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 the Anthem Blue Cross PPO and HMO 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.
- A description of your sleep apnea benefits through SleepCharge.

HOW DO I ENROLL?

In order to enroll, please provide these documents:

- A signed East Bay Drayage Drivers Security Fund enrollment form enclosed.
  (Note: Your only medical plan options for your first year of coverage are the Anthem Blue Cross PPO or HMO. 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 forms. 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 (855) 263-7242 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 ♦ FAX (925) 405-0659
kachan@corcoranadmin.com

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 options for Medical coverage are the Anthem Blue Cross Self-Funded PPO Plan or the Anthem Blue Cross HMO. You may change your plan options during the first Open Enrollment period (July) after you first become eligible for coverage.

Check all That Apply **I am a:** ☐ **NEW MEMBER**

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	EMAIL ADDRESS (OPTIONAL)	

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:**	**DENTAL SELECTION** – **CHOOSE ONE:**
☐ ANTHEM BLUE CROSS PPO	☐ ANTHEM BLUE CROSS DPPO (**CAN CHOOSE ANY DENTIST**)
☐ ANTHEM BLUE CROSS HMO	

(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** _____

East Bay Drayage Drivers Security Fund: Indemnity Plan 2002 Coverage Period: 8/01/2026– 7/31/2027

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

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.ebddsf.com or by calling 855-263-7242.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$150 person/$450 max per family per year. Deductible does not apply to services covered at 100%.	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 1st). 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. $800 annually, after deductible. If you use a Non-PPO provider for other than emergency there is no limit on your out of pocket expenses.	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 *specific* 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.

Do I need a referral to see a specialist?	No.	You can see the **specialist** 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	20% of coinsurance after deductible is met.	20% of UCR after deductible is met and 100% of non-allowable charges.	Treatment must be medically necessary.
	Specialist visit	20% of coinsurance after deductible is met.		Treatment must be medically necessary.
	Other practitioner office visit	20% of coinsurance after deductible is met.		Treatment must be medically necessary. Acupuncture is not covered for maintenance care.
	Preventive care/ screening/ immunization	No Charge.	100% of non-allowable charges.	
If you have a test	Diagnostic test (x-ray, blood work)	20% of coinsurance after deductible is met.	20% of UCR after deductible is met and 100% of non-allowable charges.	Treatment must be medically necessary.
	Imaging (CT/PET scans, MRIs)	20% of coinsurance after deductible is met.		

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.

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling ProAct at 877-635-9545	Generic drugs	No Charge.	100% of charges.	Coverage of Generics at 100% of ProAct's determination of UCR up to 90 day supply for retail pharmacies and mail-order.
	Brand drugs	$5		
	Specialty generic	No Charge.		
	Non-preferred	$10		Injectables and other "Specialty" prescriptions are subject to pre-authorization with ProAct's Specialty Drug Program, Noble Health Services
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Treatment must be medically necessary.
	Physician/surgeon fees	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Subject to pre-authorization by Anthem Blue Cross.
If you need immediate medical attention	Emergency room services	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Treatment must be medically necessary.
	Emergency medical transportation	20% coinsurance after dedutible is met.	20% of UCR after deductible is met and 100% of non-allowable charges.	Must be medically necessary
	Urgent care	20% coinsurance after deductible is met.	20% 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)	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Subject to pre-authorization by Anthem Blue Cross.
	Physician/surgeon fee	No Charge.		

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible.	20% of UCR after deductible is met and 100% of non-allowable charges.	Treatment must be medically necessary.
	Mental/Behavioral health inpatient services	No Charge.	20% 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.
	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.
If you are pregnant	Prenatal and postnatal care	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Only employee or dependent spouse is covered.
	Delivery and all inpatient services	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Only employee or dependent spouse is covered.

If you need help recovering or have other special health needs	Home health care	No Charge.	20% 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	20% coinsurance after deductible is met	20% of UCR after deductible is met and 100% of non-allowable charges.	Treatment must be medically necessary.
	Habilitation services	Not Covered.	100% of non-allowable charges.	Not Applicable.
	Skilled nursing care	No Charge.	20% of UCR after deductible is met and 100% of non-allowable charges.	Must be medically necessary. Maximum 100 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible is met.	20% of UCR after deductible is met and 100% of non-allowable charges.	Must be medically necessary.
	Hospice service	20% coinsurance after deductible is met.	20% of UCR after deductible is met and 100% of non-allowable charges.	Maximum 180 days per calendar year.
If your child needs dental or eye care	Eye exam	No Charge.	You pay all charges that exceed $45.	Covered under Vision Service Plan. One exam every 12 months.
	Glasses	Lenses – No charge Frames – No charge to maximum $195.	Lenses: Single Vision over $45 per pair. Bifocals over $65 per pair. Trifocals over $85 per pair. Frames: Charges over $75.	Covered under Vision Service Plan. One pair of frames or set of contacts every 24 months. One set of lenses every 12 months.
	Dental check-up	PPO Provider – 10% of UCR.	10% coinsurance (of allowable charges)	Covered under the self-insured dental PPO plan.

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: 1-877-474-5703. 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	$150
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$150**

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	$150
Copays	$0
Coinsurance	$750
Limits or exclusions	$80
Total	**$980**

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.

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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Primary Care. Specialist Visit. Preventive Care. Certain Prescription Drugs. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500/person or $3,000/family for In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=JMV or call (855) 333-5730 for a list of network providers. Benefits and costs may vary by site of service and how the provider bills.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	Virtual visits (Telehealth) benefits available.
	Specialist visit	No charge	Not covered	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	--------none--------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	$5/prescription (retail and home delivery)	50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)	Most home delivery is 90-day supply. For more information, refer to "CA National DMHC Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	$5/prescription (retail and home delivery)	50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	$5/prescription (retail and home delivery)	50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	$5/prescription (retail and home delivery)	50% coinsurance up to $250/prescription (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	$35/visit	Covered as In-Network	Copayment waived if admitted. No charge for Emergency Room Physician Fee. No Coverage for Emergency Room Physician Fee Out-of-Network Providers.
	Emergency medical transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	No charge	Covered as In-Network	Out-of-Network only covered when out of area. For in area,

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				contact your PCP or medical group.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit 988 lifeline/mobile crisis team covered as In-Network. Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	No charge	Not covered	No charge for Inpatient Physician Fee In-Network Providers. No Coverage for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visits/benefit period for In-Network Providers.
	Rehabilitation services	No charge	Not covered	*See Therapy Services section.
	Habilitation services	No charge	Not covered	
	Skilled nursing care	No charge	Not covered	100 days/benefit period for skilled nursing services for In-Network Providers.
	Durable medical equipment	No charge	Not covered	*See Durable Medical Equipment section.
	Hospice services	No charge	Not covered	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check-up
- Eye exams for a child
- Non-emergency care when traveling outside the U.S.
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Glasses for a child
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Hearing aids
- Bariatric surgery
- Infertility treatment - 3 oocyte egg retrievals/lifetime
- Chiropractic care 100 visits/benefit period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, https://www.dmhc.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$40**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。 您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

مهم: آیا می توانید این نامه را بخوانید؟ اگر نتوانیدمی ما، بخواهیم شخصی از توانیمی کتبی صورت به را نامه این بتوانید است ممکن همچنین. کند کمک شما به آن خواندن در شماره با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان زبان به و بگیرید تماس 1-888-254-2721. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 （TTY/TDD:711）にご連絡ください。

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Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ
យើងអាចមានអ្នកជួយអាន។
អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។
សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ
សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721.
(TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우,
이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다.
귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다.
무상으로 제공되는 도움이 필요하신 경우,
1-888-254-2721번으로 바로 연락해 주십시오.
(TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน
หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

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It’s important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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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.**

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and TEAMSTERS LOCAL 70 EAST BAY DRAYAGE DRIVERS. Take a look at your VSP vision care coverage.

VSP members save an annual average of

$489*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

Up to 40% Savings on lens enhancements‡

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

Create an account today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

vsp PREMIER edge

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 a vsp vision company

Save on Featured Frame Brands when you shop on Eyeconic®, the VSP in-network online eyewear store.

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.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible.
‡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.
*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +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. VSP Premier Edge™ is not available in all states.

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**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through TEAMSTERS LOCAL 70 EAST BAY DRAYAGE DRIVERS.

Provider Network:
VSP Signature
Effective Date:
01/01/2026

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$0 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• 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[+]	• $215 Featured Frame Brands allowance • $195 frame allowance • 20% savings on the amount over your allowance	$0	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	$0	Every 12 months
LENS ENHANCEMENTS	• Progressive lenses • Tints/Light-reactive lenses • Average savings of 40% on other lens enhancements	$0 $0	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $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[+]	• $195 frame allowance • 20% savings on the amount over your allowance	$10 for frame and lenses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with Frame	Every 12 months
VSP LIGHTCARE™[+]	• $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** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 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 • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • 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.		

GET MORE AT PREFERRED IN-NETWORK LOCATIONS

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor.

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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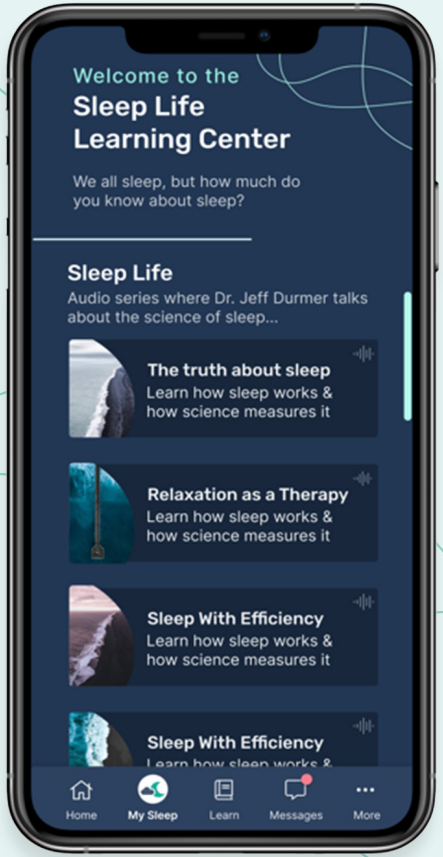

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