WESTERN STATES TRUCKING ASSOCIATION

Member Benefits Guide

Association Dental & Vision Plan

Plan Year 12/1/2026 – 11/30/2027



Western States Trucking Association

Since 1941

Benefits administered with Beni Global Insurance Services

Welcome

WSTA Association Member Dental and Vision Plans

This guide provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact Human Resources.

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Important Information

The Affordable Care Act and You – California & Federal Individual Mandates

California law, effective January 1, 2020, requires California residents to maintain qualifying health coverage or pay a penalty when they file their state tax return. The penalty is the greater of a flat dollar amount (for the 2025 tax year, $950 per adult and $475 per dependent child; amounts are adjusted annually) or 2.5% of household income.

The federal individual mandate, the Affordable Care Act (ACA) requirement that nearly every American be enrolled in medical coverage or pay a penalty, has carried no penalty since 2019.

The Health Insurance Marketplace

Because WSTA medical plans are considered affordable and meet minimum value under Health Care Reform, you will not generally see lower premiums or out-of-pocket costs through the Marketplace. In addition, employer contributions to your medical benefits will be lost if you choose to purchase coverage through the Marketplace, and your portion of medical premiums will no longer be paid via payroll deductions on a pre-tax basis. For more information on your coverage options, please visit www.healthcare.gov.

Enrollment Information

Who May Enroll?

If you are a regular full-time employee working at least 30 hours per week, you and your eligible dependents may participate in the WSTA benefits program. Eligible dependents include:

- Legally married spouse
- Registered domestic partner
- Child(ren) under age 26, regardless of student or marital status

When Can You Enroll?

- As a new hire, on the 1st of the month following 30 days from your date of hire
- Each year during Open Enrollment
- Within 30 days of a "Qualifying Event" as defined by the IRS (see Changes to Enrollment)

How to Enroll

Complete the Universal Enrollment Form provided with this guide and email it to **all four** recipients below:

1. Dianna@aadrugtesting.com
2. Vanessa@beniglobal.com
3. Elena@beniglobal.com
4. Valeria@beniglobal.com

Changes to Enrollment

Our plans are effective 12/1/2026. Each year, during the annual Open Enrollment period, you can make new benefit elections for the following plan year. Once you make your election(s), you cannot change them during the year unless you experience a "Qualifying Event" as defined by the IRS, such as:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support court order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss or gain of other GROUP coverage
- Change in residence or workplace
- Loss of coverage through Medicaid or the Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. You have 30 days from a Qualifying Event to update your coverage; please contact the Human Resources Department immediately to complete the appropriate election forms. If you do not update your coverage within 30 days, you must wait until the next annual Open Enrollment period.

Termination of Benefits for Nonpayment

Members are responsible for making premium payments on time; failure to do so will result in cancellation of benefits. Premiums are due to WSTA on the 15th of each month and are past due if not received by WSTA on or before the 15th. You have a 30-day grace period to pay past-due premiums; to ensure continued coverage and claims service, payment must be received in the WSTA office by the end of the grace period.

If past-due premiums are not paid by the end of the 30-day grace period, benefits will be automatically cancelled, and you will not be able to re-enroll until Open Enrollment for the next plan year (benefits effective December 1).

Resources and Contacts

Below are your insurance carrier and broker contacts should you need help with your benefit questions after open enrollment. If you are unable to resolve an issue with the carrier, please contact the Human Resources Department.

Guardian

Dental & Vision
Group #00554633

Member Services
800-541-7846

Carrier Website
guardiananytime.com

Beni GLOBAL

Benefits Broker

Vanessa Garcia, Account Executive
Vanessa@beniglobal.com

Elena Delgado, Account Coordinator
Elena@beniglobal.com

Valeria Gomez, Account Coordinator
Valeria@beniglobal.com



Dental Benefits

Guardian Dental Insurance

With the Guardian Preferred Provider Organization (PPO) dental plan, you may visit a PPO dentist and benefit from negotiated rates, or visit an out-of-network dentist. In-network dentists keep your out-of-pocket expenses lower. If you use an out-of-network dentist, you will be responsible for the difference between the covered amount and the actual charges, and you may need to file claims.

How to find a provider: visit www.guardianananytime.com/fpapp/search and search by city or zip code. For HMO providers, select plan type Managed Dental Care (DHMO/Prepaid); for PPO providers, select PPO: DentalGuard Preferred.

Benefit Summary*	Managed Dental Care (DHMO)	DentalGuard Preferred – Low		DentalGuard Preferred – High	
	Network only	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible – Individual	No deductible	$50	$50	$50	$75
Deductible – Family limit	—	3 per family		3 per family	
Deductible waived for	—	Preventive	Preventive	Preventive	None
Preventive Care	You pay a copay for each covered procedure. See plan details for more information.	100%	100%	100%	100%
Basic Care		90%	80%	100%	80%
Major Care		60%	50%	60%	50%
Orthodontia		Not covered		Not covered	
Annual Maximum Benefit	—	$1,500	$1,500	$2,000	$2,000
Maximum Rollover	Not applicable	**Yes**		No	
Rollover threshold	—	$700		—	
Rollover amount	—	$350		—	
In-network-only rollover amount	—	$500		—	
Rollover account limit	—	$1,250		—	
Lifetime Orthodontia Maximum	Not applicable	Not applicable		Not applicable	
Office Visit Copay	$5	None		None	
Dependent Age Limit	26	26		26	

** The benefits listed above are only brief summaries and highlights. They do not fully describe the benefits coverage for your health and welfare plans. For more details, please refer to the plan's full Summary of Benefits. Use of out-of-network providers may not be covered, or may be covered at a reduced benefit level/rate. See the full Summary of Benefits for details.*

Monthly Rates*

Coverage Tier	DHMO	PPO Low	PPO High
Employee	$11.47	$45.83	$58.04
Employee + One	$21.81	$90.91	$115.13
Employee + 2 or more	$30.41	$150.54	$190.65

Dental Maximum Rollover

Save Your Unused Claims Dollars for When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement, detailing your account and those of your dependents, at www.GuardianAnytime.com.

The example below uses the DentalGuard Preferred – Low plan. The DentalGuard Preferred – High plan does not include Maximum Rollover.

Plan Annual Maximum	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1,500	**$700**	**$350**	**$500**	**$1,250**
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to the Plan Annual Maximum for future years	Additional dollars added to the Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,750 in total

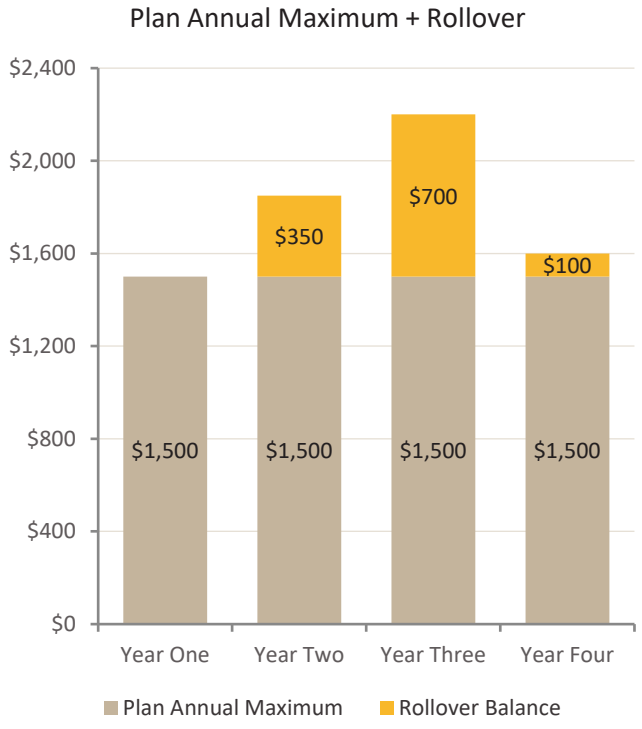
Here's How the Benefit Works

Year One: Jane starts with a $1,500 Plan Annual Maximum and submits $150 in dental claims. Because she stayed under the $700 threshold, she receives a $350 rollover for Year Two.

Year Two: Jane's Plan Annual Maximum is now $1,850. She submits $50 in claims and receives another $350 rollover.

Year Three: Jane's Plan Annual Maximum is now $2,200. She submits $2,100 in claims, and all are paid thanks to her Maximum Rollover Account.

Year Four: Jane's Plan Annual Maximum is $1,600 ($1,500 plus the $100 remaining in her Maximum Rollover Account).



For an overview of your dental benefits, see the Dental Benefits page of this guide.

Vision Benefits

Guardian / VSP Choice Network

The Guardian (VSP) vision plan provides professional vision care and high-quality lenses and frames through a broad network of optical specialists. You will receive richer benefits when you use a network provider. If you use a non-network provider, you will pay all charges at the time of your appointment and must file an itemized claim with Guardian (VSP).

Benefit Summary*	Guardian / VSP Choice Network
Network	VSP Choice Network
Exam Copay	$10 copay
Materials Copay	$10 copay
Frames Allowance	$130 allowance; 20% discount on any amount over $130
Contact Lens Allowance (in lieu of glasses)	$130 allowance; contact fitting & evaluation: 15% off UCR
Frequency – Exam	Every calendar year
Frequency – Frames	Every two calendar years
Frequency – Lenses	Every calendar year

Find a VSP doctor: Guardian uses the VSP Choice Network, which includes a large number of private-practice eye care doctors. Visit www.vsp.com/eye-doctor for the online provider list.

** The benefits listed above are only brief summaries and highlights. They do not fully describe the benefits coverage for your health and welfare plans. For more details, please refer to the plan's full Summary of Benefits. Use of out-of-network providers may not be covered, or may be covered at a reduced benefit level/rate. See the full Summary of Benefits for details.*

Monthly Rates*

Coverage Tier	VSP
Employee	$7.53
Employee + Spouse	$15.12
Employee + Child(ren)	$12.79
Employee + Family	$21.10



Annual Notices



ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. You will receive annual notices from our insurance carrier directly. For additional copies or if you have any questions, please contact the Human Resources Department. Below is a brief summary of the annual notices.

- **Summary of Benefits and Coverage (SBC):** Health insurance issuers and group health plans are required to provide you with an easy-to-understand summary of your health plan's benefits and coverage, to help you better understand and evaluate your health insurance choices.
- **Medicare Part D Notice of Creditable Coverage:** Plans are required to provide each covered participant and dependent a Certificate of Creditable Coverage to qualify for enrollment in Medicare Part D prescription drug coverage without a penalty when eligible. This notice also explains how to request and receive a Certificate of Creditable Coverage.
- **HIPAA Notice of Privacy Practices:** Informs you of the privacy practices followed by your group health plan and explains the federal privacy rights afforded to you and your family members as plan participants.
- **Women's Health and Cancer Rights Act (WHCRA):** Contains important protections for breast cancer patients who choose breast reconstruction with a mastectomy. Administered by the U.S. Departments of Labor and Health and Human Services, it applies to group health plans that provide medical and surgical benefits for a mastectomy.
- **Newborns' and Mothers' Health Protection Act:** The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.
- **Special Enrollment Rights:** Plan participants are entitled to certain special enrollment rights outside of the open enrollment period, including for loss of prior coverage or the addition of a new dependent.
- **Medicaid & Children's Health Insurance Program:** Some states offer premium assistance programs for those eligible for employer health coverage who are unable to afford the premiums. This notice explains how to determine whether your state offers a premium assistance program.

Notes

Your Benefits Broker

Beni GLOBAL

Understanding your employee benefits options can be confusing and complicated. Your Benefits Management Team at Beni Global and your Human Resources Department are here to provide answers and guidance as you navigate your benefit plans, from open enrollment to handling life's many changes.

Benefits Management Team

Vanessa Garcia
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CA License #0E04388
Vanessa@beniglobal.com

Elena Delgado
Account Coordinator
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This brochure provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment, nor is it a legal plan document.

In addition, the plans described in this brochure are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions about the benefit program, please contact the Human Resources Department.

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Any rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.