CALIFORNIA FREIGHT

2019 Employee Benefits

January 1, 2019 – December 31, 2019

The California Freight plans provides basic protection through a core group of benefit plans. The majority of the costs of these plans are paid for by California Freight. You may add several options to this foundation and purchase them via payroll deduction.

Stay Healthy

- Comprehensive Major Medical Plans - PPO & HMO options
- Prescription Coverage - CVS Caremark
- Telephonic medical services - Teladoc
- Dental Plan - Premier Access
- Vision Plan - VSP

Eligibility

Initial Eligibility

You are eligible for California Freight's plans if you are classified as a full-time employee working 30-hours or more per week.

Dependent Eligibility
You may enroll your eligible dependents in the same medical plan you choose for yourself. Eligible dependents include your legally married spouse, and your dependent children up to age 26.

How and When to Enroll

You become eligible for coverage on the first of the month following 30 days from your date of hire with California Freight.

If you do not enroll for coverage during your eligibility period you will not receive health coverage during the plan year; unless you experience a qualified family status change *(see - Making changes during the year for details)*.

Making changes during the year

The choices you make when you first become eligible remain in effect for the entire plan year – January 1, 2019 through December 31, 2019. Once you are enrolled, you must wait until the next Open Enrollment Period to change your benefits or add or remove coverage for dependents unless you have a qualified family status change as defined by the IRS.

Examples include, but are not limited to, the following:

- Marriage, divorce, annulment
- Birth or adoption of a child Death of your spouse
- Loss of other health coverage due to HIPAA Special Enrollment Situations
- Changes in your dependent(s) eligibility status because of age, etc.

You must notify the HR department within 31 days of your qualified family status change to make eligible changes in your coverage.

California Freight PPO - Platinum

Platinum	In-Network		Out-of-Network
Deductible – you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. **Out-of-Pocket** – The out-of-pocket limit is the most you could pay in a year for covered services.	$0 $2,500 Individual $5,000 Family		$0 $5,000 Individual $10,000 Family
Primary Care Office Visit	$10 co-pay		40% co-insurance
Urgent Care Services	$10 co-pay		$25 co-pay
Specialist Office Visit	$25 co-pay		40% co-insurance
Chiropractic Care	50% co-insurance 12 Visits/Calendar Year		50% co-insurance 12 Visits/Calendar Year
Outpatient Hospital Facility Services	10% co-insurance		40% up to $350 per day
Inpatient Hospital Facility Services	10% co-insurance		40% up to $2,000 per day
Emergency Room	$100 co-pay per visit plus 10% co-insurance		$100 co-pay per visit plus 40% co-insurance
Diagnostic Lab & X-Ray	10% co-insurance		40% co-insurance
Prescription Drug Coverage	**Retail** 30 day	**Mail Order** 90 day	Not Covered
Rx Generic **Rx Preferred** **Rx Non-Preferred** **Rx Specialty**	$5 co-pay $20 co-pay $40 co-pay 30%; max $250	$10 co-pay $40 co-pay $80 co-pay 30%; max $250	

Please note: *This chart is just a brief overview of benefits and coverage for the above plan. You should also look at the detailed disclosure/summary documents for each plan, available from your Human Resources Representative.*

California Freight PPO - Gold

Gold	In-Network		Out-of-Network
Deductible – you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. **Out-of-Pocket** – The out-of-pocket limit is the most you could pay in a year for covered services.	$750 Individual $1,500 Family $6,500 Individual $13,000 Family		$1,500 Individual $3,000 Family $10,000 Individual $20,000 Family
Primary Care Office Visit	$20 co-pay Deductible waived		40% after deductible
Urgent Care Services	$20 co-pay Deductible waived		$35 co-pay Deductible waived.
Specialist Office Visit	$35 co-pay Deductible waived.		40% after deductible
Chiropractic Care	50%, Deductible waived 12 Visits/Calendar Year		50%, Deductible waived. 12 Visits/Calendar Year
Outpatient Hospital Facility Services	20% after deductible		40% after deductible
Inpatient Hospital Facility Services	20% after deductible		40% co-insurance up to $2,000 per day after deductible
Emergency Room	$150 co-pay plus 20% after deductible		$150 co-pay plus 40% after deductible
Diagnostic Lab & X-Ray	20% after deductible		40% after deductible
Prescription Drug Coverage Deductible - $200 Individual/$400 Family	**Retail** 30 day	**Mail Order** 90 day	Not Covered
Rx Generic (after deductible) **Rx Preferred (after deductible)** **Rx Non-Preferred (after deductible)** **Rx Specialty (after deductible)**	$10 copay $30 copay $50 copay 30%; max $250	$20 copay $60 copay $100 copay 30%; max $250	

Please note: *This chart is just a brief overview of benefits and coverage for the above plan. You should also look at the detailed disclosure/summary documents for each plan, available from your Human Resources Representative.*

California Freight PPO - Silver

Silver	In-Network		Out-of-Network
Deductible – you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. **Out-of-Pocket** – The out-of-pocket limit is the most you could pay in a year for covered services.	$1,700 Individual $3,400 Family $6,500 Individual $13,000 Family		$3,400 Individual $6,800 Family $10,000 Individual $20,000 Family
Primary Care Office Visit	$40 co-pay Deductible waived.		50% after deductible
Urgent Care Services	$40 co-pay Deductible waived		$50 co-pay Deductible waived
Specialist Office Visit	$50 copay Deductible waived		50% after deductible
Chiropractic Care	50% co-insurance Deductible waived		50% co-insurance Deductible waived
Outpatient Hospital Facility Services	30% after deductible		50% after deductible
Inpatient Hospital Facility Services	30% after deductible		50% co-insurance up to $2,000 per day after deductible
Emergency Room	$200 co-pay plus 30% after deductible		$200 co-pay plus 50% after deductible
Diagnostic Lab & X-Ray	30% after deductible		50% after deductible
Prescription Drug Coverage Deductible - $300 Individual/$600 Family	**Retail** 30 day	**Mail Order** 90 day	Not Covered
Rx Generic **Rx Preferred** **Rx Non-Preferred** **Rx Specialty**	$15 copay $50 copay $75 copay 30%; max $250	$30 copay $100 copay $150 copay 30%; max $250	

Please note: *This chart is just a brief overview of benefits and coverage for the above plan. You should also look at the detailed disclosure/summary documents for each plan, available from your Human Resources Representative.*

What You Need To Know About The PPO

1. **Choose the plan of your choice:**
    a. Platinum
    b. Gold
    c. Silver

2. **Find a medical provider that is contracted with:**

3. **All claims inquiries contact:**

4. **All prescription inquires contact:**

Cigna Provider Search – 4 Easy Steps

1. *GO TO* www.cigna.com

2. *CLICK* 

3. *Under* Not a Cigna Customer Yet?

   SELECT 'Plans through your employer'

4. *CLICK* 'PICK'

   Under MEDICAL PLANS - *SELECT* 'PPO'

   SELECT medical need type from the POPULAR SEARCHES list

Direct Link to Cigna Network FIND PROVIDERS webpage: http://sblp.biz/cigna

CoreSource

For all questions related to your medical claims please contact CoreSource.

1. Call 866.364.3544 and have your medical card with your Group/Employee ID available
2. Visit www.mycoresource.com, click on “I am a Participant" – Create My Account

3. Download the myCoreSource Mobile app:

CVS Caremark

For all of your prescription coverage inquiries please contact CareMark.

1. Call 866.644.7527 and have your medical card available

2. Visit www.caremark.com and register for an account so you can order prescription refills, check drug cost and coverage and find ways to save on your medications

3. Download the CVS Caremark mobile application through the Apple App Store or Google Play

Teladoc

Speak to a licensed doctor by web, phone or mobile app in minutes

TREAT MANY CONDITIONS

- Sinus problems
- Bronchitis
- Allergies
- Cold and flu symptoms
- Respiratory infection
- Ear infection
- **And more!**

Learn more about Teladoc:

Teladoc.com

1-800-Teladoc (835-2362)

Teladoc.com/mobile

Facebook.com/Teladoc

Set up an account
Visit the Teladoc website and click "Set up account".

Provide medical history
Log in and complete the "My Medical History" tab.

Request a consult
A Teladoc doctor is always just a call or click away.

Pay the same low co-pay as an office visit, without driving to the doctor's office and waiting for a doctor to see you!

- Platinum members $10 co-pay
- Gold members $20 co-pay
- Silver members $40 co-pay

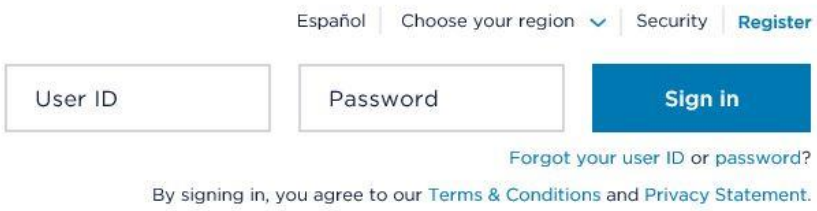
California Freight Kaiser HMO

Kaiser - Gold	In-Network		Out-of-Network
Deductible – you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. **Out-of-Pocket** – The out-of-pocket limit is the most you could pay in a year for covered services.	$0 $3,000 Individual $6,000 Family		Not Covered
Primary Care Office Visit	$30 co-pay		Not Covered
Urgent Care Services	$30 co-pay		Not Covered
Specialist Office Visit	$30 copay		Not Covered
Preventive Care	No Charge		Not Covered
Outpatient Surgery & Procedures	$250 per procedure		Not Covered
Inpatient Hospital Facility Services	$500 per day		Not Covered
Emergency Room	$150 per visit		$150 per visit
Diagnostic Lab & X-Ray	$10 per encounter		Not Covered
Prescription Drug Coverage	**Retail** 30 day	**Mail Order** 100 day	Not Covered
Rx Generic **Rx Brand-Name** **Rx Specialty**	$10 copay $30 copay $30 copay	$20 copay $60 copay	

KAISER PERMANENTE

1. Call 800.464.4000 and have your medical card available

2. Visit www.kp.org and register for an account so you can find doctors, view medical records, setup appointments, message a doctor, etc.



3. Download the Kaiser Permanente mobile app throught the Apple Store or Google Play

Premier Access Dental

	PCN	**PPO**	**Non-Network**
Calendar-year deductible (3 per family) (Does not apply to preventive services)	**$0**	**$0**	**$50**
Calendar Year Maximum	**$1,500**	**$1,500**	**$1,500**
Preventive Services • Routine oral examinations • Routine X-rays • Cleanings • Fluoride • Sealants • Space maintainers	**100%**	**100%**	**100%**
Basic Services • Fillings • Oral Surgery • Repairs – Crowns & Inlays • Brush Biopsy • Surgical Periodontics • Endotonics – Root Canals	**100%**	**90%**	**80%**
Major Services • Crowns • Inlays/onlays • Bridges • Dentures • Bridge and Denture Repairs	**70%**	**60%**	**50%**
Orthodontia	**50%** **Child (<19) Only**		
Ortho Lifetime Maximum	**$1,000**		
Waiting Period	**No Benefit Waiting Period for Major for Timely Applicants**		

*PCN – Premier Choice Network
*PPO – Preferred Provider Organization
*Non-Network – Not in the Premier Choice network of doctors

Please note: *This chart is just a brief overview of benefits and coverage for the above plan. You should also look at the detailed disclosure/summary documents for each plan, available from your Human Resources Representative.*

VSP Vision

	**VSP Choice Network**	
Covered Charges	**Benefit**	**Frequency**
Exams	$10 copay	One exam every 12 months
Prescription Glasses	$25 copay	
Lenses	Single vision, lined bifocal and lined trifocal lenses. Polycarbonate lenses for dependent children Members pay for lens enhancements as an out-of-pocket expense after the copay; they are discounted 35-40% by VSP providers. ***	Two lenses (one pair) every 24 months
Frames	$130 allowance for a wide selection of frames; 20% off amount over allowance	One set every 24 months
Elective Contacts	Up to $60 copay for your elective contact lens exam (fitting and evaluation) $130 allowance for elective contacts	Once every 24 months Contacts are instead of frames and lenses
Additional Savings* **		
Glasses and Sunglasses	Members save 20-25% off additional glasses and sunglasses, including lens options, from VSP providers within 12 months of your last Wellvision exam.	
Laser Vision Correction	Average 15% off regular price or 5% off promotional price at contracted facilities.	

VSP Vision

Your Coverage with Other Providers (Non-Network)	
Covered Charges	**Scheduled Benefit Amount**
Vision Exams	Up to $50
Single Vision Lenses	Up to $50
Lined bifocal Lenses	Up to $75
Lined trifocal Lenses	Up to $100
Progressive Lenses	Up to $75
Frames	Up to $70
Elective Contacts	Up to $105

Please note: *This chart is just a brief overview of benefits and coverage for the above plan. You should also look at the detailed disclosure/summary documents for each plan, available from your Human Resources Representative.*

How Do I Find a VSP Provider?

Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800.877.7195.

Employee Contributions

Medical Plan	Enrollment Status	Monthly Cost	Per Pay Period
Platinum	Employee Only	$70.85	$32.70
	2 Party	$494.89	$228.41
	Family	$599.99	$276.92
Gold	Employee Only	$59.04	$27.25
	2 Party	$412.40	$190.34
	Family	$500.00	$230.77
Silver	Employee Only	$47.23	$21.80
	2 Party	$329.94	$152.28
	Family	$400.01	$184.62
KAISER PERMANENTE®	Employee Only	$59.04	$27.25
	2 Party	$412.40	$190.34
	Family	$500.00	$230.77

Dental & Vision	Enrollment Status	Monthly Cost	Per Pay Period
PREMIER ACCESS	Employee Only	$4.59	$2.12
	Emp/Spouse	$17.88	$8.25
	Emp/Child(ren)	$21.02	$9.70
	Family	$34.32	$15.84
vsp	Employee Only	$.85	$.39
	Family	$6.02	$2.78

Glossary

We use a lot of terms when talking about health coverage. This glossary should help you understand most of them. As always, if you have questions, please feel free to email our benefits team at ebdcomm@capax.com.

Co-insurance – Your share of costs for a covered healthcare service, calculated as a percent (say 20%) of the allowed amount for the service. You pay co-insurance after the deductible has been satisfied. For example, if the plan allows $100 for an office visit, co-insurance at 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-payment – A fixed amount (for example, $25) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered service.

Deductible – The amount you pay for services before your health insurance or plan begins to pay. *NOTE: The deductible may not apply to all covered services. For example, preventive care is covered at 100% before the deductible has been satisfied.*

Out-of-Pocket Maximum – The most you can pay during a calendar year before your health insurance plan begins to pay 100% of the covered services for the remainder of the year. This limit doesn't include your premium, services your plan doesn't cover or charges from non-network providers the plan doesn't cover.

Medically Necessary – Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
Network – The facilities, providers, and suppliers your health insurer has contracted with to provide healthcare services.

Out-of-network providers– A provider who doesn't have a contract with your health insurer. You'll pay more to see an out-of-network (or non-preferred) provider.

In-network providers – A provider who has a contract with your health insurer to provide services to you at a discount. These providers are also referred to as "preferred providers."

Premium – The monthly amount paid to an insurance carrier for coverage. If you're enrolling only yourself on the plan, Innov8 pays this entire amount. If you're enrolling dependents, you and Innov8 will both contribute to their premium costs.

Preventive Services – Routine healthcare that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Refer to the Preventive Services section of your health plan summary for additional information.

Provider – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional, or healthcare facility licensed, certified or accredited as required by state law.

Vendor Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general questions please contact the Human Resources department.

Note: viewing on screen, you can click any link to view the website or send an email.

MEDICAL: CALIFORNIA FREIGHT PPO
Provider Name: CoreSource
Group #: FR0000
Phone Number: 866-364-3544
Para Español: oprima 1, oprima 370000
Website: www.mycoresource.com

MEDICAL: KAISER HMO
Provider Name: Kaiser Permanente
Group #: 705462
Phone Number: 800-464-4000
Para Español: oprima 2
Website: www.kp.org

DENTAL:
Provider Name: Premier Access
Group #: 101964
Phone Number: 888-715-0760
Para Español: oprima 1, oprima 4, oprima 2
Website: www.premierlife.com

VISION:
Provider Name: VSP
Group #: 12113901
Phone Number: 800-877-7195
Para Español: oprima 9
Website: www.vsp.com

CALIFORNIA FREIGHT HUMAN RESOURCES:
Contact Name: Audrey Black
Phone Number: 209-599-5023
Email: ablack@calfreight.com

Insurance Broker: Capax - Giddings, Corby, Hynes Inc

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