SUMMARY PLAN DESCRIPTION

JOINT BENEFIT TRUST

HEALTH & WELFARE BENEFITS FOR ELIGIBLE PARTICIPANTS UNDER THE

SEASONAL BENEFITS PLAN

DENTAL BENEFITS

VISION BENEFITS

ELIGIBILITY & COVERAGE

EFFECTIVE JANUARY 2025

JOINT BENEFIT TRUST (JBT)
SEASONAL BENEFITS PLAN

SUMMARY PLAN DESCRIPTION (SPD)/PLAN DOCUMENT

Amended, restated and effective **January 1, 2025**

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MESSAGE FROM THE BOARD OF TRUSTEES

This document describes the self-funded Dental and Vision Benefits of the Joint Benefit Trust Health and Welfare Seasonal Benefits Plan available to employees **who achieved 3-Years seniority status on or after July 1, 2003 (hereinafter referred to as the employees of the Seasonal Benefits Plan)**. 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 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 Benefits Plan who achieved 3-Years seniority status on or after July 1, 2003, and their eligible dependents.

Joint Benefit Trust also offers benefits to eligible Full-Time Employees, retired Full-Time Employees, and Seasonal Employees who achieved 3-Years seniority status before 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 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 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 10: 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, 2025**. 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 7: General Plan Exclusions and Chapter 11: Definitions.

This Plan provides dental and vision benefits. It does not provide medical benefits. It is also important to note that not every dental or vision expense you incur 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, 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 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 • Dental Claim Forms • Dental Table of Allowances • File Dental Claims and Appeals • Eligibility Questions (including eligibility for dental and vision) • Plan Benefit Information • Request Preauthorization of Dental Services • 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 100 Dublin, CA 94568-7755 *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 100 Dublin, CA 94568-7755
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 100 Dublin, CA 94568-7755
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 (HS&BA)** 1-800-JBT-HELP (1-800-528-4357) Mailing Address: HS&BA Privacy Officer or HS&BA Security Officer 4160 Dublin Boulevard, Suite 100 Dublin, CA 94568-7755

CHAPTER 3: ELIGIBILITY AND PARTICIPATION

Employee Eligibility and Participation

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 on or after 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 Coverage Begins

Dental coverage for you and your covered dependents begins on the first day of the month all of the above "Who is Eligible?" conditions are met.

Vision coverage does *not* cover your dependents and you qualify after you meet all of the above "Who is Eligible?" conditions. However, **Vision coverage does not begin until the first day of the following calendar year.** It makes no difference if you return to work in the following year – your coverage continues for the entire year regardless.

> For example, if you work at least 80 hours in August 2025, you will be eligible for Vision Benefits as of January 1, 2026 for the entire 2026 calendar year. This is true even if you do not work 80 hours in any month of 2026.

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

When Dental Coverage Ends

Dental coverage ends on the last day of the month in which any of the following first happens:

- you enter the Armed Forces (the military) on full-time active duty;
- you are no longer eligible to participate in the Plan;
- your employer ceases to make contributions required for your coverage;
- the date of your death;
- the second month after the month you last worked 80 hours; or
- the date the Plan is discontinued.

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

Examples of how Dental coverage ends:

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

Example: The Plan has a special rule for **Approved Treatment Plans**. 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 the approved procedures completed during the next three calendar months following the grace month.

Your Dentist submits a treatment plan based on diagnostic work done during October and November of 2025 and the treatment plan is approved. Approved procedures completed during November (the grace month) and December 2025, January 2026 and February 2026 will be covered in accordance with normal dental plan benefit rules (deductibles, calendar-year maximum benefit, etc.). Only procedures that are part of the Approved Treatment Plan will be covered.

Vision Coverage

If you do not work 80 hours in a month during the course of the calendar year your Vision Benefits will end on December 31 of the calendar year in which they began.

Employee Enrollment

In addition to the requirements described above, an employee must be enrolled 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 by the Administrative Office 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.

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 dental 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 (Dental Coverage Only)

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 a Qualified Medical Child Support Order (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 adopted the grandchild or 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 last calendar year you performed seasonal work 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);
- have a disability that 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 were not eligible in August 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 biological children, newborn biological 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 June 2020. You list your dependent child but neglect to send in a birth certificate. The annual open enrollment period is the month of July. You lose coverage in October 2020 and elect COBRA. Because your dependent child is not enrolled at the time you lost

coverage (because of the missing birth certificate) s/he cannot be enrolled until July 2021—the next annual open enrollment period.

Annual Open Enrollment

Open Enrollment Period is the period of time each year designated by the Board of Trustees during which, if you are on COBRA, 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, Space Force, 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 as 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.

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.

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.

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 elect 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 number of hours 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 YOUR SEASONAL WORK FOR THE CALENDAR YEAR 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 employment including retirement.	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage) – for example, the end of your seasonal work for the calendar year.	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.*

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 23 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 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 elect 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	Dental and employee only vision.
Death of employee	Dependent Child loses coverage because employee dies.
Notice	Same as above, you will receive a notice from 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	Dental only.

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. JBT will NOT send you a notice. You must notify 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, 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	Dental only.

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 <u>in writing</u> of that event no later than <u>60 days after that Qualifying Event occurs</u>.**

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 <u>not</u> received by the Administrative Office <u>within the 60-day period</u>, the Qualified Beneficiary will <u>not</u> be entitled to elect 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, or reduction in hours making the employee 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 dental and employee-only vision coverage that you had when the event occurred that caused your 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 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 on page 4) **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 dental and vision 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.

Insignificant 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 4.

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 within the required timeframes, the Plan will not pay benefits for any expenses incurred by you or your dependents after the date coverage ended.

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

If a dental or vision 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 dental or vision 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.

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 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;

e. 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.

f. The date JBT no longer provides group health coverage to any Participants under this Plan.

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.

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 plan after COBRA ends under this Plan.

CHAPTER 5: 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.

Covered Dental Expenses

There is 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 Plan benefit is the Allowed Charge for the procedure less any unmet deductible. 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);
- You have not already met the Plan's annual maximum.

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.

Dentists who are not in the JBT Network 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 will need to pay any amounts that exceed the Plan's covered percentage of 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 or visiting the Fund website at www.jointbenefittrust.com. 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 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.

Annual Maximum Dental Benefits

The Plan's Annual Maximum Dental Benefits payable for any individual covered under this Plan is $1,600 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 MUST 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

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 and 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 their explanations 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 7: General Plan Exclusions and Chapter 11: 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.	$1,600 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 7: General Plan Exclusions and Chapter 11: 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
• Once you have met your annual Deductible, the Plan pays up to 100% of the Allowed Charge for Eligible Dental Expenses, and you are responsible for paying the rest.	**Example:** **In Network / Out-of-Network** **Charge** $500 / $500 **Allowed charge as shown on Table of Allowances** 300 / 300 **Less deductible** (50) / (50) **Balance** 250 / 250 **Benefit (100% of balance)** 250 / 250 **Out-of-pocket cost** **Deductible** 50 / 50 **Difference between charge and allowed amount** -0-* / 200 **Total out-of-pocket cost** 50 / 250 ***Patient is not responsible for the difference between the billed charge and the Allowed Charge.**	Coverage of 100% of the Allowed Charge after the Deductible is met. Your out-of-pocket cost is limited to the Deductible and any amount that results in a benefit of over $1,600.	Coverage of 100% of the Allowed Charge after the Deductible is met Your out-of-pocket cost is the sum of the Deductible, any amount that results in a benefit payment over $1,600 AND Any difference between the billed charge and the Allowed Charge
Preventive/Diagnostic Care • 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.	• 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.	Coverage of 100% of the Allowed Charge after Deductible met	Coverage of 100% of Allowed Charge after Deductible met, plus Balance Billing

SCHEDULE OF DENTAL BENEFITS

This chart explains the benefits payable by the Plan. See Chapter 7: General Plan Exclusions and Chapter 11: 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 100% of the Allowed Charge after Deductible met	Coverage of 100% 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 100% of the Allowed Charge after Deductible met	Coverage of 100% of Allowed Charge after Deductible met, plus Balance Billing
Oral Surgery • Includes extractions	• Biopsy is considered with a pathology report.	Coverage of 100% of the Allowed Charge after Deductible met	Coverage of 100% 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 100% of the Allowed Charge after Deductible met	Coverage of 100% 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 100% of the Allowed Charge after Deductible met	Coverage of 100% of Allowed Charge after Deductible met, plus Balance Billing

SCHEDULE OF DENTAL BENEFITS

This chart explains the benefits payable by the Plan. See Chapter 7: General Plan Exclusions and Chapter 11: 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 100% of the Allowed Charge after Deductible met	Coverage of 100% of Allowed Charge after Deductible met, plus Balance Billing

Prescription Drugs Needed for Dental Purpose

Necessary Prescription Drugs for a dental purpose, such as antibiotics, periodontal mouthwash or pain medications are not covered.

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.
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, 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).

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.

28) Prescription Drugs needed for a dental purpose, such as antibiotics or pain medications and some medications for a dental purpose (such as periodontal mouthwash).

Preventive Diagnostic

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

30) Cleanings where gross residual calculus remains.

31) X-rays that are diagnostically unacceptable.

32) Photographs of teeth/gums/oral cavity

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

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

35) Dietary planning for control of dental caries.

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

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

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

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

Restorative

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

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

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

43) Composite resin restorations on lingual surfaces

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

45) Provisional crowns.

46) Temporary crown for a fractured tooth.

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

48) Crowns in the presence of gross residual calculus.

49) Composite resin restorations on molars.

50) 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).

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

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

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

54) Crowns with defective margins.

55) Fillings and crowns where large overhangs are present.

Endodontics

56) Endodontic therapy using the "Sargenti Method."

57) Root canal when used to facilitate appliance placement.

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

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

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

Periodontal

61) Gingivectomy in conjunction with crown preparation.

62) Splinting of teeth for periodontal support.

Prosthodontics

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

64) 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.

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

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

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

68) Charges for removal of unilateral partial denture.

69) 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.
70) 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.
71) Fixed partial dentures (bridges) for patients under age 16.
72) Replacement of missing posterior teeth where the space is largely closed and neither of the proximal teeth otherwise require crown restoration.
73) Replacement of missing teeth where the individual has at least 12 posterior teeth in occlusion.
74) 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

75) Surgical correction by grafts for denture retention purposes.
76) Removal of remaining crown of an exfoliating deciduous tooth where the roots are essentially reabsorbed.
77) Removal of essential and strategic teeth that can be retained with endodontic therapy.
78) Removal of teeth that can be retained to avoid unnecessary conversion of a patient to edentulism (partial or complete).
79) Palatal augmentation prosthesis, palatal lift prosthesis.
80) Reduction of dislocation and treatment of a temporomandibular disorder (other than open or closed reduction of dislocation).
81) Endosseus implants.
82) 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 7: 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 9: Claims and Appeals Procedures.

CHAPTER 6: 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.

Dependents are not eligible for Vision Benefits.

Vision Network

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 by visiting www.vsp.com or when you call VSP whose 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 VSP. 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 in 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 12 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 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 12 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 12 months, in lieu of all other lens and frame benefits.
• One set of Elective contact lenses are payable every 12 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 $120 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.

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 will not be considered for reimbursement. See also Chapter 9: Claims and Appeals Procedures.

CHAPTER 7: GENERAL PLAN EXCLUSIONS

The following is a list of services, supplies or expenses **not covered (excluded) by the Plan's Dental and Vision benefits**. The Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the 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 Dental Benefit exclusions listed in Chapter 5 and Vision Benefit exclusions listed in Chapter 6. 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 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 where there is an unconditional legal obligation to pay for charges without regard to the existence of any insurance or employee benefit 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 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 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.
9. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan Administrator or its designee.
10. **Costs of Reports, Bills, etc.:** Expenses for preparing or completing forms, 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, 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.

11. **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.
12. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any maximum Plan benefit limitation.
13. **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 8) 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.
14. **Personal Comfort Items:** Expenses for patient convenience, comfort, hygiene, or beautification.
15. **Failure to Comply with Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with appropriate treatment, as determined by the Plan Administrator or its designee.
16. **Telephone Calls:** Expenses for any and all telephone calls between a Dental Provider and any patient or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan for any purpose related to the care or treatment of a Covered Individual, consultation with any Dental Provider regarding management or care of a patient; coordinating 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.
17. **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.
18. Expenses related to **complications of a non-covered service**.
19. 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).
20. Expenses for **court-ordered services unless the services are both Medically Necessary and a covered benefit of the Plan.**
21. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Dental 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 8: COORDINATION OF BENEFITS (COB)

How Coordination of Benefits Works

If you or a dependent is covered for benefits under another group dental 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 50 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.

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 JBT in the absence of other coverage.

Examples

	Dentist NOT in JBT Network				**Dentist IN JBT Network**		
Billed charge			$850	$850	$850	$850	$850
JBT Allowed Charge			$800	$800	$800	$800	$800
Primary plan paid			$475	$700	$300	$550	$425
Difference (charge less Primary plan payment)			$375	$150	$550	$300	$425
JBT benefit, if primary plan							
100% of Allowance			$800	$800	$800	$800	$800
Less deductible, if any			$50	-0-	$50	-0-	$50
JBT benefit without regard to other coverage			$750	$800	$750	$800	$750
JBT pays as secondary plan			$375	$150	$500	$250	$375
Notes			(1)	(2)	(3)	(4)	(5)

Notes:

1. 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 ($800). JBT pays $375.
2. 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.
3. 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 ($800). Note the sum of the primary and secondary payments ($300 + $500) does NOT exceed the Allowed Charge for the procedure of $800.

4. 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 ($800 + $550) = $1,350 exceeds the Allowed Charge.
5. 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 $750 but without regard to the deductible up to the lesser of $800 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, 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 55 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—Dental HMOs ARE PRIMARY

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

Workers' Compensation Insurance

The JBT Health and Welfare Plan for employees under the Seasonal 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 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 dental expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to 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 9: CLAIMS AND APPEALS PROCEDURES

For 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).

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 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 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.

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 four types of claims described by the procedures in this chapter: Pre-service, Urgent, 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,
- be received by the Appropriate Claims Administrator as that term is defined in this chapter,
- name a specific individual,
- name and procedure code of 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 four types of claims of this Plan are:

- **Urgent Care Claim**. An urgent care claim is a Pre-Service Claim for 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 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 the Dental Benefits Chapter. 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.

- **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 or Urgent 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 requesting extension of coverage for a disabled dependent child age 26 and over where to decide if you are eligible for the benefit the Plan must first determine whether the dependent child is "disabled" as defined by the Plan.

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, Dental or Vision 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. 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 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;

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, or Pre-service Claim is denied, the "Claim Denial Information" provided will:

a. identify the claim involved (e.g., date of service, Dental 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);

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 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.;

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 Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Individual Appeal Procedure and Information: For purposes of a Post-Service Claim, Urgent 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, or other item is not Medically Necessary or not appropriate, the Plan will:

    1. consult with a Health Care Professional who has appropriate experience in the dental field 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 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 8) for more information.

When You Must Get Plan Approval in Advance of Obtaining 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 and the description of which services require preauthorization in Chapter 5: Dental Benefits.

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.

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..

Appropriate Claims Administrator:

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	Who Adjudicates the Appeal
Urgent or Pre-Service		
• Certain* Dental Claims	Administrative Office	Board of Trustees
*Please see the Dental Benefits Chapter for a Complete Description of the Services for which Preauthorization is Required		
Post Service		
• Dental Claims	Administrative Office	Board of Trustees
• Vision Benefit Claims	VSP	VSP

Pre-service claims and urgent care claims to extend approved treatment. Please see the Dental Benefits Chapter for a full description of the types of services that require Preauthorization.

Post-service claims for 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 100, 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 100, 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. The provider must be able to supply JBT with a full list of all the services performed and itemized billing.
- **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				
	Urgent	**Pre-service**	**Post-service**	**Disability**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No[1]	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
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	30 days	See below chart	See below chart
Extension permitted during appeal review?	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		
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.
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.
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 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 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 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.

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 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 Dentist 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, 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.

Post-Service Claims

Filing Initial Post-Service Claim

Generally, network Dental 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 dental 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 Administrative Office that you or your covered dependent paid some or all of the charges. If non-network benefits are payable by the Plan, the eligible dental expenses will be paid up to the amount allowed by the Plan for those expenses.

A Post-Service Dental Claim must be submitted in writing to the Administrative Office 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 Vision Service Plan which can be found at https://www.vsp.com/faqs/claims-reimbursement.)

- 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 62-63) 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 **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).
  2) 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. Appeals must be submitted in writing to the Board of Trustees for review, who 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 appeal process for dental claims, the Board of Trustees will make a determination on the post-service appeal 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 appeal process for vision claims can be found under Chapter 6: Vision Benefits – Employee Only.
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 the **Adverse Appeal Information** as explained in the Definitions section of this chapter.
6. This concludes the post-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

Disability Claims

Filing Initial Disability Claim

A disability claim is any claim requesting extension of coverage for a disabled dependent child age 26 and over where to decide if you are eligible for the benefit the Plan must first determine whether your dependent child is "disabled." The following kinds of claims for "disability benefits" are subject to these Disability Claim procedures:

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.

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 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.

Limitation On When A Lawsuit May Be Filed

You or any other claimant may not sue the Trustees, the Plan or 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 Dental Provider 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. 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.

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 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 dental and vision 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 Dental or Vision 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 Provider in consideration for 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 10: GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Your ERISA Rights

As a Plan participant in Joint Benefit Trust, 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 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 filed within one year from the date you received the final adverse benefit determination). See Chapter 9: 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).

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 Seasonal 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 100
Dublin, CA 94568-7755

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 dental and vision benefits.

Collective Bargaining

This Plan is maintained pursuant to the labor agreement between the Producers Alliance of California 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 JBT you lose your eligibility for benefits. In addition, JBT's obligation to provide benefits is limited to the extent the Bargaining Agreements provide for funding of JBT sufficient to provide benefits.

The Dental and Vision benefits are self-funded by 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 JBT for the purpose hereinbefore set forth. **In the event of termination plan assets will be used in accordance with ERISA and Internal Revenue Code requirements and in no event shall they revert back to any employer.**

Trust Agreement and Collective Bargaining Agreement Controls

The benefits of this Plan are subject to and controlled by the provisions of the Cannery Council/PAC 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/PAC 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 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 Dental Benefits with:

Health Services & Benefit Administrators (HS&BA)
4160 Dublin Boulevard, Suite 100
Dublin, CA 94568-7755
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 100
Dublin, CA 94568-7755

The 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 9) 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 100
Dublin, CA 94568-7755
Telephone: (925) 833-7300

Legal process may also be served on any Plan Trustee.

Board of Trustees

Union Trustees	Employer Trustees
Ashley Alvarado Chairperson President Teamsters Local 856 745 E. Miner Avenue Stockton, CA 95202 **Veronica Diaz** Teamsters Local 856 207 North Sanborn Road Salinas, CA 93905 **Luis Diaz** Secretary-Treasurer Teamsters Local 948 2354 W Whitendale Ave. Visalia, CA 93277 **Peter Finn** Secretary-Treasurer Teamsters Local 856 745 E. Miner Avenue Stockton, CA 95202	**Stacey Cue** Co-Chairperson IEDA 2200 Powell Street, Suite 1000 Emeryville, CA 94608 **Joti Aulak** Director of Human Resources Stanislaus Food Products 1202 D Street Modesto, CA 95354 **Adam Sroufe** Vice President, People 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 11: 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 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 9: 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 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

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 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.

Balance Billing

A bill from a Dental 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. See also the provisions related to the Plan's definition of Allowed Charge. **Non-Network Dental 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.

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").

Coinsurance

That portion of Eligible Health Care Expenses for which the covered person has financial responsibility to pay.

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 JBT by the Trustees and provides for contributions to 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 Vision Benefits.

Cosmetic

Surgery or treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

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 "

Chapter 5: 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 9.

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.

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.

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.

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 Covered Dental Expenses in the Schedule of Dental Benefits in Chapter 5.

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.

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Medical Emergency or Medical Emergencies

See Emergency.

Medically Necessary

A 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 Dentist who is authorized to provide a dental service or supply; and
2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American 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 the dental or vision issue; and
   - It is not provided solely for the convenience of the patient, Physician, Dentist; 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 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 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 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 dental coverage provided by the Plan.

A dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental 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 Practitioner.

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.

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.

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 Seasonal Benefits Plan, 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 Benefits Plan.

Plan Year

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

Preauthorization

Preauthorization is a review procedure performed by a review company under contract to JBT, **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service 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.

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.

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).

Teamsters California State Council of Cannery and Food Processing Unions, International Brotherhood of Teamsters

Please see the definition of "Cannery Council."

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).

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.

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.