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.
- A description of your sleep apnea benefits through SleepCharge

**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 ♦ 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 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	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**)

(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 2016 Coverage Period: 08/01/2026 – 07/31/2027

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 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 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. $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 *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	$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)			

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.	Cover 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	100% of charges.	Injectibles 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)	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.		

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.

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.

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.

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.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-888-254-2721

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-888-254-2721 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-888-254-2721 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-888-254-2721:

Bassa (Bàsɔ̀ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̃ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá 1-888-254-2721.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য 1-888-254-2721 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် 1-888-254-2721 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電1-888-254-2721。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl 1-888-254-2721.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u 1-888-254-2721.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-888-254-2721 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 1-888-254-2721.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie 1-888-254-2721.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο 1-888-254-2721.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો 1-888-254-2721.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-888-254-2721.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें 1-888-254-2721 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau 1-888-254-2721.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ 1-888-254-2721.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti 1-888-254-2721.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi 1-888-254-2721.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero 1-888-254-2721

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには 1-888-254-2721 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ)៖ បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ1-888-254-2721 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-888-254-2721.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면1-888-254-2721 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-888-254-2721.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih 1-888-254-2721.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-888-254-2721

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 1-888-254-2721 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-254-2721.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para 1-888-254-2721.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic 1-888-254-2721.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. 1-888-254-2721.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili 1-888-254-2721.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite 1-888-254-2721.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 1-888-254-2721.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang 1-888-254-2721.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-888-254-2721 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: 1-888-254-2721.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، 1-888-254-2721 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 1-888-254-2721.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט 1-888-254-2721 .

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe 1-888-254-2721.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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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.

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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.

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.**

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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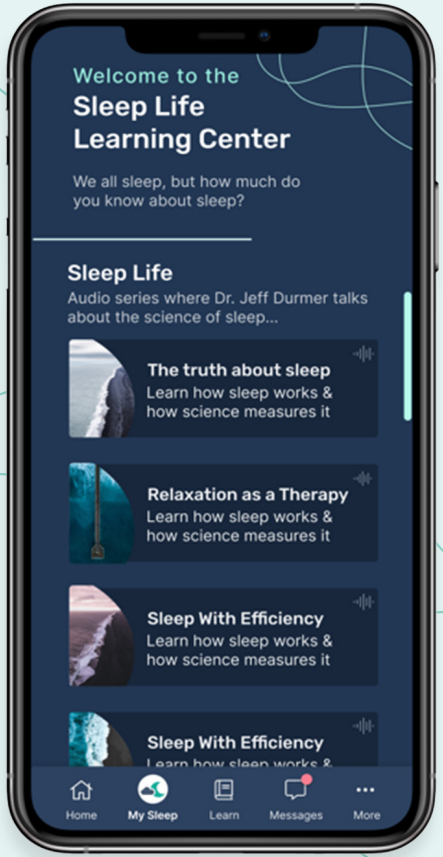

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Take the Sleep Checkup™ for your personalized sleep report and gain access to the Sleep Life Learning Center, our self-paced library of sleep education and relaxation modules.

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