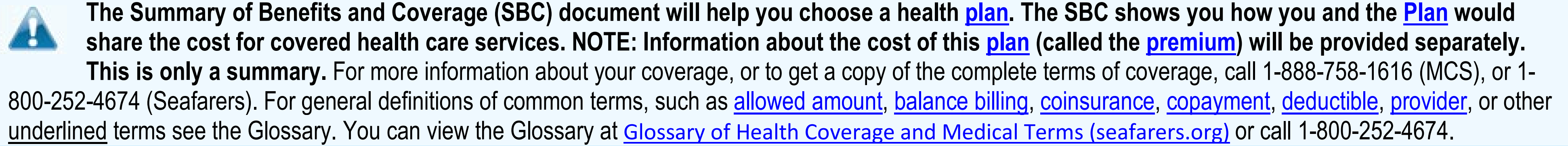
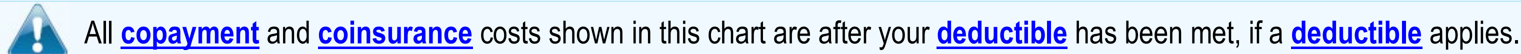


**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-758-1616 (MCS), 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 Glossary of Health Coverage and Medical Terms (seafarers.org) or call 1-800-252-4674.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250** 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, Preventive Care, 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** person/**$200** family for prescription drug coverage, except for Plan S - $100/person. No Rx deductible for Apprentices. 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?** | **$2,700** individual/**$5,500** 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://mcs.com.pr for a link to MCS'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 copayment | $10 copayment + charges above contracted amount | None |
| | Specialist visit | $15 copayment | $15 copayment + charges above contracted amount | None |
| | Preventive care/screening/ immunization | $0 | Charges above contracted amount | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 10% coinsurance + charges above contracted amount | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 10% coinsurance + charges above contracted amount | No payment if not pre-authorized. |
| **If you need drugs to treat your illness or condition** More information is available at www.optumrx.com (or call 1-800-788-4863). Maintenance drugs cost more 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. |
| | 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. |
| | 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. |
| | Specialty drugs 30-day supply limit for most; 90-day for oral HIV drugs only | 30- and 90-day supply copay (for retail or by mail) same as above | Not covered (Specialty) Not applicable (Retail) | Prior authorization required for certain drugs. All Specialty drugs must be filled through Optum Specialty Pharmacy. Contact OptumRx |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 10% coinsurance + charges above contracted amount | None |
| | Physician/surgeon fees | 10% coinsurance | 10% coinsurance + charges above contracted amount | None |
| **If you need immediate medical attention** | Emergency room care | $0 | $0 | $300 copay if non-injury related/not admitted. |
| | Emergency medical transportation | Land – $0 Air – 10% coinsurance | Land – $0 Air - 10% coinsurance + charges above contracted amount | Land -- Non-emergency limited to $75 per trip and only 4 trips per year. Air ambulance -- Only one trip per year. |
| | Urgent care (MCS facility) | $35 copayment | $35 copayment + charges above contracted amount | 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 | $450 copayment + charges above contracted amount per hospital stay | 180 continuous days or $1,000,000 maximum per illness. Inpatient benefits will resume after 60 days out of hospital.<br>Payment at semi-private room rate.<br>No payment if not pre-authorized. |
| | Physician/surgeon fees | 10% coinsurance | 10% coinsurance + charges above contracted amount | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copayment for mental/behavioral health | $15 copayment + charges above contracted amount for mental/behavioral health | None |
| | Inpatient services | $450 copayment per hospital stay | $450 copayment + charges above contracted amount 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 | $15 copayment | $15 copayment + charges above contracted amount | 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 | 10% coinsurance + charges above contracted amount | None |
| | Childbirth/delivery facility services | $450 copayment per hospital stay | $450 copayment + charges above contracted amount 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 | $7 copayment | $7 copayment + charges above contracted amount | After non-catastrophic illness/injury: 60 combined visits per year.<br>After catastrophic illness/injury: 40 combined visits per year.<br>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<br>50% coinsurance for onboard injuries | 10% coinsurance + charges above contracted amount<br>50% coinsurance + charges above contracted amount for onboard injuries | None |
| | Hospice services | 10% coinsurance | 10% coinsurance + charges above contracted amount | Up to six months. |
| If your child needs dental or eye care | Children's eye exam | Charges up to $400/24 months; includes eye wear. | Charges up to $400/24 months; includes eye wear. | Core Plus only. Other plan levels, call 1-800-252-4674 for benefits. |
| | Children's glasses | Charges up to $400/24 months; includes eye exam. | Charges up to $400/24 months; includes eye exam. | Core Plus only. Other plan levels, call 1-800-252-4674 for benefits. |
| | 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%.<br>$2,000/year; $4,000 orthodontic lifetime max; orthodontia applies to annual limit.<br>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
- Brand name drugs for Plan S and Apprentices
- Chiropractic care
- Cosmetic surgery
- Habilitation services
- Hearing aids for dependents
- Long term care
- Prescription drugs for dependents of Pensioners
- Private duty nursing (inpatient)
- Services outside the U.S. and its territories
- Treatment not medically necessary
- Vision benefits for Plan S, Apprentices, and dependent children of Pensioners
- 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
- Routine foot 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 MCS at 1-888-758-1616 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: MCS, Grievances and Appeals Unit, P.O. Box 195429, San Juan, PR 00919-5429, or via fax to 1-787-620-7765, or via email to coordinadordequerellas@medicalcardsystem.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**
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

*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 PLUS (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. 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. Plan S and Apprentices do not have prescription benefits.

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

- **The plan's overall deductible** **$250/$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 | $250/$10 |
| Copayments | $450 |
| Coinsurance | $530 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,300** |

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

- **The plan's overall deductible** **$250/$100**
- **Specialist [cost sharing]** **$30**
- **Hospital (facility) [copayment]** **$0**
- **Other [cost sharing] [coinsurance]** **10%**
- **Other [cost sharing] [copayment]** **$490**
- **Other [cost sharing] [excluded services]** **$0**

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

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250/$100 |
| Copayments | $490 |
| Coinsurance | $150 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,010** |

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

- **The plan's overall deductible** **$250/$100**
- **Specialist [cost sharing]** **$0**
- **Hospital (facility) [cost sharing]** **10%**
- **Other [cost sharing] [coinsurance]** **10%**
- **Other [cost sharing] [copayment]** **$30**
- **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 | $250/$5 |
| Copayments | $30 |
| Coinsurance | $120 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$410** |

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