ILWU-PMA BENEFIT PLANS /
International Longshore & Warehouse Union —
Pacific Maritime Association
www.benefitplans.org
1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109
PHONE (415) 673-8500
FAX (415) 749-1400

ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan
ILWU-PMA Watchmen Pension Plan

Date July 3, 2025

To: ILWU Oregon Area Locals 04, 08, 40, 92
ILWU Washington Area Locals 19, 23, 32, 47, 52, 98

From: Mario Perez, Director of Benefit Plans

**Subject: Notice to All ILWU-PMA Welfare Plan Members Enrolled in the Coastwise Indemnity Plan in Oregon and Washington in Choice Ports**

The attached notice and Summary of Benefits and Coverage (SBC) is being sent to Oregon and Washington Coastwise Indemnity Plan enrollees in Choice Ports. SBCs, in the format provided, are required by the Patient Protection and Affordable Care Act.

cc: Andrea Stevenson, Area Welfare Director
Martha Hendricks, Area Welfare Director

Attachment

A copy of this memo can be downloaded at www.benefitplans.org

MP:st/opeiu29aflcio/MTP – SBC OR WA Plan 9 070225-07032025

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ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan

June 2025

TO: ILWU-PMA Welfare Plan Participants

FROM: Mario Perez, Director of Benefit Plans

**SUBJECT: ILWU-PMA Welfare Plan**
**Summary of Benefits and Coverage (SBC)**

The enclosed Summary of Benefits and Coverage ("SBC") document provides information regarding some of your benefits under the ILWU-PMA Welfare Plan. This document includes information about covered benefits, costs, limitations, and other features.

This document is only a summary. You should refer to the ILWU-PMA Welfare Plan's Summary Plan Description, the Coastwise Indemnity Plan's Supplemental Summary Plan Description, the Chiropractic Benefit SSPD, and other applicable materials for additional information regarding benefits and coverage under the ILWU-PMA Welfare Plan, which are available at www.benefitplans.org.

Enclosure

MP:st/opeiu29aflcio/SBC Cover Letter 061725-06172025



IBT 853 - ADPRINT

**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, visit www.benefitplans.org. 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 https://www.healthcare.gov/sbc-glossary or call (415) 673-8500 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** for PPO providers.<br>**$100** individual/**$300** family for non-PPO providers.<br>Applies each July 1 – June 30. | 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**. The Plan pays for 100% of Basic Benefits including hospital benefits, surgery and anesthesia, doctor visits, outpatient diagnostic X-ray and laboratory, preventive care, and baby care (allowances may vary) before the deductible is applied. | This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **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?** | **$0** for PPO providers<br>**$1,000** per family for Non-PPO providers | 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Deductibles, premiums, balance-billing charges, charges over Maximum Allowance Charge (MAC), and health care that is not covered under this plan. | 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://www.fchn.com/Members or call 1-800-231-6935 for a list of 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | | 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 |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO 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 | No Charge | After Basic Benefit Allowance (Allowance)and deductible, 20% co-insurance on balance of charge up to Maximum Allowable Charge (MAC | Non-PPO limited to $73.35 per visit, one visit per day, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| | Specialist visit | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to $73.35 per visit, one visit per day, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information.<br><br>Chiropractic visits only covered if provided by a FCHN provider. For a list of providers, see www.fchn.com and click on "Find Care", Search for "Chiropractor" and select "ILWU-PMA Coastwise Indemnity Plan" as the Employer Name. Limited to 40 chiropractic visits per Plan Year. Additional visits are covered if determined by the Plan to be medically necessary. |
| | Preventive care/screening/ immunization | No Charge | After deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to one each Plan Year up to $400. Plan covers charges up to MAC.<br><br>You may have to pay for services that aren't |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| | | | | preventive. Ask your provider if the services needed are preventive. Then check what your Plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to $1,206.43 per condition each six months, renewing January 1 and July 1 of each year, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| | Imaging (CT/PET scans, MRIs) | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://www.benefitplans.org/rxdrug.html. | Generic drugs | $1 copay/prescription (retail & mail order) | $1 copay/prescription (retail & mail order) | Limited to a 30-day supply for retail or 90-day supply for mail order. Compound drugs will only be covered if they are dispensed by an OptumRx Credentialed Pharmacy (information at www.benefitplans.org) and do not include excluded chemical compounds on the OptumRx Exclusion List (information at www.benefitplans.org). Compound prescriptions that cost more than $1,000 will require preauthorization. Specialty drugs that are on the OptumRx exclusive specialty drug list will only be covered if they are dispensed by the OptumRx exclusive specialty pharmacy (information at www.benefitplans.org) and are limited to a 30-day supply for the first prescription fill. Specialty injectable and infusion drugs require preauthorization and may be obtained through the CIP program or OptumRx. |
| | Preferred brand drugs | $1 copay/prescription (retail & mail order) | $1 copay/prescription (retail & mail order) | |
| | Non-preferred brand drugs | $1 copay/prescription (retail & mail order) | $1 copay/prescription (retail & mail order) | |
| | Specialty drugs | $1 copay/prescription (retail & mail order) | $1 copay/prescription (retail & mail order) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | No copay for first major surgical procedure; 50% | If referred by a PPO provider, non-PPO ambulatory surgery centers will be covered |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| | | | of charge (up to MAC) for each lesser procedure | at 100% of charge (up to MAC). If referred to a non-PPO ambulatory surgery center by a non-PPO provider, the service will not be covered. |
| | Physician/surgeon fees | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to $110.19 for each Relative Value Schedule (RVS) unit up to $22,038.00 per disability for surgeon, $7,346.04 per disability for anesthesiologist, and 20% of the surgery allowance based on the RVS unit allowance up to $4,407.60 per disability for Assistant Surgeon, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| **If you need immediate medical attention** | Emergency room care | No Charge | No Charge | Patient may transfer to a PPO area as soon as medically safe and reasonable, or additional treatment will require 20% coinsurance. Post-stabilization care will be provided in accordance with the requirements of the No Surprises Act. Plan covers charges up to MAC. |
| | Emergency medical transportation | No Charge | No Charge | Plan covers charges up to MAC. Please refer to the SSPD for additional information. |
| | Urgent care | No Charge | No Charge | Patient may transfer to a PPO area as soon as medically safe and reasonable, or additional treatment will require 20% coinsurance. Plan covers charges up to MAC. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to $965.07 per day for up to 365 days per confinement, then 20% co-insurance. Non-PPO limited to $26,772.75 per hospital confinement, then 20% co-insurance. Non-PPO hospital extras limited |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| | | | | to $12,064.33, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| | Physician/surgeon fees | No Charge | No Charge | Plan covers charges up to MAC. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to $73.35 per visit, one visit per day, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. Medicare and Non-Medicare eligibles and their dependents are covered for chemical dependency recovery programs under the ILWU-PMA Alcoholism/Drug Recovery Program (ADRP). See the separate brochure describing the ADRP. |
| | Inpatient services | No Charge | After Allowance and deductible, 20% co-insurance on balance of charge up to MAC | Non-PPO limited to $965.07 per day for up to 365 days per confinement, then 20% co-insurance. Non-PPO limited to $26,772.75 per hospital confinement, then 20% co-insurance. Non-PPO hospital extras limited to $12,064.33, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| **If you are pregnant** | Office visits | No Charge | No Charge | ——————none—————— |
| | Childbirth/delivery professional services | No Charge | No Charge | Non-PPO limited to $110.19 for each RVS unit up to $22,038.00 per disability for surgeon, $7,346.04 per disability for anesthesiologist, and 20% of the surgery allowance based on the RVS unit allowance up to $4,407.60 per disability for Assistant Surgeon, then 20% co-insurance. Plan covers charges up to MAC. Amount will |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| | | | | change every April and October. Please refer to the SSPD for additional information. |
| | Childbirth/delivery facility services | No Charge | No Charge | Non-PPO limited to $965.07 per day for up to 365 days per confinement, then 20% co-insurance. Non-PPO limited to $26,772.75 per hospital confinement, then 20% co-insurance. Non-PPO hospital extras limited to $12,064.33, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | No Charge | Only covered if approved in lieu of hospitalization. Non-PPO limited to $120.41 per visit, then 20% co-insurance. Plan covers charges up to MAC. Amount will change every April and October. Please refer to the SSPD for additional information. |
| | Rehabilitation services | No Charge | After deductible, 20% co-insurance on balance of charge up to MAC | Plan covers charges up to MAC. |
| | Habilitation services | No Charge | After deductible, 20% co-insurance on balance of charge up to MAC | Plan covers charges up to MAC. |
| | Skilled nursing care | No Charge | After deductible, 20% co-insurance on balance of charge up to MAC | Limited to semi-private room rate; confinement must begin within 14 days after a confinement of at least 3 days in an acute care hospital; limited to 100 days per Plan Year for extended care in Medicare approved facilities, then 20% co-insurance. Plan covers charges up to MAC. |
| | Durable medical equipment | No Charge | After deductible, 20% co-insurance on balance of charge up to MAC | Plan covers charges up to MAC. |
| | Hospice services | No Charge | No Charge | Limited to 90 days (which can be extended |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | PPO Provider (You will pay the least) | Non-PPO Provider (You will pay the most) | |
| | | | | by physician). |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Covered through the vision plan. |
| | Children's glasses | Not covered | Not covered | Covered through the vision plan. |
| | Children's dental check-up | Not covered | Not covered | Covered through the dental plan. |

## 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.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs (except in cases of bariatric surgery)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Benefit Plans Office at (415) 673-8500. 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 on how 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 the Benefit Plans Office at (415) 673-8500 or the Department of Labor's Employee Benefits Security Administration at (800) 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:**

Spanish (Español): Para obtener asistencia en Español, llame al (415) 673-8500.

* For more information about limitations and exceptions, see the plan or policy document at www.benefitplans.org.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (415) 673-8500.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (415) 673-8500.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (415) 673-8500.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**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 copayment** | **$0** |
| **Hospital (facility) copayment** | **$0** |
| **Other copayment** | **$0** |

**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 | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$60** |

### 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 copayment** | **$0** |
| **Hospital (facility) copayment** | **$0** |
| **Other copayment** | **$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 | $0 |
| Copayments | $40 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$60** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$0** |
| **Hospital (facility) copayment** | **$0** |
| **Other copayment** | **$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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

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