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

December 14, 2022

To: ILWU Northern California Local 14
ILWU Oregon Area Locals 12, 21, 50, 53
ILWU Washington Area Locals 07, 24, 25, 27, 51

From: Mario Perez, Director of Benefit Plans

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

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

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

Attachment

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

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November 2022

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

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 deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable (No deductible).	Services covered under the plan are not subject to a deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	No Charge	None.
	Specialist visit	No Charge	No Charge	Chiropractic visits limited to 40 visits per Plan Year. Additional visits available if determined by the Plan's chiropractic consultant to be necessary.
	Preventive care/screening/ immunization	No Charge	No Charge	None.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	None.
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	
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 chemicals 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 Charge	Non-PPO limited to $105.84 for each RVS unit listed for the procedure. If referred by a PPO provider, non-PPO ambulatory surgery centers will be covered at 100% of charge (up to MAC).
	Physician/surgeon fees	No Charge	No Charge	None.
If you need immediate medical attention	Emergency room care	No charge	No charge	None.
	Emergency medical transportation	No charge	No charge	None.

* 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)	
	Urgent care	No charge	No charge	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Non-PPO limited to $25,717.90 per hospital confinement.
	Physician/surgeon fees	No charge	No charge	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	None.
	Inpatient services	No charge	No charge	Non-PPO limited to $25,717.90 per hospital confinement.
If you are pregnant	Office visits	No Charge	No Charge	None.
	Childbirth/delivery professional services	No Charge	No Charge	Non-PPO limited to $105.84 for each RVS unit listed for the procedure.
	Childbirth/delivery facility services	No Charge	No Charge	Non-PPO limited to $25,717.90 per hospital confinement.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	None.
	Rehabilitation services	No charge	No charge	None.
	Habilitation services	No charge	No charge	None.
	Skilled nursing care	No charge	No charge	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 approved facilities.
	Durable medical equipment	No charge	No charge	None.
	Hospice services	No Charge	No Charge	Limited to 90 days.
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.)

- Cosmetic surgery
- Non-emergency care when traveling outside the
- Routine eye care (Adult)

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

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Dental care (Adult)	U.S.	• Routine foot care
• Long-term care	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Infertility treatment
• Bariatric surgery	• Hearing aids	

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.

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, kwiijigo holne' (415) 673-8500.

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

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

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.