

East Bay Drayage Drivers Security Fund

171 Mayhew Way Suite 102
Pleasant Hill, CA 94523

Phone (855) 263-7242



Phone (925) 954-1439

Dear East Bay Drayage Drivers Security Fund Member,

Our records indicate that you and your dependents are eligible to enroll for benefit coverages under the East Bay Drayage Drivers Security Fund.

WHAT ARE MY BENEFITS?

In this packet, you will find:

- A Summary of Benefits and Coverage for your Anthem Blue Cross PPO medical plan that summarizes your medical coverage under the Plan. This includes information on:
 - Basic cost information such as the overall deductible and out-of-pocket limit.
 - Covered and non-covered services.
 - Costs and limitations for different services.
- Examples of how the Plan's medical care coverage can work.
- A description of your vision coverage through Vision Service Plan.
- A description of benefits for your self-funded dental plan.

**Other information is included in the Plan 2016 Summary Plan Description Booklet.*

HOW DO I ENROLL?

In order to enroll, please provide these documents:

- A signed East Bay Drayage Drivers Security Fund enrollment form enclosed
(Note: You are required to enroll in the Anthem Blue Cross PPO medical plan for the first year of coverage. After your first year of coverage, you will be entitled to change into the Kaiser Permanente plan if interested).
- Required documents for adding dependents. To enroll dependents, you will need to provide a Marriage Certificate for your spouse and Birth Certificates for any children.

Please complete and return the enclosed enrollment form. You may submit through preferred method:

- **EMAIL:** kachan@corcoranadmin.com
- **FAX:** ATTN: KATELYN CHAN @ (510) 569-1906
- **MAIL:** 400 Roland Way, Oakland, CA 94621

Your cooperation in providing this information is greatly appreciated as it will help ensure that we provide the best service possible service to you and your family.

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WHAT DO I DO IF I HAVE QUESTIONS ON THE PLANS OR MY CHOICES?

If you have any questions concerning this matter, please contact East Bay Drayage Drivers at (510) 636-0381 or e-mail your questions to kachan@corcoranadmin.com.

If you have additional questions about your coverage, contact the Trust Fund Administrative Office at (925) 954-1439 or (855) 263-7242.

Thank you,



Katelyn Chan
Client Service Manager
Local 70 H&W Office
400 Roland Way
Oakland, CA 94621
(510) 636-0381 (o)



**THE EAST BAY
DRAYAGE DRIVERS
SECURITY FUND**

**Local 70 Health & Welfare Office
400 Roland Way
Oakland, CA 94621
(855) 263-7242 ♦ (925) 405-0659 FAX**

INSTRUCTIONS: (Please read carefully before completing this form)

You must complete and sign an Enrollment Form in order to obtain benefits under the Trust. See reverse for life insurance beneficiary designation.

In the first year of your eligibility, your only option for Medical coverage is the Anthem Blue Cross Self-Funded PPO Plan. You may change your plan options during the first open enrollment period after you first become eligible for coverage.

Check all That Apply I am a: NEW MEMBER

CHANGE OF:

COMPLETE ALL INFORMATION - PLEASE PRINT IN INK

| PARTICIPANT DATA | | | | |
|------------------|----------------|----------|------------------------|---------------|
| LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NUMBER | |
| MAILING ADDRESS | | | SEX (M/F) | DATE OF BIRTH |
| CITY | STATE | ZIP | TELEPHONE NUMBER | |
| DATE OF HIRE | EFFECTIVE DATE | EMPLOYER | | |

FAMILY DATA – Attach a marriage or birth certificate for each dependent

| FULL NAME | RELATIONSHIP** | SEX M/F | DATE OF BIRTH MONTH / DAY / YEAR | SOCIAL SECURITY # |
|-----------|----------------|------------|-------------------------------------|-------------------|
| SPOUSE | | | | |
| DEPENDENT | | | | |
| DEPENDENT | | | | |
| DEPENDENT | | | | |
| DEPENDENT | | | | |

****Relationship** – Wife/Husband, Son, Daughter, Stepson, Stepdaughter, Other (Explain)

CHOICE OF PLANS

**IF YOU ARE A NEW HIRE AND FAIL TO SUBMIT ENROLLMENT INFORMATION, YOU WILL
AUTOMATICALLY BE ENROLLED IN THE SELF-FUNDED PLAN FOR YOUR MEDICAL AND DENTAL COVERAGE**

MEDICAL SELECTION – CHOOSE ONE:

ANTHEM BLUE CROSS PPO

DENTAL SELECTION – CHOOSE ONE:

ANTHEM BLUE CROSS DPPO
(CAN CHOOSE ANY DENTIST)

(OVER FOR BENEFICIARY DESIGNATION)

DEATH BENEFIT BENEFICIARY

You may designate any person or persons you want to be your beneficiary(s) for the *Life Insurance Benefits* under the Plan. If you do not designate a beneficiary, your benefits will be paid to beneficiary(s) as provided for under the Plan. Please be sure to provide complete information, such as Jr., Sr., and middle names and initials, to avoid confusion. Please note that this designation applies only to life insurance benefits under the East Bay Drayage Drivers Security Fund.

BENEFICIARY OF DEATH BENEFIT

| | | | |
|-------------------------------------|--------------|---------------|-------------------|
| Beneficiary's Full Name and Address | Relationship | Date of Birth | Social Security # |
| Beneficiary's Full Name and Address | Relationship | Date of Birth | Social Security # |
| Beneficiary's Full Name and Address | Relationship | Date of Birth | Social Security # |
| Beneficiary's Full Name and Address | Relationship | Date of Birth | Social Security # |
| Beneficiary's Full Name and Address | Relationship | Date of Birth | Social Security # |

IMPORTANT NOTICE: I apply for Health Plan membership for the person(s) listed on the reverse, and affirm under penalty of law that the information I have provided is true and complete. I agree that we shall abide by the provisions of the Health Maintenance Organization's (HMO) service agreement. I understand that the HMO's service agreement requires that all claims must be submitted to binding arbitration instead of court trial, including medical malpractice or other claims, which arise because I or my eligible dependents believed that some conduct in, or arising from my relationship with the HMO, HMO Hospitals, or the HMO medical group, as a member or as a patient, has caused me or my eligible dependents harm.

Please visit the East Bay Drayage Drivers' website at ebddsf.com to view additional Plan information and the Summary Plan Description (SPD), which includes your rights as a member.

It is your responsibility as a member to inform the Administrative Office of any qualifying event changes (marriage, divorce, newborn baby, etc.) when they first occur. If the Fund is not initially informed of your dependent losing their status as a dependent, they will be retroactively terminated on the qualifying event date, and you will be responsible for paying back any claims that were paid for by the Plan.

DATE _____

SIGNATURE _____



This is only a summary. If you want more detail about your coverage and costs, please review the plan booklet for the complete terms or get the plan booklet at www.ebdds.com or by calling 1-855-263-7242.


| Important Questions | Answers | Why this Matters: |
|---|--|--|
| What is the overall deductible ? | \$250 person/\$500 max per family per year in network. \$500 person/\$1000 max per family out of network. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Yes. \$2500 person/\$5000 per family in network. \$5000 person/\$10000 family out of network. In & out of network OOP do not cross apply. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit ? | Deductibles; charges for services not covered by the Plan; and coinsurance and/or charges in excess of covered expense (UCR) for Non-PPO providers. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers ? | Yes. For a list of Anthem Blue Cross network providers call 800-274-7767 or go to: www.anthem.com . For substance abuse treatment, TAP has its own provider list. Call TAP at 510-562-3600. | If you use an in-network hospital, doctor or other healthcare provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network hospital or doctor may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |

Questions: Call 1-855-263-7242. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-266-2269 to request a copy.

East Bay Drayage Drivers Security Fund: Indemnity Plan 2016 Coverage Period: 08/01/2025 – 07/31/2026

Summary of Benefits & Coverage: What this Plan Covers & What it Costs Coverage for: Employee & Dependents | Plan Type: PPO

| | | |
|---|------|---|
| Do I need a referral to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

- 
Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a PPO Provider | Your Cost If You Use a Non-PPO Provider | Limitations & Exceptions |
|--|--|--|---|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$15 copay/visit + 20% after deductible | 40% of UCR after deductible and 100% of non- allowable charges. | Treatment must be medically necessary. |
| | Specialist visit | \$15 copay/visit + 20% after deductible. | | Treatment must be medically necessary. |
| | Other practitioner office visit | \$15 copay/visit + 20% after deductible. | | Treatment must be medically necessary. Acupuncture is not covered for maintenance care. |
| | Preventive care/ screening/ immunization | Covered 100%; deductible waived | 40% of UCR after deductible and 100% of non- allowable charges. | Adult Routine Physical Exam (1 exam every 12 months). Well Child Care (7 exams first 12 months, 3 exams 2nd 12 months, 3 exams 3rd 12 months and 1 exam every 12 months to age 18. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$15 copay/visit + 20% after deductible. | 40% of UCR after deductible and 100% of non- allowable charges. | Treatment must be medically necessary. |
| | Imaging (CT/PET scans, MRIs) | | | |

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East Bay Drayage Drivers Security Fund: Indemnity Plan 2016 Coverage Period: 08/01/2025– 07/31/2026

Summary of Benefits & Coverage: What this Plan Covers & What it Costs Coverage for: Employee & Dependents | Plan Type: PPO

| | | | | |
|---|--|---|--|--|
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling MedImpact at 833-656-1506 | Generic drugs | No Charge. | 100% of charges. | Coverage of Brand Name or Generics at 100%. MedImpact network only. |
| | Preferred brand drugs | No Charge. | | |
| | Non-preferred branddrugs | No Charge. | | |
| | Specialty drugs | No Charge. | 100% of charges. | Injectables and other “Specialty” prescriptions are subject to pre-authorization with MedImpact. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% after deductible. | 40% of UCR after deductible and 100% of non- allowable charges. | Treatment must be medically necessary. |
| | Physician/surgeon fees | 20% after deductible. | 40% of UCR after deductible and 100% of non- allowable charges. | Treatment must be medically necessary. |
| If you need immediate medical attention | Emergency room services | Admission: 20% after deductible. No admission: \$100 copay + 20% of PPO rate after deductible. | Admission: 20% after deductible. No admission: \$100 copay + 20% of UCR after deductible. | Treatment must be medically necessary. |
| | Emergency medical transportation | 20% after deductible. | 20% of UCR after deductible is met and 100% of non- allowable charges. | Treatment must be medically necessary. |
| | Urgent care | \$50 copay, deductible waived. | 40% of UCR after deductible is met and 100% of non- allowable charges. | Treatment must be medically necessary. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% after deductible. | 40% of UCR after deductible is met and 100% of non- allowable charges. | Subject to pre-authorization by Anthem Blue Cross. Limited to 365 days per Hospital Confinement. |
| | Physician/surgeon fee | 20% after deductible. | | |

Questions: Call [1-855-263-7242](tel:1-855-263-7242). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-266-2269 to request a copy.

East Bay Drayage Drivers Security Fund: Indemnity Plan 2016 Coverage Period: 08/01/2025 – 07/31/2026

Summary of Benefits & Coverage: What this Plan Covers & What it Costs Coverage for: Employee & Dependents | Plan Type: PPO

| | | | | |
|---|--|--|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$15 copay/visit + 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Treatment must be medically necessary. |
| | Mental/Behavioral health inpatient services | \$15 copay/visit + 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Subject to pre-authorization by Anthem Blue Cross for non-emergency care. |
| | Substance use disorder outpatient services | No charge. | 20% of UCR after deductible is met and 100% of non-allowable charges. | Subject to pre-authorization by TAP. Call TAP at (510) 562-3600 for more information. |
| | Substance use disorder inpatient services | No charge. | 20% of UCR after deductible is met and 100% of non-allowable charges. | Subject to pre-authorization by TAP. Call TAP at (510) 562-3600 for more information. |
| If you are pregnant | Prenatal and postnatal care | 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Only employee or dependent spouse is covered. |
| | Delivery and all inpatient services | 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Only employee or dependent spouse is covered. |

Questions: Call [1-855-263-7242](tel:1-855-263-7242). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-266-2269 to request a copy.

East Bay Drayage Drivers Security Fund: Indemnity Plan 2016 Coverage Period: 08/01/2025 – 07/31/2026

Summary of Benefits & Coverage: What this Plan Covers & What it Costs Coverage for: Employee & Dependents | Plan Type: PPO

| | | | | |
|---|---------------------------|---|---|--|
| If you need help recovering or have other special health needs | Home health care | 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Coverage limited to a 90 day period following confinement in a hospital or a skilled nursing facility. |
| | Rehabilitation services | \$15 copay/visit + 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Treatment must be medically necessary. |
| | Habilitation services | Not Covered. | Not Covered. | Not Applicable. |
| | Skilled nursing care | 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Subject to pre-authorization. Maximum 100 days per calendar year. |
| | Durable medical equipment | 20% after deductible. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Home Medical Equipment, prosthetic/orthotics (up to \$10000 per year). |
| | Hospice service | 20% coinsurance after deductible is met. | 40% of UCR after deductible is met and 100% of non-allowable charges. | Maximum 180 days |
| If your child needs dental or eye care | Eye exam | No Charge. | You pay all charges that exceed \$50. | Covered under Vision Service Plan. Covered once in any 12 months. |
| | Glasses | Lenses – No charge. Frames – No charge to maximum \$195. Contacts – Up to \$105 | Lenses – Single Vision up to \$50 per pair. Bifocals up to \$75 per pair. Trifocals up to 100 per pair. Frames – Charges over \$70. Contacts – Up to \$105. | Covered under Vision Service Plan. One pair of frames or set of contacts in any 24 months. One set of lenses in any 12 months. |
| | Dental check-up | No Charge. | Must use DeltaCare USA dentists. | Covered under DeltaCare. Exams covered once in any 12 month period. |

Questions: Call [1-855-263-7242](tel:1-855-263-7242). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-266-2269 to request a copy.

Excluded Services & Other Covered Services: Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|---|---------------------|---|
| • Elective Abortions | • Bariatric surgery | • Cosmetic surgery |
| • Custodial care | • Hearing aids | • Illness or injury caused by third parties |
| • Infertility treatment in excess of \$25,000 | • Long-term care | • Non-emergency care when traveling outside the U.S |
| • Non-medically necessary services/treatments | • Routine foot care | • Weight loss programs |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|---|--|
| • Chiropractic care | • Dental care (Adult), under the Dental PPO or DHMO plans | • Routine eye care (Adult) through Vision Service Plan |
|---------------------|---|--|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights will be limited in duration and will require you to pay a **premium**. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at: 1-866-263-7242. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For questions about your rights, this notice, or assistance, you can contact: The Administrative Office, PO Box 5030 Walnut Creek, CA 94596 or 1-855-263-7242; or the Department of Labor Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services: Spanish (Español) Para obtener asistencia en Español, llame al 1-510-636-0381

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call **1-855-263-7242**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-266-2269 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,890
- Patient pays \$650

Sample care costs: PPO Hospital

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$250 |
| Copays | \$0 |
| Coinsurance | \$0 |
| Limits or exclusions | \$0 |
| Total | \$250 |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, or hospitalization during pregnancy or for delivery, your costs may be higher. For more information, please contact 1-866-266- 2269.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,820
- Patient pays \$580

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$50 |
| Copays | \$0 |
| Coinsurance | \$450 |
| Limits or exclusions | \$80 |
| Total | \$580 |

Questions: Call **1-855-263-7242**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-266-2269 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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East Bay Drayage Drivers Security Fund

Send claims to:
Anthem Blue Cross
PO Box 659444
San Antonio, TX 78265

Claims and Eligibility Questions Call:
Phone: 1-855-263-7242
Group #: 2785120001
Payer ID: 84105

Anthem Blue Cross DPPO/Self-Funded Dental Plan

| | |
|--|--|
| Timely Filing Policy | Initial Claims: One year from date of service. Requested additional information: 45 days from the time you are expected to receive the Explanation of Benefits |
| Pre-Determination (Expires after 180 days) | Suggested for treatment plans over \$300 and other services as shown below with * |
| Deductible | No Annual Deductible |
| Annual Maximum | No Annual Maximum |
| Diagnostic & Preventive/Basic/Major | 90% of PPO (in-network) 90% of UCR (out of network) |
| Orthodontics | 70% of UCR up to \$3,000 lifetime maximum (diagnostic services & extractions are covered under the regular plan, not under orthodontics) |
| Missing Tooth Clause or Waiting Period | No |
| Fee Schedule | Dental Blue Complete |
| Coordination of Benefits | Non-Dupe |
| Prophylaxis/Periodontal Maintenance | Limited to 2 per 12 month period |
| Exam | Limited to 2 per 12 month period (D0140 excluded from frequency limits) |
| FMX (Full Mouth X-Ray) | Limited to one set every 5 years (unless special need is shown) |
| Panoramic X-Ray | Combined frequency with FMX |
| BWX (Bitewing X-Ray) | Adults 18 & older: 1 in 12 month period Children through age 17: 2 in 12 month period |
| Periapical (PA) X-Ray | Covered if necessary to complete procedure |
| Flouride | 2 in 12 month period for children through age 17 |
| Sealants | Covered for children under age 14, posterior teeth only, every 3 years |
| Space Maintainers | Covered |
| Root Planing/Deep Cleaning/Scaling (SRP) | Limited to 4 quadrants during any 12 month period (need perio chart if more than one quadrant is billed) |
| Crown/Bridge | Once every 5 years per tooth (Seat date billing). If posterior, alternate benefits given |
| Fillings/Composites | Once every 3 years per tooth. If posterior, alternate benefits given |
| Tooth Extractions | Covered |
| Dentures | Full set (maxillary and mandibular) once every 5 years |
| Relines* | Allowed following healing period of immediate denture or 6 months following placement of denture, and once every 12 months thereafter |
| Stayplates* | Allowed during healing period of upper/lower arch anterior tooth extraction, as an anterior space maintainer for children, or temporary alternate to a permanent denture in the presence of periodontal disease which would be evaluated by the dental consultant* |
| Occlusal Guard/Night Guard | Not covered |
| Bone Grafts | Not covered |
| Implants | Not covered. If done in conjunction with a covered Prosthodontic appliance the plan will pay benefits for standard denture or partial |
| TMJ (Temporomandibular Joint) | Not covered |
| General Anesthetic | Covered for oral surgery procedures |
| Nitrous Oxide/IV Sedation | Nitrous not covered. IV not covered for children under age 14 |

*This is a general breakdown of benefits and not a guarantee of payment. Payment is based on eligibility on the date of service and on the guidelines outlined in the Summary Plan Description (SPD). **We suggest submitting a pre-determination if there is any question as to what is going to be covered.**

A Look at Your VSP Vision Coverage

With VSP and TEAMSTERS LOCAL 70 EAST
BAY DRAYAGE DRIVERS, your health
comes first.




As a member, you'll get access to savings
and personalized vision care from a VSP
network doctor for you and your family.


Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over \$3,000 in savings.

Provider choices you want.

 With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

 Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.


vision care

More Ways
to Save

Extra

\$20

to spend on

Featured Frame Brands†

bebe

Calvin Klein

COLE HAAN

DRAGON

FLEXON

LONGCHAMP
PARIS



and more

See all brands and offers
at vsp.com/offers.

+

Up to

40%

Savings on

lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or vsp.com

Your VSP Vision Benefits Summary
 TEAMSTERS LOCAL 70 EAST BAY DRAYAGE DRIVERS
 and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Signature

EFFECTIVE DATE:

01/01/2024



| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|---|---|---------------------------|---------------------|
| Your Coverage with a VSP Provider | | | |
| WELLVISION EXAM | <ul style="list-style-type: none"> Focuses on your eyes and overall wellness Routine retinal screening | \$0 Up to \$39 | Every 12 months |
| ESSENTIAL MEDICAL EYE CARE | <ul style="list-style-type: none"> Retinal imaging for members with diabetes covered-in-full Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP network doctor for details. | \$20 per exam | Available as needed |
| PRESCRIPTION GLASSES | | | |
| FRAME* | <ul style="list-style-type: none"> \$215 Featured Frame Brands allowance \$195 frame allowance 20% savings on the amount over your allowance | \$0 | Every 24 months |
| LENSES | <ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children | \$0 | Every 12 months |
| LENS ENHANCEMENTS | <ul style="list-style-type: none"> Progressive lenses Tints/Light-reactive lenses Average savings of 40% on other lens enhancements | \$0 \$0 | Every 12 months |
| CONTACTS (INSTEAD OF GLASSES) | <ul style="list-style-type: none"> \$105 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) | Up to \$60 | Every 12 months |
| ADDITIONAL PAIRS OF EYEWEAR | | | |
| FRAME* | <ul style="list-style-type: none"> \$195 frame allowance 20% savings on the amount over your allowance | \$10 for frame and lenses | Every 24 months |
| LENSES | <ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children | Combined with Frame | Every 12 months |
| VSP LIGHTCARE™+ | <ul style="list-style-type: none"> \$195 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts | \$0 | Every 24 months |
| ADDITIONAL SAVINGS | Glasses and Sunglasses <ul style="list-style-type: none"> Extra \$20 to spend on Featured Frame Brands. Go to vsp.com/offers for details. 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam. | | |
| | Laser Vision Correction <ul style="list-style-type: none"> Average of 15% off the regular price; discounts available at contracted facilities. | | |
| | Exclusive Member Extras for VSP Members <ul style="list-style-type: none"> Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers. Save up to 60% on digital hearing aids with TruHearing®. Visit vsp.com/offers/special-offers/hearing-aids for details. Enjoy everyday savings on health, wellness, and more with VSP Simple Values. | | |
| YOUR COVERAGE GOES FURTHER IN-NETWORK | | | |
| With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider. | | | |

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

†Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on vsp.com.

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Welcome to SleepCharge

Get your personalized sleep report

Complete the Sleep Checkup to get your personalized sleep report, which includes an analysis of your Duration, Timing & Quality (DTQ). Use your report to lay the foundation for sleep improvement.

Access the Sleep Life Learning Center

Explore our virtual, self-guided library of sleep education and guided bedtime mindfulness, to help you achieve a healthier sleep lifestyle.

Receive sleep health support

From sleep coaching to treatment for sleep disorders such as insomnia, sleep apnea and restless legs syndrome, SleepCharge provides proactive and virtual sleep care tailored to your needs.

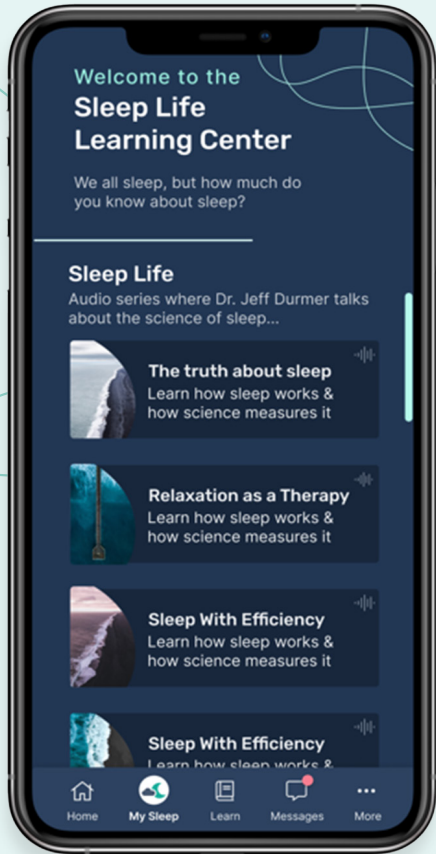


All employees are eligible
Health plan members are eligible

All confidential medical information obtained through SleepCharge will be maintained in accordance with federal HIPAA requirements

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Take the Sleep Checkup™ for your personalized sleep report and gain access to the Sleep Life Learning Center, our self-paced library of sleep education and relaxation modules.

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