

SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

November 27, 2017

Dear Plan Participant:

According to the records of the Seafarers Health and Benefits Plan, you will be eligible for health benefits as of January 1, 2018, or you were eligible during the past year (2017). For this reason, we are sending you the enclosed Summary of Benefits and Coverage (SBC). This SBC briefly describes the benefits at the **Core level for participants who reside in Puerto Rico**. The Plan utilizes Humana's network for participants who reside in Puerto Rico. You will also receive a copy of this SBC in Spanish from Humana at a later date. If you believe that you are currently receiving a different level of benefits, please contact the Plan to request a different booklet.

We are required under the Patient Protection and Affordable Care Act (ACA) to send you this Plan document. It provides a brief summary of your benefits. The SBC is **not** a guarantee of benefits. The Plan's Rules and Regulations determine whether you are eligible for benefits.

Also enclosed is a Glossary of Health Coverage and Medical Terms. This document defines common terms that are used by health plans and health insurance companies.

Reminder about the Plan's Grandfathered Status

The Plan would also like to remind you that the Seafarers Health and Benefits 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 this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. 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.

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 at 5201 Auth Way, Camp Springs, MD 20746.



You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Questions

If you have any questions about these benefits, or about the coverage that you receive from the Plan, you may contact the Plan at 1-800-252-4674. You may also view additional information about your health coverage at www.seafarers.org, under the Member Benefits tab.

Sincerely,

Margaret R. Bowen
Administrator

Enclosures



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to view the Plan's Summary Plan Description (SPD), go to www.seafarers.org or call 1-877-486-2627 (Humana), or 1-800-252-4674 (Seafarers). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.seafarers.org or call 1-800-252-4674 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$375 person/\$1125 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Inpatient Facility, Vision, and Dental are not subject to deductible .	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. \$100 for prescription drug coverage . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Prescription coverage provided through OptumRx.
What is the out-of-pocket limit for this plan ?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. See www.humana.com for a link to Humana's network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	35% coinsurance	None
	Specialist visit	20% coinsurance	35% coinsurance	None
	Preventive care/screening/immunization	20% coinsurance	35% coinsurance	In-network annual physical no charge for dependents. Out-of-network annual physical 35% coinsurance .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	No payment if not pre-authorized .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com or www.seafarers.org	Generic drugs 30 day retail; 90 day mail order	\$10 copay retail per prescription \$20 copay mail per prescription	Not covered	Prior authorization required for certain drugs. Maintenance drugs cost more when purchased at retail. Seafarer only.
	Preferred brand drugs 30 day retail; 90 day mail order	\$25 copay retail per prescription \$50 copay mail per prescription	Not covered	Prior authorization required for certain drugs. Maintenance drugs cost more when purchased at retail. Seafarer only.
	Non-preferred brand drugs 30 day retail; 90 day mail order	\$50 copay retail per prescription \$100 copay mail per prescription	Not covered	Prior authorization required for certain drugs. Maintenance drugs cost more when purchased at retail. Seafarer only.
	Specialty drugs	No charge	Not covered	You must contact SHBP at 1-800-252-4674 to obtain through home delivery. Seafarer only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	No payment if not pre-authorized .
	Physician/surgeon fees	20% coinsurance	35% coinsurance	No payment if not pre-authorized .
If you need immediate medical attention	Emergency room care	20% coinsurance	35% coinsurance	\$300 copay if non-injury related/not admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$450 <u>copayment</u> per hospital stay	30% <u>coinsurance</u> \$450 <u>copayment</u> per hospital stay	180 continuous days or \$1,000,000 maximum per illness. Inpatient benefits will resume after 60 days out of hospital. Payment at semi-private room rate. No payment if not <u>pre-authorized</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	35% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> for mental/behavioral health Not covered for substance use disorder	35% <u>coinsurance</u> for mental/behavioral health Not covered for substance use disorder	Mental/behavioral health outpatient services are not covered for dependents. Substance use disorder outpatient services are not covered.
	Inpatient services	\$450 <u>copayment</u> per hospital stay	30% <u>coinsurance</u> \$450 <u>copayment</u> per hospital stay	Mental/behavioral health inpatient services – 180 continuous days or \$1,000,000 maximum per illness. Inpatient benefits will resume after 60 days out of hospital. No payment if not <u>pre-authorized</u> . Seafarer only. Inpatient detox services and <u>rehabilitation</u> for Seafarer only; <u>rehabilitation</u> only covered at SARC in Piney Point, MD.
If you are pregnant	Office visits	20% <u>coinsurance</u>	35% <u>coinsurance</u>	For medical conditions resulting from pregnancy; otherwise office visits are included in global fee. Maternity care may include tests and services described elsewhere in this SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	35% <u>coinsurance</u>	None
	Childbirth/delivery facility services	\$450 <u>copayment</u> per hospital stay	30% <u>coinsurance</u> \$450 <u>copayment</u> per hospital stay	Payment at semi-private room rate. No payment if not <u>pre-authorized</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Amount that exceeds <u>network</u> allowed or limitations	Amount that exceeds limitations	Combined with <u>skilled nursing care</u> ; 60 visits per year. Visit equals two hours. Maximum allowed \$75 per hour.
	Rehabilitation services	20% <u>coinsurance</u>	35% <u>coinsurance</u>	Seafarer only – after non-catastrophic illness/injury: 20 visits per year for physical therapy. Seafarer or dependents: after catastrophic illness/injury: 40 visits per year; includes physical, occupational, speech, pulmonary, and cognitive therapies.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	Amount that exceeds <u>network</u> allowed or limitations	Amount that exceeds limitations	Combined with <u>home health care</u> ; 60 visits per year. Visit equals two hours. Maximum allowed \$75 per hour.
	Durable medical equipment	20% <u>coinsurance</u> 50% <u>coinsurance</u> for onboard injuries	35% <u>coinsurance</u> 50% <u>coinsurance</u> for onboard injuries	After non-catastrophic illness/injury for Seafarer only. After catastrophic illness/injury for Seafarer or dependents.
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Up to six months.
If your child needs dental or eye care	Children's eye exam	Amount that exceeds \$40/24 months; includes eye wear.	Amount that exceeds \$40/24 months; includes eye wear.	Discount may apply.
	Children's glasses	Amount that exceeds \$40/24 months; includes eye exam.	Amount that exceeds \$40/24 months; includes eye exam.	Discount may apply.
	Children's dental check-up	No charge for the first \$500; remainder 40% up to maximum.	No charge for the first \$500; remainder 50% up to maximum.	First \$500 paid at 100%. \$1,000/year; \$2,000 orthodontic lifetime max; orthodontia applies to annual limit. No limit on pediatric <u>preventive services</u> .

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery for dependents• Chiropractic care• Cosmetic surgery• Durable medical equipment for dependents, except following catastrophic illness/injury• Habilitation services• Hearing aids for dependents | <ul style="list-style-type: none">• Infertility treatment• Long term care• Mental health for dependents• Occupational, speech, cognitive, or pulmonary therapy, except following catastrophic illness/injury• Outpatient substance use disorder; inpatient substance use disorder for dependents | <ul style="list-style-type: none">• Physical therapy for dependents, except following catastrophic illness/injury• Prescriptions for dependents• Private duty nursing (inpatient)• Routine foot care• Services outside the U.S. and its territories• Treatment not medically necessary• Weight loss programs |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Bariatric surgery for Seafarer only• Dental care | <ul style="list-style-type: none">• Hearing aids for Seafarer only• Private duty nursing (for home health care only) | <ul style="list-style-type: none">• Routine eye care |
|---|---|--|

Participants in this [Plan](#) do not pay a [premium](#) for coverage.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or contact the Plan at 1-800-252-4674 for continuing the Plan's coverage through COBRA. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact Humana at 1-877-486-2627 or the Plan at 1-800-252-4674. Your [appeal](#) must be in writing and sent within 180 days of the date your [claim](#) was denied. You should include any supporting documentation you have when making your request. Your written [appeal](#) should be sent to: Humana, P.O. Box 191920, San Juan, PR 00919-1920, or via fax to 1-888-595-0462, or via email to G&APuertoRicoTeam@humana.com. If you are not satisfied with the appeal decision, please contact: Board of Trustees, Seafarers Health and Benefits Plan, P.O. Box 380, Piney Point, Maryland 20674. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-486-2627 o 1-800-252-4674.
See attached insert for information about translation services in other languages.

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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 at 1-800-252-4674. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

About these Coverage Examples for Seafarers Health & Benefits Plan – Core (Puerto Rico):



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$375/\$100
- [Specialist](#) [[cost sharing](#)] \$0
- Hospital (facility) [[copayment](#)] \$450
- Other [[cost sharing](#)] [[coinsurance](#)] 20%
- Other [[cost sharing](#)] [[copayment](#)] \$0
- Other [[cost sharing](#)] [[excluded services](#)] \$60

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,730
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$375/\$40
Copayments	\$450
Coinsurance	\$690
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,615

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$375/\$100
- [Specialist](#) [[cost sharing](#)] \$20
- Hospital (facility) [[copayment](#)] \$0
- Other [[cost sharing](#)] [[coinsurance](#)] 20%
- Other [[cost sharing](#)] [[copayment](#)] \$2,120
- Other [[cost sharing](#)] [[excluded services](#)] \$220

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,390
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$375/\$100
Copayments	\$2120
Coinsurance	\$510
<i>What isn't covered</i>	
Limits or exclusions	\$220
The total Joe would pay is	\$3,320

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$375
- [Specialist](#) [[cost sharing](#)] \$60
- Hospital (facility) [[cost sharing](#)] 20%
- Other [[cost sharing](#)] [[coinsurance](#)] 20%
- Other [[cost sharing](#)] [[copayment](#)] \$0
- Other [[cost sharing](#)] [[excluded services](#)] \$0

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,930
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$375
Copayments	\$0
Coinsurance	\$310
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$685

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance policy](#). Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

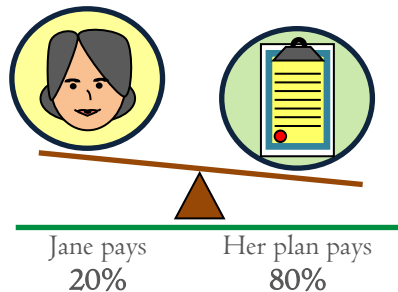
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The health insurance or [plan](#) pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

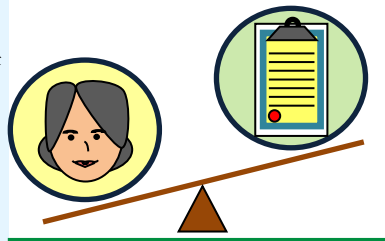
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides [minimum essential coverage](#). If you don’t have [minimum essential coverage](#), you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered healthcare services. Your share is usually lower for in-[network](#) covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-[network](#) services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the [individual responsibility requirement](#). Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

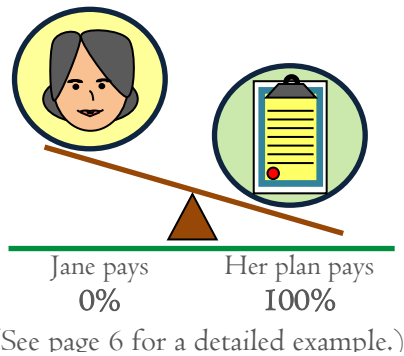
A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

A [provider](#) who doesn't have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you'll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "[health insurance](#)".

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called prior authorization, prior approval or precertification. Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each "tier" of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

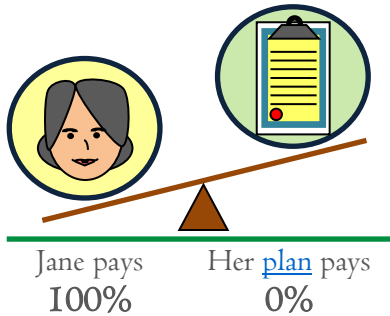
Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



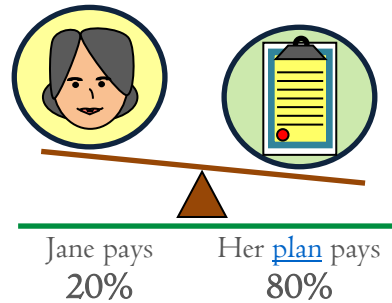
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



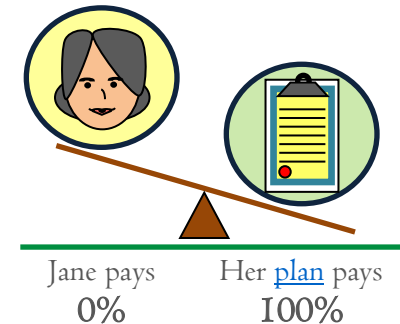
Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

Language Translation Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-252-4674

Arabic:

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-252-4674

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-252-4674

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-252-4674

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-252-4674

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-252-4674

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-252-4674

Indonesian: PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-800-252-4674

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-252-4674

Croatian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-252-4674

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-252-4674

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-252-4674。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-252-4674 번으로 전화해 주십시오.

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-252-4674

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-252-4764