

ILWU-PMA BENEFIT PLANS /

International Longshore & Warehouse Union –
Pacific Maritime Association www.benefitplans.org

1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109

PHONE (415) 673-8500

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ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan

June 16, 2023

TO: ILWU-PMA Welfare Plan Participants

FROM: Mario Perez, Director of Benefit Plans

SUBJECT: ILWU-PMA Coastwise Indemnity Plan Summary of Benefits and Coverage (SBC)

The enclosed Summary of Benefits and Coverage ("SBC") document provides information regarding some of your benefits under the ILWU-PMA Welfare Plan. This document includes information about covered benefits, costs, limitations, and other features.

This document is only a summary. You should refer to the ILWU-PMA Welfare Plan's Summary Plan Description, the Coastwise Indemnity Plan's Supplemental Summary Plan Description, the Chiropractic Benefit SSPD, and other applicable materials for additional information regarding benefits and coverage under the ILWU-PMA Welfare Plan, which are available at www.benefitplans.org.

Enclosure

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ILWU-PMA Watchmen Pension Plan

June 16, 2023

To: ILWU Oregon Area Locals 04, 08, 40, 92
ILWU Washington Area Locals 19, 23, 32, 47, 52, 98

From: Mario Perez, Director of Benefit Plans

Subject: Notice to All ILWU-PMA Welfare Plan Members Enrolled in the Coastwise Indemnity Plan in Oregon and Washington in Choice Ports


The attached notice and Summary of Benefits and Coverage (SBC) is being sent to Oregon and Washington Coastwise Indemnity Plan enrollees in Choice Ports. SBCs, in the format provided, are required by the Patient Protection and Affordable Care Act.

cc: Andrea Stevenson, Area Welfare Director
Martha Hendricks, Area Welfare Director

Attachment

A copy of this memo can be downloaded at www.benefitplans.org



 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.benefitplans.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call (415) 673-8500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 for PPO providers. \$100 individual/ \$300 family for non-PPO providers. Applies each July 1 – June 30.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. The Plan pays for 100% of Basic Benefits including hospital benefits, surgery and anesthesia, doctor visits, outpatient diagnostic X-ray and laboratory, and baby care (allowances may vary) before the deductible is applied.	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$1,000 per family for Non-PPO providers	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, charges over MAC, and health care that is not covered under this plan.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Yes. See https://www.fchn.com/Members or call 1-800-231-6935 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	After Basic Benefit Allowance (Allowance) and deductible, 20% co-insurance on balance of charge up to Maximum Allowable Charge (MAC)	Non-PPO limited to \$71.01 per visit, one visit per day, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
	Specialist visit	No Charge	After Allowance and deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to \$71.01 per visit, one visit per day, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information. Chiropractic visits only covered if provided by a FCHN provider. For a list of providers, see www.fchn.com and click on "Find Care", Search for "Chiropractor" and select "ILWU-PMA Coastwise Indemnity Plan" as the Employer Name. Limited to 40 chiropractic visits per Plan Year. Additional visits available if determined by the Plan's chiropractic consultant to be necessary.
	Preventive care/screening/immunization	No Charge	After deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to one each Plan Year up to \$400.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	After Allowance and deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to \$1,167.89 per condition each six months, renewing January 1 and July 1 of each year, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
	Imaging (CT/PET scans, MRIs)	No Charge	After Allowance and deductible, 20% co-insurance on balance of	

* For more information about limitations and exceptions, see the plan or policy document at www.benefitplans.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
			charge up to MAC	
If you need drugs to treat your illness or condition More information about prescription drug coverage at https://www.benefitplans.org/rxdrug.html .	Generic drugs	\$1 copay	\$1 copay	Limited to a 30-day supply for retail or 90-day supply for mail order. Compound drugs will only be covered if they are dispensed by an OptumRx Credentialed Pharmacy (information at www.benefitplans.org) and do not include excluded chemical compounds on the OptumRx Exclusion List (information at www.benefitplans.org). Compound prescriptions that cost more than \$1,000 will require prior authorization.
	Preferred brand drugs	\$1 copay	\$1 copay	
	Non-preferred brand drugs	\$1 copay	\$1 copay	
	Specialty drugs	\$1 copay	\$1 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No copay for first major surgical procedure; 50% of charge (up to MAC) for each lesser procedure	If referred by a PPO provider, non-PPO ambulatory surgery centers will be covered at 100% of charge (up to MAC). If referred to a non-PPO ambulatory surgery center by a non-PPO provider, the service will not be covered.
	Physician/surgeon fees	No Charge	After Allowance and deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to \$106.67 for each RVS unit up to \$21,334.00 per disability for surgeon, \$7,111.37 per disability for anesthesiologist, and 20% of the surgery allowance based on the RVS unit allowance up to \$4,266.80 per disability for Assistant Surgeon, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
If you need immediate medical attention	Emergency room care	No Charge	After Allowance and deductible, No Charge on balance of charge up to MAC	Patient may transfer to a PPO area as soon as medically safe and reasonable, or additional treatment will require 20% coinsurance.
	Emergency medical transportation	No Charge	After Allowance and deductible, No Charge on balance of charge up to MAC	Non-PPO limited to \$863.18 per confinement, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
				additional information.
	Urgent care	No Charge	No Charge	Patient may transfer to a PPO area as soon as medically safe and reasonable, or additional treatment will require 20% coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	After Allowance and deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to \$934.24 per day for up to 365 days per confinement, then 20% co-insurance. Non-PPO limited to \$25,918.65 per hospital confinement, then 20% co-insurance. Non-PPO hospital extras limited to \$11,678.84, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
	Physician/surgeon fees	No Charge	No Charge	Plan covers charges up to MAC.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	After Allowance and deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to \$71.01 per visit, one visit per day, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information. Medicare and Non-Medicare eligibles and their dependents are covered for chemical dependency recovery programs under the ILWU-PMA Alcoholism/Drug Recovery Program (ADRP). See the separate brochure describing the ADRP.
	Inpatient services	No Charge	After Allowance and deductible, 20% co-insurance on balance of charge up to MAC	Non-PPO limited to \$934.24 per day for up to 365 days per confinement, then 20% co-insurance. Non-PPO limited to \$25,918.65 per hospital confinement, then 20% co-insurance. Non-PPO hospital extras limited to \$11,678.84, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.

* For more information about limitations and exceptions, see the plan or policy document at www.benefitplans.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge	No Charge	—————none—————
	Childbirth/delivery professional services	No Charge	No Charge	Non-PPO limited to \$106.67 for each RVS unit up to \$21,334.00 per disability for surgeon, \$7,111.37 per disability for anesthesiologist, and 20% of the surgery allowance based on the RVS unit allowance up to \$4,266.80 per disability for Assistant Surgeon, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
	Childbirth/delivery facility services	No Charge	No Charge	Non-PPO limited to \$934.24 per day for up to 365 days per confinement, then 20% co-insurance. Non-PPO limited to \$25,918.65 per hospital confinement, then 20% co-insurance. Non-PPO hospital extras limited to \$11,678.84, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Only covered if approved in lieu of hospitalization. Non-PPO limited to \$116.56 per visit, then 20% co-insurance. Amount will change every April and October. Please refer to the SSPD for additional information.
	Rehabilitation services	No Charge	After deductible, 20% co-insurance on balance of charge up to MAC	Plan covers charges up to MAC.
	Habilitation services	No Charge	After deductible, 20% co-insurance on balance of charge up to MAC	Plan covers charges up to MAC.
	Skilled nursing care	No Charge	After deductible, 20% co-insurance on balance of charge up to MAC	Limited to semi-private room rate; confinement must begin within 14 days after a confinement of at least 3 days in an acute care hospital; limited to 100 days per Plan Year for extended care in Medicare

* For more information about limitations and exceptions, see the plan or policy document at www.benefitplans.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
				approved facilities, then 20% co-insurance.
	Durable medical equipment	No Charge	After deductible, 20% co-insurance on balance of charge up to MAC	Plan covers charges up to MAC.
	Hospice services	No Charge	No Charge	Limited to 90 days (which can be extended by physician).
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered through the vision plan.
	Children's glasses	Not covered	Not covered	Covered through the vision plan.
	Children's dental check-up	Not covered	Not covered	Covered through the dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs (except in cases of bariatric surgery)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Benefit Plans Office at (415) 673-8500. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the Benefit Plans Office at (415) 673-8500 or the Department of Labor's Employee Benefits Security Administration at (800) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

* For more information about limitations and exceptions, see the plan or policy document at www.benefitplans.org.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (415) 673-8500.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (415) 673-8500.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (415) 673-8500.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (415) 673-8500.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#).

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$60

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0