East Bay Drayage Drivers Security Fund

P O Box 5030
Walnut Creek, CA 94596

Phone (855) 263-7242 Phone (925) 954-1439

September 13, 2019

IMPORTANT ANNOUNCEMENT
SUMMARY OF MATERIAL MODIFICATIONS
Higher Life and AD&D Insurance Coverage

TO ALL ACTIVE PLAN PARTICIPANTS, DEPENDENTS and COBRA PARTICIPANTS:

Effective June 1, 2019, your Life and Accidental Death & Dismemberment ("AD&D") insurance coverage through ULLICO increased,

- from $7,500 to $25,000 for the covered employee, and
- from $3,500 to $12,500 (life insurance only) for your spouse or domestic partner.

The changes are detailed below.

	Old Coverage	**NEW Coverage** ***Effective June 1, 2019***
Employee	$7,500 Life Insurance and up to $7,500 Accidental Death & Dismemberment (AD&D)	**$25,000** Life Insurance and up to **$25,000** Accidental Death & Dismemberment (AD&D)
Dependent Spouse	$3,500 (Life Insurance only)	**$12,500** (Life Insurance only)
Dependent Children	Six months of age and over, through age 20 - $1,000 (Life Insurance only) Under six months of age - $100 (Life Insurance only)	No Change

If you have any questions about this notice, please contact us at (855) 263-7242 or (925) 954-1439.

Thank you,

Board of Trustees
East Bay Drayage Drivers Security Fund

In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

PLEASE NOTE

This Notice is intended to amend your Summary Plan Description.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the *Summary Plan Description*. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

Si usted gustaría una copia en español, por favor de contactar la oficina de administracion de East Bay Drayage Drivers Security Fund.

Plans 1980 and 2002 are "Grandfathered Health Plans"

The East Bay Drayage Drivers Fund Board of Trustees has concluded that Plans 1980 and 2002 are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the address listed on this notice. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

East Bay Drayage Drivers Security Fund

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December 2, 2021

IMPORTANT ANNOUNCEMENT
SUMMARY OF MATERIAL MODIFICATIONS
Retiree Health Eligibility Requirements

TO: ALL ACTIVE PLAN PARTICIPANTS

Effective January 1, 2022, the East Bay Drayage Drivers Security Fund's Retiree Plan's eligibility rules will change. **These changes will make it easier for you to qualify for retiree coverage.** The new Retiree Plan eligibility rules are as follows:

- You must have at least 5 years of coverage in an East Bay Drayage Drivers Security Fund (EBDDSF) plan for Active employees, ***and***
- You must have been covered as an Active employee by EBDDSF for at least **12** of the **24** months immediately preceding your retirement date.

The changes are detailed below.

	Old Eligibility Rules	**NEW Eligibility Rules** ***Effective January 1, 2022***
Employee/Retiree	Must have at least 10 years of coverage in an EBDDSF plan for Active employees and have been covered in an Active plan for at least 60 of the 84 months immediately preceding your retirement date.	Must have at least 5 years of coverage in an EBDDSF plan for Active employees and have been covered for at least 12 of the 24 months immediately preceding your retirement date.
Spouse	Covered if the Employee/Retiree is eligible.	No Change
Children (to age 18 and to age 26 if enrolled in educational program full time)	Covered if the Employee/ Retiree is eligible.	No Change

If you have any questions about this notice, please contact us at (855) 263-7242 or (925) 954-1439.

Thank you,

Board of Trustees
East Bay Drayage Drivers Security Fund

In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

PLEASE NOTE

This Notice is intended to amend the Retiree Plan Summary Plan Description.

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East Bay Drayage Drivers Security Fund

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September 30, 2022

PLAN CHANGE NOTICE
Summary of Material Modifications
Plan Changes Regarding the No Surprises Act
Effective November 2022
RETAIN WITH YOUR BENEFIT PACKAGE FOR FUTURE REFERENCE

To: **East Bay Drayage Drivers Security Fund Plan Participants, Covered Dependents and COBRA Participants in Plans 1980, 2002 and 2016**

(If you are enrolled in Kaiser or the Anthem HMO, Kaiser and Anthem Blue Cross will provide information on how it is implementing the changes described in this Notice.)

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

As of November 1, 2022, the "No Surprises Act" will limit your out-of-pocket costs and protect you against surprise medical bills. What your Plan pays for medical care depends on whether the hospital, doctor, or urgent care center is in the Anthem Blue Cross PPO Network *or* is "out of network" ("out-of-network" claims are also called "non-PPO" claims). If you are treated at an out-of-network hospital or urgent care center, you generally must pay more out of pocket than at an "in-network" hospital or urgent care center. However, as of November 2022 your out-of-pocket costs for only the following types of out-of-network claims will be no greater than if you were treated "in network" and the out-of-network provider cannot "balance bill" you for additional payment:

- Emergency services,
- Services provided by an *out-of-network* doctor or other health care provider at an *in-network* hospital or urgent care center, and
- Air ambulance services.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

"Balance billing" (sometimes called "surprise billing") describes when you see a doctor or other health care provider and are billed certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have to pay other costs or the entire bill if you see a provider or visit a health care facility that is not in the Anthem Blue Cross network.

"Out-of-network" describes providers and facilities that have not signed a contract to participate in the Anthem Blue Cross network (or the Teamsters Assistance Program – TAP -- provider networks for substance abuse treatment). Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is probably more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: **Emergency services**. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give informed written consent and give up your protections not to be balanced billed for these post-stabilization services.

You are protected from balance billing for**: Certain services at an in-network hospital or ambulatory surgical center.** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or where there is no in-network provider who can furnish the service. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give informed written consent and give up your protections. **If you do give written consent to continued treatment by the out-of-network provider, you will lose the protections of the No Surprises Act and, in most cases, likely be responsible for greater cost-sharing than if you do not give written consent.** You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your East Bay Drayage Drivers plan generally must:

- Cover out-of-network emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services at an in-network facility toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact the Administrative Office at (855) 263-7242 for assistance.

What should I do if I receive a surprise bill and have a billing disagreement?

If the Fund denies all or part of a claim for service, you can appeal that decision. Your Summary Plan Description contains information on the review process and how you request review of your plan's decision.

Starting on November 1, 2022, you generally will not be responsible for balance bills or out-of-network cost-sharing when getting emergency care, non-emergency care from out-of-network providers at certain in-network facilities, or air ambulance services from out-of-network providers. When this happens, instead of you paying for unexpected out-of-network costs, you will generally only need to pay your normal in-network costs (like coinsurance, copayments, and amounts paid towards deductibles). The health care provider and your health plan are responsible for negotiating the total payment amount from the plan to the provider through an independent dispute resolution process.

External Review

An adverse benefit determination related to an Emergency Service, Non-Emergency Service provided by a Non-Network Provider at an In-Network facility, and/or Air Ambulance Services, that is covered under the *No Surprises Act*, may be eligible for External Review, and this review includes East Bay Drayage plans that remain "grandfathered". Please see the External Review procedures in the SPD for further information.

Where do I go to get more help, file a complaint, or resolve billing disagreements?

If you have a question about the No Surprises Act or believe the law is not being followed, contact the Centers for Medicare & Medicaid Services No Surprises Help Desk at 1-800-985-3059 from 5 am to 5 pm PST, 7 days a week, to submit your question or a complaint. You can also submit a complaint online.

If you still need help with your health insurance and have a problem or question, contact your state Consumer Assistance Program. These programs help consumers experiencing problems with their health insurance or seeking to learn about health coverage options.

NEW MEMBERSHIP CARDS

Because the No Surprises Act requires new membership cards, the trust will issue you new member identification cards that will show your overall Plan deductible, overall out-of-pocket maximum and consumer contact information.

CONTINUITY OF CARE

You are allowed up to 90 days of continued coverage at the in-network cost-sharing amount (to allow you to transition your care to an in-network provider/facility) if your provider or facility drops out of the Anthem PPO network while you are:

- Undergoing a course of treatment *or* a course of institutional or inpatient care from that provider or facility for a serious and complex condition;
- Scheduled to undergo non-elective surgery from that provider or facility, including post-operative care from such provider or facility with respect to that surgery;
- Pregnant and undergoing treatment for pregnancy from that provider or facility; or
- Determined to be terminally ill and receiving treatment for this illness from that provider or facility.

If you are undergoing care and a contract terminates, you will receive notification from the Plan and must elect continued coverage in writing according to the notice.

IN-NETWORK PROVIDER DIRECTORY

A list of in-network providers is available to you without charge on the Anthem Blue Cross website – htts://www.anthem.com/ca/findcare or by calling the Anthem Blue Cross phone number on your new East Bay Drayage Drivers Security Fund membership card. The Anthem "Prudent Buyer" network consists of providers, including hospitals of varied specialties as well as general practice.

NEW TRUSTEE

Since the last Summary of Material Modifications, the following change has been made to the Board of Trustees. Employer Trustee Mike Carnefix resigned from the Board and was replaced by Deb Ostendorp, Labor Relations Manager, United Parcel Service (UPS), 6177 N. Basin Avenue, Portland, OR 97217.

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Si usted gustaría una copia en español, por favor de contactar la oficina de administración de East Bay Drayage Drivers Security Fund.

"GRANDFATHERED" PLAN (Not Applicable to Plan 2016)

Because East Bay Drayage Drivers Security Fund medical Plans 1980 and 2002 are "grandfathered health plans," we are required by law to provide this notice to you: The East Bay Drayage Drivers Security Fund believes your Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans -- for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act -- for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Trust Fund Office at 1-800-528-4357. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

IMPORTANCE OF THIS DOCUMENT

This Notice is intended to amend all East Bay Drayage Drivers Security Fund documents, notices and correspondence, including (but not limited to) the Summary Plan Description (SPD). This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the SPD. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of your Plan. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under East Bay Drayage Drivers Security Fund Plans, or any benefits provided under the Fund's Plan, in whole or in part, at any time and for any reason.

East Bay Drayage Drivers Security Fund

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January 19, 2023

PLAN CHANGE NOTICE – Plan 1980, Plan 2002, Plan 2016 and Retiree Plan

Summary of Material Modifications

Diabetes Coverage -- Omnipod Insulin Pump Devices and Continuous Glucose Monitors

Effective January 1, 2023

TO ALL PLAN PARTICIPANTS, DEPENDENTS and COBRA PARTICIPANTS in the Indemnity Option in all Plans and Kaiser Participants in Plan 1980 only:

Your prescription drug benefit is provided through the Fund's pharmacy benefits manager, **Elixir**. Effective January 1, 2023, if your doctor prescribes an **Omnipod insulin pump device** (such as Omnipod 5 or Omnipod DASH) or a **continuous glucose monitor** (such as Freestyle Libre and Dexcom), these devices and supplies will be covered under the ***pharmacy*** benefit instead of the ***medical*** benefit. In other words, these devices will be covered by Elixir, and not by Anthem Blue Cross or Kaiser. (However, if you are in Plan 2002 or 2016, this does NOT apply to you because your prescription drug benefits are provided by Kaiser.)

Elixir, the pharmacy benefits manager, will handle all prior authorization and medical necessity review for these products. You will pay the same copayment you pay for a brand name drug for the device and any supplies or refills.

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Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Fund Office at (855) 263-7242.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Fund Office. In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

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Plans 1980 and 2002 are "Grandfathered Health Plans"

The East Bay Drayage Drivers Fund Board of Trustees has concluded that Plans 1980 and 2002 are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the address listed on this notice. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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PLAN CHANGE NOTICE
Summary of Material Modifications
Plan Changes Related to the End of the COVID-19 Public Health Emergency and National Emergency
RETAIN WITH YOUR BENEFIT PACKAGE FOR FUTURE REFERENCE

April 2023

To: **Plan Participants, Covered Dependents, and COBRA participants in the Anthem Blue Cross PPO Medical Plan**

(If you are enrolled in Kaiser or Anthem Blue Cross HMO, the plan will provide information on how it is implementing the changes described in this Notice.)

END OF THE COVID-19 PUBLIC HEALTH EMERGENCY AND NATIONAL EMERGENCY ("COVID-19 EMERGENCY")

COVID-19 emergency declarations have been in place since early 2020. The declarations required health plans to cover COVID-19 tests and vaccines without cost sharing and extended many Plan deadlines. Some of these changes were intended to be temporary and only in effect during the COVID-19 Emergency. **The COVID-19 Emergency has now ended**. Changes to your Plan as a result of the end of COVID-19 Emergency are described below:

COVID-19 Vaccines: One thing that will *not* change: If you go to an in-network provider, COVID-19 **vaccines and boosters provided by *an in-network provider* will be covered at no out-of-pocket cost as a preventive care service – that includes both the vaccination/booster itself and the cost of administration of the vaccination or booster**. In other words, both the cost of vaccinations or boosters and the fee for putting the shot in your arm are covered at no cost if you use an *in-network* provider. For this purpose, an "in-network provider" will include major pharmacy chains like CVS, Rite Aid, and Walgreens.

The following changes are effective immediately:

- **COVID-19 diagnostic tests (excluding OTC COVID-19 tests):** Your Plan's usual cost-sharing and medical management will apply to in-network COVID-19 diagnostic tests in the same way they apply to other lab services. This means the Plan will pay 80% of the out-of-network allowed amount after the deductible is met.

- **Over-The-Counter ("OTC") COVID-19 home testing kits:** Reimbursement for over-the-counter COVID-19 home test kits will end.

Plan Deadlines

With the end of the National Emergency, the suspension of the Plan's deadlines for COBRA election and payment, special enrollment, filing claims and appeals and requests for external review will come to an end. During the COVID-19 Emergency, plans were required to disregard the "Outbreak Period" for up to one year when calculating certain plan deadlines. The Outbreak Period will end on July 10, 2023, and after that date ordinary deadlines for COBRA election

(election within 60 days after receiving a COBRA notice and within 45 days after election to make your initial COBRA payment), special enrollment (30, and in some cases, 60 days), claims (within one year) and appeals (within 180 days) or requests for external review (within 4 months) will apply as follows:

- For COBRA election and payment, special enrollment, claims and appeals or requests for external review arising during the National Emergency, the timelines listed above start to run as of July 10, 2023.

- For COBRA election and payment, special enrollment, claims and appeals or requests for external review arising after July 10, 2023, the normal Plan deadlines apply.

Examples:

Example 1 Benefit Claim – You are covered in the Anthem Blue Cross PPO Medical Plan and your EBDDSF claim for benefits was denied on September 30, 2022. Your deadline to file an appeal of that denial is 180 days after July 10, 2023 (the end of the Outbreak Period), which is January 6, 2024.

Example 2 Special Enrollment – You are covered in the Anthem Blue Cross PPO Medical Plan and your spouse gave birth to a newborn on August 2, 2022, but you never enrolled the baby for coverage as an EBDDSF dependent. You must complete your special enrollment of the newborn within 30 days after July 10, 2023, which is August 9, 2023.

Please note that there is a special 60-day enrollment period when someone loses Medicaid or CHIP coverage.

If you have questions about which deadlines apply to you, call the Plan Administrative Office at 855-263-7242.

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comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at 1-800-528-4357. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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PLAN CHANGE NOTICE
Summary of Material Modifications
Plan Changes Related to DeltaCare Dental Option
RETAIN WITH YOUR BENEFIT PACKAGE FOR FUTURE REFERENCE

November 22, 2024

To: **Plan Participants, Covered Dependents, and COBRA participants**

At the end of this year the Fund's contract for the DeltaCare Dental prepaid dental coverage option will end and will not be renewed. **If you are enrolled in the DeltaCare dental option, as of January 1, 2025 you will be enrolled for dental coverage in the Plan's Self-Funded dental option**.

Coverage under the Plan's Self-Funded dental option is not prepaid, so you can choose any dentist you like, however,

- **You can use your existing DeltaCare dentist, but your benefits will be payable according to the terms of the Self-Funded dental option (attached)**; **and**

- Your dental out-of-pocket costs will be lower if you use an Anthem Blue Cross Dental PPO Network dentist. A list of Anthem dentists can be found at https://www.anthem.com/ca/provider/dental/

A table comparing Self-Funded dental benefits vs. DeltaCare benefits is attached.

Call Corcoran Administrators at (855) 263-7242 or (925) 954-1439 if you have any questions about this notice.

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Encl.

November 2024

DENTAL BENEFITS COMPARISON CHART

Dental Services	Self-Funded Dental Program	DeltaCare
Providers	Your choice of dentist. Potential discounts and elimination of balance billing if dentist is an Anthem Dental Network provider.	Must use DeltaCare USA dentists
Annual Deductible	None	None
Annual Out-of- Pocket Maximum	None	None
Annual Maximum	None	None
Lifetime Maximum	None (except Orthodontia)	None (except Orthodontia)
Percentage of Claims Covered	90% of contract rate if Network Dentist is used; 90% of amount Plan determines to be Usual, Customary and Reasonable ("UCR") if Network Dentist is not used	Paid in full (subject to the limitations and exclusions of the benefit schedule)
Orthodontia	70% of contract rate if Network provider is used; 70% of amount Plan determines to be UCR if not. Up to a lifetime maximum of $3,000 per person	Subject to $350 "start-up" fee; covers up to $1,800 in orthodontia services covered for adults and covered dependent children age 19 or older and up to $1,600 for dependents under age 19
Preventative Dentistry Teeth cleanings, fluoride application, annual exams	Cleanings twice in a 12-month period and dental exams twice in a 12-month period Fluoride – two in a 12-month period for children through age 17	Cleanings once in a six-month period and dental exam once in a twelve-month period
Diagnostics Oral exams, X-rays	Unless special need is shown, full-mouth X- rays are covered only once in a 5-year period Bitewing X-rays are covered only twice in a 12-month period for children to age 18, or once every 12 months for adults age 18 and over	Full mouth X-rays are limited to one set every 24 consecutive months and include any combination of periapicals, bitewings and/or panoramic film Bitewing X-rays are limited to no more than one series of four films in any six-month period
Cosmetic Dentistry	Generally excluded; however, crowns, jackets, inlays, onlays and cast restorations are covered benefits on the same tooth only once every 5 years	Generally excluded; however, crowns, inlays, onlays and cast restorations are covered benefits on the same tooth only once every 5 years
Endodontics Treatment of teeth, pulp and roots	Generally covered if required in accordance with professionally recognized standards of dental practice	Generally covered if required in accordance with professionally recognized standards of dental practice

Dental Services	Self-Funded Dental Program	DeltaCare
Periodontics Treatment of the teeth, gums and jaw	Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by the Plan. However, if implants are provided along with a covered prosthodontic appliance, the Plan will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances	Periodontal scaling and root planing are limited to four quadrants during any 12-month period Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered
Major Care Crowns, jackets, inlays, onlays and cast restorations	Major Care covered once every five (5) years only if provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations.	Crowns and jackets No Cost Inlays and onlays (metallic) No Cost Inlays and onlays (non-metallic) Optional, Additional Fees apply Cast Restorations No Cost
Prosthodontics Construction or repair of fixed bridges, partial dentures and complete dentures	Prosthodontic appliances are covered only once every 5 years, unless the Plan concludes that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory	Copay of up to $50.00 may apply The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is a benefit once every 5 years
Oral Surgery Extractions and other surgical procedures, including pre- and post-operative care	Generally covered if required in accordance with professionally recognized standards of dental practice	Generally covered if required in accordance with professionally recognized standards of dental practice
Sealants Topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay	Limited to dependent children under age 14 Applicable to posterior teeth only	Benefits for sealants include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars through age nine and second molars through age 15 Benefits for sealants do not include the repair or replacement of a sealant on any tooth within 3 years of its application
For More Details	See description of specific benefits below or call the Administration Office with questions	See DeltaCare Evidence of Coverage and Disclosure Form for complete details

East Bay Drayage Drivers Security Fund

P O Box 5030
Walnut Creek, CA 94596

Phone (855) 263-7242 Phone (925) 954-1439

PLAN CHANGE NOTICE
Summary of Material Modifications
Plan Changes Related to Your Prescription Drug Benefits
RETAIN WITH YOUR BENEFIT PACKAGE FOR FUTURE REFERENCE

December 2025

To: Plan **Participants, Covered Dependents, and COBRA participants**

Effective February 1, 2026, the Fund will replace its prescription drug "pharmacy benefits manager" MedImpact. As of February 1, your Plan's pharmacy benefits manager will be ProAct **Rx**.

ProAct Rx will send you more information -- including your new prescription drug card -- in a separate mailing. The **ProAct Rx** card should be used for any prescriptions filled on or after February 1, 2026. Please do not use your MedImpact card after this date and to avoid confusion, please destroy your MedImpact card on February 1, 2026.

On and after February 1, 2026, **mail order** and **specialty** prescriptions will also be filled by **ProAct Rx**. Information on filling your mail order and specialty prescriptions will be included in the **ProAct Rx** mailing. **If you have a current prescription with MedImpact as of January 1, 2026, the Fund will transfer that prescription automatically to ProAct Rx. You do not have to do anything to transfer your current MedImpact prescription to ProAct Rx.**

Also effective **January 1, 2026**, the Plans are amended to contain the following additional prescription drug exclusion:

> The Plan does not cover GLP-1 medications (including but not limited to GLP-1 drugs known by the trade names Ozempic, Wegovy, Mounjaro, Zepbound and Trulicity), prescribed for weight loss, obstructive sleep apnea, or because you have been determined to be "pre-diabetic." The Plan will continue to cover GLP-1s for treatment of: (1) diabetes if you have a documented diagnosis of Type 2 diabetes, or (2) cardiovascular disease if you have a documented risk of cardiovascular disease and a documented cardiovascular incident. Coverage is subject to prior authorization by the Plan PBM and to all applicable Plan provisions.

Call Corcoran Administrators at (855) 263-7242 if you have any questions about this notice.

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Si usted gustaría una copia en español, por favor de contactar la oficina de administración de East Bay Drayage Drivers Security Fund.

IMPORTANCE OF THIS DOCUMENT

This Notice is intended to amend all EBDDSF documents, notices, and correspondence, including (but not limited to) the Summary Plan Description (SPD). This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the SPD. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of your EBDDSF Plan. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate, or interpret and decide all matters under the Fund's Plans, or any benefits provided under the Fund's Plans, in whole or in part, at any time and for any reason.

"GRANDFATHERED" PLAN (Not Applicable to Plan 2016)

Because East Bay Drayage Drivers Fund medical Plans 1980 and 2002 are "grandfathered health plans," we are required by law to provide this notice to you: The East Bay Drayage Drivers Fund believes your Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Fund Office at 1-800-528-4357. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Encl.