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 Kaiser Plan in Oregon and Washington

The attached notice and Summary of Benefits and Coverage (SBC) is being sent to Oregon and Washington Kaiser Plan enrollees. 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 5 070225-07032025

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ILWU-PMA Pension Plan
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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	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable (No deductible)	All services covered under the plan are not subject to a 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 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 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.

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IBT 853 • ADPRINT

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	Not covered	Not covered	——————none——————
	Specialist visit	Not covered, except as follows: No Charge for chiropractic visits	Not covered, except as follows: Chiropractic visits: Choice Ports: Not Covered Non-Choice Ports (No PPO Access): After Basic Benefit Allowance, Plan pays 100% on balance of charge up to Maximum Allowable Charge (MAC)	Limited to 40 visits per Plan Year. Additional visits covered if determined by the Plan to be medically necessary. Plan covers charges up to MAC.
	Preventive care/screening/ immunization	Not covered	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge for chiropractic visits	Choice Ports: Not Covered Non-Choice Ports (No PPO Access): After Basic Benefit Allowance, Plan pays 100% on balance of charge up to MAC	Plan covers charges up to MAC.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	——————none——————
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	——————none——————
	Preferred brand drugs	Not covered	Not covered	——————none——————

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

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)	
More information about **prescription drug coverage** is available at https://www.benefitplans.org/rxdrug.html.	Non-preferred brand drugs	Not covered	Not covered	——————none——————
	Specialty drugs	Not covered	Not covered	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	——————none——————
	Physician/surgeon fees	Not covered	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	Not covered	Not covered	——————none——————
	Emergency medical transportation	Not covered	Not covered	——————none——————
	Urgent care	Not covered	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	——————none——————
	Physician/surgeon fees	Not covered	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	——————none——————
	Inpatient services	Not covered	Not covered	——————none——————
If you are pregnant	Office visits	Not covered	Not covered	——————none——————
	Childbirth/delivery professional services	Not covered	Not covered	——————none——————
	Childbirth/delivery facility services	Not covered	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	——————none——————
	Rehabilitation services	Not covered	Not covered	——————none——————
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	Not covered	Not covered	——————none——————
	Durable medical equipment	Not covered	Not covered	——————none——————
	Hospice services	Not covered	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	——————none——————
	Children's glasses	Not covered	Not covered	——————none——————

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

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)	
	Children's dental check-up	Not covered	Not covered	——————none——————

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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic 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? No

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? No

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.

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.

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

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 coinsurance	**100%**
Hospital (facility) copayment	**n/a**
Other copayment	**n/a**

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	$12,700
The total Peg would pay is	**$12,700**

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 coinsurance	**100%**
Hospital (facility) copayment	**n/a**
Other copayment	**n/a**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,600
The total Joe would pay is	**$5,600**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**100%**
Hospital (facility) copayment	**n/a**
Other copayment	**n/a**

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	$2,800
The total Mia would pay is	**$2,800**

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