
 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/plans](http://www.seafarers.org/plans) or call 1-800-252-4674 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250 person/\$750 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Inpatient Facility, Vision, and Dental are not subject to <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 person/\$200 family for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services. <a href="#">Prescription coverage</a> provided through OptumRx.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,700 individual/\$5,500 family for in- <a href="#">network</a> services and <a href="#">out-of-network emergency room/air ambulance</a>	The <a href="#">out-of-pocket limit</a> is the most you can pay in a year for services listed in the "Answers" column. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Health care this <a href="#">plan</a> doesn't cover, prescription costs, dental, vision, <a href="#">balance billing</a> charges, and most <a href="#">out-of-network</a> services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.humana.com">www.humana.com</a> for a link to Humana's <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	In-network annual physical no charge for dependents. Out-of-network annual physical 35% <a href="#">coinsurance</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	No payment if not <a href="#">pre-authorized</a> .
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> (or call 1-800-788-4863) or <a href="http://www.seafarers.org/plans">www.seafarers.org/plans</a>  Maintenance drugs cost more when purchased at retail.	Generic drugs 30 day retail; 90 day mail order	\$10 <a href="#">copay</a> each retail \$20 <a href="#">copay</a> each mail	Not applicable	<a href="#">Prior authorization</a> required for certain drugs.
	Preferred brand drugs 30 day retail; 90 day mail order	\$25 <a href="#">copay</a> each retail \$50 <a href="#">copay</a> each mail	Not applicable	<a href="#">Prior authorization</a> required for certain drugs.
	Non-preferred brand drugs 30 day retail; 90 day mail order	\$50 <a href="#">copay</a> each retail \$100 <a href="#">copay</a> each mail	Not applicable	<a href="#">Prior authorization</a> required for certain drugs.
	<a href="#">Specialty drugs</a> 30 day supply limit for most; 90 day supply available for oral HIV drugs only	30 day supply <a href="#">copay</a> (for retail or by mail) same as above retail categories; 90 day supply <a href="#">copay</a> (for retail or by mail) same as above mail categories	Not covered (Specialty)  Not applicable (Retail)	<a href="#">Prior authorization</a> required for certain drugs.  All <a href="#">Specialty drugs</a> must be filled through Optum Specialty Pharmacy. Contact OptumRx at 1-800-788-4863.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	\$300 <a href="#">copay</a> if non-injury related/not admitted.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> for air ambulance for <a href="#">out-of-network</a>
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	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)	
<b>If you have a hospital stay</b>	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	10% <u>coinsurance</u>	35% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <u>coinsurance</u> for mental/behavioral health	35% <u>coinsurance</u> for mental/behavioral health	Mental/behavioral health outpatient services are not covered for dependents.
	Inpatient services	\$450 <u>copayment</u> per hospital stay	30% <u>coinsurance</u> \$450 <u>copayment</u> per hospital stay	Seafarer only. 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> . Inpatient detox services and <u>rehabilitation</u> ; <u>rehabilitation</u> only covered at SARC in Piney Point, MD.
<b>If you are pregnant</b>	Office visits	10% <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	10% <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.

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	35% <u>coinsurance</u>	After non-catastrophic illness/injury: 40 combined visits per year. After catastrophic illness/injury: 40 combined visits per year. Combined visits include physical, occupational, speech, pulmonary and cognitive therapies.
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered.
	<a href="#">Skilled nursing care</a>	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.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u> 50% <u>coinsurance</u> for onboard injuries	35% <u>coinsurance</u> 50% <u>coinsurance</u> for onboard injuries	None
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Up to six months.
<b>If your child needs dental or eye care</b>	Children's eye exam	Charges above \$200/24 months; includes eye wear.	Charges above \$200/24 months; includes eye wear.	Discount may apply.
	Children's glasses	Charges above \$200/24 months; includes eye exam.	Charges above \$200/24 months; includes eye exam.	Discount may apply.
	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%. \$2,000/year; \$4,000 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](#).)**

- |                                    |  |   |
|------------------------------------|--|---|
| • Acupuncture                      | • Hearing aids for dependents                                    | • Private duty nursing (inpatient)              |
| • Bariatric surgery for dependents | • Long term care   | • Routine foot care                             |
| • Chiropractic care                | • Mental health services for dependents                          | • Services outside the U.S. and its territories |
| • Cosmetic surgery                 | • Inpatient and outpatient substance use disorder for dependents | • Treatment not medically necessary             |
| • Habilitation services            |  | • 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 | • Hearing aids for Seafarer only | • Private duty nursing (for home health care only) |
| • Dental care                         | • Infertility treatment          | • 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](http://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](http://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](mailto: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](http://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](http://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 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](#). 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](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250/\$10
Copayments	\$450
Coinsurance	\$530
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,300</b>

**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](#)] \$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250/\$100
Copayments	\$460
Coinsurance	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,010</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250/\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250/\$5
Copayments	\$0
Coinsurance	\$255
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$510</b>