ILWU-PMA COASTWISE INDEMNITY PLAN

Hospital • Medical • Surgical Benefits

An ILWU-PMA Welfare Plan
Self-Funded Program

Supplemental Summary Plan Description

ILWU-PMA COASTWISE INDEMNITY PLAN

Hospital • Medical • Surgical Benefits

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Supplemental Summary Plan Description

A Supplemental Summary Plan Description of ILWU-PMA Welfare Plan Self Funded Programs

Coastwise Indemnity Plan Hospital-Medical-Surgical Benefits

This is a description of benefits provided under the ILWU-PMA Welfare Plan Self Funded Programs Coastwise Indemnity Plan. The Coastwise Indemnity Plan is effective July 1, 2000 and replaces the former "Choice Port Plan" and "Non-Choice Port Plan." The Coastwise Indemnity Plan provides **all benefits** provided under either or both of the predecessor plans as of June 30, 2000. No ILWU-PMA indemnity plan benefits are reduced or eliminated on account of implementation of the Coastwise Indemnity Plan. The Plan is administered by the ILWU-PMA Benefit Plans office. Claims are paid by an insurance company under an administrative services only (ASO) agreement with the Trustees of the ILWU-PMA Welfare Plan. The claims office is called the ILWU-PMA Coastwise Claims Office. The information in this booklet is subject to, and does not change the provisions of the ASO agreement, the provisions of the ILWU-PMA Welfare Plan Agreement, or the provisions of the Summary Plan Description of the Welfare Plan.

Each participant of the ILWU-PMA Welfare Plan has been provided with a Summary Plan Description, as required by the Employee Retirement Income Security Act (ERISA). The Summary Plan Description describes the Welfare Plan, its eligibility requirements and benefits. It also informs participants about Supplemental Summary Plan Descriptions like this booklet, which describe individual benefit programs. The Supplemental Summary Plan Descriptions are supplied to Locals and are

available from the ILWU-PMA Benefit Plans Office on request.

ILWU-PMA Benefit Plans
1188 Franklin Street – Suite 300
San Francisco, CA 94109
(415) 673-8500

Union Trustees
Robert M. McEllrath
Ray Ortiz, Jr.
Joseph Wenzl

Employer Trustees
Ronald J. Forest
Robert L. Stephens
Michael Wechsler

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Area Welfare Directors Phone Numbers

Southern California	(866) 833-5144
Northern California	(877) 885-2793
Oregon	(866) 226-0013
Washington	(877) 938-6720

IRS Employer Identification No. 94-6068578

Plan No. 501

SECTION 1

COASTWISE INDEMNITY PLAN ELIGIBILITY

Eligibility

Dual Choice

Election of Coverage

Loss of Eligibility

COBRA Continuation Coverage

COASTWISE INDEMNITY PLAN ELIGIBILITY

This section explains how Coastwise Indemnity Plan eligibility is established and may be lost, and how COBRA continuation coverage may be purchased.

Eligibility

The ILWU-PMA Welfare Plan Self Funded Coastwise Indemnity Plan provides Hospital-Medical-Surgical benefits to eligible ILWU-PMA Welfare Plan non-Medicare and Medicare eligible participants and their dependents who have elected or who are assigned Coastwise Indemnity Plan coverage under provisions of the Welfare Agreement. The following eligible Welfare Plan participants and their dependents may be covered by this Plan:

Employees and Pensioners, Including:

- Active Longshoremen, Ship Clerks, Walking Bosses/Foremen, and Watchmen members of Locals 26 and 75.
- Most Pensioners under the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan.
- Certain Social Security Retirees.
- Certain Active and Retired Employees of the ILWU, ILWU-PMA Benefit Plans and ILWU Locals.

Qualified Dependents, Including:

- Spouse.
- Unmarried dependent children to age 19.
- Unmarried dependent children age 19 to 23 who are full-time students (student certification is required).
- Unmarried dependent children age 19 or over who are physically or mentally incapacitated, who were incapacitated when they attained age 19 (or age 23 in the case of full-time

students), and who are incapable of self-sustaining employment (medical certification is required).

- Surviving spouse and surviving dependent children of eligible active and retired employees.

Address changes and changes in family status which might affect Welfare Plan eligibility such as marriage, divorce, birth or death of a dependent must be reported immediately in writing to the ILWU-PMA Benefit Plans Office. Record Change forms for this purpose are available at the Locals or on request from the Benefit Plans Office.

Dual Choice

Where a qualified HMO is available, a choice of Hospital-Medical-Surgical coverage is offered to employees, retirees and survivors who are eligible under the Welfare Plan. The choice is between an HMO (group practice) plan available in the area of the port, and the Coastwise Indemnity Plan. This choice is offered when an employee, retiree or survivor is first eligible for a dual choice, and again each year during the month of May for coverage effective the following July 1. In addition, employees, retirees and survivors are allowed to change their choice of coverage one other time during a Plan Year, (July 1 - June 30). Information about the choice is made available by the Welfare Plan Office. Currently, the choice between an HMO and the Coastwise Indemnity Plan is available to employees registered in and retirees and survivors living in the ports listed on pages 11 and 12.

New registrants and their dependents in ports with HMO coverage will, on the first of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by the HMO programs for the first eighteen (18) months of registration. After

18 months of registration the member will have a choice of HMO or Coastwise Indemnity Plan coverage and normal welfare plan eligibility requirements shall apply.

The Trustees of the Welfare Plan may provide on an "exception basis" that a person eligible for HMO coverage under this provision may be provided limited coverage under the Coastwise Indemnity Plan specific to any serious health condition for which they are receiving treatment when Welfare Plan coverage begins.

New registrants and their dependents in ports without HMO coverage will, on the first of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by the Coastwise Indemnity Plan for the first eighteen (18) months of registration and shall thereafter be subject to the Welfare Plan's normal eligibility requirements for continuation of coverage under the Coastwise Indemnity Plan.

In ports and areas where no qualified HMO is available, employees, retirees and survivors are assigned coverage under the Coastwise Indemnity Plan.

Election of Coverage

Active Employees and Their Dependents:

Eligible active employees, and their dependents, who are assigned to the following ports may elect Coastwise Indemnity Plan coverage. Currently, ILWU Locals that are offered a dual choice include:

- California Locals:
  Los Angeles Area.....13, 26, 63, 94
  San Diego Area.....29
  San Francisco Bay Area 10, 34, 75, 91
  Sacramento Area 18, 34, 91
  Stockton Area.....34, 54, 91
- Oregon Locals:
  Portland/Columbia River Area.....4, 8, 40, 92

- Washington Locals:
  Seattle/Tacoma Areas 19, 23, 52, 98
  Everett/Olympia Areas 32, 47

Retired Employees and Survivors:

When a retiree or survivor moves to any one of the dual choice port areas listed above, he or she is offered a choice of plans. Retired employees and survivors who report a change of address are transferred, if necessary, to a plan available where they live. The transfer will coincide as nearly as possible with the move.

If you are newly enrolled in the Coastwise Indemnity Plan, or if you are visiting a new doctor or medical facility, take this booklet with you on your first visit. The booklet will help explain your benefits and claim procedures to a new provider.

Loss of Eligibility

Eligibility for all ILWU-PMA Welfare Plan benefits, including Coastwise Indemnity Plan benefits, ends upon:

- Loss of eligibility under the terms and conditions of the ILWU-PMA Welfare Plan.
- Loss of qualified dependent status as defined by the ILWU-PMA Welfare Plan.

Eligibility for Coastwise Indemnity Plan Hospital-Medical-Surgical benefits ends for retired employees or survivors and their dependents who are required to enroll for Medicare but who fail to maintain Medicare Part B enrollment.

Eligibility for Coastwise Indemnity Plan coverage also ends upon transfer to an HMO plan – see page 10 “Dual Choice.”

For further information about dependent qualifications and how eligibility under the ILWU-PMA Welfare Plan is established and may be lost, please refer to the ILWU-PMA Welfare Plan Summary Plan Description.

Upon loss of eligibility for Coastwise Indemnity Plan benefits, an insurance company provides for conversion from group coverage to an individual plan. Conditions and benefits of the individual plan are different from group coverage.

Information about the individual plan and its cost is furnished upon loss of eligibility, or may be requested from the Coastwise Claims Office.

COBRA Continuation Coverage

Persons who lose ILWU-PMA Welfare Plan eligibility as described above will be informed by the Welfare Plan office if they are entitled to COBRA continuation coverage.

COBRA is the nickname of a federal law, the Consolidated Omnibus Budget Reconciliation Act. COBRA requires that the Trustees of the ILWU-PMA Welfare Plan offer Welfare Plan participants and family members the opportunity for a temporary extension of certain Welfare Plan benefits, called "continuation coverage", when coverage under the Plan would ordinarily end.

COBRA continuation coverage is self-paid coverage, that is, the eligible person must pay for it. The cost is the same as the cost to the Plan of group coverage, plus a 2% administration fee.

COBRA continuation coverage may be purchased for a limited time only, generally either 18 months or 36 months, depending on the reason for loss of group coverage. Examples: A Dependent child who loses group coverage because he or she exceeds the maximum age for dependent eligibility may purchase continuation coverage for up to 36 months, as may a spouse who loses group coverage because of divorce. An employee who loses group coverage because of insufficient hours worked or credited may purchase continuation coverage for up to 18 months. Detailed information will be provided to persons who become entitled to purchase COBRA continuation coverage. A brochure about COBRA has also been furnished to Locals and is available from the Welfare Plan office on request.

SECTION 2

IMPORTANT FEATURES OF THE PLAN

This section contains information of interest to all Coastwise Indemnity Plan eligibles, including a description of important Plan features and definitions of terms which will be used elsewhere in the booklet.

UCR (Usual, Customary and Reasonable charges)

Service Area

Plan Year

Providers of Service

Preferred Provider Organization (PPO)

Coordination of Benefits

Assignment of Benefits

Subrogation – Third Party Liability

Voluntary Hospital Utilization Review

Voluntary Case Management

In PPO Area Emergency Treatment

Out of PPO Area Urgent or Emergency Treatment

Special Rights Upon Childbirth

Special Rights Concerning Mastectomy Coverage

IMPORTANT FEATURES OF THE PLAN

Usual, Customary and Reasonable Charges (UCR)

UCR charges, as used in this booklet, refers to charges which are reasonable and in line with fees customarily charged for the treatment or service rendered by providers of care in the same area.

Service Area

All eligibles are covered for services provided anywhere in the world. Coverage outside the United States will be provided at 100% of UCR in the country where the expenses are incurred. To the extent that UCR cannot be determined specific to the area in which the claims are incurred, the Plan will use every effort to find a reasonable substitute. Claims incurred outside the United States are subject to the same standards of medical necessity and medical treatment protocols as if they had been incurred in the United States.

Plan Year

The Plan Year is July 1-June 30. This is the basis for all annual benefit renewals and limitations.

Providers of Service

The Coastwise Indemnity Plan covers services provided by any licensed doctor, or at any licensed hospital or Medicare approved skilled nursing facility. See definitions below.

The term *"Doctor"* means a licensed practitioner of the healing arts acting within the scope of his or her license as a: Medical Doctor (MD), Osteopath (DO), Podiatrist (DPM), Chiropractor (DC), Registered Physical Therapist (RPT), Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Marriage, Family and Child Counselor (MFCC), Acupuncturist, Marriage and Family Therapist (MFT), Certified Mental Health Counselor (CMHC), Board

Certified Social Worker (BCSW), Dental Surgeon (DDS), Registered Nurse Practitioner (RNP), or Physician Assistant (PA).

"Doctor" will also include:

1. A Nurse Midwife who is certified by the American College of Nurse Midwives and is licensed to practice by the state in which services are rendered.
2. An Occupational Therapist, Speech Pathologist or Audiologist when the covered person is referred to such a practitioner by a Medical Doctor (MD) or Osteopath (DO).
3. A Registered Nurse with a Masters Degree in psychiatric mental health nursing and two years of supervised experience in psychiatric mental health nursing, but only upon referral by a Medical Doctor (MD) or Osteopath (DO).

The term *"Hospital"* means a licensed acute care facility which operates primarily for the diagnostic and therapeutic treatment of sick or injured persons as resident inpatients. In no event will the term "Hospital" include any institution which is primarily a clinic, nursing home, convalescent home, skilled nursing facility or similar establishment. Confinement in a special unit of a Hospital used primarily as a rest home, convalescent home or skilled nursing facility will not be considered to be confinement in a Hospital.

The term *"Hospital"* will also include:

1. A licensed Medicare-approved ambulatory surgical facility and a licensed non-Medicare approved ambulatory surgical facility if it is operated primarily for the purpose of performing surgical procedures on an outpatient basis, has a doctor and registered nurse in attendance when a patient is present, and is not an office maintained by a physician for the general practice of medicine or dentistry.
2. A psychiatric health hospital licensed by the state in which it operates, when inpatient

treatment is provided there for psychiatric or mental conditions.

3. A medical institution licensed by the state in which it operates to provide treatment of alcoholism and drug addiction on an inpatient basis and which has the capacity to provide medical and detoxification treatment. Residential treatment facilities that do not have the capacity to provide medical treatment are not covered as hospitals.

Preferred Provider Organization (PPO)

(Non-Medicare Eligibles Only)

The Welfare Plan has entered into agreements with Preferred Provider Organizations (PPOs) to provide medical care to plan members at special rates. These preferred providers include hospitals, doctors, x-ray, laboratory and other facilities. While the contracts with preferred providers contain special reduced rates, they do not allow discrimination with regard to admissions or service; the quality of care is the same for all patients. The PPO hospitals, doctors and facilities are among those already used most frequently by Welfare Plan participants. The Preferred Provider Organizations are *Great-West Healthcare* (formerly *One Health Plan*) in California, *First Choice Health Network* in Washington; and *Managed HealthCare Northwest* in Oregon and Vancouver Washington. In addition, a panel of mental health service providers is available in California through Magellan Behavioral Health. You are free to use any hospital or doctor of your choice but the Major Medical plan will pay a higher benefit for Preferred Providers.

PPO directories listing the names and addresses of preferred providers are available from the Locals. If you have any questions about whether a provider is a preferred provider, you may call the Preferred Provider Organizations directly at the following numbers:

Coastwise Claims Office (Great-West Healthcare, formerly One Health Plan) (California)	1-800-955-7376 1-415-543-0114
Magellan Behavioral Health (California – Mental Health)	1-800-424-5945
First Choice Health Network (Washington & Oregon)	1-800-231-6935 1-206-292-8255
Managed HealthCare Northwest (Oregon & Southern Washington)	1-800-648-6356 1-503-413-5800

Coordination of Benefits

Coordination of Benefits applies to Coastwise Indemnity Plan benefits when a patient is covered by more than one group health plan. Each plan bears a share of expenses. The total combined benefit payments of the two plans will not exceed actual UCR charges.

Assignment of Benefits

Under provisions of the ILWU-PMA Welfare Plan, Welfare Plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Trustees, and any attempt to do so shall be void. However, ERISA provides that in the case of persons with coverage under a State Medicaid program, automatic assignment of benefits to State Medicaid agencies is enforceable against the Plan. Where benefits are paid directly to a doctor, hospital or other provider of care (other than to a State Medicaid agency), such direct payments are provided at the discretion of the Trustees as a convenience to Plan participants and do not imply an enforceable assignment of Welfare Plan benefits or the right to receive such benefits.

Subrogation/Reimbursement– Third-Party Liability

The Welfare Plan will pay benefits for an injury or illness for which a third party may be liable only on the condition that the covered person, or

the legal representative of the covered person, completes an "Agreement to Reimburse Benefits" form. This is an agreement to reimburse the Trustees of the ILWU-PMA Welfare Plan for any Welfare Plan benefits paid on account of an injury or illness, to the extent benefits or other compensation are received for the same injury or illness under Workers' Compensation laws or from any third party.

Voluntary Hospital Utilization Review

(Non-Medicare Eligibles Only)

The Plan contains a voluntary hospital utilization review program administered by BCE Emergis. Hospital utilization review is intended to prevent unnecessary expenses due to hospital confinements which: 1) are not medically necessary, 2) are for a longer period of time than necessary, or 3) are for care which could be given on an outpatient basis. The utilization review program may provide pre-admission certification, concurrent review and discharge planning. Pre-admission certification is performed for scheduled hospital admissions, prior to admission. Concurrent review is performed for both scheduled and non-scheduled admissions during confinement. Discharge planning may be provided to help arrange for discharge from the hospital as early as possible without jeopardizing patient care. This program is voluntary and not mandatory. To request voluntary hospitalization review, telephone 1-(800)-326-7136.

Voluntary Case Management

The Case Management program, administered by BCE Emergis, can provide help and support for patients experiencing serious or long term illness. Case Management health care professionals will work with the patient, family and doctor in arranging for treatment alternatives to lengthy hospitalizations. In certain cases, Case Management may get approval for benefits not usually covered by the Coastwise Indemnity Plan, such as home health care, and rehabilitation facility care. Case Management is a voluntary program and does not dictate the care you

receive. These important decisions stay with you and your doctor.

Patients who qualify may be identified and referred to Case Management by the Coastwise Claims Office or through the voluntary hospital utilization review process; or you may call BCE Emergis Case Management directly at 1-(800)-326-7136.

In PPO Area Emergency Treatment

If an eligible plan participant assigned to a PPO area needs emergency medical treatment, including ambulance service, the person needing the emergency treatment should go immediately to the nearest hospital emergency medical facility. The plan will reimburse the cost of such emergency treatment at 100% of PPO negotiated rates if the hospital facility, ambulance service, and/or emergency room physician is a PPO provider. If the hospital emergency facility, ambulance service or physician is not a PPO provider the plan will reimburse the cost of emergency treatment at 100% of UCR. If continued treatment or admission is needed, the participant may be required to transfer to a PPO hospital as soon as the attending physician determines it is medically safe and reasonable to be transported. If the participant elects to continue to receive treatment at the Non-PPO hospital after the emergency period, the Plan will pay basic benefits plus major medical (80% of UCR) for the additional treatment.

A “Medical Emergency” is defined as: the sudden onset of a medical condition that the patient believes requires immediate treatment because it is either (1) life threatening, or (2) would cause a serious dysfunction or impairment of a body organ or part if not immediately treated.

Out of PPO Area Emergency or Urgent Treatment

If an eligible plan participant assigned to a PPO area receives emergency or urgent medical treatment while outside of that PPO area, the plan will reimburse the cost of such emergency

or urgent treatment, including ambulance service, at 100% of UCR. If continued treatment is needed, the participant may be required to transfer back to a PPO area as soon as the attending physician determines it is medically safe and reasonable to be transported. If the participant elects to continue to receive treatment outside the PPO area after the urgent or emergency period, the Plan will pay basic benefits plus major medical (80% of UCR) for the additional treatment.

A "Medical Emergency" or Urgent Treatment is defined as: the sudden onset of a medical condition that the patient believes requires immediate treatment because it is either (1) life threatening, or (2) would cause a serious dysfunction or impairment of a body organ or part if not immediately treated, or (3) a condition for which immediate treatment would be obtained if the medical condition occurred within a PPO area.

Special Rights Upon Childbirth

Under federal law, group health plans may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean delivery. However, the attending physician may discharge the mother or her newborn at any time after consultation with the mother.

Special Rights Concerning Mastectomy Coverage

Under federal law, group health plans that provide coverage for mastectomies (the Coastwise Indemnity Plan does) are also required to provide coverage for reconstructive surgery and prostheses following mastectomies. This coverage will be provided in consultation with the patient and the patient's attending physician and is subject to the same annual deductible and copayment provisions otherwise applicable under the Plan.

SECTION 3

BASIC HOSPITAL-MEDICAL-SURGICAL BENEFITS FOR NON-MEDICARE ELIGIBLES

Maintenance of Benefits

Basic Benefits – Schedule of Allowances

Basic Benefits Exclusions

How to Claim Hospital-Medical-Surgical Benefits

BASIC HOSPITAL-MEDICAL-SURGICAL BENEFITS FOR NON-MEDICARE ELIGIBLES

*This section describes Hospital-Medical-Surgical benefits for Coastwise Indemnity Plan members who are **not** eligible for Medicare, and for active members who are eligible for Medicare with the Welfare Plan as their primary coverage. If you are a Medicare-eligible pensioner or the Medicare-eligible dependent of a pensioner, please go to the section called "Supplemental Hospital-Medical-Surgical Benefits for Medicare Eligibles" beginning on page 39. See also "Major Medical Benefits" on page 34 and "Additional Medical Benefits" on page 48.*

■ Maintenance of Benefits

The Trustees monitor the Coastwise Indemnity Plan to determine whether out-of-pocket costs to beneficiaries have increased. If so, periodic adjustments in the Basic Benefits Schedule of Allowances will be made.

■ Basic Benefits – Schedule of Allowances

The Plan pays Basic Hospital, Medical and Surgical benefits at 100% of the scheduled amounts for covered services according to the Schedule of Allowances effective on the date claims are incurred. The Schedule of Allowances shown in this booklet is effective October 2003 and will be updated every April and October. For the latest Schedule of Allowances, contact your Local or the Benefit Plans office, or call the Claims Office at (415) 543-0114 or (800) 955-7376.

In addition to the Basic Benefits provided under the Schedule of Allowances, the Coastwise Indemnity Plan provides Major Medical benefits after maximum Basic Benefits have been paid and after any applicable deductible has been satisfied. Major Medical benefits are described on page 34.

Basic Benefits cover only the specific type of expenses listed below if they are medically necessary and are ordered by a doctor for treatment of an illness or injury.

Hospital Benefits
See the definition of "Hospital" on page 17.

Room and Board: Up to $504.56 room and board per day, for up to 365 days per confinement.

Hospital Extras:
PPO: 100% of PPO charges
Non-PPO: Up to $6,307.83 with any balance at 80% of UCR under Major Medical.
No PPO Access: 100% of UCR

per confinement for necessary services and supplies charged by the hospital other than room and board. The Hospital Extras benefit covers inpatient hospital charges for supplies and services other than room and board, outpatient hospital charges for surgery or emergency care, and surgery charges from approved ambulatory surgi-centers.

Renewal of Hospital Benefits: Hospital benefits, including in-hospital doctor visits, surgery, assistant surgeon and anesthesiologist benefits, renew for each separate confinement when due to entirely unrelated causes. When successive hospital confinements are due to the same or related cause, hospital benefits renew for active employees on the earlier of return to work (including availability for work) or three months following discharge from the hospital; for retired employees, survivors and dependents, hospital benefits renew three months following discharge from the hospital.

Newborn Nursery Care
PPO: 100% of PPO charges
Non-PPO: 80% of UCR charges
No PPO Access: 100% of UCR charges

Skilled Nursing Facility
Up to 100 days per Plan Year (July 1 – June 30) for extended care in Medicare approved facilities; confinement must begin within 14 days

after a confinement of at least 3 days in an acute care hospital.
PPO: 100% of PPO semi-private room rate.
Non-PPO: 80% of UCR semi-private room rate.
No PPO Access: 100% of UCR semi-private room rate.

Hospice Care
100% up to UCR for all covered services up to 90 days which can be extended by physician. Also, 90 days for bereavement from date of death.

Ambulance Benefit
Up to $466.21 hospital per confinement for transportation to or from a hospital; included in the "Hospital Extras" benefit. Note: Emergency ambulance service is covered under Emergency Treatment on pages 21 and 22.

Medical-Surgical Benefits
Doctor Office Visits: $38.35 per visit.

Doctor Home Visits: $62.94 per visit.

See definition of "Doctor" on page 16.

Payment is limited to one visit per day for each eligible person unless the visits are to different doctors for separate and unrelated conditions.

Doctor Hospital Visits: $38.35 per visit, limited to one visit for each day of inpatient confinement. Maximum payment per hospital confinement; $13,997.75.

Surgery: Up to a maximum of $11,524 per disability. The maximum payment for any one surgical procedure is based on the 1964 Relative Value Schedule (RVS), translated to and expanded into up-to-date Current Procedural Terminology (CPT4) codes at $57.62 for each unit listed for the procedure. Radiation Therapy and surgical services for maternity are covered under the Surgical benefit.

Example: An appendectomy is listed at 40 units. The maximum allowance for the surgeon is $2,304.80 (40 units times $57.62).

Multiple Surgical Procedures During the Same Operative Session: Full Plan benefits are payable for the major surgical procedure, plus 50% of Plan benefits for each lesser procedure which adds significantly to the time and complexity of the operation, up to the Surgery maximum per disability. No benefits are payable for incidental procedures which do not add significantly to the time and complexity of an operation.

All operations for the same condition are considered a single disability, subject to the surgery maximum.

Assistant Surgeon: 20% of the Surgery allowance based on the RVS unit allowance up to a maximum of $2,304.80 per disability.

Anesthesiologist (MD): Up to $57.62 per unit based on the unit allowance and "Anesthesia Time Units" of one unit per quarter hour, up to a maximum of $3,841.35 per disability.

Example: An Appendectomy has an anesthesia value of four units. If the anesthesia time is 60 minutes, the maximum payment is $460.96 - four units plus four quarter-hour time units = eight units times $57.62. If anesthesia is administered by other than an anesthesiologist (MD), payment is one-half of the amount calculated for the anesthesiologist.

Chiropractic Treatment
$38.35 per visit, limited to 40 visits per Plan Year (July 1 – June 30) except where the Welfare Plan chiropractic consultant decides additional visits are medically necessary.

Cosmetic Surgery After Mastectomy
If all or part of a breast is surgically removed for medically necessary reasons, the following services are covered:

Reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance;

Prostheses (artificial replacements); and,

Services for physical complications resulting from the mastectomy.

Outpatient Diagnostic X-Ray And Laboratory Benefits
Maximum of $630.78 per condition each six months. Benefit renews January 1 and July 1 of each year.

Well Baby Care
PPO: Covered as any other medical condition at 100% of PPO charges during the child's first year.

Non-PPO: Covered as any other medical condition at 80% of UCR during child's first year.

No PPO Access: Covered as any other medical condition at 100% of UCR during child's first year.

Thereafter, maximum of $250.00 per year (from birthday to birthday) until the child's third birthday.

Routine Physical Examination for Adults
PPO: 100% of covered PPO charges for the exam and related lab and x-ray charges; maximum of one each Plan Year.

Non-PPO: 80% of UCR for exam and related lab and x-ray charges; maximum of one each Plan Year up to $400.

No PPO Access: 100% of UCR for exam and related lab and x-ray charges; maximum of one each Plan Year.

Services related to a diagnosis paid separately.

Routine Physical Examination for Children
PPO: 100% of PPO charges

Non-PPO: 80% of UCR

No PPO Access: 100% of UCR

Charges covered include the exam and related lab and x-ray charges. A routine physical examination benefit is provided for eligible dependent

children other than infants, up to age 19, according to the following schedule: first examination just before entering the first grade or during the first year of school; second examination after the first year of school and before age 13; third examination between ages 13 to 19.

Mammograms
Benefits are payable in full for routine mammograms for breast cancer screening, and the related office visit, according to American Cancer Society guidelines in effect at the time of treatment. Currently these guidelines are:

Age 35 – 39:	One baseline mammogram
Ages 40 and over:	One mammogram every year

Pap Smears
One Pap Smear and related office visit paid in full at intervals according to American Cancer Society guidelines in effect at the time of treatment.

Prostate Specific Antigen (PSA) Test
One PSA (or its successor) test and related office visit paid in full every year at age 50 and over (according to American Cancer Society guidelines).

Physical Therapy
PPO: 100% of PPO charges when prescribed by a Doctor.

Non-PPO: 80% of UCR when prescribed by a Doctor.

No PPO Access: 100% of UCR when prescribed by a Doctor.

Occupational Therapy
PPO: 100% of covered PPO charges when referred by a Doctor to a licensed PPO occupational therapist.

Non-PPO: 80% of covered UCR charges when referred by a Doctor to a licensed occupational therapist.

No PPO Access: 100% of UCR charges when

referred by a Doctor to a licensed occupational therapist.

Speech Therapy
PPO: 100% of PPO charges when referred by a Doctor to a licensed PPO speech pathologist or audiologist.

Non-PPO: 80% of UCR charges when referred by a Doctor to a licensed speech pathologist or audiologist.

No PPO Access: 100% of UCR charges when referred by a Doctor to a licensed speech pathologist or audiologist.

Mental Health Benefits – Inpatient
PPO: Paid the same as any other illness

Non-PPO: Paid the same as any other illness

No PPO Access: Paid the same as any other illness

Mental Health Benefits – Outpatient
PPO: First 20 visits per Plan Year paid the same as any other illness, 100% of PPO charges. Next 30 visits in same Plan Year paid at $38.35 per visit plus $10 under Major Medical. Maximum number of visits per Plan Year is 50.

Non-PPO: First 20 visits per Plan Year paid the same as any other illness, after basic benefits 80% of UCR charges. Next 30 visits in same Plan Year paid at $38.35 per visit plus $10 under Major Medical. Maximum number of visits per Plan Year is 50.

No PPO Access: First 20 visits per Plan Year paid the same as any other illness, 100% of UCR charges. Next 30 visits in same Plan Year paid at $38.35 per visit plus $10 under Major Medical. Maximum number of visits per Plan Year is 50.

Maternity
Expenses for maternity are paid on the same basis as expenses for any other medical condition. This means hospitalization for normal delivery, Cesarean delivery, and interrupted

pregnancy are payable according to the allowances listed under "Hospital Benefits." Benefits for doctors' services are paid based on the per unit surgical allowance. This allowance includes prenatal care, delivery, post-delivery care, and required urinalysis charges. Additional laboratory tests are payable under the Outpatient Diagnostic X-ray and Laboratory Benefits allowance described on page 28.

Basic Benefits Exclusions

Basic Hospital-Medical-Surgical Benefits do not cover:

- General Exclusions on page 56.
- Any type of medical expense not specifically listed as a covered Basic Plan Benefit.
- Foot appliances and required castings.
- Medical equipment, including but not limited to, casts, prosthetic devices such as artificial limbs and eyes, orthopedic appliances, braces, crutches, wheelchairs, hospital beds, oxygen and the rental of equipment for its administration. Note: Some of these items are covered under Major Medical Benefits – see pages 35, 36 and 37.
- Care in a convalescent home or rest home.
- Optometrical services, including examinations, refractions, visual aids or orthoptics.

How to Claim Basic Hospital-Medical-Surgical Benefits

Claims for Hospital-Medical-Surgical benefits described above are to be filed with the Coastwise Claims Office, using a Claim Form for Hospital, Medical, Surgical Benefits. Claim forms are available at the Locals, or may be requested from the Coastwise Claims Office or the Benefit Plans Office. The claim forms are pre-printed with the group name and the Coastwise Claims Office address; no policy number is required to identify your claim. Claims

should be filed within 180 days from the date covered expenses are incurred but will be accepted for up to three years unless a later filing date is allowed by the Trustees.

The claim form **Part 1 – Employee Statement** must be completed by the eligible claimant, active employee, pensioner or survivor. **Part 2 – Physician Statement** must be completed by the attending doctor or other provider of service. The doctor must itemize all charges on the claim form OR attach an itemized bill. For hospital benefits, an itemized bill must be attached to the claim form.

The claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See assignment of benefits on page 19.

Mail claims to:

ILWU-PMA Coastwise Indemnity
Plan Claims Office
814 Mission St., Suite 300
San Francisco, CA 94103

SECTION 4

MAJOR MEDICAL BENEFITS

Deductible and Percentage Payable

Stop Loss Provision

Lifetime Maximum

Covered Major Medical Expenses

Major Medical Exclusions and Limitations

How to Claim Major Medical Benefits

MAJOR MEDICAL BENEFITS

This section applies to all Coastwise Indemnity Plan members, both with and without Medicare.

The Coastwise Indemnity Plan provides Major Medical coverage in addition to Basic Plan Benefits for non-Medicare eligibles, and in addition to the Supplemental Plan for Medicare eligibles.

After maximum Basic Plan Benefits or Supplemental Plan benefits have been paid and any applicable annual deductible has been satisfied, Major Medical benefits will reimburse the following percentages of covered expenses, up to the lifetime maximum.

PPO	100% of PPO charges.
Non-PPO	80% of UCR charges.
No PPO Access	100% of UCR charges.

See Exclusions and Limitations on page 37.
See page 18 for information about the Preferred Provider Organizations.

Major Medical benefits also include a Stop Loss Provision, described below, which increases payment to 100% of covered expenses after a threshold of expense has been reached.

■ Deductible

The deductible is the amount of out-of-pocket expenses you must pay each year before the Plan begins to pay Major Medical benefits. The Major Medical annual deductible amount is:

PPO	None
Non-PPO	$100 per person
No PPO Access:	None

A new deductible must be satisfied each Plan Year (July 1 – June 30). Deductible amounts incurred during the last three months of a Plan Year will be carried over as a credit toward the deductible in the following year. No carry-over is allowed from any year during which the

deductible is satisfied within the first nine months of the year.

A separate deductible applies to each family member, but no more than $300 will be applied to the covered expenses of any one family.

If two or more family members are injured in a common accident, only one deductible will be charged to the group for expenses related to that accident.

Stop Loss Provision

During a Plan Year (July 1 – June 30) when a family has incurred $5,000 of covered Major Medical expenses, (in addition to any applicable deductibles) additional Major Medical covered expenses are then payable at 100% of UCR charges for the remainder of the Plan Year. This Stop Loss provision does not increase the maximum number of covered outpatient mental health visits (50 per Plan Year), nor does it increase the amounts payable for these visits.

Lifetime Maximum

The lifetime maximum Major Medical benefit per covered person is $2,000,000.

Restoration of Maximum: On July 1st of each year the maximum amount will be restored by $20,000 or the amount of Major Medical benefits used, whichever is less. In no event will the maximum amount be increased to more than $2,000,000.

Covered Major Medical Expenses

Expenses for the following are covered under the Major Medical benefit:

- Daily hospital room and board charges, beginning with the first day of confinement, are covered at the hospital's semi-private room rate.
- Intensive Care Unit (ICU) charges beginning with the first day of confinement in ICU.
- Coronary Care Unit charges beginning with the first day of confinement.

- Hospitalization in isolation when ordered by a physician.
- Emergency room charges.
- Services and supplies furnished by a hospital (hospital extras).
- Treatment by a physician or surgeon.
- Services of a registered nurse and treatment by a licensed physiotherapist, other than one related by blood or marriage to the patient or one who lives in the patient's home.
- Anesthesia and its administration.
- Dental treatment for a fractured jaw or for injury to or replacement of sound natural teeth within six months after an accident incurred while covered under the Plan (covered only after maximum payments under the Longshore Adult or Children's Dental Plan have been made).
- Diagnostic radiology, radiation therapy and laboratory examinations.
- Licensed ambulance service to and from the hospital.
- Blood and blood plasma; casts and splints.
- Braces, crutches, rental of wheelchairs or hospital beds; oxygen and the rental of equipment for its administration; and initial prosthetic devices including initial (under this plan) but not subsequent artificial limbs and eyes. See description of Subsequent Artificial Limbs and Eyes Benefit on page 50. If the rental cost of covered equipment would exceed the purchase price, the Plan will cover the purchase price. Note: These items are exclusions under Basic Plan Benefits.
- Non-PPO benefits for the treatment of mental or emotional conditions as an outpatient, visits 1 through 20 as described on page 30.
- Benefits for the treatment of mental or emotional conditions as an outpatient are limited

to $10 per visit for the 21st through 50th visits in a Plan Year (July 1 - June 30).

(Note: The doctor visit benefit under Basic Benefits is also payable for outpatient mental health visits in addition to the $10 benefit payable under Major Medical. See page 26 for Basic Benefit.)

- Skilled Nursing Facilities – extended care in Medicare-approved facilities.
- Chiropractic Treatment – limited to 40 visits per Plan Year (July 1 – June 30) except where the Welfare Plan chiropractic consultant decides additional visits are medically necessary.

Major Medical Exclusions and Limitations

- General Exclusions on page 56 are not covered under Major Medical benefits.
- Payment is made only for charges which are reasonable and in line with the fees customarily charged for the treatment or service rendered by providers of care in the same area.
- Except where specifically noted above, services that are excluded under Basic Plan Benefits or under the Supplemental Plan are also excluded under Major Medical benefits.
- Benefits for the treatment of mental or emotional conditions as an outpatient are limited to $10 per visit for visits 21 through 50 in a Plan Year (July 1 – June 30).

  (Note: The doctor visit benefit under Basic Benefits is also payable for outpatient mental health visits in addition to the $10 benefit payable under Major Medical. See page 26 for Basic Benefit.)
- Cosmetic surgery is not covered except if it is necessary as the result of an accident incurred while covered under the Plan and if it is performed within six months of the date the accident occurred. Cosmetic surgery to

correct abnormal congenital conditions of a child born while the mother is covered under the Plan is a covered benefit.

- Treatment for alcoholism and drug addiction is not covered under the Major Medical benefit. Refer to Additional Medical Benefits on page 48.
- The Prescription Drug Program co-payment is not covered.

How to Claim Major Medical Benefits

Major Medical payments are calculated at the same time as Basic Plan Benefits and Supplemental Plan payments. Therefore, it is not necessary to submit separate claims for Major Medical benefits. Claims for Major Medical Benefits are subject to the same claim procedures as Basic Benefits.

The claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See Assignment of Benefits on page 19.

SECTION 5

SUPPLEMENTAL HOSPITAL-MEDICAL - SURGICAL BENEFITS FOR MEDICARE ELIGIBLES

Medicare Enrollment

Covered Services

Supplemental Benefit Amounts

Supplemental Plan Exclusions

How to Claim Medicare Benefits

How to Claim Supplemental Plan Benefits

SUPPLEMENTAL HOSPITAL-MEDICAL-SURGICAL BENEFITS FOR MEDICARE ELIGIBLES

This section describes the Coastwise Indemnity Plan Supplemental Hospital, Medical, Surgical benefits for eligible pensioners and survivors with Medicare. If you are not eligible for Medicare (either because of your age or because you live outside the United States), or if you are an active employee (or dependent), please go to the section called "Basic Hospital-Medical-Surgical Benefits for Non-Medicare Eligibles", beginning on page 24. See also "Major Medical Benefits" on page 34.

Eligible pensioners and survivors with Medicare shall in no way be disadvantaged due to enrollment in Medicare. These eligibles are entitled to any and all benefits covered under the Coastwise Indemnity Plan.

Medicare Enrollment

Medicare coverage is available to persons age 65 and over, and to Social Security disability retirees under age 65 who have received disability benefits for 24 months. Persons requiring kidney dialysis become eligible for Medicare after a period of dialysis treatments or upon receiving a kidney transplant.

Medicare provides hospital benefits (Medicare Part A) and medical benefits (Medicare Part B). Medicare Part B is not automatic. The eligible person must enroll and pay a monthly premium, which may be deducted by Social Security from your monthly Social Security benefits. The monthly premium charged by Social Security for Medicare Part B benefits is reimbursed to the retiree or survivor by the Welfare Plan.

A handbook containing a complete explanation of Medicare benefits and instructions for filing Medicare claims is available in your Social Security Office.

Coastwise Indemnity Plan hospital-medical-surgical benefits are integrated with primary Medicare coverage. Retired members and their dependent(s) must, if eligible, enroll in Part B of Medicare in order to maintain their eligibility for Coastwise Indemnity Plan hospital-medical-surgical benefits. Retired members and/or survivors who permanently reside outside the United States and do not intend to return to obtain medical care in the United States are not required to enroll in Medicare since Medicare benefits are not available out of the country.

Under federal law, active employees and their dependents who are eligible for Medicare continue until retirement to be covered primarily under the ILWU-PMA Welfare Plan. Therefore, active employees are not required to enroll for Medicare even when eligible to do so. Upon retirement, such employees will be required to enroll for Medicare Part B, and will be advised by the Welfare Plan office as to the procedures for enrolling.

Covered Services

All Medicare-approved services are covered by the Supplemental Plan. The Medicare handbook available at your Social Security office describes Medicare-approved services in detail.

Supplemental Benefit Amounts

Supplemental **Coastwise Indemnity Plan** benefits for Medicare eligibles are intended to supplement the benefits provided by Medicare. The Supplemental Plan pays the deductibles and copayments not paid by Medicare for covered services, and pays the difference, if any, between Medicare-allowed charges and Usual, Customary and Reasonable charges for Hospital, Medical and Surgical services.

All Supplemental benefit claims for services covered by Medicare must be submitted first to Medicare for payment or denial, then to the Coastwise Claims Office for payment of Supplemental and Major Medical benefits. The claims procedure for Medicare eligibles is described in greater detail on page 43.

Hospital Benefits
Medicare Part A covers hospital charges, except for a per benefit period deductible. The Supplemental Plan pays this hospital deductible plus the daily coinsurance amount not paid by Medicare for the 61st through the 90th day of confinement per benefit period.

Medical and Surgical Benefits
After an annual deductible has been satisfied, Medicare Part B pays 80% of all Medicare allowed charges. Medicare-allowed charges are that portion of a doctor's or other provider's charges that Medicare determines to be reasonable.

The Supplemental Plan pays the Medicare Part B annual deductible, the 20% Medicare-allowed charge not paid by Medicare, and the difference, if any, between the Medicare-allowed charges and Usual, Customary and Reasonable charges. Medicare and Supplemental Plan payments will in no case exceed the actual charges.

Example:
(a) Doctor's Charge (determined to be Usual, Customary and Reasonable) $52
(b) Medicare-allowed charge $45
(c) Medicare Payment (80% of Medicare-allowed charge) $36
(d) Supplemental Plan payment $16

The Supplemental Plan payment in this example is the difference between the Medicare payment and the actual charge, determined to be a Usual, Customary and Reasonable charge.

If any UCR out-of-pocket expenses for Medicare-covered hospital-medical-surgical services remain after the Supplemental Plan

payment is made, such expenses are payable under the Major Medical Benefit. In addition, out-of-pocket expenses that are not covered by Medicare will be payable under the Supplemental Plan if they are covered under the Basic, Major Medical, or Additional Benefits for Non-Medicare eligibles. Basic and Major Medical benefits are described fully in the sections beginning on page 24 and page 34.

Mental Health Benefits
Medicare eligibles have coverage under the Supplemental Plan, at 100% of UCR fees, for Medicare covered mental health services and Coastwise Indemnity Plan covered mental health services as described on page 30.

Supplemental Plan Exclusions

Supplemental Plan Hospital-Medical-Surgical Benefits for Medicare eligibles do not include:

- General Exclusions on page 56.
- Services not covered by Medicare, except as noted above unless they are covered under the Basic, Major Medical or Additional Benefits for non-Medicare eligibles.

How to Claim Medicare Benefits

Medicare eligibles must file all claims for services covered by Medicare with Medicare first. The Social Security Medicare handbook tells how to submit and where to submit Medicare claims. *A current edition of the handbook is available at any Social Security Office.*

Medicare payments can be made directly to the doctor or other provider of service. Medicare calls this optional payment method Assignment of Benefits. When the assignment method is used, the doctor or provider agrees that the total charge for the covered service will not exceed the charge approved by Medicare.

If the provider does not accept Assignment of Benefits, then Medicare payment is made directly to the eligible person.

When Medicare processes a claim, the eligible person receives a record of the action Medicare has taken on the claim. This can be a record of hospital benefits used under Medicare or an explanation of Medicare benefits. This Medicare record must then be submitted to the Coastwise Claims Office for payment of Supplemental Hospital-Medical-Surgical Benefits.

It is important to remember that ALL claims for services covered by Medicare must be submitted first to Medicare, then to the Coastwise Claims Office. Even if Medicare denies the claim the Coastwise Claims Office needs the record of Medicare action (payment or denial) in order to calculate Supplemental benefits. If your claim is incurred outside the United States, you should submit your claim form directly to the Coastwise Claims Office as noted below.

How to Claim Supplemental Plan Benefits

Claim forms, called "Claim for Supplemental Plan Benefits", are supplied to the Locals and available on request from the Coastwise Claims Office or the Welfare Plan Office. To claim Supplemental benefits, the eligible person must complete one of these forms. The claim forms are pre-printed with the group name and the Coastwise Claims Office address. No policy number is required to identify your claim.

Claims for Supplemental Plan benefits are subject to the same claim procedures as Basic Benefits and Major Medical Benefits. The claimant may direct the Coastwise Claims Office to pay benefits directly to the provider. See Assignment of Benefits on page 19.

Medicare records of payment, or denial, must be attached to the claim form.

Mail the completed claim form, with attachments, to:

ILWU-PMA Coastwise Indemnity Plan
Claims Office
814 Mission St., Suite 300
San Francisco, CA 94103
(800) 955-7376
(415) 543-0114

SECTION 6

ADDITIONAL MEDICAL BENEFITS

Injectables Benefit

Alcohol and Drug Detoxification and Outpatient Care Benefit

Kidney Dialysis Benefit

Diabetic Durable Equipment Benefit

Subsequent Artificial Limbs and Eyes Benefit

Ophthalmology Benefit

Supplementary Accident Benefit

How to Claim Additional Medical Benefits

How to File Claims for the Subsequent Artificial Limbs and Eyes Benefit

ADDITIONAL MEDICAL BENEFITS

The additional medical benefits described in this section are provided for all Coastwise Indemnity Plan eligibles, with and without Medicare. The benefits are the same for Non-Medicare and Medicare members. These benefits are paid in full up to Usual, Customary and Reasonable (UCR) charges as determined by the Trustees.

*The Major Medical benefits deductible, lifetime maximum and percentage payable provisions are **not** applicable to the benefits described in this section.*

Injectables Benefit

This benefit pays up to 100% of PPO or 100% of applicable UCR charges for prescribed immunization materials and any therapeutic agent administered by injection in the course of covered treatment by a doctor. Chemotherapy injectable medications administered by doctors to patients who are not hospitalized are included. The benefit does not cover experimental drugs or drugs not generally accepted by the medical profession as proper treatment for the condition being treated.

Alcohol and Drug Detoxification And Outpatient Care Benefit

(Note: These benefits are outside of and in addition to ILWU-PMA Alcoholism/Drug Recovery Program (ADRP) benefits).

Non-Medicare Eligibles:

Hospital Care: Inpatient detoxification for removal of the toxic substance from the system will be paid for, up to 100% of UCR charges, when provided in a licensed hospital or in a division of a licensed general hospital to a maximum of five days per episode. Hospital room and board charges are payable at the hospital's most common semi-private room rate. Hospital Extras are payable up to 100% of UCR charges.

Outpatient Care: Up to 20 outpatient counseling visits per Plan Year for alcoholism and drug

dependency are covered up to 100% of UCR charges. The counseling must be provided by a licensed doctor or by a PhD psychologist, licensed psychiatric social worker, or a licensed medical social worker upon prescription by a licensed doctor. Covered visits are limited to one per day.

Medicare Eligibles:

Medicare-covered inpatient detoxification or outpatient counseling for alcoholism and drug dependency is covered up to 100% of UCR fees.

Exclusions: Alcoholism and Drug Dependency Treatment does not cover care in a federal or state hospital; care for a patient who, or condition which, in the professional judgment of the attending doctor, would not be responsive to therapeutic management; house calls.

In addition to these benefits for Alcoholism and Drug Dependency Treatment which are covered up to 100% of UCR charges, 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.

Kidney Dialysis Benefit

Persons under age 65 who require kidney dialysis because of permanent kidney failure become eligible for Medicare coverage after a period of dialysis treatments or upon receiving a kidney transplant. During the waiting period before Medicare coverage starts, the Kidney Dialysis benefit pays up to 100% of UCR charges for kidney dialysis treatment at home or in a non-hospital treatment center. After Medicare eligibility has been established, the Coastwise Indemnity Plan pays Supplemental Hospital-Medical-Surgical Benefits for covered kidney dialysis treatment. The Plan pays the difference between Medicare-allowed charges and actual charges, up to 100% of UCR charges.

Kidney dialysis patients must maintain enrollment

for Medicare Part B medical benefits, in order to retain eligibility for Coastwise Indemnity Plan Supplemental Benefits.

Diabetic Durable Equipment Benefit

This benefit is not provided under the Coastwise Indemnity Plan; it is paid directly by the ILWU-PMA Benefit Plans Office.

The ILWU-PMA Welfare Plan Diabetic Durable Equipment Benefit covers a Blood Sugar Monitor, when prescribed by a physician as medically necessary to monitor a permanent condition. The benefit pays up to 100% of UCR charges.

The following limitations and exclusions apply to the Diabetic Durable Equipment Benefit:

- Only one Blood Sugar Monitor is provided per family.
- The benefit is not provided for injection devices or any other kind of equipment except a Blood Sugar Monitor.
- Diabetic supplies (needles, insulin, syringes, test tape and tablets) are not covered under this benefit. These items are covered, however, under the ILWU-PMA Welfare Plan Prescription Drug Program.
- Medicare eligibles are not covered under this benefit unless a blood sugar monitor is medically necessary but not covered by Medicare. Medicare eligibles must first file a claim with Medicare and then include a copy of Medicare's denial when sending a claim form to the Benefit Plans office.

Subsequent Artificial Limbs and Eyes Benefit

The ILWU-PMA Welfare Plan Subsequent Artificial Limbs and Eyes Benefit provides for medically necessary replacements of artificial limbs and eyes.

"Medically necessary" means that a subsequent artificial limb or eye is furnished based upon a

physician's certification that it is required (1) due to loss or irreparable damage or wear to the existing device or (2) due to a change in the patient's condition.

All persons with ILWU-PMA Welfare Plan eligibility are eligible for the Subsequent Artificial Limbs and Eyes Benefit. This includes Coastwise Indemnity Plan members as well as members covered under an HMO sponsored by the Welfare Plan.

The Plan pays 100% of Usual, Customary and Reasonable charges for medically necessary subsequent artificial limbs and eyes.

Coverage is limited to standard equipment that is necessary and reasonable for treatment of the patient's illness or injury. Deluxe equipment is covered only up to the cost of such standard equipment.

The Plan does not pay for services covered under Workers' Compensation or similar laws or services for which the patient is entitled to reimbursement under a third party settlement.

A Subsequent Artificial Limb or Eye Claim Form must be completed by the eligible member and mailed to the Coastwise Claims Office. The Claim Form includes an Employee Statement, a Physician's Statement that must be completed by the attending physician, and a Dispenser's Statement that must be completed by the prosthesis vendor.

Ophthalmology Benefit

(Routine Non-VSP Panel Exam)

When a routine eye examination causes the covered person to incur expenses for an examination from a non-VSP panel ophthalmologist instead of a VSP panel member, the Plan will pay the expense incurred while this coverage is in force as to such person less VSP's payment and less a $5.00 deductible. Routine eye examinations are covered not more often than once in a 12 consecutive calendar month period, irrespective of whether the covered person sees a

non-VSP panel ophthalmologist or a VSP panel doctor.

■ Supplementary Accident Benefit

This benefit is payable only in cases of accidental injury. Expenses must be incurred within 90 days after the accident. Up to $300 is payable for the following, when not otherwise paid under the Coastwise Indemnity Plan: necessary hospital expenses; services of doctors; services of a licensed nurse (other than one who normally lives in the patient's home); braces, crutches, wheelchair rental; repair or replacement of sound natural teeth if claimant is not otherwise reimbursed under the Welfare Plan.

How to Claim Additional Medical Benefits

- Claims for Injectables, Alcoholism and Drug Dependency Treatment, Kidney Dialysis, Ophthalmology and Supplementary Accident benefits are filed with the Coastwise Claims Office:

  ILWU-PMA Coastwise Indemnity Plan
  Claims Office
  814 Mission St., Suite 300
  San Francisco, CA 94103
  (800) 955-7376
  (415) 543-0104

- To file a claim for Injectables, Alcoholism and Drug Dependency Treatment, or Kidney Dialysis benefits, claimants who do not have Medicare eligibility should use the Claim Form for Hospital, Medical, Surgical Benefits. See page 31 for additional information on how to file this claim form. Claimants with Medicare eligibility should use a Claim Form for Supplemental Plan Benefits. See page 44 for additional instructions.

- Claims for Diabetic Durable Equipment benefits are filed directly with the ILWU-PMA Benefit Plans Office:

ILWU-PMA Benefit Plans
1188 Franklin Street – Suite 300
San Francisco, CA 94109
(415) 673-8500

- Claim Diabetic Durable Equipment benefits on a Diabetic Durable Equipment Claim Form, which must be completed by the eligible claimant, the prescribing doctor, and the Diabetic Durable Equipment dispenser (dealer), and submitted with proof of purchase. Medicare eligibles must include the Medicare denial of benefits with the claim form.

How to File Claims for the Subsequent Artificial Limbs and Eyes Benefit

You may file a claim for the Subsequent Artificial Limb or Eye Benefit on a Subsequent Artificial Limb or Eye Claim Form which must be completed by the eligible member and mailed to the Coastwise Claims Office. The claim form includes an Employee Statement, a Physician's Statement that must be completed by the attending physician, and a Dispenser's Statement that must be completed by the prosthesis vendor.

SECTION 7

GENERAL EXCLUSIONS AND CLAIMS REVIEW PROCEDURES

General Exclusions

Claims Review Procedures

This Section contains a list of general exclusions under the Coastwise Indemnity Plan and explains how to obtain a review when a claim is denied or partially denied.

General Exclusions

The following general exclusions are in addition to limitations and exclusions listed elsewhere in this booklet for Basic, Major Medical, Medicare Supplemental and Additional Benefits.

- Services which are not medically necessary to treat an illness or injury, or which are customarily furnished without charge.
- Services performed in or outside the United States which are experimental in nature or do not meet established treatment protocols in the United States.
- Services performed on or to the teeth except as specifically allowed under Major Medical.
- Services for conditions covered by state or federal laws, workers' compensation or employer liability or similar laws.
- Services provided without cost by any federal or state government agency, county or municipality.
- Services for conditions caused by war or act of war.
- Benefits provided under other ILWU-PMA Welfare Plan programs.

Claims Review Procedures

The procedures described below apply to requests for benefits under the Coastwise Indemnity Plan. Please note that a mere inquiry about whether a particular item is covered under the Plan is not a claim for this purpose.

Claim Denial

If a claim is denied or partly denied by the Coastwise Claims Office, notice will be given to the claimant in writing. The notice will be written in understandable language and will state:

- Specific reasons for denial of the claim;
- Specific reference to provisions of the Welfare Agreement, the Coastwise Indemnity Plan, or contract provisions upon which the denial is based;
- A description, if appropriate, of additional information or material which might enable the claimant to perfect the claim;
- An explanation of how, where and when the claimant may obtain a review of the denial;
- If the denial is based on an internal rule, guideline, or protocol, the claimant has the right to request a free copy of the rule guideline, or protocol; and
- If the denial is based on a determination that the treatment or services are not considered to be standard medical treatment (e.g., are considered experimental), the claimant has the right to request a free copy of the scientific or clinical judgment on which such determination is based.

Notice of claim denial must be given to the claimant within a reasonable period of time, but not later than 30 days after the date the claim is received. This period may be extended an additional 15 days if the Coastwise Claims Office determines that an extension is necessary due to matters beyond its control and the claimant is notified of the extension before the end of the initial 30-day period and the date by which the Coastwise Claims Office expects to render a decision on the claim. If an extension is required because the claimant failed to submit sufficient information to enable the Coastwise Claims Office to make a determination of the claim, the notice of the extension will also describe the additional information required. In such a case, the claimant will be given at least 60 days to provide the additional information. The period from the date the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

If the Coastwise Claims Office does not respond to the claimant's claim within the time periods specified above, the claimant may deem his claim denied for this purpose as of the expiration of the applicable time period above.

Request for Claim Review by Trustees of the ILWU-PMA Welfare Plan

Within 180 days after notice that a claim has been denied by the Coastwise Claims Office, or after the claim is deemed denied as provided above, the claimant or his/her representative may make a written request for a review of the denial by the Trustees of the ILWU-PMA Welfare Plan. The claimant or his/her representative may request copies free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review.

A request for a review by the Trustees must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 300
San Francisco, CA 94109

Decision on Review by Trustees of the ILWU-PMA Welfare Plan

The Trustees of the ILWU-PMA Welfare Plan, or a committee of the Trustees, will render their decision on the claim within 60 days of receipt of the request for review.

The decision of the Trustees will be communicated in writing, and in understandable language. It will include specific references to the Welfare Agreement or contract provisions upon which the decision is based.

If the Trustees do not respond to the claimant's request for review within the time periods specified above, the claimant may deem his claim denied on review for this purpose as of the expiration of the applicable time period above.

Request for Arbitration

After notice that a claim has been denied by the

Trustees on review, or after the claim is deemed denied on review as provided above, the claimant may request that the claim be decided by the Coast Arbitrator. In order to obtain a review of a claim by the Coast Arbitrator, the claimant must have obtained a prior determination on the claim by the Trustees (or a deemed denial) in accordance with the procedures outlined above. The claimant or his/her representative may request copies, free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review by the Trustees.

A request for review by the Coast Arbitrator must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 300
San Francisco, CA 94109

Decision by Coast Arbitrator
The Coast Arbitrator will render a decision on the claim within 30 days of receipt of the request for review. The decision of the Coast Arbitrator will be communicated in writing, and in understandable language. It will include specific references to the Welfare Agreement or contract provisions upon which the decision is based.

Judicial Review
A claimant has the right to file a suit in a court of law if a claim is denied or partly denied by the Coast Arbitrator. Plan provisions and applicable law require, however, that the claimant first exhaust all of his or her appeal rights under the Plan. This means that a claimant must obtain determinations by the Trustees and by the Coast Arbitrator before he or she may file a lawsuit for a benefit under the Plan.

OTHER ILWU-PMA WELFARE PLAN PROGRAMS

In addition to the Coastwise Indemnity Plan described in this booklet, the ILWU-PMA Welfare Plan provides coverage for prescription drugs, vision care, dental benefits, death and dismemberment benefits, hearing aid benefits, benefits for temporary disabilities, and alcoholism/drug recovery program benefits. Eligibility requirements for these additional benefits vary. For information about these benefits, please see the Summary Plan Description and the applicable Supplemental Summary Plan Descriptions. To find out if you are eligible, please contact the ILWU-PMA Benefit Plans Office or your Local.

Claims administration services are provided to the Coastwise Indemnity Plan under a contract for such services between the Board of Trustees and the ILWU-PMA Coastwise Indemnity Plan Claims Office. The Coastwise Claims Office is located at 814 Mission St., Suite 300, San Francisco, California 94103. The Coastwise Claims Office telephone numbers are (415) 543-0114 or (800) 955-7376.

COASTWISE INDEMNITY PLAN

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BASIC HOSPITAL-MEDICAL-SURGICAL BENEFITS FOR NON-MEDICARE ELIGIBLES

Basic Benefits – Schedule of Allowances
Effective October 1, 2017

The following Basic Benefits are paid at 100% of the scheduled amounts shown below for the applicable type of medical expense and are not subject to a deductible. In most cases, the balance of the Maximum Allowable Charge (MAC) remaining after these Basic Benefits have been paid is covered under the Major Medical benefit. These Basic Benefits allowances are subject to periodic adjustment.

Hospital Benefits

Room & Board: Up to $804.28 per day, for up to 365 days per confinement.

Hospital Extras*:

PPO: 100% of PPO charges

Non-PPO: Up to $10,054.36 with any balance at 80% of MAC under Major Medical

No PPO Access: 100% of MAC

Ambulance: Up to $743.13 per confinement for transportation to or from a hospital (included in the "Hospital Extras" benefit).

*(The "Hospital Extras" benefit is payable for inpatient hospital charges for supplies and services other than room and board, outpatient hospital charges incurred for surgery or accident treatment, and surgery charges from approved ambulatory surgi-centers.)

Surgery and Anesthesia

Maximum per Disability (a "disability" is any one accident or sickness):

Surgeon.....$18,366.00

Anesthesiologist.....$6,122.03

Assistant Surgeon.....$3,673.20

Maximum for any one procedure – based on 1964 Relative Value Schedule (RVS) units multiplied by.....$91.83

Doctor Visits

Maximum per day:

Office Visits.....$61.14

Home Visits.....$100.34

Hospital Visits.....$61.14

Maximum hospital visit per confinement..... $22,316.10

Diagnostic X-Ray and Laboratory – Outpatient

Maximum per accident or sickness in each 6-month period..... $1,005.43

(Benefit maximum renews on January 1 and July 1 each year)

Well Baby Care Effective July 1, 2011, the maximum of $500.00 per year (from birthday to birthday) is eliminated.