The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-252-4674. 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 Glossary of Health Coverage and Medical Terms (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/**$1,125** 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. No prescription coverage for dependents.
What is the out-of-pocket limit for this plan?	**$3,000** individual/**$6,000** family for in-network services and out-of-network emergency room/air ambulance	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Health care this plan doesn't cover, prescription costs, dental, vision, balance billing charges, and most 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 https://hcpdirectory.cigna.com/web/ for a link to CIGNA's network providers.	You pay the least if you use a provider in the CIGNA network. You pay more if you use a provider in the MultiPlan network or other networks in which the Plan participates. 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	None
	Specialist visit	10% coinsurance	35% coinsurance	None
	Preventive care/screening/ immunization	10% 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)	10% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% 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 call 1-800-788-4863) or www.seafarers.org/plans Maintenance drugs cost more when purchased at retail.	Generic drugs 30 day retail; 90 day mail order	$10 copay each retail $20 copay each mail	Not applicable	Prior authorization required for certain drugs. Seafarer only.
	Preferred brand drugs 30 day retail; 90 day mail order	$25 copay each retail $50 copay each mail	Not applicable	Prior authorization required for certain drugs. Seafarer only.
	Non-preferred brand drugs 30 day retail; 90 day mail order	$50 copay each retail $100 copay each mail	Not applicable	Prior authorization required for certain drugs. Seafarer only.
	Specialty drugs 30 day supply limit for most; 90 day supply available for oral HIV drugs only	30 day supply copay (for retail or by mail) same as above retail categories; 90 day supply copay (for retail or by mail) same as above mail categories	Not covered (Specialty) Not applicable (Retail)	Prior authorization required for certain drugs. All Specialty drugs must be filled through Optum Specialty Pharmacy. Contact OptumRx at 1-800-788-4863. Seafarer only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	35% coinsurance	None
	Physician/surgeon fees	10% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	$300 copay if non-injury related/not admitted.
	Emergency medical transportation	10% coinsurance	20% coinsurance	10% coinsurance for air ambulance for out-of-network
	Urgent care	10% 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 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	10% coinsurance for mental/behavioral health	35% coinsurance for mental/behavioral health	None
	Inpatient services	$450 copayment per hospital stay	30% coinsurance $450 copayment 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 pre-authorized.
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).
	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.

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: 60 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 50% coinsurance for onboard injuries	35% coinsurance 50% coinsurance for onboard injuries	None
	Hospice services	10% coinsurance	20% coinsurance	Up to six months.
If your child needs dental or eye care	Children's eye exam	Charges up to $80/24 months; includes eye wear.	Charges up to $80/24 months; includes eye wear.	None
	Children's glasses	Charges up to $80/24 months; includes eye exam.	Charges up to $80/24 months; includes eye exam.	None
	Children's dental check-up	No charge for the first $500; 40% of remaining charges up to maximum.	No charge for the first $500; 50% of remaining charges 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 preventive services.

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 for dependents
- Chiropractic care
- Cosmetic surgery
- Habilitation services
- Hearing aids for dependents
- Long term care
- 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.)

- Bariatric surgery for Seafarer only
- Dental care
- Hearing aids for Seafarer only
- Infertility treatment
- Private duty nursing (for home health care only)
- 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: 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: 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
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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: 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

The Seafarers Health and Benefits Plan is a "grandfathered health plan" under the Patient Protection and 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 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:

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$375/$10
Copayments	$450
Coinsurance	$520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,415**

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]*	$30
Hospital (facility) *[copayment]*	$0
Other *[cost sharing]* *[coinsurance]*	10%
Other *[cost sharing]* *[copayment]*	$460
Other *[cost sharing]* *[excluded services]*	$20

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$375/$100
Copayments	$460
Coinsurance	$170
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,125**

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

The plan's overall deductible	$375/$100
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$375/$5
Copayments	$0
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$620**

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