BOT MM&P H&B Plan: Medicare-Eligible Retirees

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family **|Plan Type:** Indemnity

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 at **www.bridgedeck.org/hbforms.htm** or by calling **1-877-667-5522 or 1-410-850-8500**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person/**$500** family. Doesn't apply to prescription drugs. Balance billing, **deductibles** for specific services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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?	Yes. **$3,000** person/ **$10,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes, for pharmacies only. For a list of participating **providers** (pharmacies), see www.caremark.com or call CVS Caremark at 1-888-364-6815.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call **1-877-667-5522 or 1-410-850-8500** or visit us at **www.bridgedeck.org/hbforms.htm**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.bridgedeck.org/hbforms.htm** or call **1-877-667-5522 or 1-410-850-8500** to request a copy.

Important Questions	Answers	Why this Matters:
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 5. See your policy or plan document for additional information about **excluded services**.

- **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**.)
- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Service You May Need	Your Cost if You Use a Medicare Provider	Your Cost if You Use a Non-Medicare 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	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance. Acupuncture and Chiropractic care: Limited to 20 visits (combined) per calendar year and/or $2,100 per year.
	Specialist visit	No charge	80% coinsurance	
	Other practitioner office visit	No charge	80% coinsurance	
	Preventive care/ screening/ immunization	No charge	80% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance.
	Imaging (CT/PET scans, MRIs)	No charge	80% coinsurance	

Common Medical Event	Service You May Need	Your Cost if You Use a Medicare Provider	Your Cost if You Use a Non-Medicare Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Participating Pharmacy Retail: 20% co-insurance, minimum $7.50 copay per prescription fill or refill Mail Order: 20% coinsurance, maximum $75 copay per prescription fill or refill	Non-Participating Pharmacy Retail Only: 20% coinsurance, minimum $7.50 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy	You have Creditable Coverage under the Plan and you do not have to enroll in Medicare Part D. Retail: 30-day supply plus 2 refills. Mail order: 31-60 days supply. Mandatory mail order after 2 refills. Controlled substance limited to 30-days. No non-participating pharmacy benefits available for mail order.
	Preferred brand drugs	Retail: 20% coinsurance, minimum $15 copay per prescription fill or refill Mail Order: 20% coinsurance, maximum $75 copay per prescription fill or refill	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy	
	Non-preferred brand drugs	Retail: 20% coinsurance, minimum $15 copay per prescription fill or refill Mail Order: 20% coinsurance, maximum $75 copay per prescription fill or refill plus difference in cost between generic and brand name	Retail only: 20% coinsurance, minimum $15 copay per prescription fill or refill plus difference in cost between participating and non-participating pharmacy and generic and brand name	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance.
	Physician/surgeon fees	No charge	80% coinsurance	
If you need immediate medical attention	Emergency room services	No charge	80% coinsurance	Plan pays second to Medicare. If you are not enrolled in Medicare, you pay 80% coinsurance.
	Emergency medical transportation	No charge	80% coinsurance	
	Urgent care	No charge	80% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay all but the Part A deductible(s) for inpatient services and 80% coinsurance for physician/surgeon.
	Physician/surgeon fee	No charge	80% coinsurance	

Common Medical Event	Service You May Need	Your Cost if You Use a Medicare Provider	Your Cost if You Use a Non-Medicare Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Mental/Behavioral health inpatient services	No charge	80% coinsurance	
	Substance use disorder outpatient services	No charge	80% coinsurance	
	Substance use disorder inpatient services	No charge	80% coinsurance	
If you are pregnant	Prenatal and postnatal care	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Delivery and all inpatient services	No charge	80% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	80% coinsurance	Plan pays second to Medicare based on the Medicare allowance. If you are not enrolled in Medicare, you pay 80% coinsurance for outpatient services and all but the Part A deductible(s) for inpatient services.
	Rehabilitation services	No charge	80% coinsurance	
	Habilitation services	No charge	80% coinsurance	
	Skilled nursing care	No charge	80% coinsurance	
	Durable medical equipment	No charge	80% coinsurance	
	Hospice service	Not covered	80% coinsurance	
If your child needs dental or eye care	Eye exam	No charge for contracted provider	No charge up to Plan allowance.	1 exam/year for children under age 19; children over 19, included in Plan Allowance.
	Glasses	No charge for contracted provider	No charge up to Plan allowance.	Maximum allowance for $280 for glasses and $200 for contacts per calendar year under age 19.
	Dental check-up	20% coinsurance for contracted provider	30% coinsurance	One exam/6 months

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.)**

- Cosmetic surgery (unless necessary due to accident or breast reconstruction)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. (If you live outside the U.S., benefits are paid subject to 30% coinsurance after deductible)
- Weight loss programs

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

- Acupuncture (acupuncture and chiropractic care combined limited to 20 visits/calendar year and/or $2,100)
- Bariatric surgery (if medically necessary to treat morbid obesity)
- Chiropractic care (chiropractic care and acupuncture combined limited to 20 visits/calendar year and/or $2,100)
- Dental care (Adult) (Periodontal: $2,000 annual maximum; Orthodontic: $2,000 lifetime maximum)
- Hearing aids (Exam $75 maximum; Hearing Aids: Adults, $1,000 per hearing aid per ear once every 36 months; Children under age 19, payable as medically necessary.)
- Private-duty nursing (when provided by RN, LPN, LVN or nursing assistant in hospital)
- Routine eye care (Adult) (once every 2 years, non-contracted providers limited to $360)
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow 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 Fund Office at Masters, Mates & Pilots Health & Benefit Plan at 700 Maritime Boulevard, Suite A, Lithicum Heights, MD 21090-1996 or via phone at 1-877-667-5522 or 1-410-850-8500. 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 x61565 or www.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 Fund Office at Masters, Mates & Pilots Health & Benefit Plan, 700 Maritime Boulevard, Suite A, Lithicum Heights, MD 21090-1996 or via phone at 1-410-850-8500 or toll free at 1-877-667-5522. You may also contact 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 <u>does provide</u> minimum essential coverage.**

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). **However, <u>this standard is not applicable for this benefit.</u>**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-410-850-8500/1-877-667-5522.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-410-850-8500/1-877-667-5522.
CHINESE (**中文**): **如果需要中文的帮助**, 请拨打这个号码 1-410-850-8500/1-877-667-5522.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-410-850-8500/1-877-667-5522.

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** $7,140
- **Patient pays** $400

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	$250
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$400**

The coverage examples on this page take into account that Medicare will pay benefits first and the Plan will pay the net of what Medicare pays.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,070
- **Patient pays** $330

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	$250
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$330**

The coverage examples on this page take into account that Medicare will pay benefits first and the Plan will pay the net of what Medicare pays.

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.

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