All Alaska Longshore H&W Trust: Self Funded Medicare Retiree Plan

Coverage Period: 1/1/2017-12/31/2017 **Coverage for: Employee & Dependents | Plan Type: PPO**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling 1-503-224-0048 or 1-800-547-4457.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	This plan has no **out-of-pocket limit**.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-503-224-0048 or 1-800-547-4457. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-503-224-0048 or 1-800-547-4457 ext. 1922 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Specialist visit	No Charge.	No Charge.	Plan pays 100%of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Other practitioner office visit	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Preventive care/screening/immunization	No Charge.	No Charge	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Imaging (CT/PET scans, MRIs)	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available by calling 1-503-224-0048 or 1-800-547-4457.	Generic drugs	No charge.	Not covered.	Retail 30 day supply. Drugs and medicines furnished by a hospital are paid as hospital charges. Maintenance medications must be obtained through mail order.
	Preferred brand drugs	$20 copayment.	Not covered.	Retail 30 day supply. $0 if no equivalent generic is available. $40 **copayment** for mail order. Drugs and medicines furnished by a hospital are paid as hospital charges. Maintenance medications must be obtained through mail order.
	Non-preferred brand drugs	$20 copayment.	Not covered.	Covered the same as preferred brands. Maintenance medications must be obtained through mail order.
	Specialty drugs	Not covered.	Not covered.	Specialty drugs are covered under the Medicare medical plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Physician/surgeon fees	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
If you need immediate medical attention	Emergency room services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Emergency medical transportation	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Urgent care	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	100% of all costs above the plans daily limit for each day.	100% of all costs above the plans daily limit for each day.	Part A Benefits: • Plan pays up to $1,156 per day for 1st - 60th day of hospitalization. • Plan pays up to $289 per day for 61st - 90th day of hospitalization. • Plan pays up to $578 per day from 91st until Medicare Lifetime Reserve is exhausted.
	Physician/surgeon fee	No Charge.	No Charge.	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Mental/Behavioral health inpatient services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Substance use disorder outpatient services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Substance use disorder inpatient services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
If you are pregnant	Prenatal and postnatal care	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Delivery and all inpatient services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge.	No Charge.	Plan pays 100% of Medicare's Part A deductible and 20% of the allowed amount for Medicare Part A covered expenses. Yearly maximum of $1000.
	Rehabilitation services	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Habilitation services	Not covered.	Not covered.	None.
	Skilled nursing care	No Charge.	No Charge.	Plan pays 100% of Medicare's Part A deductible and 20% of the allowed amount for Medicare Part A covered expenses.
	Durable medical equipment	No Charge.	No Charge.	Plan pays 100% of Medicare's Part B deductible and 20% of the allowed amount for Medicare Part B covered expenses.
	Hospice service	No Charge.	No Charge.	Plan pays 100% of Medicare's Part A deductible and 20% of the allowed amount for Medicare Part A covered expenses.
If your child needs dental or eye care	Eye exam	20% coinsurance	20% coinsurance	No calendar year limit on vision care for children up to age 18.
	Glasses	20% coinsurance	20% coinsurance	No calendar year limit on vision care for children up to age 18.
	Dental check-up	20% coinsurance	20% coinsurance	No calendar year limit on dental care for children up to age 18. Maximum of 2 routine exams per year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Habilitation
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protection that allows you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-547-4457. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 or http://cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1220 SW Morrison St. Ste. 300, Portland OR 97205 or call 1-800-547-4457 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan is not subject to this requirement as it is a Retiree Plan.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan is not subject to this requirement as it is a Retiree Plan.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,690
- **Patient pays** $5,850

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$5,850
Limits or exclusions	$0
Total	**$5,850**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **Patient pays** $1,100

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits and procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$1,060
Limits or exclusions	$40
Total	**$1,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

NOTICE OF NONDISCRIMINATION

All Alaska Longshore Health & Welfare Trust ("the Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Health Plan at 800-547-4457 and ask for assistance.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: FOR FREE LANGUAGE ASSISTANCE CALL 1 (800) 547-4457

Language	Message About Language Assistance
Tagalog Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 547-4457.
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 547-4457.
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 547-4457 번으로 전화해 주십시오.
Hmoob Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1 (800) 547-4457.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 547-4457.
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 547-4457.
Gagana fa'a Sāmoa Samoan	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 547-4457.
ພາສາລາວ Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1 (800) 547-4457.
日本語 Japanese	**注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。** 1 (800) 547-4457 **まで、お電話にてご連絡ください。**
Ilokano Ilocano	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 547-4457
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dị ch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 547-4457.
Українська Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1 (800) 547-4457
ภาษาไทย Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1 (800) 547-4457
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 547-4457.
Polski Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 (800) 547-4457