. See also Chapter 7: Outpatient Prescription Drug Benefits.
	• **You must pay the full cost of the Prescription Drug up front at an In-Network Retail Pharmacy, and the Plan will reimburse you for the Plan's portion of the cost.**
	• Cost-sharing for covered outpatient Prescription Drugs accumulate to meet the annual calendar year **Out-of-Pocket Limit for Outpatient Drugs: $3,600 per person, $7,200 per family.**
	
	Please see chapter 7 for full description of Outpatient Prescription Drug Benefits
		No Medical Benefit Deductible applies to outpatient drugs
		
		In-Network Retail Pharmacy
		
		(up to a 30-day supply):
		Generic: $10 copay
		Preferred Brand: $20 copay
		Non-preferred Brand: no coverage
		
		Drugs Reimbursed at 100%: Female FDA-approved contraceptives, certain drugs to reduce the risk of breast cancer, tobacco cessation drugs and certain over-the-counter drugs.
			Not covered

SCHEDULE OF MEDICAL BENEFITS

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Durable Medical Equipment (DME)
• Coverage is provided for:
  • rental (but only up to the allowed purchase price of the DME);
  • purchase of standard model equipment. Rental or purchase determined by the Administrative Office;
  • repair, adjustment or servicing of Medically Necessary DME;
  • replacement of Medically Necessary DME if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense;
  • supplies that are necessary for the function of the DME so long as the equipment is Medically Necessary for the individual who is covered under this Plan.
• If more than one piece of DME can meet the functional needs, benefits are available only for the most cost-effective piece of Durable Medical Equipment.
• Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.
	• **Durable Medical Equipment costing over $1,000 should be preauthorized because of the risk that the charge will not be deemed medically necessary and that no benefit will be paid.**
	• To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter.
	• Durable Medical Equipment (and supplies necessary for the function of the Durable Medical Equipment) is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner.
	• For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus the breast pump supplies needed to operate the breast pump. A hospital grade breast pump is payable if the Plan determines it to be Medically Necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from In-Network providers only. No coverage for breastfeeding equipment/supplies from Non-Network providers.
	• See the exclusions related to Corrective Appliances in the Medical Benefit Exclusions section of this chapter.
		Breast pump and supplies needed to operate pump: No charge
		
		All other DME: Coverage of 80% of In-Network Allowed Charges after Deductible met
			No Coverage

SCHEDULE OF MEDICAL BENEFITS

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Emergency Room Facility **Urgent Care Facility** • **Hospital emergency room (ER)** for "Emergency Services" (as defined by this Plan). • **Urgent Care facility**. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea, vomiting, or bladder infections. • Ancillary charges (such as lab or X-ray) performed during the ER or Urgent care visit. • (See also the Ambulance section of this schedule.) • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an emergency room or urgent care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• Expenses for Emergency Room services are covered only when those services are for an **Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care." • Emergency Services do not require Preauthorization. • The Plan will pay a reasonable amount for Hospital-based Emergency Services performed Non-Network, in compliance with Affordable Care Act regulations. See the definition of Allowed Charge or contact the Administrative Office for more details on what the Plan allows as payment to Non-Network emergency service providers.	**Emergency Room**: Coverage of 80% of In-Network Allowed Charges after the Deductible is met. **Urgent Care Facility**: Coverage of 80% of In-Network Allowed Charges after the Deductible is met	**Emergency care provided in Emergency Room (Emergency Services)**: Coverage of 80% of UCR Charges after the Deductible is met. **Urgent Care Facility**: No coverage

SCHEDULE OF MEDICAL BENEFITS

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Family Planning, Reproductive, Contraceptive Services • Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure) are covered with no cost-sharing for female sterilization when performed by In-Network providers and these benefits will be paid at 100% no Deductible, In-Network only. • Coverage is provided for FDA-approved female contraceptives such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g., Implanon, Nexplanon). See also the Drug row in this Schedule for information on FDA-approved contraceptive coverage where there is no charge for generic FDA-approved contraceptives submitted with a prescription and obtained from a network pharmacy location. No charge for a brand prescription contraceptive only if a generic contraceptive is unavailable or medically inappropriate. No coverage for FDA approved contraceptives obtained from a Non-Network retail pharmacy. • Prescription Drug treatment of erectile dysfunction is payable under the outpatient drug benefits in Chapter 7.	• For maternity coverage see the Maternity row in this schedule. • See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Medical Benefit Exclusions section of this chapter. • No coverage for reversal of sterilization procedures. • Certain FDA-approved contraceptives are payable from retail pharmacies as described in the Drugs row on this Schedule. • The Plan will cover without cost-sharing at least one form of contraception in each of the methods that the FDA has identified for women in its current Birth Control Guide. This coverage includes clinical services, patient education and counseling needed for provision of the contraceptive method. The Plan will also cover without cost-sharing a contraceptive service or item not otherwise covered if that service or item is determined by the individual's provider to be Medically Necessary.	Female FDA-approved Contra-ceptives and Female sterilization procedures: 100% no Deductible. For other covered services: Coverage of 80% of In-Network Allowed Charges after Deductible met.	No Coverage

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Genetic Testing and Counseling
• Medically Necessary **Genetic Testing** payable under this Plan is for:
a) state-mandated newborn screening tests for genetic disorders;
b) fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary;
c) tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;
d) Genetic Testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis;
e) Genetic Testing (e.g., BRCA) and Genetic Counseling required as a Preventive service in accordance with Affordable Care Act guidance and regulations (see the Wellness row in this Schedule).
f) detection & evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met:
  • the testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
  • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and
  • the results of the test will directly impact clinical decision-making outcome or treatment being delivered to the covered individual.
• **Genetic Counseling** is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified Health Care Provider) and provided with regard to a genetic test that is payable by this Plan. Certain Genetic Counseling is payable as a Preventive service in accordance with the Affordable Care Act guidance and regulations.
	• No coverage for pre-parental Genetic Testing (testing for the employee, also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents.
	• No coverage of Genetic Testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. Genetic Testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a covered plan participant.
	• See the definitions of Genetic Counseling, Genetic Testing in the Definitions chapter.
		ACA-required genetic tests & counseling: 100% no Deductible
		
		All other services: Coverage of 80% of In-Network Allowed Charges after Deductible met
			No Coverage

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Hearing Aid Hearing aid benefits are available **for covered employees only. Hearing Services are not covered for Dependent Children.**	• Medically Necessary implantable hearing devices for covered individuals with profound hearing loss (e.g., cochlear implant) are covered as a Prosthetic Device (See the Corrective Appliance row in this schedule).	A Medically Necessary hearing aid device is payable for each ear once every three years to a maximum of $500 per device per ear.	
Hearing Services (Audiology Exam) • Hearing (audiology) exam are available **for covered employees only. Hearing Services are not covered for Dependent Children.**	• A hearing (audiology) exam is payable once every 3 years to screen for hearing loss.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No Coverage
Hip Replacement, Total Hip Replacement	• See the Routine Total Hip and Knee Replacement Surgery row.		
Home Health Care and Home Infusion Therapy Services • Part-time, intermittent skilled (non-custodial) nursing care services and Medically Necessary supplies to provide Home Health Care or Home Infusion Therapy services. • **Home services other than Skilled Nursing Care are not covered.**	• **Home health and Home Infusion Therapy services require Preauthorization.** See the Preauthorization section of Chapter 5 for more information. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency. • Home physical therapy, speech therapy, and/or occupational therapy services coverage is payable as Home Health Care services provided the patient is homebound. • Home health aides and custodial services are not covered.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage
Hospice • Hospice services include inpatient Hospice care and outpatient home Hospice when the patient has been diagnosed with a life expectancy of six months or less.	• Covered only when ordered by a Physician. • Many Approved Hospice Programs offer some bereavement counseling as part of their program. Counseling beyond that included as part of the Approved Hospice Program is payable under the Behavioral Health benefits of this Plan. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospice inpatient facility may be billed to the Plan separately from the facility fee. See the "Physician" row of this Schedule below for how payment to Physicians for services performed in Hospice inpatient facilities are applied.	Coverage of 100% of In-Network Allowed Charges, no Deductible applies	No coverage
Knee Replacement, Total Knee Replacement	• See the Routine Total Hip and Knee Replacement Surgery row.		

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Laboratory (Lab) Services (Outpatient) • Common Laboratory (Lab) services include diagnostic testing related to chemistry, hematology, urinalysis, toxicology, microbiology, blood banking, anatomic pathology–surgical pathology and/or cytopathology. • Specialty reference laboratory services can include gene-based and molecular testing, allergy testing, Transplant matching, tumor tissue analysis, infectious disease testing, etc. • Technical and professional fees associated with lab testing. • Diagnostic sleep study/sleep test using a full-channel nocturnal polysomnography (NPSG) (Type I device) performed in a healthcare facility. Sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are not payable by this Plan.	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services row of this Schedule of Medical Benefits. • Some laboratory services are payable at no cost under the Wellness benefits in this Schedule. • Make sure your provider refers you or your laboratory specimen to a preferred laboratory.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage except for covered services in a Medical Emergency.

SCHEDULE OF MEDICAL BENEFITS

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IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Maternity Services • Hospital, Birthing Center, Physician and/or Certified Nurse Midwife fees are payable for Medically Necessary maternity services. However, expenses in connection with a Dependent Child's pregnancy (except preventive services in accordance with the Affordable Care Act) are not payable. • See the Family Planning row and Drug row for information on contraceptive coverage. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren). • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are paid for without cost-sharing as noted on the Durable Medical Equipment row of this Schedule. • For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no Deductible, when provided by an In-Network provider acting within the scope of his/her license. In-network providers are listed on the network directory described on the Quick Reference Chart. • Elective induced abortion is covered.	• **Pregnancy-related care is covered for female Employees only**. • No coverage is provided for maternity or delivery expenses of Dependent children, including ultrasounds and other pregnancy related services. This exclusion does not apply to prenatal and postnatal care Office Visits and certain other preventive screening services mandated by the Affordable Care Act (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/), which are covered without cost sharing when obtained from In-Network providers. There is coverage for breastfeeding equipment and supplies need to operate the equipment and comprehensive lactation support and counseling. • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. The Plan may not require a Physician or other Health Care Practitioner to obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Preauthorization. **For information on Preauthorization for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section,** see the Preauthorization section of Chapter 5 for more information. • **Elective induced abortion** is covered. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	Prenatal and postnatal screenings and other services required by the ACA: 100%, no Deductible For delivery fees and all other services including ultrasounds: Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage except for covered services in a Medical Emergency.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Mental Health Services The following benefits are available: • **Inpatient acute Hospital admission** or residential treatment program. See the Definitions chapter for the meaning of the terms residential treatment. • **Outpatient visits** including necessary Psychological (Psychiatric) Testing, • **Other Outpatient Services**: partial day care/partial hospitalization or intensive outpatient program (IOP) care. • Substance Abuse Emergency Detox at inpatient Hospital (no Preauthorization required). • **For a description of covered Substance Abuse Treatment benefits** and assistance locating substance abuse treatment providers best qualified to treat your needs see Chapter 8: Substance Abuse Treatment Benefits.	• **Elective inpatient Mental Health admission to a Hospital or residential treatment program requires Preauthorization (to avoid a 50% financial penalty).** Preauthorization is also described in Chapter 5. • **See the Substance Abuse Services row of this schedule, and Chapter 8 for information on additional Substance Abuse Treatment benefits.** Preauthorization is also described in Chapter 5. • Outpatient Prescription Drugs for Behavioral Health (Mental Health and substance abuse treatment) are payable under the Outpatient Prescription Drug benefit explained in Chapter 7.	**Mental Health Treatment:** Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage except for Medical Detox in a Medical Emergency

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Nondurable Medical Supplies
• Coverage is provided for Medically Necessary Nondurable Supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual.
• Coverage is provided for up to a 31-day supply of Medically Necessary supplies for home/personal use:
  • Sterile surgical supplies used immediately after Surgery.
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Dialysis supplies.
  • Colostomy and ostomy supplies.
  • Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under the Prescription Drug benefit, not under the Medical Benefit.
	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter and item 31 in the Medical Exclusions section on page 69.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Oral and Craniofacial Injury Services
• Accidental Injury to Teeth/Jaw
• Oral and/or Craniofacial Surgery.
• Charges by an oral maxillofacial surgeon for reduction of facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones.
• See also the exclusions related to Dental services in the Medical Benefit Exclusions section of this chapter.
	• **Certain services require Preauthorization (to avoid a financial penalty).** See the Preauthorization section of Chapter 5 for more information.
	• **Treatment of Accidental Injuries to the Teeth**: This Plan covers treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all the following conditions are met:
	  • The accidental Injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
	  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
	  • The dental treatment will return the person's teeth to their pre-Injury level of health and function. Preauthorization from the Plan Administrator is required.
	  • Under this Plan, approved dental treatment related to an accidental Injury to the teeth is payable under the Medical Benefit without regard to whether there is also associated Dental Benefit coverage.
	See also the definition of Injury to Teeth in the Definitions chapter of this document.
	• Oral or craniofacial Surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute Injury and for reconstructive but not Cosmetic purposes. Other than the services noted as covered in this row, the Plan does not cover other dental services, including but not limited to removal of teeth including removal of wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), treatment of Temporomandibular Joint dysfunction/syndrome or orthognathic Surgery for treatment of aesthetic malposition of the bones of the jaw.
	• See also the exclusions related to Dental X-rays in the Medical Benefit Exclusions section of this chapter.
		Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

Outpatient (Ambulatory) Surgery Facility/Center • Ambulatory (Outpatient) Surgical Facility/Center (e.g., surgicenter, same day Surgery, outpatient Surgery). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the "Physician" row of this Schedule for how payment to Physicians for services performed are applied.	• Under certain circumstances the Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by the Dental Benefit, for small children and/or participants with a disability, if the Dental Consultant determines that hospitalization or outpatient Surgery Facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the associated dental professional fee services provided while at a Hospital or outpatient Surgery Facility as those fees would be paid by the patient's Dental Benefit coverage. • See also the Routine Total Hip and Knee Replacement Surgery row.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Prescription Drugs (Outpatient)	• See the "Drugs" row in this Schedule and Chapter 7: Outpatient Prescription Drug Benefits for information on coverage of outpatient retail medication.		
Prosthetic Devices	• See the Corrective Appliances row in this Schedule.		
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using X-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or Injury. • Common radiology services include chest X-ray, abdomen/kidney X-ray, spine X-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered at no cost under the Wellness Programs described in this Schedule. • X-rays and diagnostic imaging tests like MRI, CT and PET scans are payable. • Make sure your provider refers you to an In-Network radiology provider.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage except for covered services in a Medical Emergency.

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
• Other Reconstructive Surgery is payable to restore or improve bodily functions if necessary to maintain patient's health due to Illness, Injury, or medical condition.
	• **Certain services require Preauthorization (to avoid a financial penalty).** See the Preauthorization section of Chapter 5 for more information.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Medical Benefit Exclusions section of this chapter. Most Cosmetic and Dental (including Orthognathic) services are excluded from coverage.
		Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider

Rehabilitation Services (Physical, Occupational & Speech Therapy)
• Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician.
• Pulmonary or Cardiac Rehabilitation Services.
• Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**
• **Not covered: Habilitation Services** (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician.
	• **Outpatient Physical Therapy, Occupational and speech therapy after the first 20 visits requires submission of a treatment plan before further visits are authorized. If treatment proceeds without such preauthorization, there is a risk that such treatment will be determined to have not been Medically Necessary and all benefits will be denied.** See the Preauthorization section of Chapter 5 for more information.
	• **Preauthorization for Inpatient Rehabilitation admission is required or benefits will be reduced by 50%. If inpatient rehabilitation is determined not to be Medically Necessary then no benefits will be paid.**
	• Habilitative Services, Maintenance Rehabilitation, and coma stimulation services are not covered. See specific exclusions relating to Habilitation and Maintenance Rehabilitation listed under Habilitation and Rehabilitation in the Definitions chapter.
	• Rehabilitation Services are covered only when ordered by a Physician and include coverage for Medically Necessary:
	  • **Outpatient Rehabilitation** visits (for physical therapy, occupational therapy and/or speech therapy)
	  • **Inpatient Rehabilitation Admission**
	• Outpatient physical therapy performed in conjunction with Spinal Manipulation services is subject to the Plan's Chiropractic Treatment benefit, explained in the row of this schedule titled Chiropractic Treatment Services.
		Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Routine Inpatient Total Hip and Knee Replacement Surgery MAC (Maximum Allowable Charge) is the highest amount that JBT will pay.	• The MAC **only** applies to providers in the **state of California.** Any Surgery outside the state of California will be subject to normal Surgery benefits. • Amounts denied as over the MAC will not accumulate to your Out-of-Pocket limit on cost sharing. • Have your inpatient surgery done at an **In-Network Value-Based Facility** in order to receive the highest possible benefit reimbursement. • Find a Value-Based Site by calling the Anthem Blue Cross at the number listed on the Quick Reference Chart. • Elective Hospitalization is subject to prior authorization. See the Utilization Review chapter for details.	**Value-Based PPO Facility** Coverage of 80% of In-Network Allowed Charges after Deductible met **PPO Facility (but not a Value-Based Facility)** After Deductible, Coverage of 80% of In-Network Allowed Charges up to $35,000 You are responsible for 100% of any charges above $35,000 if you do not go to a Valued-Based Facility	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Screening Mammography	• Annual for women age 40 and over • For full benefits, must use the Mammography Center Network. This IS NOT THE SAME as the Advantage or Prudent Buyer network offered through Anthem Blue Cross. • To obtain a list of facilities in the Mammography Center Network (MCN) or to make sure the facility you plan to use is still on the list, call JBT at 1 (800) 528-4357.	Coverage of 100% of In-Network Allowed Charges, no Deductible	Benefit limited to the Allowed Charge ($163 in 2020. Call JBT for current rate). For screening mammogram purposes only, Advantage and Prudent Buyer imaging facilities are non-network providers unless they are on the MCN list.
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Skilled Nursing Facility or subacute facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Admission to a Skilled Nursing Facility or Subacute facility (also called a Long Term Acute Care facility) requires Preauthorization.** See the Preauthorization section of Chapter 5 for more information. Normally admission to such facilities follows an inpatient stay at an acute care hospital and is part of a continuing treatment plan preauthorized by Anthem Blue Cross. However, you are responsible for checking to make sure your admission has been preauthorized. If it is not and treatment is later determined not to be medically necessary, you will be responsible for the entire bill. • Services must be ordered by a Physician. • To determine if a facility is a Skilled Nursing Facility or Subacute Facility/Long Term Acute Care Facility, see the Definitions chapter of this document.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Substance Abuse/Substance Use Treatment **See Chapter 8: Substance Abuse Treatment Benefits for a description of your benefits through TARP.** The following benefits are available through Anthem: • Substance Abuse Emergency Detox at inpatient Hospital (no Preauthorization required). For individuals who use tobacco products, the Plan covers at least two tobacco cessation attempts per year. Cessation attempt includes coverage (at no cost when In-Network providers are used) for: • Four (4) **tobacco cessation counseling sessions** of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without Preauthorization; and • All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Health Care Provider without prior authorization. See Chapter 7: Outpatient Prescription Drug Benefits for more information on coverage of outpatient drugs for tobacco cessation support under Coverage of Certain Drugs for Preventive Care Under the Affordable Care Act on page 73. Contact the Administrative Office for assistance with tobacco cessation counseling benefits.	• **See Chapter 8: Substance Abuse Treatment Benefits for a description of your rehabilitation (as opposed to medical detox) benefits through TARP.** • Outpatient Prescription Drugs for substance abuse treatment are payable under the Outpatient Prescription Drug benefit explained in Chapter 7.	**Medical Detox:** Coverage of 80% of In-Network Allowed Charges after Deductible met **Tobacco Cessation Support:** No charge	No coverage except for Medical Detox in a Medical Emergency

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to Medically Necessary and non-Experimental Transplants of human organs or tissue including bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, Surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. • Reasonable and necessary medical expenses incurred by a donor who **is covered** by this Plan, are payable without any cost-sharing applicable to those expenses. • Reasonable and necessary medical expenses incurred by a donor who **is not covered** by this Plan, are payable without any cost-sharing applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.	• **Transplant services require Preauthorization.** See the Preauthorization section of Chapter 5 for more information. • For plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. • See the specific exclusions related to Experimental in the Medical Benefit Exclusions section of this chapter.	Coverage of 80% of In-Network Allowed Charges after Deductible met	No coverage

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical Benefit Exclusions section in this chapter, Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Deductible except where noted. **In-network Provider means the Anthem network you selected: the Advantage network or the Prudent Buyer Network.**
IMPORTANT: Services from Non-Network providers in a Medical Emergency are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Wellness (Preventive) Program: • The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act guidance and regulations as outlined to the right. Preventive services are payable without regard to gender assigned at birth, or current gender status. Certain prescription and non-Prescription Drugs, required to be covered in compliance with the Affordable Care Act, are available through the Outpatient Prescription Drug benefit explained in Chapter 7. • Services not covered under the wellness/preventive benefit may be covered under another portion of the Medical Benefit. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required. • For information on plan payment for certain preventive care drugs in compliance with the Affordable Care Act, see Chapter 7. • **Adult Immunizations** that are FDA approved and in accordance with the Centers for Disease Control & Prevention (CDC) recommendations for adults in the US, such as an annual flu shot. **Immunizations Available from the Retail Pharmacy:** The Plan covers certain seasonal vaccines recommended by both the Health Reform regulations and in accordance with the CDC at no charge when obtained from an In-Network Pharmacy. All other covered immunizations must be obtained from a Provider's office.	The wellness/preventive services payable by this Plan are designed to comply with ACA guidance and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable preventive services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. The frequency of preventive visits for children is payable in accordance with the "Recommendations for Preventive Pediatric Health Care" from Bright Futures/American Academy of Pediatrics, updated periodically, (website for the schedule is: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). If these websites do not specify a frequency for which the preventive service should be performed, such as is the case for a preventive Office Visit or cholesterol screening, the Plan will pay for the preventive service when performed no more frequently than once each 12 months. In addition to the wellness services listed on these websites, the Plan will pay for these wellness services at no cost when In-Network providers are used: well child Office Visits, an annual wellness/physical exam for adults, well woman Office Visits, annual prostatic specific antigen (PSA) lab test for men age 40 and older, and annual screening mammogram for women age 40 and older (**Note: mammogram benefit is limited. Exam must be received from a JBT Mammography Center Network Provider to avoid any Balance Billing. See the Screening Mammography row for more information**). • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g., Coinsurance and Deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g., Coinsurance, copay, Deductible) will apply to the diagnostic or therapeutic services provided. • No coverage for vaccines required for travel. • **For a more comprehensive list of covered Wellness/Preventive services, see the Member Friendly Preventive Care Guidelines Document.**	Coverage of 100% of In-Network Allowed Charges, no Deductible applies	No Coverage; however, to comply with ACA Guidance, if there is no network provider who can provide the ACA-required wellness service, then the Plan will cover the service when performed by a Non-Network provider without cost-sharing.

Non-Discrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any Health Care Provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any Health Care Provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Maximum Allowable Charges Apply for Hip and Knee Replacement Surgical Procedures

Charges for surgical procedures can vary greatly among Hospitals and facilities. For example, at In-Network facilities used by JBT participants, the costs for knee replacement Surgery can range from $19,000 to over $75,000. Yet, there is little evidence of a higher quality of care at a higher cost facility. The JBT will allow a Maximum Allowable Charge ("MAC") for the following surgical procedures in the state of California:

1. Routine inpatient total hip replacements;
2. Routine inpatient total knee replacements.

The MAC is the highest amount your Plan will pay for the inpatient facility fees associated with these procedures. Any amount over the MAC will be your responsibility. This benefit design applies ONLY to routine inpatient total hip or knee replacements **in the state of California**.

Procedure	* Maximum Allowable Charge per Surgery
In the State of California	
Routine Inpatient Total Hip Replacement Surgery	$35,000
Routine Inpatient Total Knee Replacement Surgery	$35,000

*** Please note: Amounts denied as over the MAC for a procedure will not accumulate toward your Out-of-Pocket Maximum.**

- The MAC does not apply to professional fees from medical providers including, but not limited to, surgeons, assistant surgeons, anesthesiologists, etc.
- The MAC for routine Total Hip and Total Knee replacements only apply **in the state of California.**

Value-Based Site

For hip and knee replacements, there are many California Hospitals that will hold costs under the MAC. We call these facilities "Value-Based Sites." For surgeries done outside the state of California normal Surgery benefits will apply.

For assistance in locating a Value-Based Site you can call the JBT Doctor Facility Helpline at 1-833-346-3365.

Exceptions Process

The inpatient services provided by a Hospital that has not agreed to accept the MAC may be paid at normal plan benefits if:

- You have no access to a MAC provider or the service cannot be obtained within a reasonable wait time or travel distance; and
- The quality of services for you or your Dependents could be compromised with the MAC provider (e.g., if co-morbidities present complications or patient safety issues).

Medical Benefit Exclusions: What's Not Covered by the Medical Benefit?

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical Benefit**. For additional **general exclusions** that apply to the self-funded Plan see Chapter 11: General Plan Exclusions.

The Plan Administrator will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

1. Expenses for services provided by a **non-network provider or a non-network facility**, including but not limited to Sutter providers/facilities if you are enrolled in the Advantage network, except for Emergency Services in accordance with the Affordable Care Act and Emergency Care given in a Medical Emergency.
2. Expenses that are **not an Allowable Charge** (as defined in Chapter 15: Definitions).
3. Charges made by an **assistant surgeon** that exceed 20% of the Allowable Charges of the primary Physician.
4. Private Hospital room, unless the private room is Medically Necessary (such as in the case of isolation room) or the facility only has private rooms.
5. Weekend Hospital admission, except in the case of a Medical Emergency.
6. Any Hospital stay that is not Medically Necessary; Hospital stays beyond those approved by a provider or any stay that is solely for the convenience of the patient.
7. **Missed appointments** 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.
8. 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.
9. **Custodial Care**.
10. **Routine eye examinations and eyeglasses** (See also Chapter10 that explains the routine eye care covered by the Vision Benefit).
11. Tests and X-rays used for purpose other than diagnosing Illness or Injury and/or as part of covered preventive services.
12. **Dental X-rays**, unless performed because of an accidental Injury to the teeth (See also Chapter 9 that explains the Dental Benefits).
13. **Substance abuse treatment** (alcohol and drug rehabilitation) other than Medical Detox in a Medical Emergency (See also Chapter 8: Substance Abuse Treatment Benefits.)

14. **Drugs and medicines** not administered during confinement in a covered Hospital, health care facility or outpatient location. (See also Chapter 7 that explains coverage for outpatient Prescription Drugs payable from a Retail Pharmacy).
15. **Vitamins**, except when payable as a preventive service. (See Chapter 7 that explains coverage for outpatient Prescription Drugs.
16. **Routine nursery care**, unless it is part of a covered newborn birth admission.
17. Expenses in connection with a **Dependent Child's pregnancy and delivery**, except for certain preventive services required to be covered in accordance with the Affordable Care Act.
18. Expenses for the **treatment of infertility** along with services to induce pregnancy and complications thereof, including, but not limited to services, Prescription Drugs, procedures or devices to achieve fertility; in vitro fertilization; low tubal transfer; artificial insemination; embryo transfer; gamete transfer; zygote transfer; surrogate expenses (surrogate refers to an arrangement for a woman to carry and give birth to a child who will be raised, and usually legally adopted, by others and often includes in-vitro fertilization, the implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman) including expenses for and related to the pregnancy, delivery fees and complications for the woman who is the surrogate; donor egg/semen or other fees; cryostorage (freezing) of egg/sperm; ovarian transplant; infertility donor expenses; fetal implants; fetal reduction services; surgical impregnation procedures; and reversal of sterilization procedures.
19. Expenses related to Adoption.
20. **Routine foot care** (including but not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, preventive care with assessment of pulses, skin condition and sensation).
21. Expenses for Habilitative services.
22. Expenses for the 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 (e.g., **foot orthotics**) used in connection with the treatment of such chronic foot conditions.
23. Expenses for **hand care** including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized Illness, Injury or symptoms involving the hand.
24. 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 (applied without respect to when the individual first became enrolled in the Plan). **Cosmetic Surgery or treatment** includes Surgery or medical treatment to improve or preserve physical appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, but not to treat physical function. Excluded Cosmetic Surgery or Treatment includes, but is not limited to:
    - removal of tattoos,
    - breast augmentation or mastopexy (except the Plan covers reconstructive services after a mastectomy),
    - breast reduction (including treatment of benign gynecomastia in males),
    - removal of redundant skin, elimination of redundant skin of the abdomen, aabdominoplasty,
    - Surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance,
    - treatment of varicose veins,

- skin resurfacing, chemical skin peel, Cosmetic skin products such as Restylane and Renova, collagen injections,
- face/forehead/brow/eyelid/neck lift, upper eyelid blepharoplasty, nose/lip/cheek/malar/chin enhancement, reduction or implant, facial bone reduction,
- calf/buttocks/pectoral implants,
- liposuction body contouring,
- reduction thyroid chondroplasty,
- voice modification Surgery (laryngoplasty or shortening of the vocal cords), voice therapy/voice lessons,
- drugs for hair loss, hair growth, hair removal, hair implantation,
- other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cosmetic Surgery does not become reconstructive Surgery because of psychological reasons.

The Medical Program **does** cover Medically Necessary Reconstructive Services. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Plan Participants should use the Plan's Preauthorization procedure to determine if a proposed Surgery or service will be considered Cosmetic Surgery or will be considered as a Medically Necessary Reconstructive Service.

25. Environmental equipment; **e**xpenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or disability including, without limitation, construction or modification of ramps, elevators, handrails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.
26. Charges for treatment of Illness or Injury that **exceed the Allowable Charge**, and charges in excess of those that would have been made in the absence of Medical Benefits.
27. Expenses that the participant is not obligated to pay or for which no charge would otherwise be made to the patient.
28. Any Experimental medical or surgical treatment (see definition of "Experimental" in the Definitions chapter). Note that under this Medical Benefit, Experimental, Investigational or Unproven does not include routine costs associated with a certain "Approved Clinical Trial" related to cancer or other life-threatening illnesses.
29. Radial keratotomy or any surgical treatment to correct nearsightedness or farsightedness.
30. Any admission or service that requires Preauthorization and where Preauthorization was not obtained (see the Preauthorization requirements earlier in Chapter 5).
31. Any medical supplies and/or equipment that are not prescribed by a provider, 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 provider, 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 the Administrative Office before purchasing supplies). Certain services require Preauthorization as explained earlier in Chapter 5.
32. Expenses for services or supplies for which a third party is required to pay.

33. Expenses for a wilderness therapy program, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care or group home, or any other facility combining Substance Abuse treatment and general education.

Special Note

The JBT Medical Benefit pays a portion of the cost of covered medical expenses, but does not recommend a course of treatment based on what the JBT Medical Benefit covers. The fact that your Health Care Provider recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be covered under the Medical Benefit or that the Plan will consider these services or supplies Medically Necessary.

CHAPTER 7: OUTPATIENT PRESCRIPTION DRUG BENEFITS

The outpatient Prescription Drug program is administered by JBT's Pharmacy Benefits Manager, CVS Caremark and is available to employees and their eligible Dependent Children who are enrolled in the JBT Medical Benefit.

Prescription Drug Benefits at a Glance

If an In-Network pharmacy is used, you will receive a discount on the drug at the time the prescription is filled. You must pay this discounted price to the pharmacy at the point of sale. Through the Pharmacy Benefit Manager, the pharmacy will send an electronic record of this purchase to the Administrative Office. If you were eligible at the time you made the purchase, the Administrative Office will deduct the applicable member copay (shown below) from the price of the drug and send you a benefit check for the difference. If you were ineligible on the date the drug was purchased, the Plan will not reimburse the cost of the drug, but you will still have received the advantage of paying the discounted network price. There is no benefit for fills at out-of-network pharmacies. If you need assistance in obtaining your prescription(s) at an In-Network Pharmacy, please contact the Administrative Office at 1-800-JBT-HELP.

The Medical Benefit Deductible does not apply to these outpatient Prescription Drug benefits, but drugs are subject to a Copayment and a different, and entirely separate, out of pocket maximum. Drugs not yet approved by the FDA are not covered. New FDA-approved drugs may be covered by the Plan, but Prescription Drugs covered are subject to a "formulary" established by the Pharmacy Benefits Manager and new drugs may be excluded from that formulary. If you or your Doctor have questions about what is covered and what is excluded from the formulary, call CVS Caremark at 1-800-294-5979. The following is an overview of what you pay:

Schedule of Outpatient Prescription Drug Benefits		
Drug Type	**In-Network Retail Pharmacy Location (up to 30-day supply)**	**In-Network Mail Order Pharmacy (up to a 90-day supply)**
Annual Outpatient Prescription Drug Out-of-Pocket Limit	$3,600 per person per year $7,200 per family per year	
Formulary Generic	$10 Copayment	$20 Copayment
Formulary Brand-Name	$20 Copayment	$40 Copayment
Non-Formulary	Not covered	Not covered
Specialty	Formulary Generic: $20 Copayment Formulary Brand-Name: $40 Copayment	Generally, not covered. Contact Administrative Office or CVS if you want a 90-day supply.
Note: If you receive a brand-name drug for which a generic equivalent exists, you must pay the full cost of the drug as the brand-name will not be covered. **You may only fill a brand-name drug when medically necessary. When the brand-name drug is medically necessary, the Fund will reimburse the entire cost after deducting the brand-name drug 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, or through the mail, using the mail order (home delivery) program. You must pay 100% of the cost at the point of purchase. The Plan will reimburse you the Plan's share of the cost.

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 generic or brand name.

Brand Drugs

A Brand drug is a drug that has been approved by the U.S. Food and Drug Administration (FDA) and has been granted a 20-year patent, which means that no other company can make the drug for the entire duration of the patent. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.

Generic Drugs

After a brand-name drug patent 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.

Generic Substitutions

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 **full cost of the brand-name drug, and the Plan will not reimburse any of the cost. 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 reimburses 100% of the cost for the brand-name drug after you pay your Copayment.

You may only fill a brand-name drug when Medically Necessary. This requires preauthorization, see page 75. When the brand-name drug is medically necessary, the Fund will reimburse the entire cost after deducting the brand-name drug copayment.

Coverage of Certain Drugs for Preventive Care Under the Affordable Care Act

Certain prescription drugs have no cost sharing **when purchased at the Plan's network retail pharmacy location or Mail Order Service**, in accordance with ACA regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations and Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women. Where the information in this document conflicts with newly released ACA guidance and regulations affecting the coverage of preventive care drugs, this Plan will comply with the new requirements on the date required.

Please refer to the Plan's Member Friendly Preventive Care Guidelines for more information on the Plan's coverage of preventive care drugs.

Limitations on Supply for Certain Prescriptions

The Fund provides coverage for up to 12 pills per month for any combination of the following:

- Caverject
- Edex
- Muse
- Cialis 10mg or 20mg
- Levitra
- Staxyn
- Stendra
- Viagra

In addition, low dosage Cialis 2.5mg or 5mg pills are covered with a one-month limit of 30 pills.

Retail Pharmacy Network

You can obtain prescription drugs from a network of participating pharmacies contracted through the Pharmacy Benefits Manager. The pharmacy network is nationwide and includes most major retail pharmacy chains and many independent retail pharmacy locations. To find the participating pharmacy nearest your home or work, call the Pharmacy Benefits Manager at the number listed on the Quick Reference Chart, or contact the Administrative Office.

Supply Limits

Drugs purchased at an In-Network pharmacy are limited to a 30-day supply. If you take a 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 Benefit, 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 need a mail order form, contact the 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.

Payments

Participants are required to pay the network-discounted full drug cost at the time of purchase, whether at retail or mail-order. If you are eligible for coverage at the time of purchase, after you pay for your prescription at a network pharmacy, the pharmacy will file a claim electronically using the information from your Drug ID card. Once received, the Administrative Office will process the claim and mail you the appropriate reimbursement. The reimbursement you receive from the Administrative Office will subtract the Copayment amount from the discounted drug cost that you paid. For Copayment amounts, see the Schedule of Outpatient Prescription Drug Benefits earlier in this chapter.

If you purchase the drug during the off season, when you are no longer eligible for coverage, you will still receive the benefit of the discounted cost for the drug. However, you will not be eligible for any reimbursement from the Administrative Office.

In the situation where you do not present a drug ID card to the In-Network pharmacy, you will not be reimbursed by the Administrative Office.

For general claim filing and appeals information, see Chapter 13: Claims and Appeals Procedures.

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 the Pharmacy Benefits Manager at the contact information listed in the Quick Reference Chart. 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 the Pharmacy Benefits Manager at 1-888-685-7752. Please allow 10 to 14 days for delivery.

Advantages of Mail Order

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; and
- The cost savings you get with a 90-day supply for the cost of a 60-day retail supply.

What's Covered?

The outpatient Prescription Drug benefit covers the following Medically Necessary Prescription Drugs and related Allowable Charges:

- Charges by a Licensed Pharmacist for drugs prescribed by a Health Care Provider acting within the scope of his or her license;
- Charges by a Provider for any drugs, insulin, or insulin injection kits supplied to the patient in the Provider's office, and for which a charge is made separately from the charge for any other item of expense.
- Diabetic monitors.

What Requires Preauthorization?

Because of their cost, possible side effects and potential for abuse, opioids, new drugs, and specialty drugs, or drugs prescribed for purposes other than their normal purpose will not be covered unless their use has been preauthorized by the Pharmacy Benefits Manager. To apply for Preauthorization, your provider must contact the Pharmacy Benefits Manager at the number provided on the Quick Reference Chart. The Pharmacy Benefits Manager will review your case with your provider and determine whether the drug should be authorized. The list of drugs requiring Preauthorization may change from time to time. To obtain the most up-to-date list contact the Pharmacy Benefits Manager.

Specialty Guideline Management

Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs may **need prior authorization**, often require special handling, are date sensitive and are generally available only in a 30-day quantity. Under this program, there will be a review of clinical information from your Doctor for approval of treatment with these medications.

Please contact the Pharmacy Benefit Manager for a complete and current list of drugs that are subject to this Specialty Guideline Management program.

What's Not Covered Under the Outpatient Prescription Drug Benefit?

The following is a list of drugs, services and supplies or expenses **not covered (excluded)** by the Medical Benefit and its outpatient Prescription Drug benefit. For additional **general exclusions** that apply to the self-funded Plan see Chapter 11: General Plan Exclusions.

The Plan Administrator will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

The Prescription Drug benefit pays no benefits for the following:

1. Drugs that can be obtained without a prescription, except those drugs required to be covered in compliance with the Affordable Care Act as described on page 73.
2. Drugs taken or administered while a patient is in a Hospital (covered drugs are payable as a Hospital expense under the Medical Benefit).
3. Blood and blood plasma (these items are covered under the Medical Benefit).
4. Biological serum drugs.
5. Appetite suppressants.
6. Appliances, devices, bandages, heat lamps, braces, splints, and medical supplies.
7. Drugs furnished or payable under any plan or law of any government agency or organization, Workers' Compensation law, or similar program.
8. Drugs for which no charge is made.
9. Drugs that replace those that have been lost or stolen.
10. 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.
11. Drugs or medicines purchased subsequent to the enrollee's termination or prior to his/her enrollment.
12. Therapeutic-devices or appliances, including hypodermic needles, syringes, support garments, and other non-medical substances (except insulin syringes).
13. Therapeutic vitamins.
14. Hair treatment prescriptions, including but not limited to Rogaine and Minoxidil.
15. Lancet devices.
16. Cosmetic, health, or beauty aids.

17. Immunizing agents, biological sera, blood or blood plasma, or medication prescribed for parenteral use or administration, except insulin.
18. Any drug labeled "Caution: Limited by federal law to investigational use," or similar labeling, or any Experimental drug, even though a charge is made.
19. Non-formulary brand drugs.
20. Fertility drugs.
21. Drugs prescribed for conditions or treatments not covered under the Medical Benefit.

Reminder: for additional general exclusions and limitations that apply to the self-funded Plan see Chapter 11: General Plan Exclusions.

Information about Medicare Part D Prescription Drug Plans for People with Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the Prescription Drug coverage outlined in this document is "creditable," meaning that the value of this Plan's Prescription Drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Prescription Drug coverage will pay.

Because this Plan's Prescription Drug coverage is generally as good as Medicare drug coverage, you do not need to enroll in a Medicare Prescription Drug Plan. If you lose your coverage in the Plan, you may enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period.

If, however, you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug plan you will have dual Prescription Drug coverage and this Plan will coordinate its drug payments with Medicare. See Chapter 12: Coordination of Benefits (COB) for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Prescription Drug plan you will need to pay the Medicare Part D premium out of your own pocket.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from the Administrative Office). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

CHAPTER 8: SUBSTANCE ABUSE TREATMENT BENEFITS

Drug and alcohol dependency assessment and referral is available to you and your dependents through the Teamsters Alcohol Rehabilitation Program (TARP), an independent contractor to the JBT. TARP's contact information is listed on the Quick Reference Chart in the front of this document under Substance Abuse Treatment Program.

The Plan's Substance Abuse Benefits are intended to comply with federal Mental Health Parity Addiction Equity Act (MHPAEA) regulations.

Eligibility for Substance Abuse Treatment Benefits: If you are eligible for JBT's Medical Benefits then you are also eligible for Substance Abuse treatment benefits. If you begin a course of treatment while you are eligible for Medical Benefits and subsequently lose eligibility for Medical Benefits during the course of treatment, that course of treatment will continue to be covered under the Substance Abuse treatment benefit until the conclusion of that course of treatment.

Provider Network: TARP provides a network of contracted Substance Abuse treatment professionals and facilities in California. These contracted providers extend a discount to you for covered Substance Abuse treatment services. Covered Substance Abuse treatment benefits are outlined in this chapter.

Medically supervised detox is covered under the Medical Benefit as any other inpatient hospital admission. Please refer to the Schedule of Medical Benefits for more information.

There is no coverage of out-of-network services (including services received at an Anthem Network Provider) except in a medical emergency.

PLEASE NOTE: If you require Substance Abuse treatment outside of California, contact TARP and they will arrange coverage or will advise you regarding network treatment facilities and providers.

Substance Abuse Treatment Benefits at a Glance

Schedule of Substance Abuse Treatment Benefits This chart explains the benefits payable by the Plan. See also Substance Abuse Treatment Limitations in this chapter and Chapter 15: Definitions for important information.	
Substance Abuse Treatment Benefits	**Within the TARP Network or a TARP-preapproved Provider (In-Network Provider)**
Preauthorization Required for Elective Admission to an Inpatient Facility or Residential Treatment Program	If you do not call TARP for an elective Hospital admission or residential treatment program admission, you risk having coverage denied. All treatment must be approved by TARP before benefits are paid. If TARP determines that admission to an inpatient facility or residential treatment program or any other form of treatment was not Medically Necessary, no benefits will be paid. TARP forwards its approval of treatment to the Administrative Office so Substance Abuse claims can be properly adjudicated.
Admission to an Inpatient Facility, Inpatient Medical Detox, or Residential Treatment Program	Coverage of 100% of In-Network Allowed Charges, no Deductible
Physician Visit to an Inpatient Facility or Residential Treatment Program	Coverage of 100% of In-Network Allowed Charges, no Deductible
Outpatient Visits: Individual or Group Counseling Sessions	Coverage of 100% of In-Network Allowed Charges, no Deductible

Schedule of Substance Abuse Treatment Benefits This chart explains the benefits payable by the Plan. See also Substance Abuse Treatment Limitations in this chapter and Chapter 15: Definitions for important information.	
Substance Abuse Treatment Benefits	**Within the TARP Network or a TARP-preapproved Provider (In-Network Provider)**
Other Outpatient Treatment, including Intensive Outpatient Program (IOP) or Partial Day Care/Partial Hospitalization	Coverage of 100% of In-Network Allowed Charges, no Deductible

How TARP Works

The Plan's Substance Abuse treatment benefits provide coverage for the treatment of Substance Use Disorder, on an outpatient or inpatient basis. The Schedule of Substance Abuse Treatment Benefits above outlines how the Plan pays toward covered Substance Abuse treatment services.

If you or one of your covered dependents has a dependency problem with alcohol or drugs, call TARP at 1-800-522-8277. Early treatment can help save your health. TARP's trained intake specialists will assess the situation, obtain some preliminary information, and explain your options.

The TARP intake specialists will locate In-Network Substance Abuse treatment providers for further assessment and/or treatment. TARP may recommend:

- Community resources (such as Alcoholics Anonymous, Al-Anon, Narcotics Anonymous);
- Outpatient treatment; or
- Inpatient treatment.

If you require Substance Abuse treatment outside of California, contact TARP so they can arrange coverage or advise you regarding network treatment facilities and providers.

Under this Plan, no Substance Abuse treatment benefits are payable from an Out-of-Network professional or facility that is not approved by TARP, except for Emergency Services. Once detoxification has been achieved, TARP may recommend moving you from an Out-of-Network provider to a TARP Network provider. Refusal to move will result in the loss of any further benefits.

If you lose eligibility for coverage while in treatment, the Plan will continue to pay for you to complete a course of treatment.

If there is a Medical Emergency related to alcohol or drug use, the claim is processed in accordance with the benefits outlined in the Schedule of Medical Benefits (located in Chapter 6) for services used in a Medical Emergency such as an ambulance or emergency room.

HEALTHSMART Tips

Be sure to call TARP (1-800-522-8277) before seeking rehabilitation treatment. TARP will recommend an appropriate facility for you.

Assessment and Referral for Certain Substance Abuse Treatment Services

Just like Preauthorization is required for certain Medical Benefit services, Preauthorization is also required for certain Substance Abuse treatment services. If you are suffering from Substance Abuse, call TARP (1-800-522-8277) for an assessment of your condition, and authorization for treatment.

During the assessment, TARP will evaluate your situation and outline options including giving you information on In-Network Substance Abuse treatment and TARP-approved Substance Abuse treatment

facilities. Assessment and referral consist of an intake session with a TARP counselor after which a referral will be made to an appropriate form of treatment, which can include:

- Hospital or residential treatment facility based care;
- Day track treatment, such as an intensive outpatient program, or partial day hospitalization;
- Outpatient visits;
- Referral to community resources; or
- Any combination of the above.

Recommendations and referrals are designed to maximize your chances of recovery. TARP counselors will follow you during treatment, and may adjust your treatment plan based on your progress.

TARP will contact the treatment Provider and patient to provide information, counsel and advice to facilitate recovery and to encourage attendance at self-help groups appropriate for their post treatment program.

Restrictions and Limitations of Preauthorization of Substance Abuse Treatment Services

1. The fact that your Health Care Provider recommends outpatient or inpatient treatment or that your Health Care Provider proposes or provides any other Substance Abuse treatment services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Plan. To be sure of coverage, you must receive TARP's approval for the treatment.
2. Assessment and Preauthorization are not intended to diagnose or treat Substance Abuse treatment conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. TARP's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits is subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before services began or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Health Care Provider. However, the benefits payable by the Plan may be affected by the determination of TARP.
4. With respect to the administration of this Plan, the JBT and TARP are <u>not</u> engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by TARP as Medically Necessary, or for the results if the patient chooses not to receive services that have not been certified by TARP as Medically Necessary.
5. Again, **Preauthorization of a treatment/service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during Preauthorization varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

Substance Abuse Treatment Limitations

Substance Abuse treatment benefits are not covered for services that are not Medically Necessary services as defined in the Definitions chapter of this document. The Plan will cover only Substance Abuse treatment services that are:

- Delivered by TARP Network Providers who are acting within the scope of their license, if any is required under state law;
- Except in the event of an emergency, the services are provided according to a treatment plan of a TARP Network Provider that prescribes Covered Services for diagnosed Substance Abuse/Substance Use Disorders; and
- Provided under a treatment plan that is developed by a Practitioner who is qualified and licensed to provide Covered Services.

Substance Abuse Treatment Exclusions (Services That Are Not Covered)

The following is a list of services and supplies or expenses not covered (excluded) under the Substance Abuse treatment benefits. The Board of Trustees or its designee have discretionary authority to determine the applicability of these exclusions and the other terms of the Substance Abuse treatment benefits and entitlement to Plan benefits in accordance with the terms of the Plan.

Please read these exclusions carefully before seeking any counseling or treatment. Note that some of the services and treatments not covered by the Substance Abuse treatment benefits may be covered by JBT's Medical Benefit (Chapter 6).

The following services are **not covered** as Substance Abuse treatment services:

1. Services in excess of those preauthorized by TARP.
2. Inpatient services, treatment, or supplies rendered without Authorization, except in the event of an Emergency.
3. Court-ordered treatment, except when Medically Necessary.
4. Private Hospital rooms and/or private duty nursing, unless determined to be Medically Necessary.
5. Custodial Services for services and supplies that are intended to help a Member meet their personal, non-medical or non-Behavioral Health needs. This exclusion does not apply to Medically Necessary Covered Services provided to a Member residing in a covered Substance Abuse treatment facility.
6. Educational skills, employment skills, social skills.
7. No coverage for services within a treatment plan designed exclusively for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.
8. Healthcare services, treatment or supplies determined to be Experimental (as defined in the Definitions chapter).
9. Biofeedback treatment, hypnotherapy or acupuncture, unless preauthorized by TARP based upon Medical Necessity.
10. Treatment received from a California facility or other California provider that is not a TARP approved provider.
11. Expenses for a wilderness therapy program, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care or group home, or any other facility combining Substance Abuse treatment and general education.

For additional general exclusions and limitations that apply to the self-funded Plan see Chapter 11: General Plan Exclusions.

Claims Administration (Claim Filing) and Claim Appeals

Substance Abuse treatment claims and claim appeals are administered by the Administrative Office (contact information is listed on the Quick Reference Chart in the front of this document). Generally, you do not have to file claim forms for TARP Network Providers. These providers will bill the Plan directly. For general claims and appeals information, see Chapter 13: Claims and Appeals Procedures.

CHAPTER 9: DENTAL BENEFITS

Dental Benefit benefits are treated as a standalone (or excepted) benefit under HIPAA and the Affordable Care Act. Employees may elect/decline Dental Benefits annually.

Eligibility for Dental Benefits

When you are eligible for JBT Medical coverage, you are eligible for the Dental Benefits described in this chapter. JBT's Dental Benefit provides benefits for many dental services and procedures.

Covered Dental Expenses

The JBT has established an Allowed Charge for most dental procedures. These allowed charges are set forth on the Table of Allowances that can be obtained by calling the Administrative Office. The benefit is a percentage of the Allowed Charge for the procedure less any unmet deductible. The JBT contracts with a network of dental providers who have agreed to accept the Allowed Charge in the Table of Allowances as payment in full.

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider (as defined in the Definitions chapter of this document) that are determined by the Plan Administrator or its designee to be "Medically Necessary," but only to the extent that they are:

- Necessary to prevent or eliminate oral disease or maintain or restore function;
- Not Experimental or cosmetic;
- Provided by a licensed practitioner, operating within the scope of his or her license;
- Not excluded from coverage;
- Within the Dental Benefit's Allowed Charge (as defined in the Definitions chapter of this document).

Dental Expenses that Will Not be Paid Explained

The Plan will not reimburse you for any expenses that are not Eligible Dental Expenses (See Predetermination of Dental Benefits). That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be the Allowed Charge.

HEALTHSMART TIPS

To receive maximum benefits provided under the Dental Benefit, use a Dentist who has agreed to participate in the Dental Network. Participating Dentists have signed contracts agreeing to charge no more than the Dental Allowed Charge for treatment and service. You will receive a directory of In-Network Dentists at no cost to you by mail at your last known address. You may also contact the Administrative Office for a list of In-Network Dentists in your area.

Non-Network Dentists have not agreed to accept the Dental Allowed Charge as full payment. They may charge you more than the benefit amounts payable under the Dental Benefit. In this case, you pay your required 50% Coinsurance of the Allowed Charge, plus any amounts that exceed the Allowed Charge.

Dental Network

Network Providers: In-Network providers (licensed Dentists and dental hygienists) have a contract with the Dental Network to provide services for the Allowed Charge set forth in the Table of Allowances. A current list of network dental providers can be obtained free of charge by contacting the Administrative Office. To receive services, simply call a network dental provider and identify yourself as a member of JBT.

Non-Network (Out-of-Network) Providers: Services may be received from any licensed dental provider; however, this Plan will pay only a percentage of the Allowed Charge. The itemized bill reflecting the Non-Network provider's fees must be submitted to the Dental Benefit Claims Administrator for reimbursement. You will be reimbursed according to the Allowed Charge.

Non-Network provider services may cost you more than if those same services were obtained from an In-Network provider. **Non-Network Providers may bill you for any balance that may be due in excess of the Allowed Charge also called "Balance Billing."** Balance Billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. **You can avoid Balance Billing by using In-Network providers.** (See the definitions of Allowed Charge and Balance Billing in the Definitions chapter of this document.)

What the Dental Benefit Pays

Calendar Year Deductible

Each calendar year, you are responsible for paying all your Eligible Dental Expenses until you satisfy the annual Deductible. Then, the Plan begins to pay benefits. This Deductible is $50 per person but not more than $100 per family. So if the employee incurs $40 of eligible dental charges and her two children each incur $30, then all covered family members will have met their deductible requirement although no one family member has yet incurred $50 of covered charges.

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 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.

Coinsurance

Coinsurance is how you and the Plan will split the cost of certain covered dental expenses, after the Deductible is met. Once you've met your annual Deductible, the Plan pays up to 50% of the Allowed Charge for Eligible Dental Expenses, and you are responsible for paying the rest. The part you pay is called the Coinsurance.

Annual Maximum Dental Benefits

The Plan's Annual Maximum Dental Benefits payable for any individual covered under this Plan is $800 per person per calendar year.

Predetermination of Dental Benefits

If the treatment plan outlined by your Dentist—including the examination and necessary X-rays—will cost $500 or more, you should get prior approval (Predetermination) from the Administrative Office to make sure that all procedures are covered. This procedure lets you know how much you will have to pay before you begin treatment. Even if your Dentist recommends them, many procedures are not covered (see Dental Services Not Covered, below) or are only covered under limited circumstances (see Schedule of Dental Benefits in this chapter). With a Predetermination, you can be certain of how much the Dental Benefit will pay for recommended treatment. If your treatment is not preauthorized, the Dental Benefit may not pay any benefits for your treatment.

To obtain a pretreatment estimate, 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 the Administrative Office for written approval. The Administrative Office will review the treatment plan to make sure that the proposed services are both covered and Medically Necessary. The Administrative Office will then send

you and your Dentist (within 30 days) a statement showing what the Plan will pay. Having your treatment plan predetermined expedites payment when a claim is submitted for these services.

If you do not have treatment predetermined and Administrative Office cannot determine after the treatment was performed whether it was necessary, benefits may be denied.

Extension of JBT Dental Coverage

Unlike all other coverages, dental coverage ends the second month after the month you last work 80 hours.

Example: You work 85 hours in September 2020 and are then laid-off. You have dental coverage in October because you worked 80 hours in September AND you have coverage in November ("grace month").

Approved Treatment Plan: If your Dentist submits a treatment plan based on work completed before the end of the "grace" month and the plan is approved, then benefits will be paid for approved procedures done during the next three calendar months following the grace month.

Example: To continue the example above, your Dentist submits a treatment plan based on diagnostic work done during October and November. The plan is approved. Approved procedures completed during November (the grace month) and December 2020, January 2021 and February 2021 will be covered in accordance with normal dental plan benefit rules (deductibles, calendar-year maximum benefit, etc.).

Only procedures completed during this time frame that are part of the treatment plan will be covered.

Schedule of Dental Benefits

A chart outlining a description of the Plan's Dental Benefits and the explanations of them plus the difference in payment when an In-network or Non-network dental provider is used, appears on the following pages.

SCHEDULE OF DENTAL BENEFITS This chart explains the benefits payable by the Plan. See Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information. All benefits are subject to the Dental Benefit Deductible except where noted. **IMPORTANT: Non-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**			
BENEFIT DESCRIPTION	**EXPLANATIONS AND LIMITATIONS OF BENEFITS**	**In-Network Provider**	**Non-Network Provider**
Annual Maximum • Determined per calendar year. • Annual maximum benefit includes both In-Network and Non-Network care.	The Annual Maximum does not include or accumulate: • The Dental Benefit Deductible • Any amounts over the Allowed Charge in the Table of Allowances. • Any other Non-Eligible Dental Expenses.	$800 per person	
Deductible • The annual Deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. • Deductibles are applied to the Eligible Dental Expenses in the order in which claims are processed by the Plan. • Only Eligible Dental Expenses can be used to satisfy the Plan's Deductibles. • The Deductible applies to all covered services, both In-Network and Non-Network.	• 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 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.	$50 per person $100 per family	

SCHEDULE OF DENTAL BENEFITS

This chart explains the benefits payable by the Plan. See Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information.
All benefits are subject to the Dental Benefit Deductible except where noted.
IMPORTANT: Non-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

<table>
<tr><th>BENEFIT DESCRIPTION</th><th>EXPLANATIONS AND LIMITATIONS OF BENEFITS</th><th>In-Network Provider</th><th>Non-Network Provider</th></tr>
<tr><td><u>Coinsurance</u>
• After the Deductible is met, Coinsurance is how you and the Plan will split the cost of Allowed Charges for certain covered dental expenses.</td><td>Coinsurance does not apply to:
• the Dental Benefit Deductible
• Any amounts over the Allowed Charge
• Any other Non-Eligible Dental Expenses.
• For Non-Network care, you are responsible for all amounts above the Allowed Charge</td><td rowspan="2">Coverage of 50% of the Allowed Charge after the Deductible is met. Your out-of-pocket cost is limited to coinsurance (50% of the Allowed Charge), the Deductible and any amount that results in a benefit of over $800.</td><td rowspan="2">Coverage of 50% of the Allowed Charge after the Deductible is met
Your out-of-pocket cost is the sum of your coinsurance (50% of the Allowed Charge), the Deductible, any amount that results in a benefit payment over $800
AND
Any difference between the billed charge and the Allowed Charge</td></tr>
<tr><td>• Once you have met your annual Deductible, the Plan pays up to 50% of the Allowed Charge for Eligible Dental Expenses, and you are responsible for paying the rest.</td><td>Example:
<table><tr><th></th><th>In Network</th><th>Out-of-Network</th></tr><tr><td>Charge</td><td>$500</td><td>$500</td></tr><tr><td>Allowed charge as shown on Table of Allowances</td><td>300</td><td>300</td></tr><tr><td>Less deductible</td><td>(50)</td><td>(50)</td></tr><tr><td>Balance</td><td>250</td><td>250</td></tr><tr><td>Benefit (50% of balance)</td><td>125</td><td>125</td></tr><tr><td>Out-of-pocket cost</td><td></td><td></td></tr><tr><td>Coinsurance</td><td>125</td><td>125</td></tr><tr><td>Deductible</td><td>50</td><td>50</td></tr><tr><td>Difference between charge and allowed amount</td><td>-0-*</td><td>200</td></tr><tr><td>Total out-of-pocket cost</td><td>175</td><td>375</td></tr></table>*Patient is not responsible for the difference between the billed charge and the Allowed Charge.</td></tr>
<tr><td><u>Preventive/Diagnostic Care</u>
• Diagnostic care includes full mouth X-rays once every five years, bitewing X-rays once every 12 months and oral examinations and cleaning once every six months.
• Preventive care includes 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.</td><td>• 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.
• 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.</td><td>Coverage of 50% of the Allowed Charge after Deductible met</td><td>Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing</td></tr>
</table>

SCHEDULE OF DENTAL BENEFITS

This chart explains the benefits payable by the Plan. See Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information.
All benefits are subject to the Dental Benefit Deductible except where noted.
IMPORTANT: Non-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Restorative Dentistry • Includes 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.	Coverage of 50% of the Allowed Charge after Deductible met	Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing
Prosthodontics • Includes 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.	Coverage of 50% of the Allowed Charge after Deductible met	Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing
Oral Surgery • Includes extractions	• Biopsy is considered with a pathology report.	Coverage of 50% of the Allowed Charge after Deductible met	Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing
Endodontics • Includes 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.	Coverage of 50% of the Allowed Charge after Deductible met	Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing
Periodontics • Includes 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.	Coverage of 50% of the Allowed Charge after Deductible met	Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing

SCHEDULE OF DENTAL BENEFITS

This chart explains the benefits payable by the Plan. See Chapter 11: General Plan Exclusions and Chapter 15: Definitions for important information.
All benefits are subject to the Dental Benefit Deductible except where noted.
IMPORTANT: Non-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	In-Network Provider	Non-Network Provider
Procedures Only Covered Under Special Circumstances • 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 metal 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; • No more than two quadrants of scaling and root planing on the same date of service without verification of the amount and type of local anesthesia utilized; or documented special circumstances. • More than four quadrants of scaling and root planing within a 24-month period; • Any treatment for bruxism	• Services must be Preauthorized. If Preauthorization is not obtained, no benefits will be payable.	Coverage of 50% of the Allowed Charge after Deductible met	Coverage of 50% of Allowed Charge after Deductible met, plus Balance Billing

Prescription Drugs Needed for Dental Purpose

Necessary Prescription Drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the Prescription Drug Benefit. Note that some medications for a dental purpose (such as periodontal mouthwash) are not covered. See Chapter 7: Outpatient Prescription Drug Benefits for more information.

Dental Services Not Covered

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

General

1) Any service or supply determined by the Plan Administrator or its designee not to be Medically or Dentally Necessary.
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) Experimental procedures.
4) Charges for services provided by any person, Dentist or organization, which normally makes no charges in the absence of dental benefits.
5) Any treatment or service for which you have no financial liability or that would be provided at no cost in the absence of dental coverage.
6) Services that are an integral component of a covered treatment (e.g., unbundling).
7) Expenses related to complications of a non-covered service.
8) Fees charged for infection control procedures and compliance with Occupational Safety and Health Administration (OSHA) requirements.
9) Hospital Expenses Related to Dental Care: Expenses for hospitalization related to Dental Surgery or care except as may be payable under the Medical Benefit as noted in the Schedule of Medical Benefits.
10) **Cosmetic Services:** Expenses for dental Surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to bleaching/whitening of teeth, veneers, for correcting the effects of enamel hypoplasia (lack of development), and fluorosis (tooth discoloration).
11) Personalized Bridges, Dentures, Retainers or Appliances: Expenses for personalization or characterization of any Dental Prosthesis, including but not limited to any Bridge, Denture, Retainer or Appliance.
12) Charges for completion of claim forms or for broken appointments.
13) Procedures where the prognosis is poor as determined by the Plan Administrator or its designee.
14) Any treatment on primary teeth that are exfoliating or are soon to exfoliate.
15) Treatment as a result of congenital malformation to the extent allowed by federal law.
16) Treatment of Jaw or Temporomandibular Joint Dysfunction (TMD): Expenses for treatment, by any means, of jaw joint problems including temporomandibular joint dysfunction (TMD), disorder, or syndrome except to the extent payable under the Schedule of Medical Benefits, and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.

17) Gnathologic Recordings for Jaw Movement and Position: Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

18) Orthopedic repositioning appliance for correction of temporomandibular joint dysfunction (TMD) (this may be an Allowable Charge under the JBT Medical Benefit if the appliance is used instead of Surgery).

19) Appliances or restorations to increase vertical dimension, restore occlusion, stabilize tooth structure lost by wear or bruxism (clenching/grinding of teeth) and devices for harmful habits such as thumb-sucking.

20) Mouth Guards: Expenses for athletic mouth guards and associated devices.

21) Orthodontic treatment.

22) Implantology: Expenses related to implantology (items that serve as artificial or replacement root structures placed into the jaw to support/anchor replacement teeth, bridgework, dentures or other dental prostheses) including, but not limited to, tooth transplants or tooth implants, also referred to as dental implants or endosseous implants, endodontic implants, intentional implantations.

23) Full mouth rehabilitation or reconstruction.

24) Expenses for and related to cryostorage of peripheral stem cells in teeth or other tissue.

25) Myofunctional Therapy: Expenses for myofunctional therapy.

26) Premedication, prophylactic therapy, hypnosis, relative analgesia (nitrous oxide), and I.V. sedation except for documented disabled or uncontrollable patients.

27) Biologic materials to aid in soft tissue regeneration, resorbable or non-resorbable barriers for guided tissue regeneration.

Preventive Diagnostic

28) Allowances for individual X-rays that exceed the allowance for a full mouth X-ray.

29) Cleanings where gross residual calculus remains.

30) X-rays that are diagnostically unacceptable.

31) Photographs of teeth/gums/oral cavity

32) Sealants on teeth for an individual age 17 or older.

33) Fluoride treatment for individuals age 18 or older—and fluoride treatment more than once every six months for individuals under age 18.

34) Dietary planning for control of dental caries.

35) Separate instruction in oral hygiene and “plaque control.”

36) Space maintainers where first permanent and second deciduous molars are in occlusion.

37) Spacers when spaces have closed or the crowns of erupting teeth have penetrated alveolar bone.

38) Bacteriologic studies and susceptibility testing for dental caries (cavities) not covered.

Restorative

39) Replacement of lost or broken crowns within five years of restoration.

40) Charges for crowns when the impression is taken in an ineligible month, even if the service was completed in an eligible month.

41) Charges for crowns that are not installed even if the impression has been taken.

42) Composite resin restorations on lingual surfaces

43) Cast restorations when the tooth can be restored with an amalgam or with a composite resin restoration.

44) Provisional crowns.

45) Temporary crown for a fractured tooth.

46) Charges for crowns on teeth where X-rays or periodontal charting indicate the need for periodontal work.

47) Crowns in the presence of gross residual calculus.

48) Composite resin restorations on molars.

49) 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).

50) Two restorations on a single tooth surface during one visit.

51) Permanent restorations performed within two months of remineralization (recalcification).

52) Allowance for multiple restorations on one tooth that exceed the cost of a covered crown.

53) Crowns with defective margins.

54) Fillings and crowns where large overhangs are present.

Endodontics

55) Endodontic therapy using the “Sargenti Method.”

56) Root canal when used to facilitate appliance placement.

57) Pulp capping unless the pulp is exposed or nearly exposed.

58) Dowels, posts, and pins unless insufficient coronal structure remains to retain the crown restoration.

59) Grossly under-filled or over-filled root canal fillings.

Periodontal

60) Gingivectomy in conjunction with crown preparation.

61) Splinting of teeth for periodontal support.

Prosthodontics

62) Replacement of lost or broken fixed partial dentures and removable prosthetic appliance (dentures, full and partial) within five years of restoration.

63) Charges for fixed partial dentures (bridges), removable partial and full dentures when the impression was taken in an ineligible month even though eligible service was completed in an eligible month.

64) Charges for fixed partial dentures, removable partial and full dentures, that are not installed even if the impression has been taken.

65) Charges for fixed or removable partial dentures on teeth where X-rays or periodontal charting indicate the need for periodontal work.

66) Fixed or removable partial dentures in the presence of gross residual calculus.

67) Charges for removal of unilateral partial denture.

68) With respect to full or partial (fixed or removable) dentures, treatment involving the following is not covered:

   a. Specialized techniques for treatment of full or partial (fixed or removable) dentures.
   b. Precision attachments or stress breakers for partial dentures and associated appliances.
   c. Personalization and characterization of full or partial dentures.
   d. Gnathologic recording (for removable or fixed prosthesis).
   e. Procedures associated with overlays (overdentures) and implants.
   f. Removable cast partial or full dentures for patients under age 16.
   g. Full dentures when partial removable dentures can be placed.

69) 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.

70) Fixed partial dentures (bridges) for patients under age 16.

71) Replacement of missing posterior teeth where the space is largely closed and neither of the proximal teeth otherwise require crown restoration.

72) Replacement of missing teeth where the individual has at least 12 posterior teeth in occlusion.

73) Interim partial dentures (stayplates) except (1) to replace extracted anterior teeth for adults during healing period; (2) as an anterior space maintainer for children; or (3) as a temporary alternative to a permanent prosthesis in the presence of progressive periodontal disease likely to lead to further tooth loss.

Oral Surgery

74) Surgical correction by grafts for denture retention purposes.

75) Removal of remaining crown of an exfoliating deciduous tooth where the roots are essentially reabsorbed.

76) Removal of essential and strategic teeth that can be retained with endodontic therapy.

77) Removal of teeth that can be retained to avoid unnecessary conversion of a patient to edentulism (partial or complete).

78) Palatal augmentation prosthesis, palatal lift prosthesis.

79) Reduction of dislocation and treatment of a temporomandibular disorder (other than open or closed reduction of dislocation).

80) Endosseus implants.

81) 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 and verified qualifications).

For additional general exclusions and limitations that apply to the self-funded Dental Benefit see Chapter 11: General Plan Exclusions.

Filing a Dental Benefit Claim/Appealing a Denied Claim

When you use the services of an In-Network dental provider, the provider will typically send their bill directly to the Administrative Office for reimbursement. Note, however, that you will need to pay the provider for any services you purchased that are in excess of the benefit allowed under the Dental Benefit or are not covered by the Dental Benefit.

If you use the services of a Non-Network dental provider, you may need to pay the provider for all services and then, at a later date but **within 12 months of the date of service**, submit the bill (and proof of payment) to the Administrative Office (whose contact information is listed on the Quick Reference Chart in the front of this document). You will be reimbursed up to the amount allowed under the Dental Benefit as noted in the Schedule of Dental Benefits. If the non-network provider bills the trust directly, after the benefit is paid you will owe the difference between the total charge and what the Plan has paid.

Dental claims submitted beyond 12 months from the date of service will not be considered for reimbursement.

See also Chapter 13: Claims and Appeals Procedures.

CHAPTER 10: VISION BENEFITS – EMPLOYEE ONLY

Vision Benefits are treated as a standalone (or excepted) benefit under HIPAA and the Affordable Care Act. Vision Benefit claims are administered under a contract separate from claims administration for any other benefits under the plan. Employees may elect/decline Vision Benefit annually.

Eligibility for Vision Benefits

JBT Vision Benefits are provided for the employee only. If you work 80 hours in any month, you will be eligible to obtain vision benefits during the following calendar year, regardless of your work history during that following calendar year. For example, if you work 80 hours in August 2019, you will be eligible for Vision Benefits during the entire 2020 calendar year. This is true even if you do not work 80 hours in any month of 2020. However, once you receive a service, you will not have additional benefit(s) for that service for 24 months (i.e., if you get glasses on February 10, 2019, you will not have a benefit for glasses again until February 10, 2021—assuming you remain eligible in 2021 by working at least 80 hours during one month of 2020).

Dependents are not eligible for Vision Benefits.

How the Vision Benefit Works

The Vision Benefit is designed to cover visual needs (rather than cosmetic materials) by providing coverage for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. The exam that is part of the Vision Benefit can detect individuals who have chronic diseases that can affect the eye such as diabetes, high blood pressure (hypertension), glaucoma, and cataracts.

Not every vision care service or supply is covered by the Vision Benefit, even if prescribed, recommended, or approved by your physician or optical provider. The Plan covers only those services and supplies that are Medically Necessary and included as a covered benefit. The Plan will not reimburse any expenses that are not eligible vision expenses. That means you will be responsible for paying the full cost of all expenses that are determined not to be Medically Necessary, determined to be in excess of the Allowed Charges, not covered by the Vision Benefit, or are in excess of a maximum Vision Benefit.

Vision Network

The JBT contracts with an independent network of vision providers (known as the Vision Service Plan Advantage Network) who extend a discount to you for covered vision services. Covered vision expenses are noted in the Schedule of Vision Benefits in this chapter and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Vision Benefit. Under this Vision Benefit, you can go to any licensed Optometrist you choose, but the benefits are higher when you use a Network eye care professional. Licensed eye Doctors include ophthalmologists, optometrists, and dispensing opticians.

- **VSP Advantage Network Providers:** Network providers (licensed ophthalmologist, optometrist or dispensing optician) have a contract to provide discounted fees to you for services covered under this Vision Benefit. By using the services of a VSP Advantage Network provider, both you and the Plan pay less (see the VSP Advantage Network column of the Schedule of Vision Benefits). A current list of VSP Advantage Network vision providers is available free of charge when you call the Vision Benefit whose name, address and telephone number are listed on the Quick Reference Chart in the front of this document. For a paper copy of the provider directory, at no charge, contact the Vision Benefit. To receive services, simply call a network vision provider and identify yourself as a member of this Plan.

NOTE: You must identify yourself as a participant in this Plan having VSP coverage at the time that you make the appointment with the VSP Advantage Network provider or you may not receive the VSP Advantage Network discounted rates.

- **Non-Network Providers:** Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, this Plan will pay at the Non-Network benefit level as shown on VSP's Out-of-Network Schedule of Vision Benefits. A copy of this schedule can be obtained from VSP. The itemized paid bill reflecting the Non-Network provider's fees must be submitted to the Vision Benefit Claims Administrator for reimbursement. You will be reimbursed accordance with the Out-of-Network Schedule of Benefits. Non-Network provider services may cost you more than if those same services were obtained from a VSP Advantage Network provider. **Non-Network Providers may bill the Plan Participant for any amount in excess of the allowance shown on the Out-of-Network Schedule of Vision Benefits, also called Balance Billing.** Balance Billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the Plan's payment for a covered service.

  You can avoid Balance Billing for your vision exam by using VSP Advantage Network providers. (See the definitions of Allowed Charge and Balance Billing in the Definitions chapter of this document.)

Definition of Terms Related to this Vision Benefit

- A **vision exam** includes a professional eye examination and an eye refraction (a refraction billed without an exam is not covered). The exam typically includes:
  - an assessment of your health history that is relevant to your vision,
  - external exam of the eyes for pathological abnormalities of the eyes including but not limited to the pupil, lens, eyelashes and eyelids,
  - internal exam including but not limited to an assessment of the lens and retina along with tonometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes' ability to focus light rays on the retina from a distance and close-up).
- **Contact lens exam** includes the comprehensive exam covered under the vision exam benefit along with the assessment of the optical and physical characteristics of the eye and the surface of the eye such as power, size, curvature, flexibility, gas-permeability, moisture/tear content, along with prescription of contact lens, fitting, evaluation, modification and dispensing of the contacts. Contact lens services may be provided by a Doctor or optician. Contact lens exams are designed to ensure the proper fit of contacts and to evaluate vision with the contacts. Although the vision may be clear and a person may feel no discomfort from their lenses, there are potential risks with improper wearing or fitting of contact lenses that can affect the overall health of the eyes. The regular "vision exam" does not include a contact lens exam. A contact lens exam is in addition to a regular eye exam.
- **Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry. Optometrists examine the internal and external structure of the eyes to diagnose eye diseases like glaucoma, cataracts and retinal disorders; systemic diseases like hypertension and diabetes; and vision conditions like nearsightedness, farsightedness, astigmatism and presbyopia.
- **Ophthalmologist** is a Physician (MD or DO) licensed to practice ophthalmology, including eye Surgery and prescription of drugs.

- **Lenticular lens (Vision):** a vision lens of high diopter power with the prescription ground only into the central portion of the lens while the periphery of the lens usually does not contain any power and serves only to give dimensions suitable for mounting in a frame. The lenticular lens design helps reduce the thickness of the lens, making it lighter weight and more cosmetically and functionally appealing.
- **Progressive Lenses (Vision):** Bifocal or trifocal lenses that appear to be single vision with no distinct lines between the various focal lengths.

SCHEDULE OF VISION BENEFITS This chart shows what the Vision Benefit pays. The single copay covers both professional fees and materials unless otherwise noted.			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Benefit Exclusions section.*	**Plan Pays**	
		VSP Advantage Network Provider	**Non-Network Provider**
Deductible and Annual Maximum		None	There is a limited allowance for these services. Please contact VSP or visit www.vsp.com for details about your Non-Network provider benefits.
Copayment		$10 copay, paid once for exam, frames and lenses combined	
Vision Examination *without* contact lens fitting.	• One vision exam is payable every 24 months.	Plan pays 100% after the copay for exam.	
Frames for Eyeglasses This program provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this Plan has a limit (determined by the Vision Benefit administrator) on the reimbursement for frames.	• One frame is payable every 24 months. • You are responsible for any amounts over the frame allowance	Plan pays 100% after the copay, not to exceed a $150 allowance. You pay the difference, if any, between the provider's charge and the Allowance.	

<table>
<tr><th colspan="4">SCHEDULE OF VISION BENEFITS
This chart shows what the Vision Benefit pays.
The single copay covers both professional fees and materials unless otherwise noted.</th></tr>
<tr><th rowspan="2">Covered Vision Benefits</th><th rowspan="2">Explanations and Limitations
See also the Vision Benefit Exclusions section.</th><th colspan="2">Plan Pays</th></tr>
<tr><th>VSP Advantage Network Provider</th><th>Non-Network Provider</th></tr>
<tr><td rowspan="6">Lenses for Eyeglasses</td><td rowspan="6">• Standard lenses are covered meaning, CR-39 basic plastic or white (clear) glass lenses.
• No coverage for special coatings or tints on lenses.
• A single vision, lined bifocal, lined trifocal, lined lenticular or progressive lens is payable once every 24 months.</td><td>Single Vision (Standard):
100% after the copay</td><td rowspan="7">There is a limited allowance for these services. Please contact VSP or visit www.vsp.com for details about your Non-Network provider benefits.</td></tr>
<tr><td>Lined Bifocal:
100% after the copay</td></tr>
<tr><td>Lined Trifocals:
100% after the copay</td></tr>
<tr><td>Lined Lenticular:
100% after the copay</td></tr>
<tr><td>Standard Progressive:
100% after an additional $55 copay</td></tr>
<tr><td>Premium Progressive:
100% after an additional $95-$105 copay</td></tr>
<tr><td rowspan="3">Contact Lenses (instead of glasses):
Medically Necessary contact lenses are considered for the following reasons:
• Following cataract Surgery; or
• Visual acuity cannot be improved to at least 20/70 in the better eye even with the use of eyeglasses.
Contact lenses that do not meet the above criteria are considered “not Visually Necessary” or Elective (Cosmetic).</td><td rowspan="3">• One set of Visually Necessary contact lenses are payable every 24 months, in lieu of all other lens and frame benefits.
• One set of Elective contact lenses are payable every 24 months in lieu of eyeglasses.
• You may use your annual contact lens allowance toward permanent and/or disposable lenses.
• No benefits for contact fitting exam, however, your cost for such exam is generally lower if you use VSP Advantage Network Providers.</td><td>Contact Lenses (Visually Necessary):
100% after the copay</td></tr>
<tr><td>Elective Lenses (not Visually Necessary):
Up to $100 allowance, no copay.</td></tr>
<tr><td colspan="2">You pay the difference between the cost of contact lenses and the amount allowed under this Vision Benefit.</td></tr>
</table>

SCHEDULE OF VISION BENEFITS This chart shows what the Vision Benefit pays. The single copay covers both professional fees and materials unless otherwise noted.			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Benefit Exclusions section.*	**Plan Pays**	
		VSP Advantage Network Provider	**Non-Network Provider**
Primary Eye Care Program Treatment and diagnosis of eye conditions including but not limited to pink eye, vision loss and monitoring cataracts, glaucoma and diabetic retinopathy.	• If you have the following symptoms and/or conditions you will be covered for certain Primary Eye Care services in accordance with the optometric scope of licensure in the VSP Doctor's state: ocular discomfort or pain, transient loss of vision, flashes or floaters, ocular trauma, blurred vision/diplopia, recent onset of eye muscle dysfunction, ocular foreign body sensation, pain in or around the eyes, swollen lids, sty, red eyes/pink-eye. • To obtain Primary Eye Care Services, contact a VSP Advantage Network Doctor's office and makes an appointment.	100% after $5 copay per visit.	Not covered.
Extra Savings **Custom Progressive Lenses** • 20% savings on custom progressive lenses from any VSP Advantage Network provider **Contact Lens Fitting Exam** • 15% savings on contact lens exam (fitting and evaluation) from any VSP Advantage Network provider **Glasses and Sunglasses**: • Extra $20 to spend on featured frame brands. Go to www.vsp.com/special offers for details. • 20% savings on any amounts over your frame allowance from any VSP Advantage Network provider • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP Advantage Network provider within 12 months of your last WellVision Exam. **Laser Vision Correction**: • Average 15% off the regular price or 5% off the promotional price. Discounts only available from VSP Advantage Network contracted facilities.			

Vision Benefit Exclusions

In addition to any limitations and exclusions described elsewhere in this Summary Plan Description, the following is a list of services and supplies or expenses **not covered (excluded) by the Vision Benefit**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Vision Benefit has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

1. Vision services and supplies that cost more than the Plan's allowance or are performed/received more frequently than permitted by the Plan, as noted in the Schedule of Vision Benefits.
2. Orthoptics (vision training to improve the visual perception and coordination of the two eyes) and supplemental testing.

3. Subnormal vision aids and any associated supplemental testing.
4. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
5. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
6. Two pair of lenses or eyeglasses in lieu of bifocals.
7. Plano (non-prescription or less than ± .50 diopter power) lenses.
8. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK), except that this Vision Benefit does offer a discount on laser eye Surgery when performed by VSP Advantage Network Vision providers.
9. Services or materials provided as a result of any Workers' Compensation Law, or similar occupational health legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof including safety glasses.
10. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
11. Vision check-ups or screenings requested by the participant's employer, school or government.
12. Treatment received from a medical department maintained by an employer, a mutual benefit association, a labor union, a trustee or a similar type group.
13. Experimental and/or Investigational/Unproven treatment or procedure.
14. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
15. Services or supplies furnished before the effective date of vision benefit coverage or beyond the termination date of vision benefit coverage.
16. Eye examinations or eyewear required as a condition of employment.
17. Expenses related to complications of a non-covered service.
18. Services performed outside of the United States of America.

Vision Benefit Limitations

The Vision benefit is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Plan will pay the cost of the allowed vision service/supply and **the covered person will pay the additional cost for the extras**, such as:

a. oversized lenses (larger than 61mm).
b. cosmetic lenses and cosmetic processes.
c. coated lenses (e.g., anti-reflective, color, mirror, scratch).
d. Color coating/tinted lenses (addition of substance to produce a color) or photochromic lenses (lenses change from clear indoors to sunglass dark outdoors according to intensity of sunlight); except that Pink #1 and Pink #2 is covered.
e. sunglasses/ultraviolet (UV) protected lenses (plain or prescription).
f. laminated lenses.
g. polycarbonate lenses.
h. blended lenses.

i. progressive multi-focal lenses.
j. certain limitations on low vision care.
k. a frame or other vision materials in excess of the Plan's allowance.

Filing a Vision Claim/Appealing a Denied Claim

When you use the services of an In-Network vision provider, you should pay the provider for your appropriate copay. The provider will typically send the remainder of their bill directly to the Vision Benefit administrator for reimbursement. Note however that you will need to pay the provider for any services you purchased that are in excess of the benefit allowed under the Vision Benefit or are not covered by the Vision Benefit.

If you use the services of a Non-Network vision provider, you will need to pay the provider for all services and then, at a later date but within **six (6) months** of the date of service, submit the bill (and proof of payment) to the Vision Benefit claims administrator (whose contact information is listed on the Quick Reference Chart in the front of this document). You will be reimbursed up to the amount allowed under the Vision Benefit as noted in the Schedule of Vision Benefits.

Vision claims submitted beyond **six (6) months** of the date of service may not be considered for reimbursement. See also Chapter 13: Claims and Appeals Procedures.

CHAPTER 11: GENERAL PLAN EXCLUSIONS

The following is a list of services, supplies or expenses **not covered (excluded) by the Plan's Medical, Substance Abuse Treatment, Outpatient Prescription Drug, Dental and Vision benefits**. The Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical Benefit and Dental Benefit has been delegated, have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

These General Plan Exclusions are in addition to the specific Medical exclusions listed in Chapter 6, the Outpatient Prescription Drug exclusions listed in Chapter 7, the Substance Abuse Treatment exclusions listed in Chapter 8, Dental Benefit exclusions listed in Chapter 9 and Vision Benefit exclusions listed in Chapter 10. No benefits are payable for the following:

1. Treatment or supplies that are **not Medically Necessary** as determined by the Board of Trustees or its designee. This includes charges for treatment of Illness or Injury or for dental services or supplies that are not reasonably necessary for medical or dental health.
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. Services or supplies provided by or paid for by **a federal government agency** or by any state or political subdivision, except (1) where there is an unconditional legal obligation to pay for charges without regard to the existence of any insurance or employee benefit plan; and (2) the Veterans Administration or military Hospital will be reimbursed in accordance with the Plan for charges incurred by a covered person for services or supplies which are unrelated to military service. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. Charges for treatment of accidental bodily injury or sickness that occurs while in the armed services and is determined by the Secretary of Veterans Affairs to be service-connected are not covered.
4. Charges for treatment of Illness or Injury that are **in excess of the Allowable Charge** (as defined in the Definitions chapter).
5. Charges 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, or for which **no charge** would otherwise be made to the patient.
6. Injuries or conditions caused by or resulting from your commission or attempted **commission of an illegal act** or an act of personal aggression as determined by the Plan Administrator in his or her sole discretion, on the advice of counsel. Provided, however, that this exclusion will not apply if the Injury or condition resulted from an act of domestic violence or a health condition (physical or mental), to the extent that treatment for the Injury or condition would otherwise be covered. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
7. Professional services provided by a person who lives in the covered individual's home or is **related to the individual** (a relative) by blood or marriage.
8. 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 except under those conditions described in Chapter 4: COBRA Continuation Coverage and Chapter 8: Substance Abuse Treatment Benefits of this document.

9. Services or supplies furnished for the treatment of a condition for which the Plan participant is **not under the care of a Physician**, except for those covered services provided by a licensed or certified Health Care Provider.
10. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan Administrator or its designee.
11. **Costs of Reports, Bills, etc.:** Expenses for preparing or completing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, e-mailing charges, prescription refill charges before scheduled supply is exhausted, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/direct primary care fees, membership/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees.
12. With the exception of ACA required preventive services, **Educational Services:** Even if they are required because of an Injury, Illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices. Expenses for educational services related to **reading, learning disorders, dyslexia, educational delays, or vocational disabilities are not covered**.
13. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by an employer for the benefit of its employees.
14. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any maximum Plan benefit limitation.
15. **Expenses for Which a Third Party Is Responsible**: Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g., no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits (Chapter 12) in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
16. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational or Unproven as defined in the Definitions chapter of this document.
17. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or disability including, without limitation, construction or modification of ramps, elevators, handrails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

18. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual.

19. **Personal Comfort Items:** Expenses for patient convenience, comfort, hygiene, or beautification including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, VCR/DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

20. **Physical Examinations, Tests, Immunizations for Employment, School, etc.:** Expenses for physical examinations, screenings, testing and immunizations such as required for functional capacity/job analysis examinations and testing required for employment/career, commercial driving, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, required by any third party, education, marriage, adoption, judicial or administrative proceedings/orders, medical research or to obtain or maintain a license of any type.

21. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.

22. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.

23. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.

24. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.

25. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.

26. **War or Similar Event:** Expenses incurred as a result of an Injury or Illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

27. Expenses related to **complications of a non-covered service**.

28. Expenses for **wilderness therapy program**, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care and group home.

29. Expenses for **hypnosis/hypnotherapy** (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness) except hypnosis as a method to achieve tobacco cessation.
30. Expenses for **equine (horse) assisted therapy**.
31. Expenses for **court-ordered services unless the services are both Medically Necessary and a covered benefit of the Plan.**
32. **Parental custody services or adoption services.**
33. Expenses for and related to **service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.
34. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, notification to the Administrative Office is suggested in order to assure the participant is enrolled in an "Approved Clinical Trial" and to provide notification to the Administrative Office that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
35. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Medical Benefit will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided, unless an earlier limit applies such as the 6 months from the date of service for Vision Benefits claims.

CHAPTER 12: COORDINATION OF BENEFITS (COB)

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—the Plan coordinates the benefits it pays with benefits provided by the other plan. See "Determining Which Plan is Primary" on page 115 to determine whether this Plan will pay as primary or secondary. A typical example of this is the birthday rule. If your child is covered under both this Plan and your spouse's plan, then your child has primary coverage under this Plan if you are born earlier in the calendar year than your spouse. Otherwise, your child has secondary coverage under this Plan.

Medical

When this Plan pays as secondary the benefit is limited to the difference between:

1. The lesser of:
    a. Where the provider is in both the primary plan's network and the JBT network, the lower network contract amount (or the agreed amount) as negotiated on behalf of the primary plan or the secondary plan; or
    b. Where the provider is only in one plan's network (i.e., the JBT network or the primary plan's network, but not both), the contract rate with the network the provider is in, or
    c. Where the provider is not in either the primary plan or JBT network and no requirement exists in the JBT plan to use a network provider (i.e., no network provider available or the treatment is an emergency) then U&C as determined by each plan, AND
2. The amount paid by the primary plan.

However, this Plan will never pay more than its Plan maximum (example $680 per year for chiropractic treatment) or more than this Plan would be obligated to pay in the absence of coverage by this Plan. This means for example that:

- The Plan will pay nothing as secondary for non-emergent treatment if the provider is out-of-network (Sutter if you are enrolled in the Advantage plan, not contracted with Blue Cross if you are enrolled in either Advantage or Prudent Buyer).
- The Plan will pay no more than the difference between $50 per day (the chiropractic benefit limit) and what the primary plan paid for chiropractic treatment.
- The Plan will pay no more than the copay if the prime plan's carrier is an HMO.
- If the primary plan limits the patient's obligation to a scheduled amount (such as, for example, a contract rate), even if this scheduled amount is less than what was billed, as secondary JBT will limit its payment to the difference between the prime plan's scheduled amount and the benefit paid by the primary plan.

See the chart on the following page for examples of how this Plan calculates the secondary payment when coordinating medical benefits.

	Non-Emergency Care						Emergency Care		
Participant Enrolled	Advantage	Prudent Buyer	Advantage	Prudent Buyer	Advantage	Prudent Buyer	Advantage	Advantage	Advantage
JBT Provider Network	Advantage	Prudent Buyer	Prudent Buyer	Prudent Buyer	Advantage	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer
Primary Plan Network	In-Network	In-Network	In-Network	In-Network	Out-of-Network	Out-of-Network	In-Network	In Network	Out-of-Network
Billed charge	$12,000	$13,000	$12,000	$12,000	$12,000	$12,000	$13,000	$12,000	$12,000
Allowed Charge as determined by									
• JBT	n/a	n/a	n/a	n/a	n/a	n/a	$11,500	$10,000	$11,250
• Primary Plan	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$11,000
Network Contract Rate									
• JBT	$8,000	$9,000	n/a	$10,000	$8,000	$10,000	n/a	n/a	n/a
• Primary Plan	$7,000	$10,000	$9,000	$9,000	n/a	n/a	$9,000	$10,500	n/a
Primary Plan Pays	$5,550	$7,150	$7,150	$7,150	$9,600	$9,600	$7,150	$9,600	$9,600
JBT (Secondary Plan) Pays	$1,450	$1,850	$0	$1,850	$0	$400	$1,850	$900	$1,400
Notes	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

Notes:

1. The difference between the lower contract rate ($7,000) and the rate paid by the primary plan ($5,550).
2. The difference between the lower contract rate (JBT - $9,000) and the rate paid by the primary plan ($7,150).
3. No secondary payment is made because the participant is enrolled in the Advantage plan and used a provider that is not in the Advantage network. The only payment that is available is that made by the primary plan.
4. The difference between the lower contract rate (primary plan - $9,000) and the rate paid by the primary plan ($7,150).
5. The primary plan paid more than the JBT contract rate, so no payment is made by JBT as the secondary plan.
6. The JBT contract rate exceeds the primary plan payment by $400.
7. Same as number 3, above, except that the treatment is considered by the JBT plan to be emergency care. Therefore, JBT provides coverage and will coordinate up to the contract rate, in this case the $9,000 negotiated by the primary plan.
8. The JBT plan pays only the difference between the applicable contract rate (primary plan - $10,500) and what the primary plan paid, even though JBT's Allowed Charge as determined by JBT is less. Where a contract rate applies, it is used regardless of the Allowed Charge.
9. Because the care is considered by the JBT Plan to be emergency care, the claim is payable even though the provider is not in the JBT network (in this example, a participant enrolled in the Advantage plan used a Prudent Buyer network provider) and is not in the primary plan's network. As the secondary payer, JBT pays the difference between the lower of the Allowed Charge as determined by the two plans, and the benefit amount paid by the primary plan.

Important Limits

The above examples notwithstanding, the JBT will never pay more than the patient is obligated to pay.

Example: If the primary plan is an HMO, the secondary payment is generally limited to the HMO copayment and deductible for the service.

Example: If the primary plan limits the patient's obligation to a scheduled amount, and even if that scheduled amount is less than what was billed, JBT will only coordinate up to that scheduled amount.

Dental

Dental benefits are determined by the Table of Allowances. With few exceptions, there is a set allowance for all covered procedures. When this Plan pays as secondary the benefit is as follows: if the provider is not part of the JBT Dental Network as secondary JBT pays the lesser of:

1. The difference between the billed charge and the benefit paid by the primary plan, OR
2. Without regard to the deductible, the amount that would have been paid by JBT in the absence of other coverage.

If the provider is in the JBT Dental Network as secondary JBT pays the lesser of:

1. The difference between the billed charge and the benefit paid by the primary plan, OR
2. The difference between the JBT Allowance and the benefit paid by the primary plan; BUT
3. Without regard to the deductible, not more than the amount that would have been paid by the JBT in the absence of other coverage.

Examples

	Dentist NOT in JBT Network				**Dentist IN JBT Network**		
Billed charge	$850	$850	$850	$850	$850	$850	$850
JBT Allowed Charge	$800	$800	$800	$800	$800	$800	$800
Primary plan paid	$300	$300	$475	$700	$300	$550	$425
Difference (charge less Primary plan payment)	$550	$550	$375	$150	$550	$300	$425
JBT benefit, if primary plan							
50% of Allowance	$400	$400	$400	$400	$400	$400	$400
Less deductible, if any	-0-	$50	$50	-0-	$50	-0-	$50
JBT benefit without regard to other coverage	$400	$350	$350	$400	$350	$400	$350
JBT pays as secondary plan	$400	$400	$375	$150	$400	$250	$375
Notes	(1)	(2)	(3)	(4)	(5)	(6)	(7)

Notes:

1. Remaining balance after primary plan pays exceeds what JBT would have paid if prime (50% of Allowed Charge). Secondary payment limited to amount JBT would have paid as primary plan.
2. Same as example 1 above, except secondary payment also includes deductible that would otherwise have been taken.
3. Remaining balance after primary plan pays is $375 which is less than what JBT would have paid as primary plan without regard to the deductible ($400). JBT pays $375.
4. Remaining balance after primary plan pays is less than the amount JBT would have paid as prime. Secondary benefit is limited to remaining balance after primary plan payment.

5. Secondary payment for charges from In-Network dentists is the lesser of the remaining balance after the primary plan pays ($550) or the amount JBT would have paid without regard to the deductible ($400). Note the sum of the primary and secondary payments ($300 + $400) does NOT exceed the Allowed Charge for the procedure of $800.
6. Secondary payment is limited to the difference between the Allowed Charge and the amount the primary plan paid ($800 - $550) = $250. Note that what JBT would have paid without regard to other coverage and the amount paid by the primary plan ($400 + $550) = $950 exceeds the Allowed Charge.
7. As in 6 above, the secondary payment is limited to the difference between the Allowed Charge and what the primary plan paid ($800 - $425) = $375. As primary, JBT would have paid $350 but without regard to the deductible up to the lesser of $400 and $375.

Coordination Generally

This Plan does not coordinate benefits with an individual plan. This means that when a plan participant is covered by this Plan and also covered by an individual (non-group) plan/policy, including a policy through the Health Insurance Marketplace, this Plan will pay benefits without regard to whether the participant is also covered by an individual plan/policy.

If you or your dependents are covered under any other group plan, you must inform the Administrative Office. If you do not notify the Administrative Office of other group plan coverage, benefits may be overpaid in error. The Plan will require you to repay any overpayment that was made in error and will withhold future benefits if you fail to do so. See the section Payments Made in Error on page 121 for further information regarding JBT's rights and your obligations in the event you receive a payment that was made in error.

Determining Which Plan Is Primary

The following rules are used to determine which plan is "primary." The rules are applied in the following order:

- A Plan without a Coordination of Benefits Provision or with a provision that bars coordination with the Plan will be primary.
- Another plan that covers you as an employee is primary before a plan that covers you as a dependent.
- 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.
- If a child's parents are divorced or separated, the birthday rule does not apply. Instead, claims are processed in this order:
  - 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).
  - The plan of the parent who has custody.
  - The plan of the stepparent married to the parent who has custody.
  - The plan of the parent who does not have custody.
  - The plan of the stepparent married to the parent who does not have custody.

- 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.
- 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.

If (1) this Plan is secondary and (2) the plan that would pay primary under these rules limits or reduces its payment of benefits because of coordination with this Plan, then this Plan will pay no more than it would have paid as a secondary payer had the primary plan paid benefits notwithstanding coordination with this Plan and without regard to such limitation or reduction of benefits because of coordination with this Plan.

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.

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 child is enrolled in the Plan and your spouse's HMO, your spouse's HMO coverage is always primary.

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.

If You Are Eligible for Medi-Cal

If you are eligible for medical assistance under a state Medi-Cal plan, benefits provided under the JBT Medical Benefit will not be reduced or denied based on your eligibility for Medi-Cal coverage. JBT will reimburse the state Medi-Cal plan for the cost of any Allowable Charges paid by Medi-Cal that would have been payable by JBT.

Coordination of Benefits with Medicare

If you are an active employee enrolled in a JBT Plan and are also eligible for Medicare coverage the Plan will coordinate with Medicare. If you need more information on the Medicare Coordination of Benefits Rules, please call the Administrative Office, or refer to https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html.

Medicare Part D

If you have dual coverage under both this Plan and Medicare Part D, for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

For more information on Medicare Part D refer to www.medicare.gov or contact the Administrative Office.

Workers' Compensation Insurance

The JBT Health and Welfare Plan for employees under the Seasonal Medical Benefits Plan 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 and 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.

Third Party Liability

If the Plan pays claims for expenses incurred because of an Illness or Injury for which a third party is (or may be) responsible, by submitting the claim for payment, 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 an equitable lien on any recovery received by you (or your dependent, legal representative, trustee 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, trustee 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 or your dependent are not fully compensated ("made whole") for your losses;
- 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 JBT's claim shall not be reduced under the doctrine of contributory or comparative negligence;
- 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, including timely submission of JBT's third party lien form and accident questionnaire, keeping JBT informed of the progress of any trial, settlement or disposition of your claim;
- 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; and
- To the entry of judgment against you and, if applicable, your dependent, legal representative, agent, trustee or trust fund 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 or not provide any benefits until you agree to comply with the terms of this section, including executing any agreement requiring such compliance; 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 have questions about how to comply with these third party liability rules, contact the Administrative Office.

CHAPTER 13: CLAIMS AND APPEALS PROCEDURES

For the Medical Benefit, Outpatient Prescription Drugs, Substance Abuse / Chemical Dependency, and the Dental and Vision Benefits, you or the Provider must file a claim. The claim procedures are described here. If your claim has been denied in whole or in part, you have the right to appeal the decision.

This chapter also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is Experimental or Investigational).

This chapter describes:

- How to file an initial claim for benefits under each benefit option;
- The rules that the Plan must follow when making decisions on claims or appeals, and
- The rules that you must follow to appeal the denial of a claim under the Plan.

Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document and Appendix A.

Payments Made in Error

In the event the Plan erroneously makes benefit payments to a participant or provider in excess of the amounts provided for by this Plan, or erroneously makes benefit payments to a participant or provider for expenses for which benefits are not payable under this Plan, or erroneously makes benefit payments to, or on behalf of, an individual who was ineligible for or fraudulently participates in the Plan based on a mistake or misrepresentation of facts, the erroneous amounts are to be repaid to the JBT by the participant, individual or provider.

By submitting a claim for payment by the Plan, you (and a covered dependent if he or she incurs an Illness or Injury) and/or your provider are deemed to have agreed to each of the following conditions with regard to any payment that is made in error:

- That JBT has established an equitable lien on any payment made in error that you (or your dependent, legal representative, trustee, assignee or agent) or your provider receive;
- That you are to notify JBT if you have reason to believe that a payment was made in error;
- That you (or your dependent, legal representative, trustee, assignee or agent) or your provider will hold any payment received in error in trust on behalf of JBT and will reimburse JBT promptly for the benefits paid;
- That JBT’s claim shall not be reduced under the doctrine of contributory or comparative negligence;
- That you will not take or omit to take any action to prejudice JBT's ability to recover the payment made in error;
- To cooperate in doing what is necessary to assist JBT to recover the payment made in error; and

- If a written demand for repayment is made by JBT, to repay the amount paid in error to JBT within the time specified in the written demand.

If you (or your dependent, legal representative, trustee, assignee or agent) or your providers fail or refuse to assist JBT in recovering the payment made in error, JBT may:

- Offset what is paid on your and/or your dependents' future benefits claims until JBT is completely reimbursed for the amount paid in error; and
- File a lawsuit against you (or your dependent, legal representative, trustee, assignee or agent) or your provider to fully recover the amount paid in error and recover JBT's attorneys' fees and costs incurred in connection with the lawsuit, and/or
- Take any other action deemed appropriate by the Board of Trustees.

If you have questions about how to comply with these rules, contact the Administrative Office.

TIME LIMIT FOR INITIAL FILING OF CLAIMS

All Medical Benefit and Dental Benefit claims must be submitted to the Plan within 12 months from the date of service.

All Vision Benefit claims must be submitted to the Plan within 6 months from the date of service.

No Plan benefits will be paid for any claim submitted after these time periods.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after the stated timeframe.

Authorized Representative

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan), or an individual given authority by a court order to submit claims on your behalf.

An authorized representative under this Plan also includes a network Health Care Professional. Under this Plan non-network providers cannot automatically be designated to be an Authorized Representative, the plan participant must make a written designation if they desire a non-network provider to be their authorized representative for a claim appeal; however, this designation does not extend to the non-network provider the right to file legal action on behalf of the participant or their claim appeal.

The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.*, notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Types of Claims

For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined in this chapter) in accordance with the Plan's claims procedures, described in this chapter. There are five types of claims described by the procedures in this chapter: Pre-service, Urgent, Concurrent, Post-service, and Disability. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

Any request for Plan benefits must be made according to the Plan's claims filing procedures, including any request for a service that must be preauthorized.

A claim must include the following elements to trigger the Plan's claims processing procedures:

- be written or electronically submitted (oral communication is acceptable only for urgent care claims),
- be received by the Appropriate Claims Administrator as that term is defined in this chapter,
- name a specific individual,
- name a specific medical condition or symptom,
- name a specific treatment, service or product for which approval or payment is requested,
- made in accordance with the Plan's claims filing procedures described in this chapter and
- contains all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits.

The five types of claims of this Plan are:

- **Urgent Care Claim**. An 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 Provider 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.

- **Pre-Service Claim**. A pre-service claim is generally a request for a determination of coverage before the treatment is rendered, where the Plan conditions payment, in whole or in part, on approval in advance of obtaining the health care service. The services that require Preauthorization (pre-approval) are listed in Chapter 5. Under this Plan, the Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing Preauthorization (that were obtained without prior approval) if the patient was unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (Preauthorization) procedure could have seriously jeopardized the patient's life or health.

- **Concurrent Care Claim**. A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment.

Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

- **Post-Service Claim**. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A post-service claim is a claim other than a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.
- **Disability Claim.** 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" as defined by the Plan. The following kinds of claims are Claims for Disability Benefits:
    - Extension of coverage for disabled employees or dependents for up to twelve months when employer-paid coverage ends,
    - Extension of coverage for a disabled dependent child age 26 and over.

Other Definitions and Important Concepts

You should refer to these definitions below when reviewing the particular Claims and Appeals Procedures addressed in this chapter:

Adverse Appeal Information: For purposes of a Post-Service Claim, Urgent Care Claim, Concurrent Care Claim, or Pre-service Claim, "Adverse Appeal Information" means the following:

a. information that is sufficient to identify the claim involved (e.g., date of service, Health Care Provider, claim amount if applicable);
b. a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided;
c. the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
d. reference the specific Plan provision(s) on which the determination is based;
e. a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
f. a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
g. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
h. 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;
i. the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;"
j. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is relevant);

k. information to assist you if you do not understand English and have questions about a claim denial (see the General Claims Filing Information section) in this chapter.

Adverse Benefit Determination, Adverse Decision, or Adverse Decision on Appeal. Any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

- a payment of less than 100% of a claim for benefits (including Coinsurance or Copayment amounts of less than 100% and amounts applied to the Deductible);
- a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;
- a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary or not medically appropriate;
- a decision that denies a benefit based on a determination that you are not eligible to participate in the Plan;
- a Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time is considered an Adverse Benefit Determination.

Adverse Disability Appeal Information: For purposes of a Disability Claim, "Adverse Disability Appeal Information" means the following:

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 Administrative Office for assistance.

Claim Denial Information: When a Post-Service Claim, Urgent Care Claim, Concurrent Care Claim, or Pre-service Claim is denied, the "Claim Denial Information" provided will:

a. identify the claim involved (e.g., date of service, Health Care Provider, claim amount if applicable);
b. state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided, if applicable. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);
c. give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
d. reference the specific Plan provision(s) on which the determination is based;
e. contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
f. describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
g. provide an explanation of the Plan's internal appeal procedure (and external review process when external review is relevant) along with time limits and information regarding how to initiate an appeal. For urgent care claim denials, a description of the expedited appeal review process for urgent care claims will be provided. For the external review process (when external review if relevant) a description of the expedited external review process will be provided for urgent care claims;
h. contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
i. if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
j. if the denial was based on medical necessity, Experimental treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
k. disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals; and
l. provide information to assist you if you do not understand English and have questions about a claim denial (see the General Claims Filing Information section) in this chapter.

Days: For the purpose of the Claims and Appeals Procedures outlined in this chapter, "days" refers to calendar days, not business days.

Disability Claim Denial Information: When a Disability Claim is denied, the "Claim Denial Information" provided will contain:

a. 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. References to 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, records, and other information relevant to your claim;

d. Descriptions of any additional information needed to perfect the claim and an explanation of why such additional information is necessary;

e. An explanation of the Plan's appeal procedures along with time limits;

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

g. 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);

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. A statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Administrative Office to find out if assistance is available.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Independent Review Organization or IRO: Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

Individual Appeal Procedure and Information: For purposes of a Post-Service Claim, Urgent Care Claim, Concurrent Care Claim, Pre-service Claim, or Disability Claim, "Individual Appeal Procedure and Information" means 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, 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 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, 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;

e. 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;

f. 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 Plan 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.

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required contributions or self-payments. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Additional Information Needed

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated periods.

Coordination of Benefits (COB) Provision

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits chapter (Chapter 12) for more information.

When You Must Get Plan Approval in Advance of Obtaining Health Care

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as Preauthorization). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care including care provided in a Hospital Emergency Room, or Hospital admission for delivery of a baby. See Chapter 5 for information on the services that require Preauthorization and see Chapter 9 for information on the Dental Plan services that require Preauthorization.

Review of Issues That Are Not a Claim as Defined in This Chapter

A Plan participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document. If the request for review of the issue is received by the Plan more than 30 days before the next Board meeting, the review will generally occur at the next Board meeting date and no later than the second meeting following receipt of the appeal. If the request for review of the issue is received by the Plan within 30 days of the next Board meeting, the Board review will occur no later than the second meeting following receipt of the appeal. After the Board makes their decision, you will be notified of the outcome of the review no later than 5 calendar days after the decision on the review of the issue is made.

General Claims Filing Information

If you do not understand English and have questions about a claim denial, contact the Administrative Office to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-528-4357.

Participants and beneficiaries may request documents and plan instruments regarding whether the Plan is providing benefits in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with the MHPAEA.

How to File a Claim

Unless the service you receive requires Preauthorization, most of your claims will be filed after you receive the service (a post-service claim). The procedure for filing these claims depends on the type of service you receive and whether you use In-Network or non-network providers.

When you obtain services from a provider that participates in a provider network under contract to JBT you generally do not need to file a claim for benefits. The In-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 appropriate claims administrator.

When you obtain services from a provider that does not participate in a provider network under contract to JBT (a non-network provider), you must file a claim with the appropriate claims administrator. Remember, within the United States there are no benefits payable under this Plan if you use a Non-Network provider for medical services (except emergency room services in an emergency situation), or Prescription Drugs including no benefits payable for Anthem Blue Cross Providers that are not in the Advantage network if you are enrolled in the Advantage plan.

Appropriate Claims Administrator:

Various organizations are under contract to the JBT to perform claims adjudication services (meaning the administration of health and Prescription Drug claims and/or claim appeals) and to perform medical review/utilization review services and claim appeals.

Claims are adjudicated by several different claims administrators depending on which type of benefit is being sought. The organizations that administer each type of health claim (the Appropriate Claims Administrator) are outlined in the chart below. (For contact information for each claims administrator, see the Quick Reference Chart in the front of this document.)

Type of Claim	Who Adjudicates the Claim	Level(s) of Appeal	Who Adjudicates the Appeal
Urgent, Pre-Service or Concurrent			
• Certain* Dental Claims	Administrative Office	Level One	Board of Trustees
• Certain* Medical Benefit Claims	Anthem Blue Cross	Level One	Anthem Blue Cross
• Certain* Landmark Chiropractic Claims	Landmark	Level One	Landmark
• Substance Abuse Treatment Claims	TARP	Level One	Board of Trustees

Type of Claim	Who Adjudicates the Claim	Level(s) of Appeal	Who Adjudicates the Appeal
• Outpatient Drug Claims	Prescription Drug Program	Level One Only	Prescription Drug Program
*Please see the Utilization Management Chapter for a Complete Description of the Services for which Preauthorization is Required			
Post Service			
• Medical, Anthem Chiropractic Claims	Anthem Blue Cross	Level One	Anthem Blue Cross
		Level Two	Board of Trustees
• Claims for Medical, Anthem Chiropractic Claims received from a provider outside of California	Blue Card	Level One	Blue Card
		Level Two	Board of Trustees
• Dental Claims	Administrative Office	Level One Only	Board of Trustees
• Landmark Chiropractic Claims	Landmark	Level One	Landmark
		Level Two	Board of Trustees
• Substance Abuse Treatment Claims	TARP	Level One Only	Board of Trustees
• Outpatient drug claims	Prescription Drug Program	Level One Only	Prescription Drug Program
• Eligibility issues	Administrative Office	Level One Only	Board of Trustees
• Vision Benefit Claims	VSP	Level One Only	VSP
Disability			
• Disability Claims	Administrative Office	Level One Only	Board of Trustees

Pre-service claims, urgent care claims, and concurrent care claims to extend approved treatment:

- Please see the Utilization Management Chapter, Dental Benefits Chapter, and/or the Outpatient Prescription Drug Benefits Chapter for a full description of the types of services that require Preauthorization.
- For all elective admissions to a Hospital, Skilled Nursing Facility admissions, or other type of Health Care Facility for medical treatment, Home Health Care, or for participation in a clinical trial, have your Physician call Anthem Blue Cross at (800) 274-7767. If your Doctor thinks the request for Preauthorization needs to be handled as an urgent care claim, he or she should indicate this to Anthem Blue Cross.
- For Durable Medical Equipment that requires Preauthorization, physical therapy or acupuncture visits after the 20th visit in a calendar year, or when planning to participate in a clinical trial, your Physician should call the Administrative Office at (800) 528-4357.

- For Substance Abuse treatment, call the Teamsters Alcohol/Drug Rehabilitation Program (TARP) at (800) 522-8277. If you think your request for a referral needs to be handled as an urgent claim, you should indicate this to TARP.
- For Prescription Drugs that require Preauthorization, your Physician should call CVS/Caremark at (800) 294-5979.

Post-service claims for medical, chiropractic, Chemical Dependency, outpatient Prescription Drugs, and dental benefits: Contract Providers will submit your claims for you. All claims must be submitted directly to the Administrative Office electronically to JBT@HSBA.com or by faxing to 925-828-8558, or by mail to Health Services & Benefit Administrators, 4160 Dublin Blvd., Suite 400, Dublin, CA, 94568.

Post-service claims for vision care benefits (*necessary only if you use a non-VSP Advantage provider*): Send your Out-of-Network Reimbursement Form (available at www.vsp.com or 800-877-7195) with your itemized receipt to the following address: Vision Service Plan, Attn: Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.

Claims incurred outside the U.S.: In most cases you will have to pay the provider at the time of service. Then at a later date you can submit the foreign claim and your proof of payment to the Administrative Office at Health Services & Benefit Administrators, 4160 Dublin Blvd., Suite 400, Dublin, CA 94568, for consideration of reimbursement in accordance with Plan rules outlined in this document.

- **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 Seal of Registration authorizing the provider to render professional services or the Pharmacist to supply medication. The provider must be able to supply the JBT, upon request, with documentation of services performed.
- **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.

Outline of Timeframes for the Initial Claim filing and Claim Appeal Process

Overview of Claims and Appeals Timeframes Please Note: External Review is only available for certain types of claims. Please refer to page 140 for more information and for the Timeframes applicable to External Review.					
	Urgent	**Concurrent**	**Pre-service**	**Post-service**	**Disability**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days	Up to two extensions, each 30 days
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days

Overview of Claims and Appeals Timeframes Please Note: External Review is only available for certain types of claims. Please refer to page 140 for more information and for the Timeframes applicable to External Review.					
	Urgent	**Concurrent**	**Pre-service**	**Post-service**	**Disability**
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	See below chart	See below chart
Extension permitted during appeal review?	No	No	No	See below chart	Yes

[1] *no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.*

Post-service Appeal Timeframes for Plan with Boards of Trustees that meet at least Quarterly		
Level One Appeal filed to Appropriate Claims Administrator that is not the Board of Trustees	Determination will be made on the appeal no later than: • 60 days if one level of appeal, • 30 days if two levels of appeal.	There is no extension permitted in the Level One appeal review.
Level One or Two Appeal filed to Board of Trustees **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Level One or Two Appeal filed to Board of Trustees **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.

Urgent Care Claims

Filing an Initial Urgent Care Claim

1. Urgent Care Claims, which may include requests for Preauthorization of Hospital admissions and Preauthorization of services, may be requested orally or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document. Any Urgent Care Claim requested in writing should prominently designate on its cover that it is an "Urgent Care claim" requiring immediate attention. If a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (as defined by this Plan), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.
2. You will be notified orally of the Plan's benefit determination as soon as possible, but not later than ***72 hours*** after receipt of the Claim by the Appropriate Claim Administrator. A written notice of the determination will also be provided no later than **3 calendar days** after the oral notice. For claim

denials, the Plan will send a notice of initial urgent care claim denial which will include the **Claim Denial Information** as explained in the Definitions section earlier in this chapter. You will also be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

3. If an Urgent Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Appropriate Claims Administrator will notify the claimant as soon as possible, but not later than ***24 hours*** after receipt of the claim, of the specific information necessary to complete the claim. The claimant must provide the specified information within ***48 hours*** after receiving the request for additional information. If the information is not provided within that time, the claim will be denied.
4. During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either ***48 hours*** or the date claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than ***48 hours*** after receipt of the specified information.
5. If a claimant improperly files an Urgent Care Claim, the Appropriate Claims Administrator will notify the claimant as soon as possible but not later than ***24 hours*** after receipt of the claim of the proper procedures required to file an Urgent Care Claim. Improperly filed claims include, but are not limited to:
   - claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or
   - claims that do not name a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

   The notification may be oral unless the claimant or authorized representative requests written notification. Unless re-filed properly, an improperly filed claim will not constitute a claim.

What You Can Do if Your Urgent Care Claim is Denied

If you disagree with a denial of an urgent care claim, you or your authorized representative may ask for an appeal review as described below. You have 180 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.

1. This Plan maintains a one-level claim appeal process for urgent care claims. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.
2. You will be provided with the **Individual Appeal Procedure and Information** as identified in the Definitions section of this chapter.
3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than **72 hours** after receipt of the appeal.
4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include the **Adverse Appeal Information**, as identified in the Definitions section of this chapter.
5. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process. However, see the “External Review of Claims” described on page 140.

Pre-Service Claims

Filing Initial Pre-Service Claim

1. Pre-Service claims may be submitted orally or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.
2. The Appropriate Claims Administrator will notify the claimant of an improperly filed Pre-Service Claim and of the proper procedures to be followed in filing a claim, including additional information needed to make the claim complete, as soon as possible, taking into account the medical exigencies, but no later than ***5 days*** after receipt of the claim in the case of Pre-Service claims.
3. For properly filed Pre-Service Claims, the Appropriate Claims Administrator will notify, in writing, claimant and, if requested, claimant's Doctor or other provider of a decision within ***15 days*** after receipt of the claim unless additional time is needed. If the claim is denied, the notice of initial pre-service care claim denial which will include the **Claim Denial Information** as explained in the Definitions section earlier in this chapter.
4. The time for response may be extended for up to an additional ***15 days*** if necessary due to matters beyond the control of the Appropriate Claims Administrator. If an extension is necessary, the Appropriate Claims Administrator will notify the claimant, in writing, of the need to extend the initial *15-day* period prior to the expiration of the initial *15 day* period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.
5. If an extension is required because the Appropriate Claims Administrator needs additional information from the participant, the Appropriate Claims Administrator will issue a request for additional information that specifies the information needed.
    a. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you. Tolled means stopped or suspended, particularly as it refers to time periods during the claims process.
    b. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
    c. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed 60 days from the date the Notice was sent (and in no event less than 45 calendar days from receipt of the Notice of Extension) to provide the additional information.
    d. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.

What You Can Do if Your Pre-Service Claim is Denied

If you disagree with a denial of a Pre-Service claim, you or your authorized representative may ask for an appeal review as described below. You have 180 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.

1. This Plan maintains a one-level claim appeal process for pre-service claims. Appeals must be submitted in writing to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document. You will be provided with the Individual Appeal Procedure and Information as identified in the Definitions section of this chapter.
2. Under this Plan's one-level appeal process, the Plan will make a determination on the appeal no later than **30 calendar days** from receipt of the appeal. There is no extension permitted to the Plan in the appeal review process.
3. There is **no extension permitted** to the Plan in the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
5. If the claim was denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
6. You will receive a notice of the appeal determination. If that determination is adverse, it will include the **Adverse Appeal Information** as identified in the Definitions section of this chapter.
7. This concludes the pre-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process. However, see the "External Review of Claims" described on page 140.

Concurrent Care Claims

Filing Initial Concurrent Care Claim

1. A claim involving concurrent care (as defined earlier in this chapter) may be filed in writing (or orally for expedited review) to the Appropriate Claims Administrator, whose contact information is listed in the Quick Reference Chart at the front of this document.
2. If a decision is made to reduce or terminate an approved course of treatment, the participant will be notified sufficiently in advance of the reduction or termination to allow the Participant or Beneficiary to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.
3. Concurrent Care Claims that are an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Section for Urgent Care Claims. Concurrent Care Claims that are not an Urgent Care Claim will be processed according to the procedures and timeframes noted in this Chapter for Concurrent Care Claims.
4. If the Concurrent Care Claim is approved, the participant will be notified orally followed by written notice provided no later than ***3 days*** after the oral notice. If the Concurrent Care Claim is denied, in whole or in part, the participant will be notified orally followed by written notice. The initial concurrent care claim denial will include the **Claim Denial Information** as explained in the Definitions section earlier in this chapter.

What You Can Do if Your Concurrent Care Claim is Denied

If you disagree with a denial of a concurrent care claim, you or your authorized representative may ask for an appeal review as described below. You have 180 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.

1. This Plan maintains a 1-level claim appeal process for concurrent care claims. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document. You will be provided with the **Individual Appeal Procedures and Information** as identified in the Definitions section of this chapter.
2. A determination will be made on the appeal (without the opportunity for extension) **as soon as possible before the benefit is reduced or treatment is terminated**.
3. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include the **Adverse Appeal Information**, as identified in the Definitions section of this chapter.
4. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process. However, see the "External Review of Claims" described on page 140.

Post-Service Claims

Filing Initial Post-Service Claim

Generally, network Health Care Providers send their bill directly to the Plan. This means that when using network providers there are generally no forms or claims paperwork to complete.

If you pay for non-network health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of the charges. If non-network benefits are payable by the Plan, the eligible medical and dental expenses will be paid up to the amount allowed by the Plan for those expenses.

A Post-Service Claim must be submitted in writing to the Appropriate Claims Administrator, using an appropriate claim form **within one (1) year after expenses are incurred**. (This does not apply to vision claims, which must be submitted to Vision Service Plan under the terms and timeframes established by that Plan.)

- The claim form must be completed in full and the written proof of claim (generally the itemized bill(s), but sometimes additional information or records may be required, see pages 129-131) must be attached to the claim form in order for the request for benefits to be considered a claim. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, cancelled checks, or credit card receipts as proof of claim. The Provider or Physician may file the claim on the participant's behalf. The claim form and/or itemized bill(s) must include all required information for the request to be considered a claim and for the Plan to be able to decide the claim.
- A Post-Service Claim is considered to have been filed upon receipt of the claim by the Appropriate Claims Administrator. The Appropriate Claims Administrator will notify claimants of decisions on Post-Service Claims in writing within ***30 days*** of receipt of the claim. If the claim is denied, the Plan will send a notice of initial post-service care claim denial which will include the **Claim Denial Information** as explained in the Definitions section earlier in this chapter.

- The Appropriate Claims Administrator may extend the period to provide the claimant with notice of the decision on the claim one time for up to ***15 days*** if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Appropriate Claims Administrator will notify claimants, in writing, of the need to extend the initial ***30-day*** period prior to the expiration of the initial ***30-day*** period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered.
- If an extension is required because the Plan needs additional information from the participant, the Appropriate Claim Administrator shall request additional information from provider and/or claimant via fax, telephone, Explanation of Benefits (EOB) or letter within ***30 days*** of the receipt of the claim or within ***45 days*** if a ***15-day*** extension is taken. The request for additional information shall specify the information needed. Claimant has ***45 days*** from receipt of the request for additional information to supply the additional information. If the information is not provided within that time, the claim will be denied. During the ***45-day*** period in which the participant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the request for additional information until the earlier of: (i) ***45 days*** from receipt of the request for additional information; or (ii) the date the participant responds to the request. The Appropriate Claim Administrator shall notify, in writing, the claimant and, if requested, the claimant's Doctor or other provider of a decision within ***15 days*** after receipt of any additional information.
- **Proof of Dependent Status:** (See also the Eligibility chapter of this document for information on Proof of Dependent Status.)
  1) When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g.*, copy of certified birth certificate for newborn).
  2) When processing claims submitted on behalf of a **Dependent Child who is age 26 or older,** the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g., disabled adult child verification).
  3) If claims are submitted on behalf of a **Dependent child for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.
- When processing **claims related to an accident** the Appropriate Claims Administrator will need information about the details of the accident in order to consider the claim for payment.

What You Can Do if Your Post-Service Claim is Denied

If you disagree with a denial of your post-service claim, you or your authorized representative may ask for a post-service appeal review. 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.

1. This Plan maintains a 2-level appeals process for medical post-service claims. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Board of Trustees for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with **Individual Appeal Procedure and Information** as defined in the Definitions section of this chapter.
2. Under this Plan's 2 level appeal process for medical claims, the Plan routes the first level of review to the Appropriate Claims Administrator who will make the first level determination on the post-service appeal no later than **30 calendar days** from receipt of the appeal.
   (a) There is **no extension permitted** in the first level of the appeal review process.

(b) You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

(c) If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document.

3. The Board of Trustees then will make a second level determination according to the following timeframes:

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

   (b) **If an appeal is filed with the Plan within 30 days 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 5 calendar days after the benefit determination is made.

4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

5. If the claim was denied due to medical necessity, Experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional (known as a Medical Review Organization) who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual. The Plan contracts with three Medical Review Organizations to whom it may reach out for consultation on an appeal.

6. You will receive a notice of the appeal determination. If that determination is adverse, it will include (at each level of the appeal review), the **Adverse Appeal Information** as explained in the Definitions section of this chapter.

7. This concludes the post-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process. However, see the "External Review of Claims" described below on this page 140

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Disability Claims

Filing Initial Disability Claim

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 these Disability Claim procedures:

- Extension of coverage for disabled employees or dependents for up to twelve months when an employer-paid coverage ends;

- Extension of coverage for a disabled dependent child age 26 and over.

To apply for a disability benefit, you need to obtain a disability claim form from the Administrative Office, 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 Administrative Office whose contact information is listed in the Quick Reference Chart of this document.

For the Disability 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 date of service. Disabled dependent children will not qualify absent submission of evidence satisfactory to the Plan of the onset of the disabling condition prior to reaching age 26.

The Administrative Office will determine your disability benefits claim no later than 45 calendar days after receipt. This 45-day period may be extended for up to 30 calendar days provided the Administrative Office determines that an extension is necessary due to matters beyond their control and notifies you in writing 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 Administrative Office 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.

You will also 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 will have 45 calendar days from the date of this notice to provide this additional information, and the 45-day period for the Administrative Office to determine your disability benefits claim will be tolled during this time.

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, Disability Claim Denial Information will be provided to you in writing.

What You Can Do if Your Disability Claim is Denied

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.

1. Appeals must be submitted in writing to the Board of Trustees for the appeal review. You will be provided with **Individual Appeal Procedure and Information** as defined in the Definitions section of this chapter.
2. The Board of Trustees then will make an appeal determination according to the following timeframes:
   (a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.
   (b) **If an appeal is filed with the Plan within 30 days 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 5 calendar days after the benefit determination is made.
3. 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 period for making a decision on appeal (based on Board meeting date).
4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.
5. You will receive a notice of the appeal determination. If that determination is adverse, it will include (at each level of the appeal review), the **Adverse Disability Appeal Information** as explained in the Definitions section of this chapter.

This concludes the disability claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

Right to Continued Coverage

If you initiate an internal appeal in compliance with the internal appeals process described in this chapter and if the appeal concerns a previously approved ongoing course of treatments to be provided over a period of time or number of treatments, the Plan will continue to provide such coverage pending the outcome of the internal appeal.

External Review of Claims

External Review is only applicable in certain cases. If your appeal for urgent care, pre-service, or post-service medical benefits was denied on the basis of a medical judgment or if your coverage was rescinded (retroactively terminated) other than for non-payment of contributions, you may request further review by an Independent Review Organization (IRO) as set forth below.

External review is not available for any other types of denials, including if your claim was denied because you failed to meet the Plan's eligibility requirements.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that you generally may only seek external review after a final determination has been made on appeal.

Your request for an external review should be made to the following appropriate **Plan designee**:

- The Administrative Office with respect to a denied Medical Benefit claim including chiropractic services or a denied retail Prescription Drug claim, (but not involving Substance Abuse treatment expenses);
- TARP with respect to a denied claim involving Substance Abuse treatment expenses;
- The Utilization Management Company, with respect to a denied Pre-service or concurrent review determination not involving Prescription Drug expenses or Substance Abuse treatment expenses;

Contact information for the Administrative Office, TARP, and the Utilization Management Program for Preauthorization review is identified in the Quick Reference Chart at page 3.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited (Urgent) Claims.

External Review of Standard Claims (Non-Urgent)

Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an initial claim benefit determination or when applicable, an adverse benefit determination on appeal that your appeal has been denied. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Preliminary Review of Standard Claims.

Within five (5) business days of the appropriate Plan designee's receipt of your request for an external review of a standard claim, the appropriate Plan designee will complete a preliminary review of the request to determine whether:

1) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
2) The reason for the denial satisfies the requirements for external review and is not, for example, your failure to meet eligibility requirements, or based on a contractual or legal determination;
3) You have exhausted the Plan's internal claims and appeals process (except in limited exceptional circumstances not required to do so); and
4) You have provided all information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request meets the threshold requirements for external review. If necessary, this notification will inform you if your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration, or if additional information or materials are needed to make the request complete. If additional information is needed, you may perfect the request for external review within 48 hours after you receive the notification or within the four (4) month filing period, whichever is later.

Review of Standard Claims by an Independent Review Organization (IRO).

If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. Once the claim is assigned to an IRO, the following procedure will apply:

1) The assigned IRO will notify you of the eligibility of your request and its acceptance of the claim for external review. The notice will explain how you may submit additional information regarding your claim (generally, you must submit such information within ten (10) business days).

2) Within five (5) business days, the Plan will provide the IRO with the documents and information the Plan considered in making its determination.

3) If you submit additional information related to your claim, the assigned IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of the reversal to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4) The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim as if it is new and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the Plan terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

   In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating Health Care Providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

5) The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee within 45 days after the IRO receives the request for the external review.

6) The assigned IRO's decision notice will contain:

   - A general description of the reason(s) for the request for external review, including information sufficient to identify the claim (including the date(s) of service, Health Care Provider, claim amount (if applicable), diagnosis code and treatment code and corresponding meaning, and reason for the previous denial);
   - The date that the IRO received the request for external review and the date of its decision;
   - References to the evidence or documentation considered in reaching its decision, including specific coverage provisions and evidence-based standards;
   - A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
   - A statement that the determination is binding (except to the extent that other remedies are available to you or the Plan under applicable State or Federal law);
   - A statement that judicial review may be available to you; and
   - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review (Urgent Care)

You may request an expedited external review if you receive an adverse decision on a claim, or on an appeal, that involves a medical condition for which the timeframe for completion of an internal appeal

or completion of a standard external review – whichever applies -- would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function. You may also request an expedited external review if you receive an adverse appeal decision that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not yet been discharged from a facility.

Preliminary Review for an Expedited Claim.

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard, non-urgent claims above). The Plan will notify you as soon as possible whether your request for review meets the preliminary review requirements.

Review of Expedited Claim by an Independent Review Organization (IRO).

If your request meets the applicable standards, the Plan will assign an IRO. The Plan will expeditiously provide or transmit all necessary documents and information that it considered in making its Adverse Determination to the assigned IRO.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents provided. In reaching a decision, the assigned IRO must review the claim as if it is new and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO must ensure that the IRO decision is not contrary to the terms of the Plan, unless the Plan terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

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

After External Review

If the IRO's final external review reverses the Plan's Adverse Determination, the Plan will provide coverage or payment for the reviewed claim upon receipt of the IRO's decision.

If the final external review upholds the Plan's Adverse Determination and you are dissatisfied with the external review determination, you may seek judicial review as permitted by ERISA Section 502(a). A civil lawsuit challenging a final external review determination must be commenced within one (1) year of the date the IRO upholds the Plan's Adverse Determination.

Limitation On When A Lawsuit May Be Filed

You or any other claimant may not sue the Trustees, the Plan or the JBT or bring other legal action to obtain Plan benefits, including proceedings before courts or administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that additional time will be necessary to reach a final decision.

A non-network Health Care Provider/facility is not a claimant entitled to sue or bring other legal action to obtain Plan benefits.

The law permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. If you receive an adverse benefit determination, you may seek review of the claim by IRO or file a lawsuit in federal court. You have one year from the date of the notice of adverse benefit determination to file such lawsuit. A lawsuit filed after this one-year period will be time-barred. Any such lawsuit must be filed in the United States District Court for the Eastern or Northern Districts of California.

If you sought review of the denial of your claim by the IRO (as described on pages 140) and disagree with the decision of the IRO, you have one year from the date of receipt of the IRO's determination to file suit in federal court. A lawsuit filed after this one-year period will be time-barred. Any such suit must be filed in the United States District Court for the Eastern or Northern Districts of California.

Discretionary Authority of Plan Administrators and Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan have been delegated and have discretionary authority to interpret the terms of the Plan including, but not limited to the discretionary authority to resolve ambiguities or inconsistencies in the Plan and to determine the extent to which a person is eligible and entitled to any Plan benefits.

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, claim administrator nor any other designee of the Plan Administrator is required to oversee the application of the money so paid.

Assignment

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for Hospital, medical, dental or vision care services rendered or to be rendered. (Note: A Participant may not assign any right available under applicable law, including, but not limited to, ERISA such as the right to file suit under ERISA or the right to request documents under ERISA Section 104(b)(4)).

CHAPTER 14: GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Obtain, upon written request to the plan administrator, copies of 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 updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps 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 them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 (however, any such lawsuit will be deemed untimely under the Plan unless file within one year from the date you received the final adverse benefit determination or external review denial). See Chapter 13: Claims and Appeals Procedures for the requirement to appeal a denied claim and exhaust the Plan's appeal process **before** filing a lawsuit. 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 Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay 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, DC 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 Toll-Free: 1.866 444.EBSA (3272).

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).

Spanish Language Assistance

Este documento contiene una breve descripción sobre los derechos de participantes del plan, en ingles. Si es dificil comprender cualquier parte de este documento, por favor de ponerse en contactó con la Administrative Office a la dirección y teléfono en la Lista de Numeros de Telefono Importantes (Important Phone Numbers Chart) de este documento.

Plan Information

Name of Plan

The full name of this Plan is the Joint Benefit Trust Health and Welfare Seasonal Medical Benefits Plan.

Name and Address of Plan Sponsor/Plan Administrator Maintaining the Plan

The Plan is administered and maintained by the Joint Benefit Trust (JBT) Board of Trustees at the following address:

JBT Board of Trustees

Health Services & Benefit Administrators
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756

A complete list of the employers sponsoring the Plan may be obtained by participants upon written request to the Plan Administrator, and is available for examination by Plan participants.

Participants may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a Plan Sponsor, and if the employer is a Plan Sponsor, the Sponsor's address.

Type of Plan

This is a welfare Plan that provides group health benefits including medical, surgical, Hospital, Prescription Drugs, Mental Health, and Substance Abuse treatment benefits, dental benefits, and vision benefits.

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 providing for contributions under the Plan. Copies of any such Agreement are available for examination during normal business hours by Plan participants and Beneficiaries at the Administrative Office. Copies will be provided to Plan participants and Beneficiaries upon written request to the 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 Dependent Children. A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries.

Assets of the Plan are held in trust, and benefits are funded through the Joint Benefit Trust.

Eligibility for benefits under the Plan 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 JBT's obligation to provide benefits is limited to the extent the Bargaining Agreements provide for funding of the JBT sufficient to provide benefits.

The JBT self-funded Medical Benefit includes outpatient Prescription Drugs, Chiropractic Treatment, and Substance Abuse treatment (alcohol & Chemical Dependency) coverage. The Dental Benefit and the Vision Benefit are also **self-funded** 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.

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 JBT for the purpose hereinbefore set forth. If the Trust Agreement and Plan are not voluntarily extended by the Participating Employers and the Union, the JBT shall be applied and disbursed by 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 ERISA section 404(a)(1).

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.

Payment of Plan Expenses

The expenses of administering the Plan, including (1) the fees and expenses of the 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 JBT. 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 under an administrative service only agreement for administration of Medical Benefits (including medical, surgical, Hospital, Chiropractic Treatment, treatment for alcohol and Chemical Dependency, outpatient Prescription Drug benefits) and Dental Benefits with:

Health Services & Benefit Administrators (HS&BA)
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
1-925-833-7300 or 1-800-528-4357 (toll-free in California)

Correspondence may be addressed to:

Joint Benefit Trust Administrator
c/o Health Services & Benefit Administrators
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756

The Medical Benefit and Dental Benefits described above are not guaranteed under a contract or policy of insurance. Appeal of claims is explained in the Claims and Appeals Procedures (Chapter 13) of this document.

The Vision Benefits are provided under an administrative service only agreement with:

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

Agent for Service of Legal Process

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

Amy Lambert
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
Telephone: (925) 833-7300

Legal process may also be served on any Plan Trustee.

Board of Trustees

Union Trustees	Employer Trustees
Ashley Alvarado Chairperson Vice President Teamsters Local 856 745 E. Miner Avenue Stockton, CA 95202 **Crescencio Diaz** President and Principal Officer Teamsters Local 890 207 North Sanborn Road Salinas, CA 93905 **Luis Diaz** Secretary-Treasurer Teamsters Local 948 2354 W Whitendale Ave. Visalia, CA 93277 **(Open Seat)**	**Stacey Cue** Co-Chairperson IDEA 2200 Powell Street, Suite 1000 Emeryville, CA 94608 **Michael Mendoza** Vice President of Distribution & Operations Support Stanislaus Food Products 1202 D Street Modesto, CA 95354 **Adam Sroufe** Director, Employee and Labor Relations Pacific Coast Producers 621 North Cluff Avenue P.O. Box 1600 Lodi, CA 95241 **JP Bradley** Manager Labor Relations ConAgra Brands Nine Conagra Dr. Omaha, NE 68102

Participating Employers

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

Privacy of Your Health Information

If you have any questions regarding the Plan's privacy policies and procedures, please call the 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 the Administrative Office at 1-800-JBT-HELP (1-800-528-4357).

HIPAA Privacy Notice

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

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. Except as permitted by

HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization.

Restriction on Plan disclosure to the Board of Trustees. Neither the Plan nor any of its business associates, or health insurance issuers, 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.

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

- 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;
- 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;
- 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;
- 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;
- 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. Generally, the Plan will require that you sign a valid authorization form in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization;
- 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;
- 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;
- 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;
- 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. If such return or destruction is not feasible, the Board will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

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.

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.

Miscellaneous.

- **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.
- **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.
- **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.
- **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.

HIPAA Security Notice

Effective Date. This Amendment is effective as of April 20, 2005.

HIPAA Security Rule Requirements. The Board of Trustees will reasonably and appropriately safeguard EPHI that it creates, receives, maintains or transmits on behalf of the Plan, other than EPHI that is summary health information disclosed pursuant to 45 C.F.R. 164.505(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. 164.508. In implementing such safeguards, the Board of Trustees is required to do the following:

- **Safeguards.** The Board of Trustees will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the EPHI that it creates, receives, maintains or transmits on behalf of the Plan.
- **Adequate Separation**. The Board of Trustees will ensure that the adequate separation between the Plan and the Board as required by 45 C.F.R. 164.504(f)(2)(iii) of the HIPAA Security Rule is supported by reasonable and appropriate security measures.
- **Agents.** The Board of Trustees will ensure that any agents (including subcontractors) to whom it provides EPHI received from the Plan agrees to implement reasonable and appropriate security measures.
- **Report**. The Board of Trustees will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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

Miscellaneous.

- **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 of Trustees.

- **Amendment.** The Board of Trustees 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.
- **Delegation.** The Board of Trustees may delegate or allocate any authority or responsibility with respect this Amendment. The Board of Trustees (or its delegate) has discretion to construe and interpret the terms, provisions and requirements of this Amendment. All decisions of the Board of Trustees (or its delegate) with respect to this Amendment will be given the maximum deference permitted by law.
- **Document Retention.** If a communication under this amendment is required by the HIPAA regulations to be in writing, the Board of Trustees 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 of Trustees will maintain a written or electronic record of such action, activity or designation. The Board of Trustees 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.
- **Construction.** The terms of this Amendment shall be construed in accordance with the requirements of the HIPAA Security Rule and in accordance with any applicable guidance on the HIPAA Security Rule issued by the Department of Health and Human Services.

CHAPTER 15: DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded services in the self-funded Medical Benefit and Dental Benefit. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to claims administration and claim appeals are found in Chapter 13: Claims and Appeals Procedures of this document. Certain definitions pertaining to Vision Benefits are found in the Vision Benefit chapter.

Administrative Office

Administrative Office means an independent third-party company appointed by the Board of Trustees to perform the day-to-day administration of the JBT and its benefit plans and who regularly engages in the business of verifying eligibility, claims administration, adjustment and payment, and claims review services to employee welfare benefit plans.

Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee (applicable to the Medical Benefit)

This means the amount upon which the payment of the Medical Benefit is based for eligible Medically Necessary services or supplies. (For the Allowed Charge applicable to the Dental Benefit, please refer to Dental Allowed Charge below.) The Allowed Charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to an In-Network provider (preferred provider/facility)**, the negotiated fee/rate set forth in the agreement between the participating network Health Care Provider/facility and the network or the Plan (also known as the Contract Rate); **or**
2. **With respect to a Non-Network provider**, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers (what the Plan formerly referred to as "usual and customary"); **or**
3. For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, or workers' compensation, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim. Where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the lesser of the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim, or the Primary Plan's Contracted Rate (for more information please see Chapter 12: Coordination of Benefits (COB)); **or**
4. The Health Care Provider /facility's actual billed charge.

In accordance with federal law, with respect to Emergency Services performed in a Non-Network Emergency Room (ER), the Medical Benefit's allowance for Emergency Room visit facility fees is to pay the **greater** of:

a) the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or
b) 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing); or
c) (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

See also the definition of **Emergency Services** in this chapter.

The Medical Benefit Allowed Charge for Non-Network Providers is usually based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary

(R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter.

The Medical Benefit will not always pay benefits equal to or based on the Health Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Medical Benefit covers only the "Allowed Charge" amount for health care services or supplies.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Medical Benefit will base its payment for covered services for the non-network provider considering the Plan's cost-sharing provisions, In-Network/non-network Plan design.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Limits. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee (applicable to the Dental Benefit)

This means the amount the Dental Benefit allows as payment for eligible Medically Necessary Dental services or supplies listed on the Table of Allowances. The Dental Allowed Charge amount is determined by the Plan Administrator or its designee and set out in the Dental Table of Allowances.

The Dental Benefit's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The reimbursement for certain procedures listed in the Dental Table of Allowances shall be determined by an independent dental review firm that assists the JBT in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter.

Plan benefits will not always equal the Dental Provider's actual charge for dental services or supplies, even after you have paid any applicable Deductible, Coinsurance and/or Copay. This is because the Dental Benefit covers only the "Allowed Charge" amount for dental services or supplies. If you use an In-Network provider, the amount you will pay is your Deductible and your Coinsurance for the service. If you use a Non-Network provider, you will also pay the difference between the provider's billed charge and the amount set forth for that service on the Dental Table of Allowances.

Additionally, the Plan reserves the right to negotiate with a non-network dental provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, dental claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Dental Benefit will base its payment for covered services for the non-network provider considering the Plan's cost-sharing provisions and In-Network/non-network Plan design.

Ambulatory Surgical Facility/Center

A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all the following requirements:
   - is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
   - requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
   - provides at least one operating room and at least one post-anesthesia recovery room.
   - is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
   - has trained personnel and necessary equipment to handle emergency situations.
   - has immediate access to a blood bank or blood supplies.
   - provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
   - maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays), an operative report and a discharge summary.

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan. Ambulatory Surgical Facility/Center is sometimes called an Outpatient Surgicenter or Outpatient Surgical Facility.

Approved Clinical Trial

An "Approved Clinical Trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial or investigation must be (1) federally funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Approved Hospice Program

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

Balance Billing

A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with

Balance Billing **are not covered** by this Plan, even if the Plan's annual Out-of-Pocket Limit has been reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's annual Out-of-Pocket Limit and may result in Balance Billing to you. **Non-Network Health Care Providers commonly engage in Balance Billing**. Balance Billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. Generally, you can avoid Balance Billing by using In-Network providers for covered services. Typically, In-Network providers do not balance bill except in situations of third-party liability claims. **Generally, you can avoid Balance Billing by using In-Network providers.**

Bargaining Agreement

See Collective Bargaining Agreement.

Behavioral Health

Behavioral Health is an umbrella term that refers to Mental Health and/or Substance Abuse. A Behavioral Health Disorder is any illness that is defined within the Mental Disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. See also the definitions of Chemical Dependency and Substance Abuse.

Beneficiary

Beneficiary means the person or persons you have designated to receive the Plan benefits payable if you die. See also Chapter 4 for information on a COBRA Qualified Beneficiary.

Birth (or Birthing) Center

A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all the following requirements:
   - is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center.
   - is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic X-rays, or has an arrangement to obtain those services.
   - has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - provides at least two beds or two birthing rooms.
   - is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - has trained personnel and necessary equipment to handle emergency situations.
   - has immediate access to a blood bank or blood supplies.
   - has the capacity to administer local anesthetic and to perform minor Surgery.
   - maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.

- is expected to discharge or transfer patients within 48 hours following delivery; and
- is accredited by the American Association of Birth Centers (AABC).

A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Board of Trustees

See Trustees**.**

Cannery Council

Cannery Council means the Teamsters California State Council of Cannery and Food Processing Unions, International Brotherhood of Teamsters ("Cannery Council" or "Union").

Chemical Dependency

This is another term for Substance Abuse/Substance Use Disorder. See also the definitions of Behavioral Health Disorders and Substance Abuse/Substance Use Disorder.

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.

Chiropractor

A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

Coinsurance

That portion of Eligible Health Care Expenses for which the covered person has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered medical expenses after the Plan's Deductible has been met.

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 JBT.

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.

Copayment

Also known as a "Copay," this is the fixed dollar amount you are responsible for paying when you incur certain eligible health care expense. Services payable with a Copayment are explained in the Schedule of Medical Benefits or Schedule, Outpatient Prescription Drug Expenses, or Schedule of Vision Benefits.

Corrective Appliances

The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions

of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic

Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, Prescription Drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

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.

Deductible

The amount of Eligible Medical or Dental Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of Deductibles is discussed in "Chapter 6: Medical Benefits" and "Chapter 9: Dental Benefits" of this document.

Dental Care Provider

A dentist, dental hygienist or other Health Care Practitioner or nurse as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of their license.

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. The current Dental Table of Allowances is available upon request.

Delinquency Control Procedures

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

Dentist

A person who holds the degree of Doctor of Dental Science or Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.) who is licensed to practice Dentistry in the state, country or other jurisdiction in which he or she renders treatment.

Dependent Child

For the purposes of this Plan, a Dependent Child is any of the employee's children as provided on page 10.

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

See Physician.

Domestic Partner

For the purposes of this Plan, a Domestic Partnership exists only if all the following criteria are satisfied at all times:

A Domestic Partner is a person of the same or opposite gender who has the same principal place of abode as the employee and both the employee and Domestic Partner meet the following requirements:

1. both are of legal age to marry in the State in which the employee and Domestic Partner reside.
2. they are not related to each other by blood to the extent that it would prohibit them from legally marrying in the State in which they reside.
3. neither one is legally married to anyone else or in another Domestic Partnership.
4. they complete and the employee submits to the Plan the Declaration of Domestic Partnership filed with a state or local government demonstrating Domestic Partnership status.

Domestic Partners are not eligible for benefits under the Plan.

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 (or other licensed Health Care Provider) licensed by law to administer such an article. For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug/Compounding:** Any drug that has more than one ingredient and at least one ingredient is a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order. Pharmacy compounding is a practice in which a Pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient. Under this Plan certain multi-ingredient compound drugs may require precertification. Compound drugs are made from individual ingredients in a certain strength and dosage form that are mixed together based on a provider's prescription.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.

5. **Specialty drug**: Generally, refers to high-cost, low volume, biotechnology-engineered FDA approved, non-Experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty drugs are managed by a specialty drug pharmacy that is part of the Pharmacy Benefit Manager under contract to the Plan. See Chapter 7 for more drug information.

Durable Medical Equipment

Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness; and is not disposable or non-durable, is for the exclusive use of the patient, and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Eligible Medical Expenses

Eligible Medical Expenses/Eligible Charges: Expenses for medical services or supplies, but only to the extent that the expenses meet all the following qualification as determined by the Plan Administrator or its designee: are Medically Necessary, as defined in this Definitions chapter; and the charges for them are an Allowed Charge, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded as explained in Chapter 6, Chapter 11, or in the Schedule of Medical Benefits; and are not services or supplies in excess of a maximum plan benefit; and are ordered by a Physician or Health Care Practitioner for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document); and are expenses incurred while the individual is covered under this Plan.

Emergency, Emergency Care, Medical Emergency

The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as given in a Medical Emergency. Emergency care means medical or dental care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services

Emergency Services means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a Hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

- The term "**to stabilize**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical

probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

- The term "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Experimental, Investigational or Unproven

The Board of Trustees or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

The fact that an Experimental or Investigational or Unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

A service or supply will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for the Plan's Preauthorization, <u>any</u> of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as Experimental and/or Investigational or Unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.
5. Under the Medical Benefit, Experimental, Investigational or Unproven does not include **routine costs associated with a certain "Approved Clinical Trial" related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, <u>Preauthorization is recommended</u> (see Chapter 5) in order to determine if the participant is enrolled in an "Approved Clinical Trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or Beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

b. An "**Approved Clinical Trial**" means a phase I, II, III, or IV clinical trial including a clinical trial titled as a pilot study conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial including a clinical trial titled as a pilot study or investigation must be (1) federally funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

c. Subject to subsection d, below, a participant or Beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an Approved Clinical Trial; and (2) either the individual's referring Physician is a participating Health Care Provider in the plan who has determined that the individual's participation in the Approved Clinical Trial is medically appropriate, or the individual provides the Plan with medical and scientific information establishing that participation in the trial would be medically appropriate, and (3) the Plan's medical review firm concurs that the individual's participation in the trial is medically appropriate.

d. The Plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "Approved Clinical Trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See Chapter 13: Claims and Appeals Procedures for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

e. The Plan may require that an eligible individual use an In-Network provider as long as the provider will accept the patient. This Plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

In determining if a service or supply is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its designee will rely only on the following specific information

and resources (that are available at the time the service or supply was performed, provided or considered for Preauthorization):

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information" and "American Hospital Formulary Service";
5. The published opinions of the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the US such as Aetna, Anthem, or United Healthcare, or MCG, formerly Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain a Preauthorization of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, see Chapter 5.

Genetic Counseling

Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information

Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing

Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitation Services

Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal

functional abilities. Examples of habilitative services include Physician-prescribed therapy for a child who is not walking or talking at the expected age. Habilitative services are not covered by the Plan.

Health Care Facility

For the purposes of this Plan, a facility for the delivery of health care services including an Outpatient Ambulatory Surgical Facility/Center, Hospital, Behavioral Health Treatment Facility, Birthing Center, Inpatient Hospice Facility, Residential Treatment Facilities, Inpatient Rehabilitation Facility, Skilled Nursing Facility, and Subacute Care Facility/Long Term Acute Care (LTAC) facility, Urgent Care Facility all of whom are legally licensed and/or legally authorized to provide certain health care services in that facility under the laws of the state or jurisdiction where the services are rendered. Many of these facility terms are separately defined in this chapter.

Health Care Practitioner

Acupuncturist, Certified Registered Nurse Anesthetist (CRNA), Chiropractor, Dental Hygienist, Dentist, Nurse (RN, LVN, LPN), Nurse Practitioner, Certified Nurse Midwife, Physician Assistant (PA), Registered Physical Therapist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Optometrist, Optician for Vision Benefits, Registered Dietitian Certified Diabetes Educator, or Pharmacist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice. See also the definition of Physician. To the extent required by ACA regulations, a Health Care Practitioner includes a Health Care Provider acting within the scope of the provider's license or certification under applicable State laws and is performing a covered service under this Plan.

Health Care Provider

A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility/Center, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility.

Home Health Care Agency

An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all the following requirements:
    - has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
    - has a full-time administrator.
    - is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
    - maintains written clinical records of services provided to all patients.
    - its staff includes at least one Registered Nurse (RN), or it has nursing care by a Registered Nurse (RN) available.
    - its employees are bonded.
    - maintains malpractice insurance coverage.

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, and nursing care provided by a registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.); and
- Services that are Medically Necessary for treatment of an Illness, Injury or condition and ordered by the attending Physician and approved by the JBT's Utilization Review Organization.

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

- Custodial Care or homemaker services, or
- 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, and
- Bereavement and emotional support services for the patients' family.

Hospital

Hospital means an institution that meets all 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 skilled nursing facilities are not Hospitals.

Illness

Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy of a covered Employee will be considered to be an Illness only for the purpose of coverage under this Plan.** However, **infertility is not an Illness** for the purpose of coverage under this Plan.

Injury

Any damage to a body part resulting from trauma from an external source.

Injury to Teeth

An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits in Chapter 6.

Joint Benefit Trust (JBT)

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

See Emergency.

Medically Necessary

A medical, Prescription Drug, dental or vision service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:

1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
3. is determined by the Plan Administrator or its designee to meet all the following requirements:
   - It is consistent with the symptoms or diagnosis and treatment of an Illness or Injury; and
   - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
   - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
   - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
   - It is safe and effective for the Illness or Injury for which it is used.

A medical or dental service or supply will be considered to be **"Appropriate"** if:

1. It is a diagnostic procedure that is called for by the health status of the patient and is as likely to result in information that could affect the course of treatment and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

2. It is care or treatment that is as likely to produce a significant positive outcome and no more likely to produce a negative outcome relative to any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medicare

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

Mental Health; Mental Disorder

See the definition of Behavioral Health Disorder.

Nondurable Supplies

Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. Only those Nondurable Supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Office Visit

An office "visit" is a personal interview between the patient and the provider, or services billed as part of the provider's care.

Orthotic (Appliance or Device)

A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Benefit, this definition does **not** include Dental Orthotics. See also the definitions of Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

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

A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM), and authorized to practice medicine, to perform Surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered and who acts within the scope of his or her license. See also the definition of Chiropractor, Dentist and Health Care Practitioner.

Placed for Adoption

A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Plan

Plan means the Joint Benefit Trust Health and Welfare Seasonal Medical Benefits Plan Who Attained Three-Years Seniority by June 30, 2003, as amended and restated.

Plan Administrator/Plan Sponsor

Plan Administrator means the Board of Trustees of the Joint Benefit Trust.

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 Seasonal Medical Benefits 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**.**

Preauthorization

Preauthorization is a review procedure performed by a review company under contract to the JBT, **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary. During the Preauthorization process the review company can also provide guidance on the location for In-Network providers. Preauthorization is also referred to as predetermination, pre-service review, prior authorization, precert, precertification, prior auth, pre-admission review or preapproval.

Prescription Drug

See Drug**.**

Producers Alliance of California

Producers Alliance of California ("PAC"), formerly California Processors, Inc. is an association of employers engaged in the processing of fruits and vegetables.

Prosthetic Appliance (or Device)

A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and eyes, or heart pacemaker. See also the definitions of Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

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.

Rehabilitation Services

Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of Illness, Injury or Surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Injury, Illness or Surgery, and that is performed by a licensed therapist acting within the scope of his or her license. Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to Injury or Illness, while Habilitation focuses on therapy to help an individual attain certain functions that they never have acquired, such as speech therapy to assist a child in talking. See also the definition of Habilitation. See the Schedule of Medical Benefits (Chapter 6) to determine the extent to which Rehabilitation Services are covered.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the Rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for Passive Rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Residential Treatment Program/Facility/Care for Mental Health

Residential Treatment Program/Facility/Care is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with behavioral health disorders including mental (psychiatric) disorders that are unable to be safely and effectively managed in outpatient care. To be considered payable by this Plan, a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state). In addition to licensure, the residential treatment facility must also have a comprehensive written patient assessment upon

admission to include eligibility and suitability for admission, onsite licensed behavioral health providers providing at least 20 hours/week of individual and group counseling, and 24/7 access to necessary medical and prescription drug services, along with discharge criteria with a written discharge summary.

Residential Treatment Program/Facility/Care for Substance Use Disorders

Residential Treatment Program/Facility/Care is an intermediate non-hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be considered payable by this Plan, a facility must be licensed as a residential treatment facility in the state in which it operates (licensure requirements for this residential level of care may vary by state), develop treatment plans for individuals suffering from substance use/abuse disorders and provide services that include detoxification, group and individual counseling by credentialed personnel, and aftercare planning.

Skilled Nursing Facility (SNF)

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, licensed and operated according to the applicable state laws and regulations and meets the following conditions:

1. It provides skilled nursing and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis, and
2. 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 impaired, custodial or educational care, or for care of Mental Disorders. A Skilled Nursing Facility is not a Hospice, as defined earlier in this section.

Spouse

An employee's or retiree's Spouse means a person of the opposite gender or same gender to whom the employee is legally married. For purposes of this Plan, the term "Spouse" includes a Domestic Partner. Spouses are not eligible for benefits under the Plan.

Stepchild

For purposes of coverage under this Plan, Stepchild is the biological child, legally adopted child, or child placed for adoption with an Employee's Spouse. For purposes of this Plan, the term "Stepchild" includes a biological child, legally adopted child, or child placed for adoption with an Employee's Domestic Partner. Proof of Dependent status will be required (i.e., marriage certificate, birth certificate, court order paper signed by the judge showing that Employee's Spouse has adopted or intends to adopt the child, as applicable).

Subacute Care Facility/Long Term Acute Care Facility

A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and

3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care (non-skilled/custodial assisted living care facility), or care of individuals who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Subacute Care Facility is sometimes referred to as a specialty hospital or post-acute care, or long-term acute care (LTAC) facility.

Substance Abuse/Substance Use Disorder

A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery

Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowed Charge
Secondary and additional procedures	50% of the Allowed Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

3. For multiple surgeries performed at the same operative session by multiple physicians each with a unique specialty (for example, a neurosurgeon, a cardiothoracic surgeon, an orthopedic surgeon), each unique surgeon's procedures will be paid according to the following:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

Teamsters California State Council of Cannery and Food Processing Unions, International Brotherhood of Teamsters

Please see the definition of "Cannery Council."

Transplant

The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

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.

Visually Necessary

Contact lenses are considered to be Visually Necessary for the following reasons only:

1. Following cataract surgery; or
2. Visual acuity cannot be improved to at least 20/70 in the better eye even with the use of eyeglasses.

Contact lenses that do not meet the above criteria are considered "not Visually Necessary" but rather Elective (Cosmetic).

APPENDIX A - QMCSO

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (Special Rule for Enrollment)

1. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, which is typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. A QMCSO usually results from a divorce or legal separation and typically:
   - Designates one parent to pay for a child's health plan coverage;
   - Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
   - Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
   - States the period for which the QMCSO applies; and
   - Identifies each health care plan to which the QMCSO applies.
2. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).
4. **Enrollment Related to a Valid QMCSO:** If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received, without regard to typical enrollment restrictions.
   a. **If the employee is already a Plan Participant**, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
   b. **If the employee is not yet a Plan Participant** when the QMCSO is received, but is eligible for coverage, and if the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the employee and the alternate recipient specified

by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.

5. **Termination of Coverage:** Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA chapter of this document.
6. **Additional Information:** For additional information or a complete copy of the QMCSO procedures (free of charge) regarding the procedures for administration of QMCSOs, contact the Administrative Office.

APPENDIX B - SPECIAL ENROLLMENT

This Plan complies with federal law regarding Special Enrollment because all eligible employees and their eligible Dependent Children are automatically enrolled in this Plan as soon as the Eligibility requirements of the Plan are met. There is no option to decline coverage. For more information about Special Enrollment under this Plan contact the Administrative Office.

If <u>you are enrolled</u> for coverage under this Plan and if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for your newly acquired Dependent(s) no later than 31 days after the date of the marriage, birth, adoption or placement for adoption.

If <u>you are eligible for coverage but not yet enrolled</u> for coverage under this Plan and you acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, (and you are eligible to enroll the dependent under the terms of this Plan) you may request enrollment for yourself and/or your new Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

Loss Of Other Coverage

If you did not request enrollment under this Plan for yourself and any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance (including coverage purchased through a Health Exchange or Marketplace such as Covered California), Medicare, or other public program **and** you and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and any Dependent Child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but not including loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis.

- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

Medicaid or a State Children's Health Insurance Program (CHIP)

You and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

Coverage of an individual enrolling because of loss of other coverage: If the individual requests Special Enrollment **within 31 days** of the date of the event that created the Special Enrollment opportunity, (except for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) generally coverage will become effective on the first day of the month following the date the Plan receives the request for special enrollment.

If the individual requests enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.