**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 1-800-314-3121 (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?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. | There is no deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **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 | 30% coinsurance | 35% coinsurance | None |
| | Specialist visit | 30% coinsurance | 35% coinsurance | Chemotherapy/radiation not covered. |
| | Preventive care/screening/ immunization | 30% coinsurance | 35% coinsurance | No immunization coverage. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 35% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 30% 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<br><br>Maintenance drugs cost more at retail. | Generic drugs<br>30 day retail; 90 day mail order | 30% coinsurance retail per prescription<br>25% coinsurance mail per prescription | Not applicable | Prior authorization required for certain drugs. |
| | Preferred brand drugs | Not covered | Not applicable | Preferred brand drugs excluded. |
| | Non-preferred brand drugs | Not covered | Not applicable | Non-preferred brand drugs excluded. |
| | Specialty drugs<br>30 day supply limit for most; 90 day supply available for oral HIV drugs only | 30% coinsurance retail per prescription<br>25% coinsurance mail per prescription | Not covered (Specialty)<br><br>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. Generic only. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 35% coinsurance | No payment if not pre-authorized. |
| | Physician/surgeon fees | 30% coinsurance | 35% coinsurance | No payment if not pre-authorized. |
| **If you need immediate medical attention** | Emergency room care professional services<br>Emergency room care facility services | 30% coinsurance<br><br>No charge | 30% coinsurance<br><br>No charge | $300 copayment if non-injury related or not admitted. $5,000 maximum per emergency room visit. |
| | Emergency medical transportation | Not covered | Not covered | Not covered. |
| | Urgent care | 30% 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) | No charge | 30% coinsurance | $50,000 maximum or 31 days at semi-private room rate per hospital stay. No payment if not pre-authorized. |
| | Physician/surgeon fees | 30% 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 | Mental/behavioral health not covered. No charge for substance use disorder | Mental/behavioral health not covered. 30% coinsurance substance use disorder | Mental/behavioral health inpatient services - not covered. Substance use disorder for inpatient detox services for Seafarer only. No payment if not pre-authorized. |
| **If you are pregnant** | Office visits | 30% 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 | 30% coinsurance | 35% coinsurance | None |
| | Childbirth/delivery facility services | No charge | 30% coinsurance | $50,000 max or 31 days at semi-private room rate per hospital stay. |
| **If you need help recovering or have other special health needs** | Home health care | Not covered | Not covered | Not covered. |
| | Rehabilitation services | Not covered | Not covered | Not covered. |
| | Habilitation services | Not covered | Not covered | Not covered. |
| | Skilled nursing care | Not covered | Not covered | Not covered. |
| | Durable medical equipment | Not covered | Not covered | Not covered. |
| | Hospice services | Not covered | Not covered | Not covered. |
| **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
- Durable medical equipment
- Habilitation services
- Hearing aids
- Home health and skilled nursing
- Hospice
- Immunizations
- Infertility treatment
- Inpatient substance use disorder, except for employee detox
- Long term care
- Mental health services
- Outpatient substance use disorder
- Private duty nursing
- Rehabilitation services
- Routine eye care
- 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.)**

- None

**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 1-800-314-3121 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**
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 – Apprentice (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 | $0 |
| Specialist *[cost sharing]* | $0 |
| Hospital (facility) *[copayment]* | $0 |
| Other *[cost sharing]* *[coinsurance]* | 30% |
| Other *[cost sharing]* *[copayment]* | $5 |
| 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 | $0 |
| Copayments | $5 |
| Coinsurance | $1,670 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,735** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $90 |
| Hospital (facility) *[copayment]* | $0 |
| Other *[cost sharing]* *[coinsurance]* | 30% |
| Other *[cost sharing]* *[copayment]* | $1,050 |
| Other *[cost sharing]* *[excluded services]* | $810 |

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

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

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,050 |
| Coinsurance | $390 |
| *What isn't covered* | |
| Limits or exclusions | $810 |
| **The total Joe would pay is** | **$2,250** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $100 |
| Hospital (facility) *[cost sharing]* | 30% |
| Other *[cost sharing]* *[coinsurance]* | 30% |
| Other *[cost sharing]* *[copayment]* | $5 |
| Other *[cost sharing]* *[excluded services]* | $1,340 |

**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 | $0 |
| Copayments | $5 |
| Coinsurance | $265 |
| *What isn't covered* | |
| Limits or exclusions | $1,340 |
| **The total Mia would pay is** | **$1,610** |

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