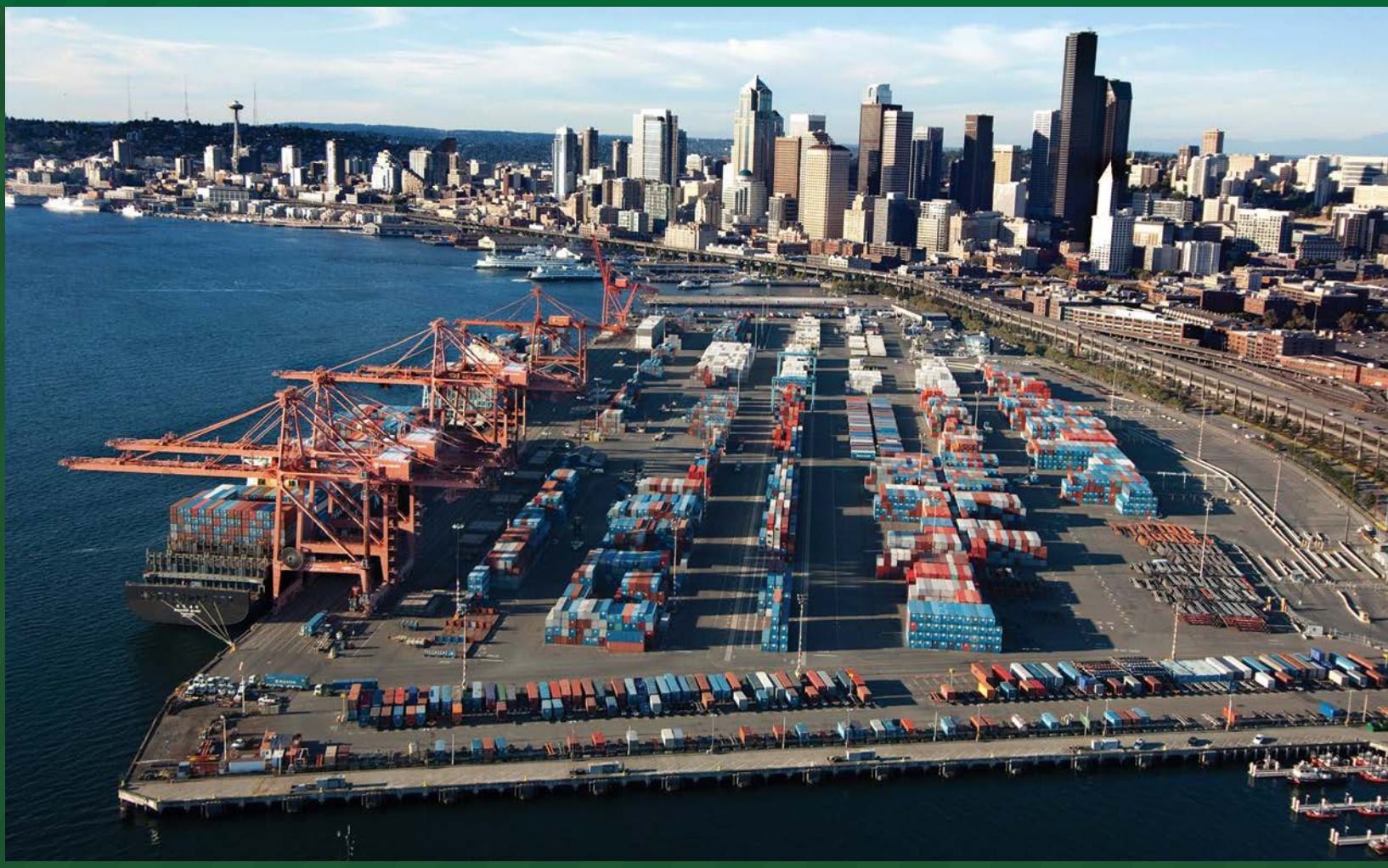

ILWU-PMA Coastwise Indemnity Plan

International Longshore and Warehouse Union

Pacific Maritime Association

Printed September 2021

Benefits:

- Hospital
- Medical
- Surgical

A Supplemental Summary Plan Description

ILWU-PMA Welfare Plan Self-Funded Program

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This Supplemental Summary Plan Description describes the main features of the ILWU-PMA Coastwise Indemnity Plan. The benefits described are summaries of the official ILWU-PMA Welfare Plan Agreement (Welfare Plan) documents and contracts that govern the Plan. This booklet is written in plain language to help you understand how the Coastwise Indemnity Plan works. If there is any conflict between the information in this Supplemental Summary Plan Description and the official Welfare Plan documents, the Welfare Plan documents will always govern. In no event may oral representations by any person change the terms of the Welfare Plan or Coastwise Indemnity Plan. The ILWU and the PMA, by their mutual agreement in writing, may at any time amend, modify or delete any provisions of the Welfare Plan. This power specifically includes the authority to change, retroactively or prospectively, eligibility requirements and benefits provided under the Welfare Plan.

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A Message From the Trustees

The Trustees are pleased to provide you with this Supplemental Summary Plan Description, which summarizes the eligibility requirements, benefits, and claims review procedures of the ILWU-PMA Coastwise Indemnity Plan. It also provides important information about the operation of the Coastwise Indemnity Plan, and about the rights of Plan Participants under the law.

This Supplemental Summary Plan Description includes the provisions of the ILWU-PMA Welfare Plan adopted by the International Longshore and Warehouse Union (ILWU) and Pacific Maritime Association (PMA) - the bargaining parties - to conform the Coastwise Indemnity Plan with the Employee Retirement Income Security Act of 1974 (ERISA). It reflects provisions established through the most recent (2014-2022) ILWU-PMA Collective Bargaining Agreements.

Please write to the Benefit Plans Office if you have any questions about the Welfare Plan or the Coastwise Indemnity Plan.

ILWU-PMA Welfare Plan benefits for eligible Longshoremen, Marine Clerks, and Walking Bosses/ Foremen are established by collective bargaining between the ILWU and PMA. Copies of the Welfare Agreement are on file at the Benefit Plans Office, are furnished to ILWU locals and are available to Participants and beneficiaries on request. The information in the Supplemental Summary Plan Description booklet is subject to, and in no way modifies or interprets, the provisions of the ILWU-PMA Welfare Agreement. To the extent there is any ambiguity, difference or inconsistency between this Supplemental Summary Plan Description and the Welfare Agreement, the provisions of the Welfare Agreement shall govern.

Where the masculine or feminine gender is used in the Supplemental Summary Plan Description, its use is meant to be applicable to both genders.

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Section I:

General Information

This is a description of benefits provided under certain ILWU-PMA Welfare Plan (Welfare Plan) self-funded programs and an insured vision program as of July 1, 2019. The Coastwise Indemnity Plan (Plan), which was effective July 1, 2000, replaced the former "Choice Port Plan" and "Non-Choice Port Plan." The Plan is administered by the Board of Trustees. The Trustees of the Welfare Plan contracts with a Third Party Administrator to provide claims administration services. The claims administration services office is called the ILWU-PMA Coastwise Claims Office. The information in this booklet is subject to, and does not change the provisions of the ILWU-PMA Welfare Agreement or the provisions of the Summary Plan Description of the Welfare Plan.

Each Participant of the Welfare Plan has been provided with a Summary Plan Description, as required by the Employee Retirement Income Security Act (ERISA). The Summary Plan Description describes the Welfare Plan, its eligibility requirements, and benefits. It also informs participants about supplemental summary plan descriptions like this booklet, which describe the Welfare Plan's individual benefit programs. The supplemental summary plan descriptions are supplied to ILWU locals and are available from the ILWU-PMA Benefit Plans Office (the Benefit Plans Office or BPO) upon request.

The BPO is located at 1188 Franklin Street, Suite 101, San Francisco, CA 94109; 415-673-8500.

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Section II:

Coastwise Indemnity Plan Eligibility

A. Who Is Eligible to Participate

The Plan provides hospital, medical and surgical benefits to eligible Welfare Plan non-Medicare and Medicare-eligible participants and their dependents who have elected or who are assigned Coastwise Indemnity Plan coverage under provisions of the Welfare Agreement. Terms capitalized here and unless otherwise defined shall have the same meaning as in the Welfare Plan. The following eligible Welfare Plan participants and their dependents may be covered by this Plan:

1. **Employees and Pensioners**
   - Active Registered Longshore Workers, Ship Clerks, Walking Bosses/Foremen, and Watchmen members of Locals 26 and 75.
   - Most Pensioners under the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan.
   - Certain Social Security Retirees.
   - Certain Active and Retired Employees.
2. **Dependents**

   You can choose to cover your eligible dependents under the Plan. Your eligible dependents include:
   - Spouse (including same-sex spouse).
   - Child (natural, legally adopted, step, foster or child who has or had a parent/child relationship with an employee or Pensioner, if such child's natural parent is not in fact supporting such child) to age 26.
   - Unmarried dependent children age 26 or older who are physically or mentally incapacitated, who were incapacitated when they attained age 26, and who are incapable of self-sustaining employment. Medical certification is required.
   - Surviving spouse and surviving dependent children of eligible Active Employees and Pensioners.

Address changes and changes in family status which might affect Welfare Plan eligibility such as marriage, divorce, birth or death of a dependent must be reported immediately in writing to the Benefit Plans Office. Record Change forms for this purpose are available at the ILWU locals or on request from the Benefit Plans Office or online at **www.benefitplans.org**.

B. Dual Choice

Where a qualified Health Maintenance Organization (HMO) is available, a choice of hospital, medical and surgical coverage is offered to employees, Pensioners, and survivors who are eligible under the Welfare Plan. The choice is between an HMO (group practice) plan available in the area of the port, and the Coastwise Indemnity Plan. This choice is offered when an employee, Pensioner or survivor is first eligible for a dual choice, and again each year during the month of May for coverage effective the following July 1.

In addition, employees, Pensioners, and survivors are allowed to change their choice of coverage one other time during a Plan Year (July 1 - June 30) and annually during the month of May. Information about the choice is made available by the Benefit Plans Office. Currently, the choice between an HMO and the Coastwise Indemnity Plan is available to employees registered in, and Pensioners and survivors living in, the ports listed on the following page.

In ports and areas where no qualified HMO is available, employees, Pensioners and survivors are assigned coverage under the Coastwise Indemnity Plan.

Dual Choice Eligibility

Eligible Active Employees and their dependents who are assigned to the following ports may elect Coastwise Indemnity Plan coverage. Currently, ILWU locals that are offered a dual choice include:

a. **California Locals:**

- Los Angeles Area 13, 26, 63, 94
- San Diego Area 29
- Port Hueneme 46
- San Francisco Bay Area 10, 34, 75, 91
- Sacramento Area 18, 34, 91
- Stockton Area 34, 54, 91

b. **Oregon Locals:**

- Portland/Columbia River Area 4, 8, 40, 92

c. **Washington Locals:**

- Seattle/Tacoma Areas 19, 23, 52, 98
- Everett/Olympia Areas 32, 47

d. **Pensioners and Survivors:**

When a Pensioner or survivor moves to any one of the dual choice port areas listed above, he or she is offered a choice of plans. Pensioners and survivors who report a change of address are transferred, if necessary, to a plan available where they live. The transfer will coincide as nearly as possible with the move.

C. When Coverage Begins

Coverage begins on the first of the month coinciding with or following the date eligibility is met under the Welfare Plan, or in accordance with the rules established for Dual Choice above.

New registrants and their qualified dependents in ports with HMO coverage will, on the first of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by the HMO programs for the first twenty-four (24) months of registration. After 24 months of registration the member will have a choice of HMO or Coastwise Indemnity Plan coverage and normal Welfare Plan eligibility requirements shall apply.

New registrants and their qualified dependents in ports without HMO coverage will, on the first of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by the Coastwise Indemnity Plan for the first twenty-four (24) months of registration and shall thereafter be subject to the Welfare Plan's normal eligibility requirements for continuation of coverage under the Coastwise Indemnity Plan.

The Trustees of the Welfare Plan may provide on an "exception basis" that a person eligible for HMO coverage under this provision may be provided coverage under the Coastwise Indemnity Plan if they are receiving treatment for a serious health condition when Welfare Plan coverage begins.

New dependents will be eligible to enroll on the first of the month coinciding with or following the qualifying event (see HIPAA Special Enrollment Rights on the following page), or the date the employee enrolls in the Welfare Plan.

D. Changing Your Benefit Options

1. Annual Enrollment Period

Prior to enrollment, the Benefit Plans Office will provide you materials explaining your benefits, and instructions to complete the enrollment process. Your selections remain in effect through June 30 of each year if you continue to qualify for the Welfare Plan as an eligible employee. In addition, employees, Pensioners and survivors are allowed to change their choice of coverage one other time during a Plan Year (July 1 - June 30) and annually during the month of May. Information about your plan choice is made available by the Benefit Plans Office.

There are also special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and described in the next section.

2. HIPAA Special Enrollment Rights

There are two circumstances under which you will qualify for a HIPAA special enrollment right:

a. Acquisition of a new dependent: If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your new dependent (with proof of dependent eligibility) in any medical benefit option. If you are already enrolled in the Welfare Plan when you acquire a new dependent, you may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different option.

To exercise your special enrollment rights, you must request enrollment for yourself and/or your dependents no more than **30 days** after the date you acquire the new dependent.

b. Loss of other coverage: If you declined enrollment for yourself or for an eligible dependent because other health coverage (including COBRA coverage) was in effect, you may enroll yourself and your dependents in the Welfare Plan if you or your dependents lose eligibility for that other coverage or if employer contributions for that coverage are terminated. For this purpose, "loss of eligibility" includes, but is not limited to:

- A loss of coverage that results from termination of your or your spouse's employment; reduction in hours of employment; legal separation or divorce, death, or cessation of dependent status (e.g., reaching the maximum age to be eligible as a dependent under a plan);
- In the case of HMO coverage, a loss of benefits that results when an individual no longer resides, lives or works in an HMO service area and there is no other benefit package available to the individual;
- A situation in which an individual has a claim that would meet or exceed a lifetime limit on all benefits under the other plan; and
- A situation in which a plan no longer offers any benefits to the class of individuals to which that individual belongs.

Loss of eligibility for other coverage does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause, such as fraud.

If you were not enrolled in the Welfare Plan, you may enroll yourself and your eligible dependents in any benefit option. If you are already enrolled in the Welfare Plan and one of your dependents loses other coverage (or employer contributions for the other coverage terminate), you may enroll your dependent in your current option or you may change your election and enroll yourself and your dependent in a different option.

To exercise your special enrollment rights, you must request enrollment for yourself and/or your dependents and provide proof of dependent eligibility no more than **30 days** after the date the other coverage ends (or employer contributions terminate). Coverage of a newly acquired child through birth, adoption, or placement for adoption will begin on the date of the event. For all other circumstances, your elections will be effective on the first day of the month following the special enrollment event.

3. **Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA):**

   If you or your dependents lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or you or your dependents become eligible for a premium assistance subsidy through these programs to pay for the cost of medical coverage, you may be able to enroll in one of the Welfare Plan *medical plan options* during the Plan Year, even if you previously declined coverage. This special enrollment right will be extended to you only if you notify the BPO within **60 days** of the event. See page 49 for more details.

4. **Other Qualifying Change in Status Events**

   If you experience one of the following events, notify the BPO of the change in status within **30 days** of the event, as your spouse or dependent may lose or gain coverage under the Welfare Plan.

   - Your marriage, divorce, legal separation or annulment;
   - Birth or adoption of your child;
   - Death of your spouse or child; or
   - Any change in your child's eligible dependent status.

   If you experience the following events, you may qualify for a change in your benefit elections. Please contact the BPO as some events may qualify you for a Special Enrollment event.

   - A gain or loss of coverage due to a change in your spouse's employment status;
   - A significant change in coverage or cost under another plan during the year for you or your dependents;
   - A change in your place of residence or work that impacts your available choice of benefit plans (you can only make a change to the benefit plan affected);
   - A qualified medical child support order (QMCSO) is issued or changed regarding medical coverage for a dependent child; or
   - You, your spouse or your child becomes eligible for or loses eligibility for Medicare or Medicaid.

E. When You Reach Age 65

Coastwise Indemnity Plan hospital, medical and surgical benefits are integrated with Medicare coverage. Pensioners and/or survivors and their dependent(s) must, if eligible, enroll in Part B of Medicare in order to maintain their eligibility for Coastwise Indemnity Plan hospital, medical and surgical benefits. Pensioners and/or survivors who permanently reside outside the United States and do not intend to return to obtain medical care in the United States are not required to enroll in Medicare (since Medicare benefits are not available out of the country) and are therefore not reimbursed for Medicare Part B premiums.

Under federal law, Active Employees and their dependents who are eligible for Medicare continue until retirement to have primary coverage under the Welfare Plan. Therefore, Active Employees are not required to enroll in Medicare even when eligible to do so. Upon retirement, such employees will be required to enroll in Medicare Part B, and will be advised by the Benefit Plans Office as to the procedures for enrolling.

Exception to Medicare Enrollment

Persons requiring kidney dialysis become eligible for Medicare after the third full month of dialysis treatment for end stage renal disease, or the first of the month upon receiving a kidney transplant. Kidney dialysis patients and/or kidney transplant patients must maintain enrollment in Medicare Part B medical benefits, in order to retain eligibility for Coastwise Indemnity Plan Supplemental Benefits.

Kidney dialysis patients and kidney transplant patients should notify the BPO of their enrollment status.

Medicare Part D

The prescription drug benefits provided in the Welfare Plan are considered to be creditable coverage for purposes of Medicare Part D. See the "Medicare Part D Notice of Creditable Coverage" beginning on page 53. **Therefore, as long as you have coverage under the Welfare Plan, there is no need to enroll in Medicare Part D.**

F. If You Go On Leave of Absence

During a leave of absence authorized by the Joint Port Labor Relations Committee (JPLRC) and the Coast Labor Relations Committee (CLRC), you may be entitled to continue coverage, depending on the nature of the leave. For example, if the JPLRC/CLRC authorizes your leave as an absence taken under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to up to 90 days of continued coverage during your leave of absence. If you are on a leave of absence for military service, your coverage may be terminated and later reinstated, depending on the duration of the leave period. All leaves of absence that may impact your eligibility for Plan coverage are subject to the policies adopted by the CLRC. In advance of your leave, to the extent feasible, you should provide notice to the Benefit Plans Office of any leave of absence that may impact your eligibility for coverage under the Welfare Plan.

If you have any questions about your Welfare Plan eligibility status, please contact the Benefit Plans Office at 415-673-8500.

G. When Coverage Ends

Eligibility for all Welfare Plan benefits, including Coastwise Indemnity Plan benefits, ends upon:

- Loss of eligibility under the terms and conditions of the Welfare Plan;
- Loss of qualified dependent status as defined by the Welfare Plan;
- Eligibility for Coastwise Indemnity Plan hospital, medical and surgical benefits ends for Pensioners, survivors, and their dependents who are required to enroll for Medicare, but who fail to maintain Medicare Part B enrollment; or
- Eligibility for Coastwise Indemnity Plan coverage also ends upon transfer to an HMO plan – see page 3 "Dual Choice."

For further information about dependent qualifications and how eligibility under the Welfare Plan is established and may be lost, please refer to the ILWU-PMA Welfare Plan Summary Plan Description.

H. Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation of Coverage

Persons who lose Welfare Plan eligibility as described above will be notified by the Benefit Plans Office if they are entitled to COBRA continuation coverage.

COBRA is the acronym for a federal law, the Consolidated Omnibus Budget Reconciliation Act. COBRA requires that the Trustees of the Welfare Plan offer Welfare Plan participants and family members the opportunity for a temporary extension of certain Welfare Plan benefits, called "continuation coverage," when coverage under the Plan would ordinarily end.

You must pay for COBRA continuation coverage. The coverage is offered at the cost of group coverage under the Welfare Plan plus a 2% administrative fee.

COBRA continuation coverage may be purchased for a limited time only—generally either 18 months or 36 months, depending on the reason for loss of group coverage. Examples of how COBRA coverage could apply include:

1. A dependent child who loses group coverage because he or she exceeds the maximum age for dependent eligibility may purchase continuation coverage for up to 36 months.
2. A spouse who loses group coverage because of divorce may purchase continuation coverage for up to 36 months.
3. An employee who loses group coverage because of insufficient hours worked or credited may purchase continuation coverage for up to 18 months.

Detailed information will be provided to those eligible to purchase COBRA continuation coverage. A COBRA brochure has also been furnished to ILWU locals and is available from the Benefit Plans Office on request.

Other health coverage options may be available to you, including coverage through the Health Insurance Marketplace at **www.HealthCare.gov** or call 800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

Section III:

Important Plan Features

A. Plan Year

July 1 – June 30

B. Maximum Allowable Charge (MAC)

MAC, as used in this booklet, refers to the Maximum Allowable Charge, which includes any of your deductible payments, coinsurance payments and the total payments issued from the Welfare Plan. MAC refers to charges which are reasonable and in line with fees customarily charged for the treatment or service rendered by providers of care in the same area. The Trustees will determine, in their sole, absolute, and full discretion, the MAC primarily by reference to a fee schedule derived from a national database of charges of health care providers.

Amounts exceeding the MAC for non-PPO providers are considered non-covered expenses and are not applied toward your deductible or any out-of-pocket limits under the Plan.

For example, if you were to visit a non-PPO provider, such as an acute care hospital, for a colonoscopy which charged $5,000 for the procedure, but the MAC for a colonoscopy is determined to be $3,000, then the amount in excess of MAC is $2,000. The Basic Benefit payment under the Plan would be $1,500, or 100% of the Scheduled Amount. The Major Medical Benefit payment would be 80% of the difference between MAC and the Scheduled Amount or $1,200. The total Plan payment for this procedure would therefore be $2,700, assuming you had already satisfied your annual deductible and had not reached your out-of-pocket annual maximum. You may be responsible for the remainder of the non-PPO provider's charge, or $2,300.

The costs that you may be responsible for could apply toward your deductible of $100 per single person or up to $300 per family, which must be paid prior to the Plan paying any portion of the Major Medical benefit. Once your annual deductible is satisfied, any remaining charges you pay may also apply toward your annual out-of-pocket maximum of $1,000. The Plan does not apply amounts over MAC, such as the $2,000 in the example above, against either your deductible or the out-of-pocket annual maximum.

The following table illustrates the above example.

Non-PPO Outpatient Facility – Colonoscopy		
Provider Billed Charges	$ 5,000	
Plan MAC	$ 3,000	
Amount in Excess of MAC (not applied toward annual out-of-pocket)	$ 2,000	
Basic Benefit Payment	$ (1,500)	100% of Scheduled Amount
Major Medical Benefit Payment	$ (1,200)	80% of the difference between MAC and Scheduled Amount
Total Plan Payment	$(2,700)	
Member's Financial Responsibility	$ 2,300	What you may be required to pay
Amount Applied Toward Annual Out-of-Pocket Maximum	$ 300	Difference between MAC and plan payment

C. Service Area

In General

All eligible participants and beneficiaries are covered for services provided anywhere in the world. Claims incurred outside the United States are subject to the same Welfare Plan terms, and standards of medical necessity and medical treatment protocols as if they had been incurred in the United States. Eligible procedures are covered at 100% of the MAC in the country where the expenses are incurred. To the extent that MAC cannot be determined specific to the specific area in which the claims are incurred, the Plan will use every effort to find a reasonable substitute.

D. Providers of Service

The Coastwise Indemnity Plan covers services provided by any licensed doctor. See definitions below.

Definitions

The term **"Doctor"** means a licensed practitioner of the healing arts acting within the scope of his or her license as a: Medical Doctor (MD), Osteopath (DO), Podiatrist (DPM), Chiropractor (DC), Physical Therapist (PT), Doctor of Physical Therapy (DPT), Psychologist (Ph.D. or Psy.D.), Acupuncturist, Dental Surgeon (DDS), or Physician Assistant (PA) or (PA-C).

"Doctor" will also include:

- A Nurse Midwife who is certified by the American College of Nurse Midwives and is licensed to practice by the state in which services are rendered.
- An Occupational Therapist, Speech Pathologist or Audiologist when the covered person is referred to such a practitioner by a Medical Doctor (MD) or Osteopath (DO).
- A Registered Nurse with a Masters' Degree in psychiatric mental health nursing and two years of supervised experience in psychiatric mental health nursing, but only upon referral by a Medical Doctor (MD) or Osteopath (DO).
- An Optometrist.
- A Licensed Clinical Social Worker (LCSW) in California and Oregon, a Licensed Independent Clinical Social Worker (LICSW) in Washington, and those with equivalent qualifications in other states.
- A Licensed Marriage and Family Therapist (LMFT) in California, Oregon and Washington, and those with equivalent qualifications in other states.
- A Licensed Professional Clinical Counselor (LPCC) in California, a Licensed Professional Counselor (LPC) in Oregon, a Licensed Mental Health Counselor (LMHC) in Washington, and those with equivalent qualifications in other states.
- A Nurse Practitioner (NP) in California and Oregon, an Advanced Registered Nurse Practitioner (ARNP) in Washington who is practicing as a Nurse Practitioner, and those with equivalent qualifications who are so practicing in other states.
- A state licensed or state-recognized Board Certified Behavioral Analyst (BCBA) or state licensed or state-recognized BCBAs with a Ph.D. (BCBA-D), when the covered person has a diagnosis of autism spectrum disorder and is referred to such a practitioner for Applied Behavioral Analysis (ABA) therapy by a Medical Doctor (MD) or Psychologist (Ph.D. or Psy.D.).

The term **"Hospital"** means a licensed acute-care facility which operates primarily for the diagnostic and therapeutic treatment of sick or injured persons as resident inpatients. In no event will the term "Hospital" include any institution which is primarily a clinic, nursing home, convalescent home, skilled nursing facility or similar establishment. Confinement in a special unit of a Hospital used primarily as a rest home, convalescent home or skilled nursing facility will not be considered to be confinement in a Hospital.

The term "Hospital" will also include:

- A psychiatric health hospital licensed by the state in which it operates, when inpatient treatment is provided there for psychiatric or mental conditions.
- A medical institution licensed by the state in which it operates to provide treatment of alcoholism and drug addiction on an inpatient basis and which has the capacity to provide medical and detoxification treatment. Residential treatment facilities that do not have the capacity to provide medical and mental health treatment are not covered as hospitals.
- A licensed or accredited Medicare-approved ambulatory surgery center and a licensed or accredited non-Medicare-approved ambulatory surgery center if it is operated primarily

for the purpose of performing surgical procedures on an outpatient basis, has a doctor and registered nurse in attendance when a patient is present, and is not an office maintained by a physician for the general practice of medicine or dentistry.

E. Preferred Provider Organization (PPO) (Non-Medicare-Eligible Only)

The Welfare Plan has entered into agreements with Preferred Provider Organizations (PPOs) to provide medical care to Plan members at special rates which are available to both Dual Choice Port and Non-Choice Port participants. These preferred providers include hospitals, doctors, and X-ray, laboratory and other facilities. While the contracts with preferred providers contain special reduced rates, they do not allow discrimination with regard to admissions or service; the quality of care is the same for all patients. The preferred provider organizations are Blue Shield of California for services provided in California and BlueCard for services provided outside California, and First Choice Health Network for services provided in Oregon, Washington, Alaska, Montana, Idaho, North Dakota and South Dakota, and First Health Network for services provided outside of those states.

In addition to the mental health services providers in the Blue Shield of California Network, a panel of mental health service providers is available in California through Magellan Behavioral Health.

The chiropractic PPO network in California is Chiropractic Health Plan of California. The chiropractic PPO network in Oregon and Washington is First Choice Health Network. Chiropractic benefits for participants in Choice Ports are only payable for services provided by these chiropractic networks.

In general, you are free to use any hospital or doctor of your choice but if you use a non-PPO hospital or doctor, the Plan will not pay more than the Plan's MAC for a service or procedure, and you may be required to pay charges that exceed the Plan's MAC, in addition to any applicable deductible and co-pay.

Effective November 11, 2015, for Choice Port enrollees, the Plan will pay for procedures rendered at Non-PPO ambulatory surgery center providers at 100% of the Plan's MAC, only if your PPO (in-network) doctor refers you to have treatment at a Non-PPO ambulatory surgery center. In other words, if your Non-PPO doctor refers you to have treatment at a Non-PPO ambulatory surgery center, none of the resulting expenses will be covered by the Plan.

Furthermore, for Choice Port participants, for all other surgical procedures, including colonoscopies, only those performed at acute care hospitals or at a PPO (in-network) ambulatory surgery center will be covered by the Plan.

PPO directories listing the names and addresses of preferred providers are available from the Plan's online directory. If you have any questions about whether a provider is a preferred provider, you may visit them online or call the numbers below:

Blue Shield of California, including mental health providers, excludes chiropractor	Visit **www.blueshieldca.com/ilwupma** or call the Coastwise Claims Office at 800-955-7376
BlueCard Provider (outside of California) *Effective March 1, 2019 for non-Medicare retirees*	**www.blueshieldca.com/ilwupma** or call 800-810 BLUE (2583)
First Choice Health Network (Oregon, Washington, Alaska, Idaho, Montana, North Dakota, South Dakota, Wyoming) Includes Chiropractor	800-231-6935 or visit **www.fchn.com**
First Health Network (Outside of Oregon, Washington, Alaska, Idaho, Montana, North Dakota, South Dakota, Wyoming) *Effective April 1, 2019*	800-226-5116 or visit **www.myfirsthealth.com**
Magellan Behavioral Health (California – Mental Health PPO Network)	800-424-5945 or visit **www.MagellanAscend.com**
Chiropractic Health Plan of California – CHPC (California – Chiropractic)	800-995-2442 or visit **www.chpc.com**

F. Coordination of Benefits

Coordination of benefits applies to Coastwise Indemnity Plan benefits when you or your eligible dependents are eligible for payment under more than one group health plan. The purpose of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments. Here is how the coordination of benefits provision in this Plan works:

- If you or your eligible dependents are eligible to receive benefits under another group health plan, benefits under this Plan will be coordinated with the benefits from any other group health plan so that the total combined benefit payments of the two plans will not exceed the MAC or the PPO rate for covered services.
- When your other group health plan does not mention coordination of benefits, then that other plan pays first. Benefits paid or payable by the other group coverage will be taken into account in determining if additional benefit payments can be made under this Plan.
- When the person who received care is covered as an employee under one plan and as a dependent under another plan, the plan under which the person is covered as an employee is primary and pays first.
- When the person who received care is covered as an employee or as the dependent of an employee under one plan and as a retiree or as the dependent of a retiree under another plan, the plan under which the person is covered as an employee or as the dependent of an employee is primary and pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first.
- When a child is covered under two group plans, the plan covering the parent whose birthday falls earlier in the calendar year is primary and pays first. If both parents have the same birthday, the plan which covered the parent the longer will be the primary plan.

If you and your spouse are separated or divorced, the following applies to your children:

- If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
- If the divorced parent with custody has remarried, the coverage of the parent with custody pays first, but the step-parent's coverage pays before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

G. Voluntary Hospital Utilization Review (Non-Medicare-Eligible Only)

The Plan contains a Voluntary Hospital Utilization Review program administered by Innovative Care Management, Inc. (ICM). Hospital utilization review is intended to prevent unnecessary expenses due to hospital confinements which: 1) are not medically necessary; 2) are for a longer period of time than necessary; or 3) are for care which could be given on an outpatient basis. The utilization review program may provide pre-admission certification, concurrent review and discharge planning. Pre-admission certification is performed for scheduled hospital admissions prior to admission. Concurrent review is performed for both scheduled and non-scheduled admissions during confinement. Discharge planning may be provided to help arrange for discharge from the hospital as early as possible without jeopardizing patient care. This program is voluntary and not mandatory. To request voluntary hospitalization review, you may call 866-275-1014.

H. Voluntary Case Management

The Case Management program, administered by ICM, 866-275-1014, can provide help and support for patients experiencing serious or long term illness. Case Management health care professionals will work with the patient, family and doctor in arranging for treatment alternatives to lengthy hospitalizations. In certain cases, Case Management may get approval for benefits not usually covered by the Coastwise Indemnity Plan, such as home health care, and rehabilitation facility care. Case Management is a voluntary program and does not dictate the care you receive. These important decisions are confidential, and stay with you and your doctor.

Patients who qualify may be identified and referred to Case Management by the Coastwise Claims Office or through the Voluntary Hospital Utilization Review process; or you may call ICM Case Management directly at 866-275-1014.

I. Voluntary Pre-certification of Benefits

Before services are provided, if you or your provider would like to determine whether a procedure or treatment is covered under the terms of the Plan or if an alternative service is recommended, contact ICM at 866-275-1014, Monday through Friday, 7:00 AM to 5:00 PM Pacific Time. This program is voluntary and not mandatory. If your request for pre-certification is denied, you may follow the claim procedures outlined below to appeal the denial.

J. Retrospective Review of Benefits

This Plan also allows the Coastwise Claims Office to review, retrospectively, procedures/treatment that you have already been given to determine if those procedures/treatment are covered under the Plan. If those procedures are determined to be excluded from coverage under the Plan's terms, the Plan will not cover the costs for those procedures. In such a case, you will be notified of your responsibility to pay for those procedures, and the costs for those excluded procedures cannot be applied to your annual out-of-pocket maximum amount or deductible. If your claim is denied, you may follow the claim procedures outlined below to appeal the adverse benefit denial of your claim.

K. If Your Claim for Benefits Is Denied

1. **Claims Review Procedures**

   The procedures described below apply to requests for benefits under the Coastwise Indemnity Plan and not for benefits under any other Welfare Plan option, for example, an HMO. Please note that a mere inquiry about whether a particular item is covered under the Plan is not a claim for this purpose.[1]

2. **Claim Denial**

   If a claim is denied or partly denied by the Coastwise Claims Office, notice will be given to the claimant in writing. The notice will be written in understandable language and will contain:

   - Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount;
   - Specific reasons for denial of the claim;
   - Specific reference to provisions of the Welfare Agreement, this Plan or to contract provisions upon which the denial is based;
   - A description, if appropriate, of additional information or material which might enable the claimant to perfect the claim and an explanation of why the requested information or material is necessary;

[1] *See page 33 for How to File a Claim.*

- An explanation of how, where, and when the claimant may obtain a review of the denial and the applicable time limits;
- A statement of the claimant's right to bring legal action under ERISA;
- If the denial is based on an internal rule, guideline, or protocol, that the claimant will be provided free of charge upon request; and,
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Notice of claim denial must be given to the claimant within a reasonable period of time, but not later than 30 days after the date the claim is received. This period may be extended an additional 15 days if the Coastwise Claims Office determines that an extension is necessary due to matters beyond its control and the claimant is notified of the extension before the end of the initial 30-day period and the date by which the Coastwise Claims Office expects to render a decision on the claim. If an extension is required because the claimant failed to submit sufficient information to enable the Coastwise Claims Office to make a determination of the claim, the notice of the extension will also describe the additional information required. In such a case, the claimant will be given at least 45 days to provide the additional information. The period from the date the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

If the Coastwise Claims Office does not respond to the claimant's claim within the time periods specified above, the claimant may deem his or her claim denied for this purpose as of the expiration of the applicable time period above.

3. Request for Claim Review by Trustees of the ILWU-PMA Welfare Plan

Within 1 year after notice that a claim has been denied by the Coastwise Claims Office, or after the claim is deemed denied as provided above, the claimant or his/her representative may make a written request for a review of the denial by the Trustees of the Welfare Plan. The claimant or his/her representative may request copies free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review.

A request for a claim review by the Trustees must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

When making your request for a claim review, you should submit it to the ILWU-PMA Benefit Plans Office in writing and describe the reasons for the appeal. Along with your written appeal, you may, but need not, submit additional documentation, issues and comments for the Trustees to consider during their review of your denied claim.

If you or your representative requests, the Benefits Plans Office will provide reasonable access to and copies of all documents, records and other information on your claim, free of charge, including:

- Information relied upon in making the denial;
- Information submitted, considered or generated during the denial decision, whether or not it was used in making the decision;
- Records of any independent reviews conducted by the Coastwise Claims Office; and,
- Expert advice and consultation obtained by the Coastwise Claims Office in connection with the denial decision, if any.

4. Decision on Review by Trustees of the ILWU-PMA Welfare Plan

The Trustees of the Welfare Plan, or a committee of the Trustees, will render their decision on the claim within 30 days of receipt of the request for review. This period may be extended an additional 30 days if the Trustees determine that an extension is necessary and the claimant is notified of the extension before the end of the initial 30-day period and provided the date by which the Trustees expect to render a decision on the claim.

If a claim is denied or partly denied by the Trustees following review, notice will be provided in writing to the claimant. The notice will be written in understandable language and will contain:

- Specific reason or reasons for upholding in part or in full the denial of the claim;
- Specific reference to provisions of the Welfare Agreement, this Plan or to contract provisions upon which the decision was based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement describing the Plan's appeal procedures and the claimant's right to obtain the information about such procedures from the Benefit Plans Office, and a statement of the claimant's right to bring an action under ERISA;
- If the decision was based on an internal rule, guideline, or protocol, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination will be provided free of charge upon request;
- If the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and,
- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If the Trustees do not respond to the claimant's request for review within the time periods specified above, the claimant may deem his or her claim denied on review for this purpose as of the expiration of the applicable time period above.

5. Request for Arbitration

Within 180 days after notice that a claim has been denied by the Trustees on review, or after the claim is deemed denied on review as provided on the previous page, the claimant may request that the claim be decided by the Coast Arbitrator. In order to obtain a review of a claim by the Coast Arbitrator, the claimant must have obtained a prior determination on the claim by the Trustees (or a deemed denial) in accordance with the procedures outlined above. The claimant or his/her representative may request copies, free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review by the Trustees.

A request for review by the Coast Arbitrator must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

6. Decision by Coast Arbitrator

The Coast Arbitrator will render a decision on the claim within 30 days of receipt of the request for review.

The time period for completion of arbitration may be extended at the request and agreement of the claimant, if for example the claimant wishes to have a hearing and/or to submit a brief or desires that a representative submit a brief on his or her behalf. The time period may also be extended if the claimant submits new evidence in support of their claim that was not considered by the Trustees during their review.

The decision of the Coast Arbitrator will be communicated in writing, and in understandable language. It will include specific references to the Welfare Agreement or contract provisions upon which the decision is based.

7. Judicial Review

A claimant has the right to file a suit in a court of law if a claim is denied or partly denied by the Coast Arbitrator. Plan provisions and applicable law require, however, that the claimant first exhaust all of his or her appeal rights under the Plan. This means that a claimant must obtain determinations by the Trustees and by the Coast Arbitrator before he or she may file a lawsuit for a benefit under the Plan.

L. Third-Party Settlements

Subrogation/Reimbursement–Third-Party Liability

The Welfare Plan will pay benefits for an injury or illness for which a third party may be liable only on the condition that the covered person, or the legal representative of the covered person, completes an "Agreement to Reimburse Benefits" form. This is an agreement to reimburse the Welfare Plan for any Welfare Plan benefits, including Coastwise Indemnity Plan benefits, paid on account of an injury or illness, to the extent benefits or other compensation are received for the same injury or illness under Workers' Compensation laws or from any third party.

Any person who has received, is receiving, or is eligible to receive benefits under the Welfare Plan agrees: (1) to reimburse the Welfare Plan the portion it is due for benefits paid on account of any illness, injury, or condition for which an employer or other third party (or their respective insurers) may be liable, regardless of whether such recovery is less than the actual loss suffered by the person, from the proceeds of any judgment, settlement, payment or otherwise, and irrespective of whether responsibility is accepted or denied by an employer or other third party; (2) to waive any argument or contention that any action by the Trustees in state court is pre-empted by federal law; and, (3) to assign to the Trustees the person's right of action against the employer or other third party (or their respective insurers) to the extent benefits have been paid or may be paid in the future. In addition, any person eligible for benefits must, in order to receive any benefits and to maintain eligibility under the Welfare Plan: (i) notify the Trustees of the Welfare Plan within thirty (30) days after making a claim against an employer or other third party (or their respective insurers) relating to an incident leading to damages, benefits and/or other compensation, of the fact and nature of such claim; (ii) furnish any information or assistance and execute any documents that the Trustees may require; and, (iii) take no action that may prejudice or interfere with such rights.

Whether or not the preceding requirements are satisfied, the Trustees shall: (1) be automatically assigned such person's right of action against the employer or other third party (or their respective insurers) to recover benefits that have been paid or may be paid in the future; (2) have the right to intervene at any time in any action brought against an employer or other third party (or their respective insurers) to recover all benefits that have been paid or may be paid in the future; (3) be reimbursed fully from the proceeds of any judgment, settlement, payment or other resolution of any action or proceeding, including from the estate of any covered person, to recover benefits that have been paid or may be paid in the future, regardless of whether the total amount of such recovery is less than the actual loss suffered by the person; (4) be reimbursed 100% of the charges the Welfare Plan paid in a lump sum at the time payment is received by a covered person, his or her dependents, or his or her representative; and, (5) have an automatic first lien upon any recovery to the extent of benefits that have been paid or in the future may be paid. In all five instances set forth above in this paragraph, the Trustees shall have such rights regardless of whether the total amount of such recovery is less than the actual loss suffered by the person. The Trustees shall also be fully reimbursed for any charges paid in error, whether the error was that of the Welfare Plan, participant or dependent.

If any person does not comply with any of the foregoing requirements, the Trustees may suspend that person's ongoing eligibility for benefits and deny pending or future claims until such time that he or she is in compliance with such requirements. Specifically, if any participant or dependent enters into any settlement of his/her claim(s) pursuant to the Longshore and Harbor Workers' Compensation Act and/or state workers' compensation law or personal injury law (whether or not a lawsuit is filed) that does not include complete and final resolution of the Welfare Plan's lien, claim for reimbursement and/or subrogation claim immediately upon effectuation of such settlement, the Welfare Plan may suspend the person's ongoing eligibility for benefits and deny pending or future claims until the Welfare Plan has recouped an amount equal to the value of such claims. Such recoupment may be accomplished via processing of weekly indemnity and/or medical benefit claims without any issuance to such person of payment(s) of the amounts normally payable under the Welfare Plan.

The Welfare Plan expressly disavows the application of legal theories such as the "collateral source", the "make-whole" doctrine and the "common fund" doctrine to the extent that they may prevent or limit the Plan's recovery from any payment a person with eligibility receives from a third party (or its insurer). The Welfare Plan's reimbursement will not be reduced to pay any portion of the attorneys' fees and costs associated with the person's legal recovery. The Welfare Plan's cost of collection would be part of the Plan's subrogation claim in instances when the Welfare Plan pursues collection of reimbursable amounts.

The information in this section applies to any no fault insurance recoveries and all proceedings and actions, including but not limited to proceedings under the Longshore and Harbor Workers' Compensation Act, other workers' compensation acts, and actions for negligence, medical malpractice, products liability, and other torts or wrongful acts.

M. Overpayment of Benefits

The Trustees of the Welfare Plan, or their representatives, may, in their sole, absolute, and unreviewable discretion, require repayment of any overpaid amount directly from a provider of service and/or a beneficiary, through collection proceedings and/or by offset of any overpaid amount against other Benefits payable by the Welfare Plan, under the following circumstances:

1. If the Welfare Plan issues reimbursement payments through error, misrepresentations, or fraud to a provider of service, or to a beneficiary, which exceeds the allowed amount under the Welfare Plan; or
2. If a beneficiary is paid any money, or receives anything of other than nominal value, from a provider of service and a reimbursement claim is made that misstates the amount actually charged by the provider of service.

The Trustees may collect the amount of any such overpayment(s) and any amounts expended or incurred in investigating the matter and collecting the overpayment(s), including, but not limited to, expenses of the Trustees' staff and reasonable fees of any investigators, attorneys and/or consultants retained by or on behalf of the Trustees. If a provider of service fails to collect all or a portion of an applicable copayment or deductible from a beneficiary, resulting in a reimbursement claim that misstates the amount actually charged by the provider of service, the Trustees may require repayment of any amounts the Welfare Plan paid to the provider. The Trustees may also, in their sole, absolute and unreviewable discretion, suspend Eligibility or Benefits with respect to such person found to have furnished incorrect or incomplete information in order to qualify for Eligibility or Benefits, and take any other action they may deem necessary or appropriate under the circumstances. Nothing in this section limits any rights that the Trustees or the Welfare Plan may have to recover any amounts allowed by law.

N. Assignment of Benefits

Under provisions of the Welfare Agreement, Welfare Plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Trustees, and any attempt to do so shall be void. However, ERISA provides that in the case of persons with coverage under a state Medicaid program, automatic assignment of benefits to state Medicaid agencies is enforceable against the Plan. Where benefits are paid directly to a doctor, hospital or other provider of care (other than to a state Medicaid agency), such direct payments are provided at the discretion of the Trustees as a convenience to Plan participants and do not imply an enforceable assignment of Welfare Plan benefits or the right to receive such benefits.

Section IV:

Medical Plans

After maximum Basic Benefits or Supplemental Plan Benefits have been paid and any applicable annual deductible has been satisfied, Major Medical Benefits will reimburse a percentage of covered expenses. (See Sections D., E., and F. at pages 28-30.)

A. Who Is Eligible to Participate

1. **Basic Benefits**
   - Members who are not eligible for Medicare.
   - Active members for whom the Welfare Plan is their primary plan, but who also are eligible for Medicare.
2. **Major Medical Benefits (provided after Basic Benefits have been paid and the applicable deductible has been satisfied)**
   - Members who are not eligible for Medicare.
   - Medicare-eligible participants and beneficiaries.
3. **Supplemental Plan**
   - Medicare-eligible participants and beneficiaries.

B. ILWU-PMA Coastwise Indemnity Plan Schedule of Benefits

For many services listed in this table, Basic Benefits are paid first for a covered expense as indicated; Major Medical Benefits are then paid according to whether the service was received from a PPO Provider or a Non-PPO Provider. "No PPO Access" refers to a participant who, because of his/her registered Port location (Non-Choice Port), does not have a choice between the Coastwise Indemnity Plan and a local HMO. The Supplemental Plan applies only to Medicare-eligible participants and beneficiaries and is described in the sections following the Schedule below.

The Basic Benefits–Schedule of Allowances is generally updated every April and October. For the latest Basic Benefits–Schedule of Allowances, contact your ILWU local office or the Benefit Plans Office, go online to: **www.benefitplans.org**, or call the Coastwise Claims Office at 800-955-7376.

Note: After maximum Basic or Supplemental Plan Benefits have been paid and any applicable annual deductible has been satisfied, Major Medical Benefits will reimburse a percentage of covered expenses up to MAC for Non-PPO charges.

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID	
Deductible		
Basic Benefit	The deductible is not applicable to the Basic Benefit portion of this Plan.	
Major Medical Benefit	**INDIVIDUAL** PPO: N/A Non-PPO: $100 per person No PPO Access: N/A	**FAMILY** PPO: N/A Non-PPO: $300 No PPO Access: N/A
Out-of-Pocket Maximum		
Only applies to Non-PPO providers; $1,000 per Plan Year (see Section below Schedule of Benefits for a description of the Out-of-Pocket Maximum).		

(Table continued on next page.)

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID		
Hospital Benefits*			
Room and Board			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% of Basic Benefit Allowance for room and board per day, for up to 365 days per confinement.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Hospital Extras			
Basic Benefit	100% of Basic Benefit Allowance for hospital extras.		
Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Newborn Nursery Care			
Basic Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Skilled Nursing Facility			
Basic Benefit	Up to 100 days per Plan Year for extended care in Medicare-approved facilities; confinement must begin within 14 days after confinement of at least 3 days in an acute care hospital.		
Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Hospice Care			
Basic Benefit	PPO: 100% for all covered services up to 90 days (can be extended by physician); 90 days for bereavement from date of death	Non-PPO: 100% up to MAC for all covered services up to 90 days (can be extended by physician); 90 days for bereavement from date of death	No PPO Access: 100% up to MAC for all covered services up to 90 days (can be extended by physician); 90 days for bereavement from date of death
Ambulance Benefit			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to Basic Benefit Allowance per confinement for transportation to or from a hospital (included in "Hospital Extras" benefit). Emergency ambulance service is covered under Emergency Treatment on page 31.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC

(Table continued on next page.)

* *Hospital benefits, including doctor hospital visits, surgery, assistant surgeon and anesthesiologist benefits, renew for each separate confinement when due to entirely unrelated causes. When successive hospital confinements are due to the same or related cause, hospital benefits renew for Active Employees on the earlier of return to work (including availability for work) or three months following discharge from the hospital; for Pensioners, survivors, and their dependents, hospital benefits renew three months following discharge from the hospital.*

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID		
Medical/Surgical Benefits			
Doctor Office Visits			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to Basic Benefit Allowance per visit, limited to one visit/day for each eligible person unless the visits are to different doctors for separate and unrelated conditions.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Doctor Home Visits			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to Basic Benefit Allowance per visit, limited to one visit/day for each eligible person unless the visits are to different doctors for separate and unrelated conditions.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Doctor Hospital Visits			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to Basic Benefit Allowance per visit, limited to one visit for each day of inpatient confinement. Maximum payment per hospital confinement is listed in the Basic Benefits—Schedule of Allowances.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
In-Patient Surgery			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	Up to maximum of listed in the Basic Benefits—Schedule of Allowances per disability.* Radiation therapy and surgical services for maternity are covered under the surgical benefit. **Maximum payment for any one surgical procedure is based on the 1964 Relative Value Schedule (RVS) Units, translated to and expanded into up-to-date Current Procedural Terminology (CPT) codes at amount listed in the Basic Benefits—Schedule of Allowances for each unit listed for the procedure.*		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Out-Patient Surgery In An Ambulatory Surgery Center (ASC)			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	Up to maximum of listed in the Basic Benefits—Schedule of Allowances per disability.* Radiation therapy and surgical services for maternity are covered under the surgical benefit. Basic Benefits will not be provided for Out-Patient Surgery charges in an ASC unless referred to by a PPO provider. **Maximum payment for any one surgical procedure is based on the 1964 Relative Value Schedule (RVS) Units, translated to and expanded into up-to-date Current Procedural Terminology (CPT) codes at amount listed in the Basic Benefits—Schedule of Allowances for each unit listed for the procedure.*		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: Not Covered (only if referred by a PPO Provider; then 100% of MAC)	No PPO Access: 100% of MAC

(Table continued on next page.)

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID		
Multiple Surgical Procedures During the Same Operative Session			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	Full Plan benefits are payable for the major surgical procedures. 50% of Plan benefits for each lesser procedure which adds significantly to the time and the complexity of the operation, up to the surgery maximum per disability. All operations for the same condition are considered a single disability, subject to the surgery maximum. *No benefits are payable for incidental procedures which do not add significantly to the time and complexity of an operation.*		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Assistant Surgeon			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	20% of the surgery allowance based on the RVS unit allowance, up to maximum listed in the Basic Benefits—Schedule of Allowances per disability.		
Anesthesiologist (MD)			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to maximum listed in the Basic Benefits—Schedule of Allowances per unit based on the unit allowance and "Anesthesia Time Units" of one unit per quarter hour, up to a maximum listed in Basic Benefits—Schedule of Allowances per disability.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Chiropractic Treatment			
Limited to 40 visits per Plan Year (except when the Welfare Plan chiropractic consultant decides additional visits are medically necessary).			
CHOICE PORTS			
Basic Benefit	PPO: 100% of covered charges	Non-PPO: Not covered	
NON-CHOICE PORTS (NO PPO ACCESS)			
Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to the maximum listed in Basic Benefits—Schedule of Allowances per visit or if visiting a PPO provider: 100% of the PPO rate for covered charges.		
Major Medical Benefit (in addition to Basic Benefit)	100% of MAC		
Cosmetic Surgery After Mastectomy			
If all or part of a breast is removed for medically necessary reasons, the following services are covered the same as any other surgery: reconstruction of the breast on which mastectomy performed, and surgery and reconstruction of the other breast to produce symmetrical (balanced) appearance, prosthesis, and services for physical complications resulting from mastectomy.			
first, Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	Covered the same as any other surgery.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC

(Table continued on next page.)

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID		
Outpatient Diagnostic X-Ray / Laboratory Benefits			
Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to maximum listed in Basic Benefits—Schedule of Allowances per accident or sickness in each six-month period. Benefit renews January 1 and July 1 of each year.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Well Baby Care			
Basic Benefit	PPO: 100% of covered charges during the child's first year	Non-PPO: 80% of MAC during child's first year	No PPO Access: 100% of MAC during child's first year
Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Routine Physical Examination for Adults			
Basic Benefit	PPO: 100% of covered charges for the exam and related lab and x-ray charges; maximum of one each Plan Year.	Non-PPO: 80% of MAC for exam and related lab and x-ray charges; maximum of one each Plan Year, up to $400.	No PPO Access: 100% of MAC for exam and related lab and x-ray charges; maximum of one each Plan Year.
Routine Physical Examination for Children			
Basic Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Mammograms			
Basic Benefit	Benefits payable in full for routine mammograms for breast cancer screening, and related office visit (according to current American Cancer Society guidelines in effect at time of treatment).		
Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Pap Tests (Routine)			
Basic Benefit	One pap smear and related office visit paid in full intervals according to the American Cancer Society guidelines in effect at the time of treatment.		
Pap Tests (Diagnostic)			
Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Prostate Specific Antigen (PSA) Test (Routine)			
Basic Benefit	One PSA (or its successor) test and related office visit paid in full every year at age 50 and over (according to American Cancer Society guidelines).		
Prostate Specific Antigen (PSA) Test (Diagnostic)			
Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Physical Therapy (when prescribed by a doctor)			
Basic Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC

(Table continued on next page.)

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID		
Occupational Therapy (when referred by a doctor to a licensed occupational therapist)			
Basic Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Speech Therapy (when referred by a doctor to a licensed speech pathologist or audiologist)			
Basic Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Mental Health Benefits — Inpatient			
Basic Benefit	Paid the same as any other illness.		
Major Medical Benefit	Paid the same as any other illness.		
Mental Health Benefits — Outpatient			
Basic Benefit *(refer to the Basic Benefits—Schedule of Allowances)*	100% up to Basic Benefit Allowance per visit. Limited to one visit/day for each eligible person unless the visits are to different doctors for separate and unrelated conditions.		
then, Major Medical Benefit	PPO: 100% of covered charges	Non-PPO: 80% of MAC	No PPO Access: 100% of MAC
Maternity			
Basic Benefit	Paid the same as any other illness.		
Major Medical Benefit	Paid the same as any other illness.		

Prescription Drug Program

Network Pharmacy (OptumRx)	
Retail	$1.00 copayment for each prescription or refill at time of purchase.
Prescriptions by Mail	No copayment for each prescription or refill ordered through mail service.

Compound Drugs

If your compound pharmacy is not on the current Credentialed Pharmacies Listing found at **www.benefitplans.org**, your compound prescription will not be covered.

Effective August 22, 2016, if the compound drug you are being prescribed will cost more than $1,000 per prescription you must have the prescription prior-authorized. To request a prior-authorization your doctor and/or pharmacy can:

- Call OptumRx at the toll-free number on the back of your OptumRx ID card
- FAX a completed prior-authorization form available on **OptumRx.com** to OptumRx
- Submit the information through the online provider portal at **OptumRx.com**

After OptumRx receives the request, they will notify you, your doctor, and/or your pharmacy to let you know if the medication is covered under your pharmacy benefit plan. If coverage of the compound medication is not approved you can still get the medication, but you will pay the full cost of the prescription.

Participants will have to pay out-of-pocket for prescription compound drugs that contain non-covered bulk chemicals or that are filled by a compound pharmacy that is not credentialed by OptumRx.

If you have any questions regarding coverage for benefits provided by OptumRx, please contact the ILWU-PMA Benefit Plans Office at 415-673-8500.

Non-PPO Pharmacy

Pay for entire cost of prescription at time of purchase and submit claim form for reimbursement. You will be reimbursed for up to the reasonable charges less the $1.00 co-pay.

Copayment may be more than $1.00 if pharmacy's charges exceed reasonable charges.

(Table continued on next page.)

SCHEDULE OF BENEFITS

Vision Service Plan (VSP)

BENEFIT	HOW IT'S PAID
Eye Exams	
Well vision exam allowed once every 12 months from your last date of service. You can receive benefits for eyeglass lenses and contact lenses. Under the Ophthalmology Benefit, when you are entitled to a routine eye examination through VSP, you may elect to obtain the examination from a non-Member ophthalmologist instead of a VSP Member Doctor. In such case, the Welfare Plan will supplement the benefit paid to you by VSP, up to Maximum Allowable Charge (MAC) for the examination. The Welfare Plan supplement is subject to the $5 deductible you normally pay to a VSP Member ophthalmologist. The Ophthalmology Benefit does not cover visits to an ophthalmologist for treatment of eye disease; such treatment is covered under your health plan hospital-medical-surgical benefits.	
VSP Provider	**Non-VSP Provider**
$5 copayment; then VSP pays provider directly for covered services and materials.	Plan pays up to MAC less $5 deductible and the amount paid by VSP. You pay member doctor; then submit claim form to VSP for reimbursement for covered services and materials (may not be paid in full). Claims must be submitted within 6 months from the date of service. If you choose to make an appointment for a routine eye examination with an ophthalmologist who is not a VSP Member Doctor, pay your own bill for the examination. It would be helpful to request two copies of the itemized bill, since you will be filing a claim both with VSP and with the ILWU-PMA Coastwise Claims Office. Then file a claim with VSP—send a copy of your itemized bill along with your VSP benefit form. VSP will partially reimburse you according to a schedule, and will send you an explanation of their payment. After you receive payment from VSP, file a claim with the ILWU-PMA Coastwise Claims Office. Use an Ophthalmology Benefit Claim Form (available at your local, the Benefit Plans Office or online at **www.benefitplans.org**) and attach a copy of your itemized bill and a copy of the VSP explanation of payment (Washington eligibles) or a copy of the VSP check. Mail to the address indicated on the form. Payment of Ophthalmology Benefit claims are issued by the ILWU-PMA Coastwise Claims Office. The amount of payment is generally the difference between the VSP reimbursement and the Maximum Allowable Charge (MAC) for the examination and the $5 deductible which you would normally pay a VSP Member Doctor.
Eyeglasses	
Well vision exam and prescription eyeglass lenses and contact lenses allowed once every 12 months from your last date of service; prescription eyeglass frames allowed once every 24 months from your last date of service. You can receive benefits for eyeglass lenses and contact lenses.	
VSP Provider	**Non-VSP Provider**
Frames: $300 allowance every 24 months; then 20% discount on the cost over the allowance. **Lenses:** Single vision, lined bifocal, lined trifocal, lenticular lenses are covered in full. **Lens options:** Anti-reflecting coating, scratch coating, mirror coating, color coating, blended lenses, polycarbonate lenses, high index lenses, progressive lenses; photochromic lenses, polarized lenses—covered in full when prescribed by a VSP Member Doctor.	**Frames:** Up to $47 **Lenses:** **Single Vision:** Up to $45 **Bifocal:** Up to $65 **Trifocal:** Up to $85 You pay the doctor; then submit claim form to VSP for reimbursement for covered services and materials (may not be paid in full).

(Table continued on next page.)

SCHEDULE OF BENEFITS

BENEFIT	HOW IT'S PAID
Contact Lenses	
Well vision exam and prescription eyeglass lenses and contact lenses allowed once every 12 months from your last date of service; prescription eyeglass frames allowed once every 24 months from your last date of service. You can receive benefits for eyeglass lenses and contact lenses.	
VSP Provider	**Non-VSP Provider**
Elective: $300 allowance (for exam, fitting and lenses) every 12 months. Any costs exceeding the allowance are the patient's responsibility. **Medically Necessary:** Covered in full after a $5 copayment for eye conditions that prohibit the use of glasses. Covered conditions include: aphakia, anisometropia, high ametropia, nystagmus, keratoconus.	**Elective:** $300 allowance (for exam, fitting and lenses) every 12 months. Any costs exceeding the allowance are the patient's responsibility. **Medically Necessary:** $5 copayment then $250 allowance (for exam, fitting and lenses).
Extra Discounts and Savings	
VSP Provider	**Non-VSP Provider**
Eyeglasses and Sunglasses Average 35% to 40% savings on all non-covered lens options 30% off additional eyeglasses and sunglasses, including lens options, from the same doctor on the same day as your Well vision exam. Or get 20% off from any VSP doctor within 12 months of your last Well vision exam. **Contacts** 15% off cost of contact lens exam (fitting and evaluation). **Laser Vision Correction** Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.	N/A
Diabetic Eyecare	
Available to participants and their dependents who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions.	

Service	Benefit	Frequency
Ophthalmological Services and Office Visits	Covered in full, less $20.00 Copayment	Once every 12 months
Gonioscopy	Covered in full	Once every 12 months
Extended Ophthalmoscopy	Covered in full	Once every 6 months
Fundus Photography	Covered in full	Once every 6 months

Limitations apply. Doctors should consult VSP for details before rendering services.

- When you are entitled to a routine eye examination through VSP, you may elect to obtain the examination from a non-VSP ophthalmologist. The benefit will supplement VSP's charge, up to MAC for the examination. The supplement is subject to the $5 copay.
- Exam allowed once every 12 months from your last date of service and is instead of a VSP exam.
  This benefit does not cover visits to an ophthalmologist for treatment of eye diseases.
- You pay the ophthalmologist at time of service, and submit the claim to VSP. VSP will partially reimburse you according to the payment schedule; then you file a claim using the Ophthalmology Benefit Claim form. The amount of reimbursement is generally the difference between the VSP reimbursement and MAC and $5 copayment for the examination.

(Table continued on next page.)

C. Additional Benefits

Injectables Benefit

- Pays 100% of PPO or 100% of MAC for prescribed immunization materials and any therapeutic agent administered by injection in the course of covered treatment by a doctor.
- Chemotherapy injectable medications administered by doctors to patients who are not hospitalized are included. The benefit does not cover experimental drugs or drugs not generally accepted by the medical profession as proper treatment for the condition being treated.
- Self-administered injectables, other than insulin.

Kidney Dialysis Benefit

Non-Medicare Eligible

Persons under age 65 who require kidney dialysis because of permanent kidney failure—End Stage Renal Disease become eligible for Medicare coverage after a period of dialysis treatments or upon receiving a kidney transplant. Before Medicare coverage starts, the Kidney Dialysis Benefit pays up to 100% of MAC or 100% of PPO for kidney dialysis treatment at home or in a non-hospital treatment center. After 30 months of treatment, Medicare is primary.

Medicare Eligible

- After Medicare eligibility has been established, supplemental hospital, medical and surgical benefits pays the difference between Medicare-allowed charges and actual charges up to 100% of MAC.
- Kidney dialysis patients must maintain enrollment for Medicare Part B medical benefits, in order to retain eligibility for Coastwise Indemnity Plan Supplemental Benefits.

Durable Medical Equipment Benefit for TENS Units and Cold Therapy Units

Medicare and Non-Medicare Eligible

Effective May 29, 2007, the Plan provides coverage for TENS units and cold therapy units as durable medical equipment, when prescribed by a physician as medically necessary. TENS units are covered for the treatment of knee osteoarthritis in patients who cannot undergo a definitive surgical procedure, or for urinary incontinence for women with urge incontinence.

Durable Medical Equipment and Apparatuses Benefit for Treatment of Temporal Mandibular Joint (TMJ) Dysfunction

Non-Medicare Eligible

This benefit covers durable medical equipment and apparatuses benefit for treatment of TMJ dysfunction when prescribed by a physician as medically necessary to monitor a permanent condition.

Medicare Eligible

Medicare-eligible participants are not covered under this benefit unless it is medically necessary but not covered by Medicare. Medicare-eligible participants must first file a claim with Medicare and then include a copy of the Medicare denial when sending a claim form to the Benefit Plans Office.

Supplementary Accident Benefit

Non-Medicare Eligible

This benefit is payable only in cases of accidental injury. Expenses must be incurred within 90 days after the accident. Up to $300 is payable for the following, when not otherwise paid under the Plan.

- Necessary hospital expenses
- Services of doctors
- Services of a licensed nurse (other than one who normally lives in the patient's home)
- Braces
- Crutches
- Wheelchair rental
- Repair or replacement of sound natural teeth if claimant is not otherwise reimbursed under the Plan

D. Basic Benefits

The Coastwise Indemnity Plan pays basic hospital, medical and surgical benefits at 100% of the amounts for covered services according to the Basic Benefits—Schedule of Allowances effective on the date claims are incurred. The Basic Benefits—Schedule of Allowances will be updated every April and October. For an up–to-date Basic Benefits—Schedule of Allowances, you may go online to **www.benefitplans.org** or contact your local or the Benefit Plans Office, or call the Coastwise Claims Office at 800-955-7376.

Basic Benefits cover only the specific type of expenses listed in the Schedule of Benefits above if they are medically necessary and are ordered by a doctor for treatment of an illness or injury.

E. Major Medical Benefits

In addition to the Basic Benefits outlined in the Schedule of Benefits above, the Coastwise Indemnity Plan provides Major Medical Benefits that pays benefits after maximum Basic Benefits have been paid and after any applicable deductible has been satisfied.

If you reach the annual out-of-pocket maximum under the Major Medical Benefits described above, the Plan pays further covered charges at 100% of MAC for the remainder of that Plan Year.

1. **Deductible**

   The deductible is the amount of out-of-pocket expenses you must pay each year before the Plan begins to pay benefits under the Major Medical Benefit provision.

   A new deductible must be satisfied each Plan Year (July 1 – June 30). Deductible amounts incurred during the last three months of a Plan Year will be carried over as a credit toward the deductible in the following year. No carry-over is allowed from any year during which the deductible is satisfied within the first nine months of the year.

   A separate $100 deductible applies to each family member, but no more than $300 will be applied to the covered expenses of any one family.

   If two or more family members are injured in a common accident, only one deductible will be charged to the group for expenses related to that accident.

2. **Out-of-Pocket Maximum**

   During a Plan Year (July 1 – June 30) when a family has incurred $5,000 of covered Major Medical Benefit expenses (of which the family has paid $1,000—in addition to any applicable deductibles) additional Major Medical Benefit covered expenses are then payable at 100% of the MAC for covered services for the remainder of the Plan Year.

3. **Covered Major Medical Benefit Expenses**

   Expenses for the following are covered under the Plan's Major Medical Benefits:

   - Anesthesia and its administration.
   - Blood and blood plasma; casts and splints.
   - Braces, crutches, rental of wheelchairs or hospital beds; oxygen and the rental of equipment for its administration; and initial prosthetic devices including initial (under this Plan) but not subsequent artificial limbs and eyes. See description of Subsequent Prosthetic Devices Benefit in the separate SSPD for that benefit. If the rental cost of covered equipment would exceed the purchase price, the Plan will cover the purchase price.
     Note: These items are exclusions under Basic Benefits.
   - Chiropractic Treatment – limited to 40 visits per Plan Year (July 1 - June 30) for PPO and No PPO Access, except where the Welfare Plan chiropractic consultant decides additional visits are medically necessary.
   - Coronary Care Unit charges beginning with the first day of confinement.

- Daily hospital room and board charges, beginning with the first day of confinement, are covered at the hospital's semi-private room rate.
- Dental treatment for a fractured jaw or for injury to or replacement of sound natural teeth within six months after an accident (covered only after maximum payments under the Longshore Adult or Children's Dental Plan have been made).
- Diagnostic radiology, radiation therapy and laboratory examinations.
- Emergency room charges.
- Foot appliances and castings, when prescribed by a Podiatrist, up to $400 per year.
- Hospitalization in isolation when ordered by a physician.
- Intensive Care Unit (ICU) charges beginning with the first day of confinement in ICU.
- Licensed ambulance service to and from the hospital.
- Intraocular Lens (IOL) Implants such as premium multifocal lenses, accommodating lenses, and astigmatism-correcting lenses (e.g., aspheric, toric) inserted after cataract surgery.
- Services and supplies furnished by a hospital (hospital extras).
- Services of a registered nurse and treatment by a licensed physiotherapist, other than one related by blood or marriage to the patient or one who lives in the patient's home.
- Treatment by a physician or surgeon.
- Treatment of mental or emotional conditions.
- Skilled Nursing Facilities – extended care in Medicare-approved facilities.

F. Supplemental Plan: Hospital, Medical and Surgical Benefits for Medicare-Eligible Participants

This section describes the Coastwise Indemnity Plan supplemental hospital, medical and surgical benefits for eligible Pensioners and survivors with Medicare.

Eligible Pensioners and survivors with Medicare shall in no way be disadvantaged due to enrollment in Medicare. These eligible participants are entitled to any and all benefits covered under the Coastwise Indemnity Plan.

1. Medicare Enrollment

Medicare coverage is available to persons age 65 and older, and to Social Security disability Pensioners under age 65 who have received disability benefits for 24 months. Persons requiring kidney dialysis become eligible for Medicare after a period of dialysis treatments or upon receiving a kidney transplant.

Medicare provides hospital benefits (Medicare Part A) and medical benefits (Medicare Part B). Medicare Part B is not automatic. The Medicare-eligible person must enroll and pay a monthly premium, which may be deducted by Social Security from your monthly Social Security benefits. The monthly premium charged by Social Security for Medicare Part B benefits is reimbursed to the Pensioner, his Medicare-eligible dependent spouse or survivor by the ILWU-PMA Welfare Plan.

A handbook containing a complete explanation of Medicare benefits and instructions for filing Medicare claims is available in your local Social Security Office or online at **www.medicare.gov**.

Coastwise Indemnity Plan hospital, medical and surgical benefits are integrated with primary Medicare coverage. Pensioners and/or survivors and their dependent(s) must, if eligible, enroll in Part B of Medicare in order to maintain their eligibility for Coastwise Indemnity Plan

hospital, medical and surgical benefits. Pensioners and/or survivors who permanently reside outside the United States and do not intend to return to obtain medical care in the United States are not required to enroll in Medicare since Medicare benefits are not available out of the country and are therefore not reimbursed for Medicare Part B premiums.

Under federal law, Active Employees and their dependents who are eligible for Medicare continue to be covered primarily under the Welfare Plan until retirement. Therefore, Active Employees are not required to enroll for Medicare Part B even when eligible to do so, except for persons with End Stage Renal Disease. Upon retirement, such employees will be required to enroll for Medicare Part B and will receive enrollment instructions and information from the Benefit Plans Office.

2. Covered Services

All Medicare-approved services are covered by the Supplemental Plan. The Medicare handbook available at your Social Security office describes Medicare-approved services in detail. You can also download a copy from the Social Security Administration website at **www.ssa.gov**.

3. Supplemental Benefit Amounts

Coastwise Indemnity Plan Supplemental Benefits for Medicare-eligible participants are intended to supplement the benefits provided by Medicare. If your provider does not participate in Medicare, Supplemental Benefits pay the difference between what the provider may charge (in accordance with Medicare requirements) and the Medicare-allowed charge.

4. Hospital Benefits

Medicare Part A covers hospital charges, except for a per-benefit period deductible. The Supplemental Plan pays this hospital deductible plus the daily coinsurance amount not paid by Medicare for the 61st through 90th day of confinement per benefit period.

5. Medical and Surgical Benefits

After you satisfy your annual deductible, Medicare Part B pays 80% of all Medicare-allowed charges. Medicare-allowed charges are that portion of a doctor's or other provider's charges that Medicare determines to be reasonable.

The Plan's Supplemental Benefits pay the Medicare Part B annual deductible and the 20% Medicare-allowed charge not paid by Medicare.

Example	
Doctor's charge (determined by MAC)	$52
Medicare-allowed charge	$45
Medicare payment (80% of Medicare-allowed charge)	$36
Supplemental Plan payment	$9

In addition, out-of-pocket expenses that are not covered by Medicare, such as acupuncture and services provided by a marriage and family therapist (MFT), will be payable under Supplemental Benefits if they are covered under the Basic Benefit, Major Medical Benefit or Additional Benefits for Non-Medicare-Eligible Participants. Basic and Major Medical Benefits are described fully in the sections beginning on page 28. However, in no case will the Plan pay an amount over the Medicare amount you would be responsible to pay if you did not have coverage under this Plan.

6. Mental Health Benefits

If you are eligible for Medicare, you have coverage under the Supplemental Plan at 100% of MAC for Medicare-covered mental health services and Coastwise Indemnity Plan-covered mental health services as described on page 24.

G. Maintenance of Benefits

The Trustees monitor the Coastwise Indemnity Plan to determine whether the out-of-pocket costs to beneficiaries have increased. If so, periodic adjustments in the Basic Benefits Schedule of Allowances will be made.

H. Emergency Treatment

1. **In PPO Area**

   If an eligible Plan participant in a PPO network area needs emergency medical treatment, including ambulance service, he/she should go immediately to the nearest hospital emergency medical facility. The Plan will reimburse the cost of such emergency treatment at 100% of PPO negotiated rates if the hospital facility, ambulance service, and/or emergency room physician is a PPO provider.

   If the hospital emergency facility, ambulance service or physician is not a PPO provider, the Plan will reimburse the cost of emergency treatment at 100% of MAC. If continued treatment or admission is needed, the participant may be required to transfer to a PPO hospital as soon as the attending physician determines it is medically safe and reasonable to be transported. If the participant chooses to continue to receive treatment at the non-PPO hospital after the emergency period, the Plan will pay Basic and Major Medical Benefits at the non-PPO services level (80% of MAC after the deductible) for the additional treatment.

   A **"Medical Emergency"** is defined as: the sudden onset of a medical condition that the patient believes requires immediate treatment because it is either (1) life threatening, or (2) would cause a serious dysfunction or impairment of a body organ or part if not immediately treated.

2. **Out of PPO Area Emergency or Urgent Treatment**

   If an eligible Plan participant assigned to a PPO area receives emergency or urgent medical treatment while outside of that PPO area, the Plan will reimburse the cost of such emergency or urgent treatment, including ambulance service, at 100% of MAC. If continued treatment is needed, the participant may be required to transfer back to a PPO area as soon as the attending physician determines it is medically safe and reasonable to be transported. If the participant chooses instead to continue to receive treatment outside the PPO area after the urgent or emergency period, the Plan will pay Basic and Major Medical Benefits at the non-PPO services level (80% of MAC after the deductible, or 100% of MAC after satisfying both the deductible and out-of-pocket maximum) for the additional treatment.

   A **"Medical Emergency"** or **"Urgent Treatment"** is defined as: the sudden onset of a medical condition that the patient believes requires immediate treatment because it is either (1) life threatening, or (2) would cause a serious dysfunction or impairment of a body organ or part if not immediately treated, or (3) a condition for which immediate treatment would be obtained if the medical condition occurred within a PPO area.

I. General Exclusions Under the Plan

- Services which are not medically necessary to treat an illness or injury, or which are customarily furnished without charge.
- Services performed in or outside the United States which are experimental in nature or do not meet established treatment protocols in the United States.
- Services performed on or to the teeth except as specifically allowed under the Plan's Major Medical Benefits.

- Services for conditions covered by state or federal laws, workers' compensation or employer liability or similar laws.
- Services provided without cost by any federal or state government agency, county or municipality.
- Services (excluding dental) provided by relatives (by blood, marriage, or legal adoption) or by people ordinarily residing in the member's household.
- Services for conditions caused by war or act of war.
- Benefits provided under other ILWU-PMA Welfare Plan programs.
- For Choice Port enrollees, treatment provided after November 11, 2015 by an out-of-network (Non-PPO) ambulatory surgery center unless referred by an in-network (PPO) doctor.

J. What the Basic Benefits Do Not Cover

- Any type of medical expense not specifically listed as a covered Basic Benefit.
- Medical equipment, including but not limited to, casts, prosthetic devices such as artificial limbs and eyes, orthopedic appliances, braces, crutches, wheelchairs, hospital beds, oxygen and the rental of equipment for its administration.
  Note: Some of these items are covered under Major Medical Benefits—see page 28.
- Care in a convalescent home or rest home.
- Optometric services, including examinations, refractions, visual aids or orthoptics.
  Note: These may be covered under the VSP vision plan—see page 41.
- *General Exclusions* are not covered under Basic Benefits.

K. What the Major Medical Benefits Do Not Cover

- Charges for covered services which exceed the Maximum Allowable Charge. Payment is made only for charges which are reasonable and in line with the fees customarily charged for the treatment or service rendered by providers of care in the same area.
- Except where specifically noted above, services that are excluded under Basic Benefits or under Supplemental Benefits are also excluded under Major Medical Benefits.
- Cosmetic surgery is not covered except if it is necessary as the result of an accident and if it is performed within six months of the date the accident occurred. Cosmetic surgery to correct abnormal congenital conditions of a child is a covered benefit, if performed prior to the child's 26th birthdate.
- The Prescription Drug Program copayment is not covered.
- *General Exclusions* are not covered under Major Medical Benefits.

L. What the Supplemental Plan Benefits Do Not Cover

- Services not covered by Medicare, except as noted above unless they are covered under Basic Benefits, Major Medical or Additional Benefits for non-Medicare-eligible participants.
- *General Exclusions* are not covered under Supplemental Benefits.

M. How to File a Claim

1. **Basic Hospital, Medical and Surgical Benefits**

   All claims should be filed within 180 days from the date covered services are incurred but will be accepted for up to three years, unless a later filing date is allowed by the Trustees.

   You should identify yourself as a Plan participant to your provider, and generally the provider will file the claim for you. However, if you receive services from a non-PPO provider or an out-of-area provider who does not file the claim on your behalf, you will be responsible for ensuring that the claim is filed correctly and on time.

   To obtain a claim form, you may go on-line to **www.benefitplans.org**. If filing your own claim, you must complete the appropriate claim form and provide an itemized original bill from your provider that includes the following: Patient name, date of birth, and diagnosis; Date or dates of service; Procedure codes and descriptions of services rendered; Charge for each service rendered; and Service provider's name, address, and tax identification number.

   The claim form Part 1 – Employee Statement must be completed by the eligible claimant, Active Employee, Pensioner, or survivor. Part 2 – Physician Statement must be completed by the attending doctor or other provider of service.

   You may send the form and original bills to the address listed on the claim form, as detailed further below.

   Participants and providers must submit appropriate documentation to support the diagnosis and services or supplies billed.

2. ***For Participants in California***

   For non-Medicare-eligible participants, medical claims for services incurred in California should be submitted to Blue Shield of California, PO Box 272540, Chico, CA 95927-2540.

   Medical claims for services incurred outside of California, except for claims incurred using a BlueCard Program service provider, should be submitted to the ILWU-PMA Coastwise Claims Office, PO Box 429101, San Francisco, CA 94142. Claims incurred using a BlueCard Program service provider will be filed by the provider with the local Blue Shield Blue Cross. Claims incurred using the Magellan Health network of providers should be submitted by the provider electronically, via **www.MagellanHealth.com/provider** or through a clearinghouse. When submitting electronically, providers should use the HAI-CA's submitter ID 01260. Paper claims may be submitted to Magellan Health Services, PO Box 2216, Maryland Heights, MO 63043.

   All other claims for Medical Services, including claims incurred using the Chiropractic Health Plan of California network, should be filed with the ILWU-PMA Coastwise Claims Office, PO Box 429101, San Francisco, CA 94142.

   All Medicare-eligible (Pensioners, survivors, and their Medicare eligible dependents) claims, regardless of where incurred, should be filed by you or your healthcare provider to Medicare. Medicare, after processing will issue an Explanation of Medicare Benefits (EOMB) and in most cases will then electronically submit the claim directly to the Coastwise Claims Office for final benefit review and payment of any Supplemental Benefit. This process is known as Medicare Crossover.

   In the case of secondary payments after Medicare, the claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See Assignment of Benefits on page 18.

3. For Participants Assigned to First Choice Health Network and First Health Network

For non-Medicare eligible participants who obtain services through the First Choice Health Network or First Health Network, medical claims for services should be submitted to First Choice Health PPO Network, PO Box 2289, Seattle, WA 98111-2289.

All Medicare-eligible (Pensioners, survivors, and their Medicare eligible dependents) claims, regardless of where incurred, should be filed by you or your healthcare provider to Medicare. Medicare, after processing, will issue an Explanation of Medicare Benefits (EOMB) and in most cases will then electronically submit the claim directly to the Coastwise Claims Office for final benefit review and payment of any Supplemental Benefit. This process is known as Medicare Crossover.

In the case of secondary payments after Medicare, the claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See Assignment of Benefits on page 18.

4. Supplemental Plan Benefits for Medicare-Eligible Participants

For claims from providers who do not accept Medicare assignment and do not bill secondary coverage, claim forms, called "Claim for Supplemental Plan Benefits", are supplied to ILWU locals and available on request from the Coastwise Claims Office, the Benefit Plans Office or online at **www.benefitplans.org**. To claim Supplemental Plan Benefits, the eligible person must complete one of these forms. The claim forms are pre-printed with the group name and the Coastwise Claims Office address. No policy number is required to identify your claim.

Claims for Supplemental Plan Benefits are subject to the same claim procedures as Basic Benefits and Major Medical Benefits and the rules on Medicare reimbursement. The claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See Assignment of Benefits on page 18.

For Medicare-eligible participants, an Explanation of Medicare Benefits (EOMB), must be attached to the claim form.

Mail the completed claim form, with attachments to:

ILWU-PMA Coastwise Claims Office
PO Box 429101
San Francisco, CA 94142
800-955-7376

All Supplemental Plan Benefit claims for services covered by Medicare must be submitted first to Medicare for payment or denial, then to the Coastwise Claims Office for payment of Supplemental Plan and Major Medical Benefits. The claims procedure for Medicare-eligible participants is described in greater detail below.

5. Medicare Benefits

Medicare-eligible persons must have all claims for services covered by Medicare filed with Medicare first. In most cases, your provider will file your claim for you. Please confirm with your provider whether they will file with Medicare or if you will be required to do so. The Social Security Medicare handbook tells how to submit and where to submit Medicare claims. A current edition of the handbook is available at any Social Security Office or online at the website **www.medicare.gov**. This handbook provides additional information and instructions on filing claims with Medicare.

Medicare payments can be made directly to the doctor or other provider of service. Medicare calls this optional payment method "Assignment of Benefits." When the assignment method is used, the doctor or provider agrees that the total charge for the covered service will not exceed the charge approved by Medicare.

If the provider does not accept Assignment of Benefits, then Medicare payment is made directly to the eligible person.

When Medicare processes a claim, the eligible person receives an Explanation of Medicare Benefits which is a record of the action Medicare has taken on the claim. Based on an agreement with the Medicare Part A and Part B claim processor, the Coastwise Claims Office can receive an electronic copy of the EOMB. Upon receipt of the EOMB the Coastwise Claims Office will process the claim under the provisions of the Supplemental Hospital, Medical and Surgical Benefits and issue payment to the provider. If there are issues with the Coastwise Claims Office receiving the electronic copy of the EOMB, please have your provider mail the claim to the Coastwise Claims Office and not to Blue Shield of California or First Choice Health Network. This may happen when you initially become eligible for Medicare Part B.

It is important to remember that ALL claims for services covered by Medicare must be submitted first to Medicare, then to the Coastwise Claims Office. Even if Medicare denies the claim, the Coastwise Claims Office needs the record of Medicare action (payment or denial) in order to calculate Supplemental Benefits. If your claim is incurred outside the United States, you should submit your claim form directly to the Coastwise Claims Office as noted below.

6. Major Medical Benefits

Major Medical Benefit payments are calculated at the same time as Basic Benefits and Supplemental Plan payments. Therefore, it is not necessary to submit separate claims for Major Medical Benefits. Claims for Major Medical Benefits are subject to the same claim procedures as Basic Benefits.

The claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See Assignment of Benefits on page 18.

7. Additional Benefits

Claims for injectables are filed with the Coastwise Claims Office:

ILWU-PMA Coastwise Claims Office
PO Box 429101
San Francisco, CA 94142
800-955-7376

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Section V.

Prescription Drug Program

Eligibility

All persons with ILWU-PMA Welfare Plan eligibility who are eligible for Welfare Plan hospital-medical-surgical benefits through the Coastwise Indemnity Plan are eligible for the Prescription Drug Program.

A. How the Program Works

This program provides three ways to obtain prescriptions and refills written by a physician, dentist, optometrist or podiatrist.

1. **Network Pharmacy – Retail**

   For short-term medications a retail network pharmacy may work best for you. You do not have to pay the entire cost of prescriptions at the time of purchase. Simply present your OptumRx ID card to a network pharmacy, and you will be charged a $1.00 co-payment for each covered new prescription or refill. To locate a network pharmacy, call OptumRx toll free Customer Service at 800-RxRxRx1 (800-797-9791) or go to **www.optumrx.com** to find a network pharmacy in your area.

2. **Prescriptions by Mail**

   As a convenience to you, you may order prescriptions through the mail from OptumRx. There is no copayment for prescription drugs ordered through the mail order service. The mail order service works as follows:

   - **New Prescriptions by Mail:** When you (or eligible dependent) start a newly prescribed maintenance medication, request two prescriptions and have one filled immediately at a retail network pharmacy, paying the $1.00 copayment (see above). When you are confident that you will continue using the prescribed medication, you should complete a mail service order form and mail the second prescription to OptumRx, at least 14 days before you need the medicine. There is no copayment when filling your prescriptions by mail. If you are currently taking a maintenance medication, you should ask the doctor to provide a new prescription and then mail it to OptumRx at the address on the mail order service form. The prescription order will arrive at the member's home with a reorder form that shows the number of refills remaining.
   - **Refills by Mail:** At least two weeks before a refill is needed, the member should send OptumRx the reorder form. Refills may also be ordered by calling 800-797-9791 or visit **www.optumrx.com**. Reorder forms are available at **www.benefitplans.org**.
   - **Mail Service Prescription Drug Order Forms:** Forms may be obtained from the Union locals or the Benefit Plans Office. OptumRx's self-addressed envelopes are also available at the Union locals or the Benefit Plans Office.

3. **Non-PPO Pharmacy**

   Members who are unable to use a PPO or network pharmacy may pay the entire cost of the prescription at the time of purchase and submit a claim form for reimbursement, up to reasonable charges less the $1.00 copayment per prescription. The member's copayment will be higher if the Non-PPO pharmacy's charges exceed reasonable charges. Claim forms are available at your local, the Benefit Plans Office or at **www.benefitplans.org**. The Employee portion certifying the claim is valid and the pharmacist portion of the form must both be completed. Members will be required to attach their original pharmacy receipt(s) to the claim form. Reimbursement payments are processed within 21 days of OptumRx's receipt of the claim form.

4. What Drugs Are Covered

Any legend drug that requires a written prescription is covered. Ask your doctor or a pharmacist about generic options every time you fill a prescription. When you have your prescription filled with a generic, you can be sure you are getting the medication you need at a better value.

5. Days Supply

The maximum prescription dispensed at any time is a 30-days supply for retail (100-days supply when prescribed by the patient's doctor as a maintenance drug) and 90-days for mail order prescriptions. Prescriptions for controlled substances have different rules. Ask your doctor for details. Please note the list of excluded items under the heading *What Items Are Not Covered*. Refills are covered on the same basis as the original prescription.

6. What Over-The-Counter Drugs Are Covered

The following drugs, which are over-the-counter drugs, are covered only when prescribed in writing by a doctor for a diagnosed condition:

- Insulin/diabetic supplies: Including insulin syringes, needles, sugar test tablets, sugar test tape, acetone test tablets, Benedict's solution or equivalent.
- Compounded dermatological preparations, including ointments and lotions prepared by a pharmacist under doctor's prescription.
- Anti-acids, including: aluminum hydroxide, aluminum hydroxide with magnesium trisilicate, aluminum and magnesium hydroxide gel, calcium carbonate, magnesium carbonate suspension, and dihydroxlaluminum amino-acetate.
- Eye and ear medications.
- Therapeutic vitamins.
- Colostomy supplies.
- Nasal preparations.
- Cough preparations.
- Miscellaneous: elixir terpin hydrate, n.f.; epinephrine usp; ephedrine sulfate 25 mg. (3/8 gr.); ferrous sulfate 25 mg.; Sudafed 60 mg.; Fluoride, oral and topical.

7. What Items Are Not Covered

- Drugs or medicines purchased and received prior to the member's effective date or subsequent to the member's termination.
- Drugs or medicines delivered or administered to the member by a prescriber or prescriber's staff.
- Drugs or medicines prescribed as a result of war or acts of war.
- Drugs or medicines furnished or payable under any plan or law of any government agency or organization, Workers' Compensation Law, or under any insurance plan or similar plan.
- Drugs or medicines for which no charge is made.
- Medications received/consumed while in a licensed hospital, facility or medical institution.

- Medications prescribed for experimental or non-FDA approved indications unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopoeial Convention, or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law.
- Supplies and devices unless listed as covered.
- Injectable drugs.
  (**Note:** Coastwise Indemnity Plan offers an injectable benefit.)
- Immunization agents.
- Biological sera.
- Gerovital (alleged youth restoring agents).
- Nicorette Gum and other OTC smoking cessation products.
- Inhaler extender devices (e.g., Aerochamber, Inspirease, Easivent).
- T.R.U.E. test.
- Medications available without a prescription (over-the-counter) even if ordered by a physician via a prescription, except as listed under *What Over the Counter Drugs Are Covered* on page 38.
- Alternative medications.
- Prescription Misc. Nutritional Substances & Nutritional Supplements.
- Compound drugs that contain non-covered bulk chemicals identified on Excluded Bulk Chemical list found at **www.benefitplans.org**.
- Compound drugs filled by a compound pharmacy that is not on OptumRx's current Credentialed Pharmacies Listing found at **www.benefitplans.org.**

8. Claims Review Procedure

Requests for review of a denied Prescription Drug Benefit claim should be submitted to the Benefit Plans Office. *See Section K. If Your Claim for Benefits is Denied* on page 13.

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Section VI.

Vision Service Plan

A. How the Program Works

1. Utilizing a VSP Member Doctor

- When you are ready to obtain vision care services, call your VSP member doctor. If you need to locate a VSP provider, call Vision Service Plan at 800-877-7195 or visit **www.vsp.com**.
- When making an appointment, identify yourself as a VSP member and your group's name as the ILWU-PMA Welfare Plan. The doctor will contact VSP to verify your eligibility, Plan coverage and will also obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you.
- At your appointment, the doctor will provide an eye examination and determine what care, if any, is necessary. The doctor will coordinate the prescription with a VSP-approved contract laboratory. The doctor will itemize any non-covered charges and have you sign a form to document that you received services. VSP will pay the VSP provider directly for covered services and materials. You are responsible for paying the doctor a $5 copayment and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a member doctor from VSP's network assures direct payment to the doctor and guarantees quality services and materials.

2. Utilizing a Non-Member Provider

Although you may select any licensed vision care provider for services, the reimbursement schedule does not guarantee full payment, nor can VSP guarantee patient satisfaction when services are obtained from a non-member provider.

Follow these steps if you obtain services and/or materials from a non-member provider:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the services provided.
- Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:
  - — Member's name and mailing address
  - — Member's welfare identification number
  - — Member's employer or group name (ILWU-PMA Welfare Plan)
  - — Patient's name, relationship to member and date of birth

You may submit the above information on any insurance claim form that may be available from your non-member provider upon request. For any questions regarding submitting a claim, visit **www.vsp.com** or call 800-877-7195.

Please mail the itemized bill(s) and form to the following address:

Vision Service Plan
PO Box 385018
Birmingham, AL 35238-5018

Please note that you must file this claim for reimbursement within six months of the date services were completed.

B. Benefits and Coverage

1. Standard Eye Examination and Eyeglasses

- Well vision exam: Every 12 months from your last date of service.
- Prescription eyeglass lenses: Every 12 months from your last date of service.
- Prescription eyeglass frame: Every 24 months from your last date of service.

2. **Copayment**

You pay a $5.00 copayment to a VSP provider at the time of the examination.

3. **Frames**

VSP covers a wide selection of frames, but not all frames will be covered in full. The Plan allows a $300 benefit allowance every 24 months for frames and 20% off the amount over your allowance.

4. **Lenses**

The following lenses are covered in full when provided by a VSP provider:

- Single vision
- Bifocal
- Trifocal
- Lenticular
- High Index

The following lens options are covered in full when provided by a VSP provider:

- Anti-reflecting coating
- Scratch coating
- Mirror coating
- Color coating
- Blended lenses
- Polycarbonate lenses
- Progressive lenses
- Photochromic lenses
- Polarized lenses

5. **Contact Lenses**

The Plan allows a $300 benefit allowance every 12 months which applies to the cost for your standard eye examination, contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of the contacts. Any costs exceeding the allowance are your responsibility.

6. **Medically Necessary Contact Lenses**

Medically necessary contact lenses are covered in full when VSP benefit criteria are met and verified by a VSP provider for eye conditions that would prohibit the use of eyeglasses. The conditions covered include:

- Aphakia
- Anisometropia
- High ametropia
- Nystagmus
- Keratoconus
- Certain other eye conditions that make contact lenses necessary

C. Extra Discounts and Savings

1. **Eyeglasses and Sunglasses**
   - Average 35% to 40% savings on all non-covered lens options.
   - 30% off additional eyeglasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam; or receive 20% off from any VSP doctor within 12 months of your last exam.
2. **Contacts**
   - 15% off cost of contact lens exam (fitting and evaluation).
3. **Laser Vision Correction**
   - Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.

D. Limitations

This Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional costs for the options:

- Optional cosmetic processes
- Cosmetic lenses
- Oversize lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

VSP also has controlled costs for cosmetic options, and these charges are typically less than the MAC. Please consult your VSP provider about lens options which may be cosmetic in nature, and may result in additional costs.

There is no benefit under the Plan for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (non-prescription).
- Two pair of eyeglasses in lieu of bifocals.
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an experimental nature.
- Costs for services and/or materials above Plan benefit allowances or not indicated as a covered Plan Benefit.
- Any eye examination or any corrective eyewear required by an employer as a condition of employment.

E. Claim Review Procedure

If a claim for vision benefits is wholly or partially denied, VSP will notify the claimant in writing of the specific reasons for the denial, including specific references to pertinent Plan provisions. VSP will also describe any additional materials or information, if any, necessary for the claimant to perfect his/her claim, and will explain VSP's claim review procedure.

Within 180 days of the date of receipt of written denial of a claim, the claimant or his/her duly authorized representative may request a review of the decision denying the claim. The claimant will have a reasonable opportunity for a full and fair review of the decision denying the claim. He/she will be given the opportunity to review pertinent documents, and to submit any statements, documents or written arguments in support of his/her claim.

Within 30 days after receipt of the request for review, VSP will advise the claimant in writing of its decision, including specific reference to Plan provisions on which the decision is based.

Requests for review of wholly or partially denied claims may also be submitted to the ILWU-PMA Benefit Plans Office. The Claims Review Procedure is described completely in your Welfare Plan Summary Plan Description.

A Special Note about the California Department of Managed Health Care's Review of Member Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number 888-466-2219 to receive complaints regarding health plans.

Where to Submit Complaint/Requests for Review:

Vision Service Plan
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

Section VII.

Plan Administration Information

A. Plan Sponsor and Administrator

Union Trustees
Bobby Olvera Jr.
Francisco Ponce De Leon, III
Cameron Williams

Employer Trustees
Michael H. Wechsler
William Hirai
Bettye Page-Wilson

The Trustees have delegated the claims administration services to Zenith American Solutions (Zenith) and such services are provided to the Welfare Plan under a contract between the Board of Trustees and Zenith. Zenith is the Plan's Third Party Administrator for claims and is the operator of the Coastwise Claims Office.

The Coastwise Claims Office address is:

PO Box 429101
San Francisco, CA 94142
Telephone number: 800-955-7376

B. Plan Amendment or Termination

The ILWU and PMA, by their mutual agreement in writing, may at any time amend, modify or delete any provisions of the Welfare Plan. This power specifically includes the authority to change, retroactively or prospectively, eligibility requirements and benefits provided under the Welfare Plan, in whole or in part, at any time and without prior notice to participants.

The ILWU, PMA and Trustees intend to comply with all applicable laws and regulations. You will be notified if you are affected by any change to the Welfare Plan.

C. Plan Sponsor Employee Identification Number (EIN)

The employer identification number (EIN) assigned by the Internal Revenue Service is 94-6068578.

D. Plan Year

The Plan Year is July 1-June 30. This is the basis for all annual benefit renewals and limitations.

E. Agent for Legal Process

The agent of service of legal process is the Trustees of the ILWU-PMA Welfare Plan, who can be served at the BPO whose address is listed below.

The Trustees of the ILWU-PMA Welfare Plan
1188 Franklin Street, Suite 101
San Francisco, CA 94109

F. Administration of Benefits

Each benefit is administered and/or insured by the entities shown on pages 9 through 44. Phone numbers and website addresses are included so you may contact the claims administrators or insurance companies listed if you have questions.

- Blue Shield of California – **www.blueshieldca.com/ilwupma**
- Chiropractic Health Plan of California – 800-995-2442, **www.chpc.com**
- Coastwise Claims Office – 800-955-7376
- First Choice Health Network – 800-231-6935, **www.fchn.com**
- ILWU-PMA Benefit Plans Office – 415-673-8500, **www.benefitplans.org**
- Innovative Care Management – 866-275-1014, **www.innovativecare.com**
- Magellan Behavioral Health – 800-424-5945, **www.MagellanAscend.com**
- OptumRx – 800-797-9791, **www.optumrx.com**
- Vision Service Plan – 800-877-7195, **www.vsp.com**

G. Your Rights Under ERISA

The benefits described in this document are governed by ERISA, the Employee Retirement Income Security Act of 1974, as amended. As a participant in these plans, you are entitled to certain rights and protections under ERISA. You are entitled to:

1. **Receive Information About Your Plan and Benefits**
   - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
   - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Welfare Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
   - Receive a summary of the Welfare Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
2. **Continue Group Health Plan Coverage**
   - If there is a loss of coverage under the Welfare Plan as a result of a qualifying event, you can continue health care coverage for yourself, your spouse or your dependents. You or your dependents may have to pay for such coverage. Review this Supplemental Summary Plan Description and the documents governing the Welfare Plan on the rules governing your COBRA continuation coverage rights.
3. **Prudent Actions by Plan Fiduciaries**

   In addition to creating rights for Welfare Plan participants, ERISA imposes duties upon the people who are responsible for the operation of your employee benefit plan. The people who operate your Welfare Plan, called "fiduciaries" of the plan(s), have a duty to do so prudently and in the interest of you and other Welfare Plan participants and beneficiaries. No one, including your employer or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Delegation of Authority to the Trustees

The Welfare Plan has delegated full and discretionary authority to the Trustees to administer and interpret the Welfare Plan and Coastwise Indemnity Plan. The Trustees may, at any time and in their discretion, delegate to third parties such responsibilities, such as the authority to make initial benefit determinations, to facilitate the day-to-day administration of the Welfare Plan.

5. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance,

- If you request a copy of Welfare Plan documents or the latest annual report from a Plan and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, after exhausting your internal and appeal review rights under the Welfare Plan, you can file suit in a state or federal court. In addition, if you disagree with a Welfare Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.
- If it should happen that Welfare Plan fiduciaries misuse Welfare Plan money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court can order the person you have sued to pay these costs and fees. If you lose, the court can order you to pay these costs and fees, for example, if it finds your claim is frivolous.

6. Assistance with Your Questions

If you have any questions about a plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

H. Grandfathered Health Plan

Please note that the Trustees believe that the Welfare Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for independent review of adverse benefit determinations by an organization that has no connection to the Plan. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Although it is a "grandfathered health plan," you should know that the Welfare Plan provides health coverage benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Welfare Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage. Nor does the Welfare Plan discriminate in favor of certain members based on compensation or health status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan administrator, ILWU-PMA Benefit Plans Office, at 415-673-8500. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

I. Other ILWU-PMA Welfare Plan Programs

In addition to the Coastwise Indemnity Plan described in this booklet, the Welfare Plan provides coverage for other benefits, including but not limited to, dental benefits, death and dismemberment benefits, Alcoholism Drug Recovery Program benefits, hearing aid benefits and benefits for temporary disabilities. Eligibility requirements for these additional benefits vary. For information about these benefits, please see the Welfare Plan Summary Plan Description and the applicable supplemental summary plan descriptions. To determine if you are eligible, please contact the Benefit Plans Office or your ILWU local office.

Section VIII.

Legal Notices and Special Rights

A. Special Rights Concerning Maternity Stays

Under federal law, group health plans may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean delivery. However, the attending physician may discharge the mother or her newborn at any time after consultation with the mother.

B. Special Rights Concerning Mastectomy Coverage

Under federal law, group health plans that provide coverage for mastectomies (as the Coastwise Indemnity Plan does) are also required to provide coverage for reconstructive surgery and prostheses following mastectomies. This coverage will be provided in consultation with the patient and the patient's attending physician and is subject to the same annual deductible and copayment provisions otherwise applicable under the Plan.

If all or part of a breast is surgically removed for medically necessary reasons, the following services are covered:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance;
- Prostheses (artificial replacements); and,
- Services for physical complications resulting from the mastectomy.

C. CHIPRA Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the following pages, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 877-KIDS NOW (877-543-7669) or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 1, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800-359-1991/ State Relay 711

FLORIDA – Medicaid

Website: http://flmedicaidmanagedcare.com
Phone: 877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479

All other Medicaid

Website: http://www.indianamedicaid.com
Phone 800-403-0864

IOWA – Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/agencies/dms/Pages/default.aspx
Phone: 800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888-342-6207

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800-977-6740 if you are already registered 855-797-4357 if you want to see if you are eligible
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800-862-4840

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid

Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov/members/home
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/ombp/medicaid/index.htm
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 888-901-4999

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 800-356-1561 or 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 888-245-0179 or 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insurekidsnow.gov
Phone: 888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
Phone: 800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA - Medicaid

Website: https://dss.sd.gov/medicaid/
Phone: 888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 800-662-9651

VERMONT – Medicaid

Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: https://www.dmas.virginia.gov/#/index
Medicaid Phone: 804-786-6145

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since March 1, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 6
Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

D. Medicare Part D Notice

This is a required notice for all Medicare eligible employees, Pensioners, and/or dependents who are age 65 or older or are disabled and are receiving Social Security disability benefits. If you or your dependents do not fall within these categories, this notice does not apply to you at this time. The purpose of this notice is to provide proof of "creditable coverage" for Medicare eligible employees, Pensioners, and/or dependents.

- Effective January 1, 2006, new prescription drug coverage from Medicare (Medicare Part D) became available to everyone eligible for Medicare benefits. **Your existing prescription drug coverage under the Welfare Plan has been determined to be better than coverage under a Medicare Part D prescription drug plan. Therefore, do not enroll in a Medicare Part D prescription drug plan**.
- **You will continue to receive prescription drug coverage under the ILWU-PMA Welfare Plan**. Because your existing coverage under the Welfare Plan (regardless of whether you are enrolled in the Coastwise Indemnity Plan or an HMO) is better than the standard Medicare prescription drug coverage, we urge you **not to enroll in a Medicare Part D prescription drug plan and not to agree to pay a premium for a prescription drug plan offered by any other group or individual prescription drug plan**.
- If you drop or lose your current prescription drug coverage under the Welfare Plan, you should enroll in Medicare Part D as soon as possible after your Welfare Plan coverage ends. If you do not immediately enroll in Medicare's prescription drug coverage after your Welfare Plan prescription drug coverage ends, you may have to pay more to enroll in Medicare's prescription drug coverage later. If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month you did not have prescription drug coverage. You would have to pay this higher premium as long as you have Medicare Part D coverage. In addition, you may have to wait until the next standard enrollment period of October 15th through December 7th. Remember: This only applies in the event you drop or lose your current coverage under the Welfare Plan.

- If you have any questions about this notice or your current prescription drug coverage, contact the Benefit Plans Office.

NOTE: You may receive this notice at other times in the future such as before the period you can enroll in Medicare prescription drug coverage (annually between October 15th and December 7th) or if Medicare prescription drug coverage changes. You also may request a copy from the Benefit Plans Office.

More detailed information about Medicare plans that offer prescription drug coverage can be found in the "Medicare & You" handbook, which you will receive in the mail every year from Medicare.

E. Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder (HIPAA) require a health plan to notify participants about its privacy policies and procedures with respect to participants' health information. This document is intended to satisfy HIPAA's notice requirement.

This notice is effective as of June 1, 2017 and supersedes all previous notices. If you have any questions about this notice, please contact the Benefit Plans Office as follows:

Privacy Officer
ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109
Telephone: 415-673-8500

The Benefit Plans Office and the Coastwise Claims Office, which administer health benefit claims for the Welfare Plan may share enrollment information with the ILWU and/or the PMA (Plan Sponsors) and may provide summary health information to the Plan Sponsors for plan design purposes.

The Welfare Plan has authorized certain employees of the BPO, CCO, and Plan Sponsors to have access to your health information (referred to as "employees with access"), so that they may perform certain administrative functions for the Welfare Plan. These administrative functions — treatment, payment, and health care operations — are described below. Employees with access also may use and disclose your health information for other purposes, which are outlined in this notice. Plan Sponsors, and third party "business associates", including Zenith, that perform various services for the Welfare Plan also may have access to your health information. However, the Welfare Plan's business associates are subject to the HIPAA Privacy and Security rules in the same way that the Welfare Plan is subject to such rules. In addition, each of the Welfare Plan's business associates has entered into an agreement with the Welfare Plan to safeguard your health information in accordance with HIPAA.

This notice will tell you about the ways in which employees with access to your health information and the Welfare Plan's business associates may use and disclose such information. It also describes the Welfare Plan's obligations and your rights regarding the use and disclosure of your health information.

The Welfare Plan is required by HIPAA to:

- Make sure that your health information is kept private;
- Give you this notice of the Welfare Plan's legal duties and privacy practices with respect to your health information; and,
- Follow the terms of the notice that is currently in effect.

In addition, if the Welfare Plan determines that a breach of your unsecured health information has occurred, the Welfare Plan must notify you of the breach. In certain circumstances, the Welfare Plan must also notify the Department of Health and Human Services, and possibly the media.

The Welfare Plan also is required to designate a Privacy Officer who is responsible for the development and implementation of the Welfare Plan's Privacy and Security Policies and Procedures. The Welfare Plan has designated a Privacy Officer that may be contacted as noted on page 59.

1. **How Employees With Access and Business Associates May Use and Disclose Your Health Information**

   The following categories describe different ways in which employees with access and the Welfare Plan's business associates are permitted or required to use and disclose your health information. Not every use or disclosure in a category will be listed. In any event, the Welfare Plan is prohibited from using or disclosing any genetic health information for underwriting purposes.

   a. For Treatment

   Employees with access and business associates may use and disclose your health information to facilitate medical treatment or services by health care providers. For example, if you are unable to provide your medical history as the result of an accident, a business associate may advise an emergency room physician about the types of prescription drugs you currently take.

   b. For Payment

   Employees with access and business associates may use and disclose your health information to make coverage determinations and payment in accordance with the terms of the Welfare Plan (this includes billing, claims management, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorization). For example, a business associate may tell your health care provider whether you are eligible for Plan coverage. Also, your health information may be shared with another health plan to coordinate benefit payments.

   c. For Health Care Operations

   Employees with access and business associates may use and disclose your health information to enable the Plan to operate or to operate more efficiently. This includes: conducting quality assessment and improvement activities, submitting claims for stop-loss coverage, determining employee contributions, conducting or arranging for medical review, legal services, and audit services, disease management, case management, planning and development and general Welfare Plan administrative activities. For example, the Plan may use your claims information to refer you to a disease management program, project future benefit costs, or audit the accuracy of its claims processing functions. In addition, the Plan may contact you to provide you information about treatment alternatives or other health-related benefits that may be of interest to you.

   In general, if the Welfare Plan receives direct or indirect payment by an outside entity to send you a communication, prior authorization from you will be required.

2. Other Permitted Uses and Disclosures

- The Welfare Plan may be required by law to disclose your health information.
- The Welfare Plan will make your health information available to you, and to the Secretary of the Department of Health and Human Services for purposes of HIPAA enforcement.
- Your health information may be disclosed to a public health agency. This may include disclosing your health information to report certain diseases, death, abuse, neglect or domestic violence or reporting information to the Food and Drug Administration, if you experience an adverse reaction from any of the drugs, supplies or equipment that are involved in your care.
- Your health information may be disclosed to government agencies so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.
- Your health information may be disclosed as authorized by law to comply with workers' compensation laws.
- Your health information may be disclosed in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Your health information may be disclosed to law enforcement officials to report or prevent a crime, locate or identify a suspect, fugitive or material witness or assist a victim of a crime.
- Your health information may be used or disclosed to avert a serious threat to health or safety if the use or disclosure is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public, and is disclosed to a person who is reasonably able to prevent or lesson the threat, including the target of the threat.
- Your health information may be used or disclosed for limited research purposes, provided that a waiver of the authorization required by HIPAA has been approved by an appropriate privacy board.
- If you are a member of the armed forces, the Plan may disclose your health information as required by military command authorities or to evaluate your eligibility for veteran's benefits. The Plan also may disclose health information about foreign military personnel to the appropriate foreign military authority.
- Your health information may be disclosed to coroners, health examiners and funeral directors so that they can carry out their duties or for purposes of identification or determining cause of death.
- Your health information may be disclosed to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.
- The Welfare Plan may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your health information to the correctional institution or law enforcement official.
- Your health information may be disclosed to your spouse, a family member or a close personal friend if the health information is directly relevant to your spouse's, family member's or close personal friend's involvement with payment related to your health care.

Pursuant to an Authorization

For uses and disclosures of your health information beyond the uses and disclosures described above, the Welfare Plan is required to obtain your written authorization. You may revoke an authorization at any time.

3. Your Rights With Respect to Your Health Information

You have the following rights with respect to your health information.

a. Right to Inspect and Copy

You have the right to inspect and copy your coverage, payment and claims record and other health information used by the Welfare Plan to make benefit determinations about you. To inspect and copy such information, you must submit your request in writing to the Benefit Plans Office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may file a complaint regarding the denial.

If the Welfare Plan maintains an electronic health record ("EHR") that contains your health information, you may have the right to request an electronic copy or direct that a copy of the EHR be sent to a designated individual. The Welfare Plan may charge you a fee (not greater than its labor costs) for responding to your request. Contact the Benefit Plans Office at 415-673-8500 for more information.

b. Right to Amend

You have the right to request that the Welfare Plan amend your coverage, payment and claims record and other health information used by the Welfare Plan to make benefit determinations about you. You have the right to request an amendment for as long as the information is maintained by or for the Plan.

To request an amendment, you must submit your request in writing to the Benefit Plans Office. In addition, you must provide a reason that supports your request.

In general, we are not required to agree to your request. If your request is denied in whole or in part, the Welfare Plan will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosure of your health information.

c. Right to an Accounting of Disclosures

You have the right to request an "accounting" of the Welfare Plan's disclosures of your health information during a time period which may be no longer than six years prior to the date of your request (three years for electronic health records ("EHRs"), if applicable). There are exceptions to the types of disclosures for which the Welfare Plan is required to account. For example, for health information that is not in an EHR, the Welfare Plan is not required to give you an accounting of disclosures for purposes of treatment, payment or health care operations, and the Welfare Plan is not required to account for disclosures made prior to April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Benefit Plans Office. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12 month period will be free. For additional accountings, the Welfare Plan may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

d. Right to Request Restrictions

You have the right to request a restriction on the health information that the Welfare Plan may use or disclose about you for treatment, payment or health care operations, or that the Welfare Plan may disclose to your spouse, a family member or a close personal friend who is involved with payment related to your health care.

In general, we are not required to agree to your request. However, we are required to agree to a request to restrict disclosure of your health information for payment or health care operations (but not for treatment purposes) if you have paid your provider in full, out-of pocket.

Requests for restrictions must be made in writing to the Benefit Plans Office. In your request, you must provide: (1) what information you want to restrict; (2) whether you want to restrict use, disclosure or both; and (3) to whom you want the restrictions to apply.

e. Right to Request Confidential Communications

You have the right to request that the Welfare Plan communicate with you in a certain way or at a certain location, such as only at work or by mail.

Requests for confidential communications must be made in writing to the Benefit Plans Office.

The Welfare Plan will attempt to honor all reasonable requests. Your request must specify how or where you wish to be contacted.

f. Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

4. Changes to This Notice

The Welfare Plan reserves the right to change the terms of this notice. The Welfare Plan reserves the right to make the revised notice effective with respect to all of your health information already maintained by the Welfare Plan, as well as any of your health information maintained by the Plan in the future. In the event of a material change to the notice, a revised version of the notice will be provided by mail.

5. Complaints

If you believe your privacy rights have been violated or if you have been notified by the Welfare Plan that a breach of your health information has occurred, you may file a complaint with the Welfare Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Welfare Plan, contact the Privacy Officer at the address listed below. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

Privacy Officer
ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109
Telephone: 415-673-8500

Notes

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