

 **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.ebddsfs.com or by calling 1-855-263-7242.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$300 per person per calendar year	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2000 per person per calendar year after deductible is met.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Deductibles; charges for services not covered by the Plan; and charges in excess of covered expense (UCR) for Non-PPO providers.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of Anthem Blue Cross network providers call 800-274-7767 or go to: www.anthem.com .	If you use an in-network hospital, doctor or other healthcare <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.

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East Bay Drayage Drivers Security Fund: Indemnity Plan Retiree Coverage Period: 08/01/2025 – 07/31/2026
Summary of Benefits & Coverage: What this Plan Covers & What it Costs Coverage for: Employee & Dependents | Plan Type: PPO

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 .
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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
	Specialist visit	20% coinsurance after deductible is met.		Treatment must be medically necessary.
	Other practitioner office visit	20% coinsurance after deductible is met.		Treatment must be medically necessary. Acupuncture is not covered for maintenance care.
	Preventive care/ screening/ immunization	0% coinsurance.	20% of UCR.	Preventive care services can be reviewed on: https://www.healthcare.gov/coverage/preventive-care-benefits/
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.

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	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling MedImpact at 833-656-1506	Generic drugs	\$10 copay.	100% of charges.	Injectables and other “Specialty” prescriptions are subject to pre-authorization with MedImpact.
	Preferred brand drugs	\$10 copay.		
	Non-preferred brand drugs	\$10 copay.		
	Specialty drugs	\$10 copay.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
	Physician/surgeon fees	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
	Emergency medical transportation	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
	Urgent care	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Subject to pre-authorization by Anthem Blue Cross.
	Physician/surgeon fee	20% coinsurance after deductible is met.		
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Subject to pre-authorization by Anthem Blue Cross for non-emergency care.
	Substance use disorder outpatient services	Not Covered.	Not Covered.	
	Substance use disorder inpatient services	Not Covered.	Not Covered.	
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Only employee or dependent spouse is covered.
	Delivery and all inpatient services	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Only employee or dependent spouse is covered.

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If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Coverage limited to a 90 day period following confinement in a hospital or a Convalescent Hospital.
	Rehabilitation services	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Treatment must be medically necessary.
	Habilitation services	Not Covered.	Not Covered.	
	Skilled nursing care	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Covered for up to one hundred (100) days per calendar year.
	Durable medical equipment	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	
	Hospice service	20% coinsurance after deductible is met.	20% of UCR after deductible is met.	Covered up to thirty (30) days. \$1500 max for outpatient care provided in the home.

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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 | • TMJ (Temporomandibular Joint Disorder) | • Cosmetic surgery |
| • Custodial care | • Hearing aids | • Illness or injury caused by third parties |
| • Maintenance Care | • 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
- Physical or Occupational Therapy
- Durable Medical Equipment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights will be limited in duration and will require you to pay a **premium**. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at: 1-877-474-5703. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For questions about your rights, this notice, or assistance, you can contact: The Administrative Office, PO Box 2330, Stockton, CA 95201 or 1-877-474-5703; 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 1-877-474-5703

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

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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	\$50
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$0
Total	\$50

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

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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.

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