SEAFARERS HEALTH AND BENEFITS PLAN

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

Margaret R. Bowen
Administrator

November 27, 2018

Dear Plan Participant:

According to the records of the Seafarers Health and Benefits Plan, you are currently eligible for pensioner health benefits. For this reason, we are sending you the enclosed Summary of Benefits and Coverage (SBC). This SBC briefly describes the benefits at the **Pensioners' Medicare level and Pensioners' Non-Medicare 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/**$750** 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 and Vision 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. No prescription coverage for dependents.
What is the out-of-pocket limit for this plan?	**$2,700** individual/**$5,500** family for in-network services only	The out-of-pocket limit is the most you can pay in a year for covered in-network services.
What is not included in the out-of-pocket limit?	Health care this plan doesn't cover, prescription costs, dental, vision, and out-of-network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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	10% coinsurance	35% coinsurance	Pensioner only.
	Specialist visit	10% coinsurance	35% coinsurance	Pensioner only.
	Preventive care/screening/ immunization	10% coinsurance	35% coinsurance	Pensioner only. Annual physical no charge for dependents.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	35% coinsurance	Pensioner only.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	35% coinsurance	No payment if not pre-authorized. Pensioner only.
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. Pensioner 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. Pensioner 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. Pensioner only.
	Specialty drugs	No charge	Not covered	You must contact SHBP at 1-800-252-4674 to obtain through home delivery. Pensioner only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	35% coinsurance	No payment if not pre-authorized.
	Physician/surgeon fees	10% coinsurance	35% coinsurance	No payment if not pre-authorized.

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 immediate medical attention	Emergency room care	10% coinsurance	35% coinsurance	$300 copayment if non-injury related or not admitted.
	Emergency medical transportation	10% coinsurance	20% coinsurance	None
	Urgent care	10% coinsurance	35% coinsurance	Pensioner only.
If you have a hospital stay	Facility fee (e.g., hospital room)	$450 copayment per hospital stay	30% coinsurance $450 copayment 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 pre-authorized.
	Physician/surgeon fees	10% coinsurance	35% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Not covered.
	Inpatient services	Not covered	Not covered	Not covered.
If you are pregnant	Office visits	10% coinsurance	35% coinsurance	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). Pensioner only.
	Childbirth/delivery professional services	10% coinsurance	35% coinsurance	None
	Childbirth/delivery facility services	$450 copayment per hospital stay	30% coinsurance $450 copayment per hospital stay	Payment at semi-private room rate. No payment if not pre-authorized.

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 network allowed or limitations	Amount that exceeds limitations	Combined with skilled nursing care; 60 visits per year. Visit equals two hours. Maximum allowed $75 per hour.
	Rehabilitation services	10% coinsurance	35% coinsurance	After non-catastrophic illness/injury: 20 combined visits per year. After catastrophic illness/injury: 40 combined visits per year. Combined visits include physical, occupational, speech, pulmonary and cognitive therapies.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	Amount that exceeds network allowed or limitations	Amount that exceeds limitations	Combined with home health care; 60 visits per year. Visit equals two hours. Maximum allowed $75 per hour.
	Durable medical equipment	10% coinsurance	35% coinsurance	None
	Hospice services	10% coinsurance	20% coinsurance	Up to six months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (routine)
- Habilitation services
- Hearing aids for dependents
- Infertility treatment
- Inpatient and outpatient substance use disorder
- Long term care
- Mental health
- Outpatient services for dependents
- Prenatal and postnatal care for your spouse or daughter, unless included with delivery fees
- 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.)

- Hearing aids for Pensioner only
- Private duty nursing (for home health care only)
- Routine eye care

Participants in this Plan 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, Claims Department, 45353 St. George's Avenue, 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:

ATTENTION: if you need language assistance, free translation services are available. Call 1-800-252-4674

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

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

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

See attached insert for information about translation services in other languages.

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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 -- NON-MEDICARE PENSIONERS (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. Note: Amounts to be paid in each example could be reduced if out-of-pocket maximum has been satisfied.

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]*	10%
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$375/$40
Copayments	$450
Coinsurance	$330
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,255**

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]*	$27
Hospital (facility) *[copayment]*	$0
Other *[cost sharing]* *[coinsurance]*	10%
Other *[cost sharing]* *[copayment]*	$2,120
Other *[cost sharing]* *[excluded services]*	$55

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$375/$100
Copayments	$2,120
Coinsurance	$270
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,920**

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

The plan's overall deductible	$375
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]* *[coinsurance]*	10%
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$375
Copayments	$0
Coinsurance	$156
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$531**

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