GUIDE TO YOUR HEALTH BENEFITS

FROM THE

SEAFARERS HEALTH AND BENEFITS PLAN

FOR PARTICIPANTS WHO ARE RECEIVING

RETIREMENT BENEFITS FROM

THE SEAFARERS PENSION PLAN

June 2015

TABLE OF CONTENTS

TABLE OF CONTENTS continued

INTRODUCTION

This booklet describes the benefits available to you and your dependents from the Seafarers Health and Benefits Plan. It was written for those individuals who are receiving pension benefits from the Seafarers Pension Plan and who are participants in this Plan.

The Seafarers Health and Benefits Plan is a multi-employer employee benefit plan. It provides benefits to retirees of employers who have collective bargaining agreements with the Seafarers International Union of North America, Atlantic, Gulf, Lakes, and Inland Waters or affiliated unions, and to the families of those pensioners. The Plan is funded through contributions made by these employers. The assets of the Plan are held in trust for the participants.

This booklet contains important information about your benefits. Read it carefully and keep it for future use. You may find it useful to read this booklet through several times. You may also view the booklet online at www.seafarers.org under the Member Benefits section.

For disabled participants, this booklet is also available in large print and recorded versions. To request these versions, you can contact the Plan's office at:

Seafarers Health and Benefits Plan
5201 Auth Way
Camp Springs, Maryland 20746
(301) 899-0675

This booklet is only a summary of the Seafarers Health and Benefits Plan. This booklet is referred to as the Summary Plan Description (SPD). The Rules and Regulations of the Plan and the Trust Agreement, together with laws that apply to benefit plans, control the payment of benefits.

The Seafarers Health and Benefits Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 5201 Auth Way, Camp Springs, MD 20746. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

INFORMATION YOU SHOULD BE AWARE OF

The Seafarers Health and Benefits Plan is directed by a group of people called the Board of Trustees. The Board of Trustees has the absolute authority to make changes to the Plan. As of the date of this booklet, the members of the Board of Trustees are:

Dean Corgey	John Dragone
Ambrose Cucinotta	Todd Johnson
David Heindel	Rudy Leming
Nicholas Marrone	Anthony Naccarato
Thomas Orzechowski	William Pagendarm
Joseph Soresi	Robert Rogers
Chester Wheeler	David Schultze

The members of the Board of Trustees are called fiduciaries. As fiduciaries, they have a duty to make prudent decisions regarding the Plan and to act in the best interest of the participants.

The Board of Trustees appoints a person to take care of the daily operations of the Plan. This person is called the Plan Administrator. The Plan Administrator of the Seafarers Health and Benefits Plan is Margaret R. Bowen.

You can contact the Board of Trustees and the Plan Administrator at:

Seafarers Health and Benefits Plan
5201 Auth Way
Camp Springs, Maryland 20746
(301) 899-0675

Legal process may be served on the Plan Administrator or the Board of Trustees at the above address.

Since the Plan's records are kept on a calendar year basis, the end of the Plan year is December 31.

The Internal Revenue Service identification number for the Seafarers Health and Benefits Plan is 13-5557534.

WORDS YOU NEED TO UNDERSTAND

beneficiary—The person or persons that you choose to have your death benefit paid to as shown on your enrollment beneficiary card.

catastrophic illness or injury—An illness with an acute onset, or a medical condition resulting from an injury that will require extensive rehabilitation and/or nursing care. Examples include: a stroke, heart attack, or severe injuries received in a serious accident. Chronic conditions (such as diabetes or multiple sclerosis) are not considered to be catastrophic illnesses for the purpose of receiving rehabilitation benefits from this Plan.

claim—An itemized paper bill or electronic itemization of services provided.

COBRA—Continuation of health coverage available from the Plan for a monthly premium when you or your dependents are no longer eligible for coverage.

coinsurance amount—The amount that you are responsible for paying after Seafarers Health and Benefits Plan or Medicare has paid benefits.

covered employment—Days that you worked for a signatory employer and certain other days described in this booklet.

date the claim accrued—The first day you saw the doctor, entered the hospital, or had something else happen that caused you to have a claim.

dependent child—Your child up to age 26 is a covered dependent, if he or she is your natural, adopted, foster, or step-child. Your child may also be your dependent if the Plan has received a Qualified Medical Child Support Order which requires you to provide health coverage to the child.

dependent spouse—Your husband or wife is a covered dependent if you are legally married. The Plan will recognize your common law marriage, if the state where you live considers you married.

employee—a person who is, or was, working for a signatory employer and is, or was, covered by the Plan.

formulary—A list of brand-name drugs specified by the Pharmacy Benefit Manager.

generic drug—A medication that is not a brand name medication, but by law must have the same active ingredients as the brand name medication, and is subject to the same standards as its brand name counterpart.

out-of-network savings program—This program provides discounts for many health care providers that are not in the primary Network. While you are still required to pay the out-of-Network co-payment when you visit a provider that participates in this program, there will be no additional balance billing. This program only applies to participants who are not eligible for Medicare.

participant—A person who is eligible or may become eligible to receive benefits from the Plan.

pharmacy benefits manager (PBM)—A company that provides pharmacy benefits either by presenting a card at a pharmacy, or through mail order. The Plan currently uses OptumRx as its pharmacy benefits manager.

Plan—The Seafarers Health and Benefits Plan (also referred to as SHBP).

preferred provider Network—Doctors, hospitals, dentists, and other health care providers that have agreed to provide Plan participants with health care services at a reduced cost. This Plan currently participates in the CIGNA Network for all participants **except** for participants who reside in Puerto Rico or participants who are eligible for Medicare. If you reside in Puerto Rico, please contact the Plan for information about your Network. The Network logo is on your Plan ID card. You must use this card whenever you visit an in-Network health care provider in order to receive services at the reduced cost. If you are a participant who is eligible for Medicare, you should contact the Plan to request an SHBP Medicare Pensioners ID card.

reasonable and customary charge—The amount allowed by the Plan for a medical treatment or service for a non-Network provider. These amounts are determined by comparing amounts charged by other providers for the same service in the same area of the country. (Also referred to as "R&C".)

Signatory employer—An employer who agrees to make payments to the Plan so that their employees will receive benefits.

WHAT IS THE ENROLLMENT BENEFICIARY CARD AND WHY IS IT IMPORTANT?

The enrollment beneficiary card tells the Plan who you and your dependents are. It also tells the Seafarers Pension Plan to whom you want your death benefit paid. For you to receive benefits, you must have an enrollment beneficiary card on file with the Plan. The card must include the names of each of your dependents that you want to enroll in the Plan.

The information on your enrollment beneficiary card must be accurate and up-to-date. You may need to complete a new enrollment beneficiary card if:

- Your home address changes.
- Your number of dependent children changes.
- You get married, divorced, or your spouse dies.
- You want to change your beneficiary.

For a participant to receive benefits, his or her Social Security number must be on file with the Plan. To be properly enrolled, you must send the Plan a copy of your Social Security card. If you are married or have dependent children, you must also send the Plan copies of their Social Security cards. The Plan will need a copy of an official marriage certificate, before a claim will be paid for your dependent spouse. If you are married under common law, you must prove that your marriage is legally recognized in the state where you live. It is also important that you immediately notify the Plan if you get a divorce so that the Plan may update its records. If you do not promptly notify the Plan, you may forfeit your right to future benefits.

Before the Plan will pay benefits for your dependent children, you must send the Plan an official copy of each child's birth certificate. For adopted children, the Plan will need a copy of the adoption papers. For stepchildren, a copy of the custody award or other written proof will be required.

If you do not already have an enrollment beneficiary card on file with the Plan, you must complete one and send it to the Plan as soon as possible. Enrollment beneficiary cards are available from your local Plan representative or from the Plan office at:

Seafarers Health and Benefits Plan
5201 Auth Way
Camp Springs, Maryland 20746
Telephone: 1-800-252-4674

HOW DO I BECOME ELIGIBLE FOR BENEFITS?

You will be eligible for health care benefits after you retire if you meet the following requirements:

- You retire on a Regular Normal or Early Normal Pension from the Seafarers Pension Plan and you have credit for at least **5,475 days of covered employment** with Seafarers Health and Benefits Plan (SHBP);

OR

- You retire on a Disability Pension from the Seafarers Pension Plan and you have credit for at least **4,380 days of covered employment** with Seafarers Health and Benefits Plan (SHBP);

AND

- **If you retire in 2015 or thereafter**, at least 60 days of covered employment in each of the 2 six month eligibility periods immediately preceding the date you become eligible for and apply for a pension, or a combined total of at least 125 days of covered employment distributed between these 2 eligibility periods. (For example, if you retire in August 2015, you will need at least 60 days of covered employment during the eligibility period from January 1, 2015 through June 30, 2015; and 60 days of covered employment during the eligibility period from July 1, 2014 through December 31, 2014; OR a total of 125 days distributed between these two periods.)

Eligibility is determined without reference to reciprocity agreements. Covered employment does not include extra service credit, other supplemental service credit, or other time that is used to qualify you for a pension. This means that you may only receive one day's credit for each day actually worked in covered employment.

If you do not have enough days of covered employment to qualify for health benefits when you begin receiving pension benefits from the Seafarers Pension Plan, you cannot later qualify for pensioner's health benefits by returning to covered employment and working additional days. However, if you qualify for pensioner's health benefits and you return to covered employment, your pensioner's health benefits will resume as soon as you stop working and your pension benefits are reinstated.

WHEN WILL I BEGIN TO RECEIVE PENSIONER'S BENEFITS?

You will begin to receive pensioner's health benefits when your eligibility for health benefits as an active employee runs out.

There are differences between the health benefits that you and your family received when you were an active employee and the benefits you will receive when you are a pensioner. If you wish, you may elect COBRA continuation coverage at the time you become eligible for pensioner's benefits, which will allow you to continue to receive the same health benefits that you received when you were an active employee for a certain period of time. You must pay a monthly premium for this coverage. The amount of the COBRA premium depends on the level of benefits that you received before you retired. There are special rules that apply to this extension of eligibility. A complete notice of your coverage continuation rights under COBRA appears at the end of this booklet. For more information concerning your right to extend eligibility by paying premiums yourself, contact the Plan at:

Seafarers Health and Benefits Plan
Attn: COBRA
PO Box 380
Piney Point, Maryland 20674
1-800-252-4674

If you elect COBRA, you will begin to receive pensioner's health benefits when the COBRA period is over. Once you begin to receive pensioner's health benefits, you can continue to use the same ID card that you already have, unless you are eligible for Medicare. In that case, you should contact the Plan to request a new ID card.

DOES THE PLAN CHARGE A PREMIUM FOR PENSIONER'S HEALTH COVERAGE?

If you are not eligible for Medicare at the time you retire, you must pay a monthly premium to the Plan. The amount of this monthly premium is $100 for individual or $200 for family coverage. If you are eligible for Medicare but your spouse is not, you must pay a $100 monthly premium for your spouse or a $200 monthly premium for your spouse and dependent children.

Upon becoming eligible for Medicare, you must enroll in Medicare Part A and Part B coverage. However, you need not enroll in Medicare Part D as the Plan provides prescription coverage. The Seafarers Health and Benefits Plan will then become the secondary payer to Medicare. **If you fail to enroll in Medicare, you will not be eligible to receive benefits from the Plan. If you decide to enroll in Medicare Part D, you will lose your prescription coverage from this Plan and cannot re-enroll in the future.**

WHAT DAYS CAN BE COUNTED AS COVERED EMPLOYMENT?

In order to establish your eligibility for health benefits when you become a pensioner, the following days can be counted as covered employment:

- Days you worked for an employer who was obligated to pay into the Plan for your benefits.

- Days you received Maintenance and Cure, Longshore and Harbor Workers' compensation, or Workers' Compensation payments, up to a maximum of 273 days during a single period of disability. However, to receive credit for these days you must have been eligible for Seafarers Health and Benefits Plan benefits at the time your disability began based upon actual days of employment. Days when you received Maintenance and Cure payments count as covered employment if you were at the Core-Plus benefit level. At the Core benefit level, these days only count if your employer was remitting contributions on your behalf during this period.

- One half of the days you attended a qualified upgrading course at the Seafarers Harry Lundeberg School of Seamanship, as long as you successfully completed the course and met Seafarers Health and Benefits Plan eligibility requirements when you began attending the school.

- Days you received a Seafarers Scholarship Award.

- Days you received Sickness and Accident Benefits (S&A) or state disability Payments. The maximum number of S&A days or days of state disability you can be credited with depends on your years of service. The chart shown below explains how these days will be credited.

YEARS OF SERVICE	CREDITED DAYS
15 years or more	180 days
At least 10 years but less than 15	120 days
At least 5 years but less than 10	90 days
At least 2 years but less than 5	45 days
Less than 2 years	20 days

WHAT IS THE ANNUAL DEDUCTIBLE AND HOW DOES IT WORK?

You are responsible for paying a certain amount of the first health care bills you have each calendar year. In addition, if you have a spouse or dependent children, you will have to pay a certain amount of the first health care bills that they have each calendar year. The amount that you are responsible for paying each year is called the annual deductible.

The following are the annual deductible amounts:

If you and your spouse are not eligible for Medicare, the amount of the annual deductible is $375 per person, but not more than $750 per family.

If you and your spouse are eligible for Medicare, the amount of the annual deductible is $125 per person, but not more than $250 per family.

All benefits are subject to the deductible except:

- Inpatient hospital facility charges
- Hospice care
- Prescription drug benefits, which have a separate deductible
- Dental benefits
- Vision care benefits

Even before you have reached the deductible amount, it is important to file a claim promptly, since no claims will be paid until you have received credit for satisfying the annual deductible. Never hold medical bills. **File a claim immediately to avoid any chance of your claim being denied because of the 180 day late filing rule.**

WHAT HEALTH CARE BENEFITS ARE PAID FOR BY THE PLAN?

The Seafarers Health and Benefits Plan will pay toward the cost of health care services that are needed to treat an illness or injury. The Plan also pays benefits for certain services that are needed to maintain the health of you and your family.

The chart on the following page is a summary of the health care benefits covered by the Plan **for Pensioners and dependents who are <u>not</u> eligible for Medicare**, including the co-payment and co-insurance amounts. For more details, please review the appropriate benefit description listed after the chart.

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS		
DESCRIPTION	**Pensioner Non-Medicare**	**Pensioner Dependent Non-Medicare**
Annual Deductible	$375 Individual $750 Family	$375 Individual $750 Family
Hospital Room and Board	**Pre-certification required** In-network 100% Out-of-network 70% R&C $450 admission copayment Maximum of 180 days or $1,000,000 per illness (whichever comes first) per hospitalization Intensive care - maximum of 15 days at the hospital's intensive care rate. Beginning with 16th day, paid at semi-private room rate.	**Pre-certification required** In-network 100% Out-of-network 70% R&C $450 admission copayment Maximum of 180 days or $1,000,000 per illness (whichever comes first) per hospitalization Intensive care - maximum of 15 days at the hospital's intensive care rate. Beginning with 16th day, paid at semi-private room rate.
Inpatient Rehabilitation (at skilled nursing facility or acute rehabilitation facility **NOTE**: This benefit is only payable for pensioners or dependents recovering from a catastrophic illness or injury such as stroke, severe accident or heart attack.	Paid in the same manner as Hospital Room and Board above.	Paid in the same manner as Hospital Room and Board above.
Hospital Miscellaneous Extras	In-network 100% Out-of-network 70% R&C	In-network 100% Out-of-network 70% R&C
Surgical, Outpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Diagnostic Tests and X-rays, Inpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Diagnostic Tests and X-rays, Outpatient	In-network 80% * Out-of-network 65% R&C * **Pre-certification required for PET scan, CT scan, and MRI**	Non-covered

*Subject to annual deductible

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS		
DESCRIPTION	**Pensioner Non-Medicare**	**Pensioner Dependent Non-Medicare**
Doctor's Visits, Inpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Doctor's Visits, Outpatient	In-network 80% * Out-of-network 65% R&C *	Non-covered
Emergency Treatment	In-network 80% * Out-of-network 65% R&C * $300 co-pay if treated for illness and not admitted to hospital	In-network 80% * Out-of-network 65% R&C * $300 co-pay if treated for illness and not admitted to hospital
Home Health/Home Nursing Care	100% R&C* Combined maximum of 60 visits a year (*a visit is defined as 2 hours or less*) with a maximum allowable charge of $75 per hour for nurse or home health aide	100% R&C * Combined maximum of 60 visits a year (*a visit is defined as 2 hours or less*) with a maximum allowable charge of $75 per hour for nurse or home health aide
Hospice Care	In-network 80% Out-of-Network 80% R&C	In-network 80% Out-of-Network 80% R&C
Physical Therapy (**for non-catastrophic illnesses or injuries)**	In-network 80% * Out-of-network 65% R&C * Limit 20 visits per year	Non-covered
Physical/Occupational/ Speech/Pulmonary/ Cognitive Therapies **(following catastrophic illnesses or injuries)**	In-network 80%* Out-of-network 65% R&C* Limit 40 visits per year (for all therapies combined)	In-network 80%* Out-of-network 65% R&C* Limit 40 visits per year (for all therapies combined)
Organ and Tissue Transplants	Non-covered	Non-covered
Vision Care	$40 maximum in 24 months	$40 maximum in 24 months

*Subject to annual deductible

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS		
DESCRIPTION	**Pensioner Non-Medicare**	**Pensioner Dependent Non-Medicare**
Dental Care	Allowance per code on dental schedule: Dentures and related services only: 80% R&C; Limited to once every 5 years; Oral surgery and anesthesia only: 100% R&C	Allowance per code on dental schedule: Oral Surgery and anesthesia only: 80% R&C
Prescription Drugs	$10-Generic @ Retail** $25-Brand Name on Formulary @ Retail** $50-Brand Name Not on Formulary @ Retail** ***For 30 day supply.* *(Mail order also available at different co-pays).* $100 deductible	Non-covered
Sickness and Accident	Non-covered	Non-covered
Death Benefit	Non-covered	Non-covered
Accidental Dismemberment	Non-covered	Non-covered
Psychiatric Inpatient	Non-covered	Non-covered
Psychiatric Outpatient	Non-covered	Non-covered
Substance Abuse Detox	Non-covered	Non-covered
Scholarship Program	Non-covered	Dependents - 5-four year scholarships @ $20,000 each
Lifetime Limitation	None	None

*Subject to annual deductible

The following chart is a summary of the health care benefits covered by the Plan, including the copayment and coinsurance amounts. **This chart is for Pensioners and dependents who are eligible for Medicare.** For more details, please review the appropriate benefit description listed after the chart.

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS		
DESCRIPTION	**Pensioner Medicare**	**Pensioner Dependent Medicare**
Annual Deductible	$125 Individual $250 Family	$125 Individual $250 Family
Hospital Room and Board	$300 copay then 100% of Medicare coinsurance and deductible Maximum of 180 days or $1,000,000 per illness (whichever comes first) per hospitalization Intensive care - maximum of 15 days at the hospital's intensive care rate. Beginning with 16th day, paid at semi-private room rate.	$300 copay then 100% of Medicare coinsurance and deductible Maximum of 180 days or $1,000,000 per illness (whichever comes first) per hospitalization Intensive care - maximum of 15 days at the hospital's intensive care rate. Beginning with 16th day, paid at semi-private room rate.
Inpatient Rehabilitation (at skilled nursing facility or acute rehabilitation facility) **NOTE:** This benefit is only payable for pensioners and dependents recovering from a catastrophic illness or injury such as stroke, severe accident or heart attack.	Paid in the same manner as Hospital Room and Board above.	Paid for in the same manner as Hospital Room and Board above.
Hospital Miscellaneous Extras	$300 copay then 100% of Medicare coinsurance and deductible	$300 copay then 100% of Medicare coinsurance and deductible
Surgical, Outpatient	50% of Medicare coinsurance and deductible *	50% of Medicare coinsurance and deductible *

*Subject to deductible

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS		
DESCRIPTION	**Pensioner Medicare**	**Pensioner Dependent Medicare**
Diagnostic Tests and X-rays, Inpatient	50% of Medicare coinsurance and deductible *	50% of Medicare coinsurance and deductible *
Diagnostic Tests and X-rays, Outpatient	50% of Medicare coinsurance and deductible *	Non-covered
Doctor's Visits, Inpatient	50% of Medicare coinsurance and deductible *	50% of Medicare coinsurance and deductible *
Doctor's Visits, Outpatient	50% of Medicare coinsurance and deductible *	Non-covered
Emergency Treatment	50% of Medicare coinsurance and deductible * $300 copay if treated for illness and not admitted to hospital	50% of Medicare coinsurance and deductible * $300 copay if treated for illness and not admitted to hospital
Home Health/Home Nursing Care	50% of Medicare coinsurance and deductible * Combined maximum of 60 visits a year (*a visit is defined as 2 hours or less)* with a maximum allowable charge of $75 per hour for nurse or home health aide	50% of Medicare coinsurance and deductible * *Combined maximum of 60 visits a year (a *visit is defined as 2 hours or less*) with a maximum allowable charge of $75 per hour for nurse or home health aide
Hospice Care	50% of Medicare coinsurance and deductible	50% of Medicare coinsurance and deductible
Physical Therapy **(for non-catastrophic illnesses or injuries)**	50% of Medicare coinsurance and deductible * Limit 20 visits per year	Non-covered
Physical/Occupational/ Speech/Pulmonary/ Cognitive Therapies **(following catastrophic illnesses or injuries)**	50% of Medicare co insurance and deductible * Limit 40 visits per year (for all therapies combined)	50% of Medicare co insurance and deductible * limit 40 visits per year (for all therapies combined)
Organ and Tissue Transplants	Non-covered	Non-covered
Vision Care	$40 maximum in 24 months	$40 maximum in 24 months

*Subject to annual deductible

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS		
DESCRIPTION	**Pensioner Medicare**	**Pensioner Dependent Medicare**
Dental Care	Allowance per code on dental schedule: Dentures and related services only: 80% R&C; Limited to once every 5 years; Oral surgery and anesthesia only: 100% R&C	Allowance per code on dental schedule: Oral Surgery and anesthesia only: 80% R&C
Prescription Drugs	$10-Generic @ Retail;** $25-Brand Name on Formulary @ Retail** $50-Brand Name not on Formulary @ Retail** ***For 30 day supply.* *(Mail order also available at different copays).* $100 deductible	Non-covered
Sickness and Accident	Non-covered	Non-covered
Death Benefit	Non-covered	Non-covered
Accidental Dismemberment	Non-covered	Non-covered
Psychiatric Inpatient	Non-covered	Non-covered
Psychiatric Outpatient	Non-covered	Non-covered
Substance Abuse Detox	Non-covered	Non-covered
Scholarship Program	Non-covered	Dependents - 5-four year scholarships @ $20,000 each
Lifetime Limitation	None	None

*Subject to annual deductible

The following health care benefits are covered by the Plan:

Hospital Room and Board

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 100 percent of the Network allowed charge for hospital room and board, for a maximum of 180 days or $1,000,000 per illness (whichever comes first) for confinement in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge for a maximum of 180 days or $1,000,000 per illness, whichever comes first. Once you reach the limit of 180 days or $1,000,000 in benefit payments, you must be out of the hospital for at least 60 days before the Plan will pay additional hospital fees for your care for the same illness. This limit applies to all facility related fees, including hospital extras, described below.

Payments for hospital charges are subject to a $450 admission copayment for pensioners and their dependents who are not eligible for Medicare. You are only required to pay this $450 payment once for an entire hospital stay.

For pensioners and their dependents who are eligible for Medicare, you will be required to pay a $300 admission co-payment. You are only required to pay this $300 payment once for an entire hospital stay. The Plan will pay the remainder after Medicare benefits have been paid. However, payment is limited to a maximum of 180 days or $1,000,000 per illness, whichever comes first. Once you reach the limit of 180 days or $1,000,000 in benefit payments, you must be out of the hospital for at least 60 days before the Plan will pay additional hospital facility fees for your care for the same illness. This limit applies to all facility related fees, including hospital extras, described below.

Payment for hospital room and board is based upon the hospital's semi-private room rate, unless a private room is medically necessary.

Intensive Care

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 100 percent of the Network allowed charge for confinement in an intensive care unit in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge. Payment for intensive care is subject to a $450 admission co-payment for pensioners who are not eligible for Medicare, unless this payment was already satisfied by paying other hospital charges.

For pensioners and their dependents who are eligible for Medicare, you will be required to pay a $300 admission co-payment unless this payment was already satisfied by paying other hospital charges. The Plan will pay the remainder after Medicare benefits have been paid.

The Plan will pay for intensive care confinements, based upon the hospital's intensive care rate for up to 15 days. Beginning with the 16th day, the Plan will pay for intensive care at the hospital's semi-private room rate, in the same way as hospital room and board. Intensive care units include cardiac care units, burn units, and other special care units.

Hospital Extras

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 100 percent of the Network allowed charge for hospital extras while confined in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge. Payment for hospital extras is subject to a $450 admission co-payment, unless this payment was already satisfied by paying other hospital charges.

For pensioners and their dependents who are eligible for Medicare, you will be required to pay a $300 admission co-payment, unless this payment was already satisfied by paying other hospital charges. The Plan will pay the remainder after Medicare benefits have been paid.

Hospital extras include such things as: operating room charges, X-rays, oxygen, dressings, and drugs.

Once you reach the maximum of 180 days, or $1,000,000 in benefits per illness for all hospital facility related fees (including hospital extras), you must be out of the hospital for at least 60 days before the plan will pay additional fees for hospital extras for the same illness.

Surgery

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge for the surgeon when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for the surgeon. The Plan will pay an assistant surgeon (a physician) 20 percent of the amount allowed for the surgeon. The Plan will pay surgical assistants who are not physicians 10 percent of the amount allowed for the surgeon. If more than one surgical procedure is performed during the same session, payments for all but the first procedure will be reduced by 50 percent of the allowed charge. Payments for anesthesia are calculated using a formula for out-of-network claims. This formula is available from the Plan upon request.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

Benefits are payable only after you have satisfied the annual deductible.

Visits by Doctors and Specialists in the Hospital

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge for a doctor's visit in the hospital when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

Benefits are payable only after you have satisfied the annual deductible.

Emergency Treatment

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge for emergency treatment when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

Emergency treatment is service that is needed immediately because of an accidental injury or a sudden unexpected illness requiring urgent medical attention. If you receive emergency treatment for an illness that does not result in a hospital admission, you are responsible for paying the first $300 in charges. The Plan may deny payment for emergency treatment where a medical emergency did not exist.

Benefits are payable only after you have satisfied the annual deductible.

Inpatient Rehabilitation

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay benefits for inpatient rehabilitation when rehabilitation is required to recover from a catastrophic illness or injury.

The Plan will pay 100 percent of the Network allowed charge for a maximum of 180 days or $1,000,000 per illness, or until you reach maximum medical improvement (whichever comes first) for confinement in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge for a maximum of 180 days or $1,000,000 per illness, or until you reach maximum medical improvement (whichever comes first).

Once you reach the limit of 180 days or $1,000,000 in benefit payments, you must be out of the rehabilitation facility for at least 60 days before the plan will pay additional benefits for your care. The Plan will no longer pay for inpatient rehabilitation once you reach maximum medical improvement. These limits apply to all facility-related fees. The Plan will not pay benefits for custodial care.

Payments for inpatient rehabilitation are subject to a $450 admission copayment for pensioners and their dependents who are not eligible for Medicare. You are only required to pay this $450 payment once for the entire confinement in the rehabilitation facility.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay benefits for inpatient rehabilitation when rehabilitation is required to recover from a catastrophic illness or injury.

The Plan will pay 100 percent of the Medicare coinsurance and deductible amounts for a maximum of 180 days or $1,000,000 per illness, or until you reach maximum medical improvement (whichever comes first) for confinement in a rehabilitation facility.

Once you reach the limit of 180 days or $1,000,000 in benefit payments, you must be out of the rehabilitation facility for at least 60 days before the Plan will pay additional benefits for your care. The Plan will no longer pay for inpatient rehabilitation once you reach maximum medical improvement. These limits apply to all facility-related fees. The Plan will not pay benefits for custodial care.

Payments for inpatient rehabilitation are subject to a $300 admission copayment for pensioners and their dependents who **are** eligible for Medicare. You are only required to pay this $300 payment once for the entire confinement in the rehabilitation facility.

Outpatient Doctor's Visits and Services

For pensioners who are not eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For Medicare eligible pensioners, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

This benefit includes such services as: X-rays, lab work, immunizations and physical examinations.

There is no dependent coverage for outpatient doctor's visits.

Benefits are payable only after you have satisfied the annual deductible.

Physical Therapy

The Plan offers two types of physical therapy benefits for pensioners: benefits for therapy required following **a non-catastrophic illness or injury** (such as a broken leg) and benefits for therapy required following a **catastrophic illness or injury** (such as a stroke). Pensioners' dependents have benefits for physical therapy required following a catastrophic illness or injury (such as a stroke). **There is no dependent coverage for physical therapy following a non-catastrophic condition.**

For pensioners who are not eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 80 percent of the Network allowed charge for physical therapy when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For Medicare eligible pensioners, following a non-catastrophic illness or injury, the Plan will pay 50% of the Medicare coinsurance amount after Medicare benefits have been paid.

Payments for physical therapy for pensioners following a non-catastrophic condition are limited to twenty visits during a calendar year.

For pensioners and their dependents, following a catastrophic illness or injury, the Plan provides physical therapy, occupational therapy, pulmonary therapy and cognitive therapy benefits to both you and your dependents to aid in rehabilitation. In order to qualify for these benefits, the pensioner or dependent must be expected to improve to a certain level of recovery.

For pensioners and their dependents who are <u>not</u> eligible for Medicare, following a catastrophic illness or injury, the Plan will pay 80 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For Medicare eligible pensioners and their dependents, following a catastrophic illness or injury, the Plan will pay 50% of the Medicare coinsurance amount after Medicare benefits have been paid.

These benefits are limited to 40 visits per calendar year for any combination of therapies. For pensioners only, these benefits are in addition to the physical therapy benefits for non-catastrophic conditions.

Benefits are payable only after you have satisfied the annual deductible.

<u>Podiatric Surgery</u>

The Plan will not pay for routine visits to a podiatrist. When medically necessary, the Plan will pay for podiatric surgery up to a maximum of $1,000 per year.

<u>Maternity Benefit</u>

For pensioners and their spouses who are <u>not</u> eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge for maternity benefits when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For pensioners and their spouses who <u>are</u> eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

This benefit is to pay the doctor's charge for delivery of a child born to **you or your spouse only. The Plan does not provide maternity coverage to your child if she becomes pregnant.** Charges for hospital room and board, hospital extras and surgery, are paid in the same way as any other medical condition. To receive maternity benefits, you must be eligible for benefits at the time of delivery.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of 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 section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours) as applicable.

Benefits are payable only after you have satisfied the annual deductible.

Elective Abortion

The Plan will pay toward the cost of an elective abortion for **you or your spouse,** up to a maximum of $300, including all related charges. If the abortion is not medically necessary, the Plan will pay for no more than one such abortion during a 12-month period. If an abortion is needed to preserve the health of the mother, the Plan will pay in the same way as for any other medical condition.

Benefits are payable only after you have satisfied the annual deductible.

Transportation by Ambulance

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge when a Network provider is used to transport a patient to the hospital, and transportation by ambulance is medically necessary. When a non-network provider is used, the Plan will pay 80% of the reasonable and customary charge for transportation by ambulance.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

Benefits are payable only after you have satisfied the annual deductible.

Home Health and Home Nursing Care

The Plan will pay for a combined total of up to 60 visits per year for either home health care and/or home nursing care. A "visit" equals up to two hours of home health or home nursing services provided by a nurse or home health aide.

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay the cost for the services of a home health aide or nurse, up to a maximum of $75.00 per hour. Other home health care services such as drugs and supplies are paid for at 100 percent of the reasonable and customary charge, up to the maximum daily rate. The maximum daily rate is the average daily rate of your prior hospital stay, plus $50.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50% of the Medicare co-insurance amount, for up to 60 visits a year.

Generally, in order to be eligible for this benefit, the home care must begin within 14 days following a hospital confinement of at least two days. However in certain circumstances, following review by the Plan, the Plan will pay for home health services even if you were not previously hospitalized for your condition. Services must be provided by an approved home health agency and they must be medically necessary.

Both you and your dependents are covered for home health care. Benefits are payable only after you have satisfied the annual deductible.

Hospice Care

For all pensioners and their dependents, the Plan will pay 80 percent of the daily reasonable and customary cost for hospice care.

In order to be eligible for this benefit, a doctor must certify that you or your dependent is not expected to live for more than six months. Services must be provided by an approved hospice provider.

Durable Medical Equipment

Only pensioners are eligible for durable medical equipment benefits for a non-catastrophic illness or injury, or a chronic medical condition. The Plan does not provide coverage to dependents for durable medical equipment required due to a non-catastrophic illness or injury or chronic medical condition.

Both pensioners and their dependents are covered for durable medical equipment benefits when it is required to assist with rehabilitation following a catastrophic illness or injury**.**

For pensioners who are not eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 80 percent of the Network allowed charge for durable medical from a Network provider. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for durable medical equipment.

For pensioners who are eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 70 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

For pensioners and their dependents who are not eligible for Medicare, following a catastrophic illness or injury, the Plan will pay 80 percent of the Network allowed charge for durable medical from a Network provider. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for durable medical equipment.

For pensioners and their dependents who are eligible for Medicare, following a catastrophic illness or injury, the Plan will pay 70 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

Durable medical equipment includes such things as prosthetic devices, medical appliances and other durables. The Plan will not pay to maintain or repair durable medical equipment.

The Plan also will pay toward the cost of a hearing aid for pensioners only. Payments for hearing aids are limited to $350 every five years. There is no spouse or dependent coverage for hearing aids.

The Board of Trustees must approve all durable medical equipment benefits over $1,000 if purchased or over $500 per month if rented. To apply for the durable medical equipment benefit, you must send the Plan a letter from your doctor describing the type of equipment and the reason it is needed. The letter from your doctor must also include the estimated cost of the equipment.

Benefits are payable only after you have satisfied the annual deductible.

Vision Care

The Plan will pay a maximum of $40 in vision care charges during a 24-month period for each pensioner and dependent.

Vision care services include eye examinations, eyeglasses, and contact lenses. Vision care services are available once every 24 months. There may be a medical reason for your dependent child (who is under age 19 only) to receive vision services more often than every 24 months. If you send the Plan written proof of this reason, your child under age 19 may be eligible for this benefit more often.

Annual Physical Examinations

For all pensioners and their dependents, the Plan will pay 100 percent of the cost of a routine physical examination when it is performed at a clinic that is contracted to the Plan that provides this service. **There is no dependent coverage for annual physical exams performed at any other location.**

For pensioners who are not eligible for Medicare, and the exam is not performed at a Plan-contracted clinic, the Plan will pay 80 percent of the Network allowed charge for an annual physical when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

For pensioners who are eligible for Medicare, and the exam is not performed at a Plan-contracted clinic, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid.

To arrange for an annual physical examination at a clinic that is contracted to the Plan, you should contact the local Plan office.

This benefit is available once every twelve months.

WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?

For all pensioners, the Plan provides prescription drug coverage through an arrangement with a Pharmacy Benefit Manager (PBM). **There is no dependent coverage for prescription drugs.**

The annual prescription deductible is $100. This deductible is in addition to the health care annual deductible.

The PBM will issue you a prescription card. You must present this card when you fill your prescription.

This program allows you to purchase prescription drugs at either a local participating pharmacy or through a mail order service. However, benefits are not payable if your prescription is filled by a non-participating pharmacy. The Plan pays for prescription drugs only if they are medically necessary. The Plan does not pay for drugs that can be purchased over-the-counter. However, the Plan will pay for insulin even though you can buy it without a prescription.

You will be expected to make a co-payment each time you purchase prescription drugs. Generic drugs have the lowest co-payment amounts, while brand-name drugs have the highest. In addition, there is an especially high co-payment when maintenance drugs are purchased at a retail pharmacy instead of through the mail order service. The Plan considers a maintenance drug to be any drug that is used for more than two months.

When your prescription is filled, you will receive a generic drug. Generic drugs are medications that are not a brand name medication, but by law must have the same active ingredients as the brand name medication, and are subject to the same standards as their brand name counterpart. Generic drugs usually cost less. If a generic drug is not available, your prescription will be filled with a brand name drug. If you choose to buy a brand-name drug when a generic is available, the Plan will only pay the benefit it would have paid for the generic drug.

Certain brand-name drugs are included on the "formulary" which is a list of drugs specified by the Pharmacy Benefit Manager. Drugs included on the formulary are widely available and reasonably priced. Drugs not included on the formulary are generally more expensive than those on the list, so your co-payment will be higher.

Maintenance drugs, which are prescription drugs that you will be using for more than two months, should be purchased through the mail order program. If you do not purchase maintenance drugs by mail order, your co-payment will increase, beginning with the prescription for the third month. For more information about placing mail orders you should contact the Pharmacy Benefit Manager.

PRESCRIPTION DRUG CO-PAY AMOUNTS

PURCHASE	CO-PAY AMOUNT
Generic Drugs Retail *(30 day supply)*	$10
Generic Maintenance Drugs Retail *(beginning with 3rd 30-day supply)*	$30
Generic Maintenance Drugs Mail Order *(90-day supply)*	$20
Brand-name Drugs Retail included on Formulary *(30-day supply)*	$25
Brand-name Drugs Retail not included on Formulary *(30-day supply)*	$50
Brand-name Maintenance Drugs Retail included on Formulary *(beginning with 3rd 30-day supply)*	$75
Brand-name Maintenance Drugs Retail not included on Formulary	$150
Brand-name Maintenance Drugs Mail Order included on Formulary *(90-day supply)*	$50
Brand-name Maintenance Drugs Mail Order not included on Formulary *(90-day supply)*	$100

For more information about your prescription coverage, call the phone number on your prescription card. If you do not have a prescription card, you may contact the Plan office at 1-800-252-4674, or check the Member Benefits section of the Seafarers website at www.seafarers.org.

DOES THE PLAN PAY FOR DENTAL CARE?

For all pensioners, the Plan will pay toward the cost of dentures and surgical extractions (oral surgery) only. These dental benefits are paid using a schedule. The dental schedule is a list of services that includes the amount the Plan will pay for each service. The Plan will pay the scheduled amount for dentures at 80% R&C once every five years. In addition, the Plan will pay the scheduled amount at 100% R&C for surgical extractions, oral surgery, and anesthesia associated with the oral surgery.

There is no dependent coverage for routine dental care; however, the Plan will pay the scheduled amount at 80% R&C for oral surgery and anesthesia associated with the oral surgery.

For information about the dental services that are covered by the Plan, or to request a copy of the dental schedule, you can contact the Plan at:

Seafarers Health and Benefits Plan
P.O. Box 380
Piney Point, Maryland 20674
1-800-252-4674

WHAT IS THE PENSIONER NURSING HOME BENEFIT?

The Plan can help pay the cost of nursing home care for **non-Medicare eligible pensioners. There is no nursing home benefit for dependents.** To receive this benefit, a pensioner must first exhaust his or her Social Security and pension benefits. The Plan will then pay up to $100 per week toward the remaining nursing home cost.

WHAT BENEFITS DOES THE PLAN PROVIDE FOLLOWING A MASTECTOMY?

The Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, as well as complications resulting from a mastectomy, including lymphedema. These benefits are provided to both pensioners and their dependents. The same limitations and deductibles that apply to other benefits apply to these mastectomy-related services. For more information, call the Plan at 1-800-252-4674.

WHAT SHOULD I DO IF I FIND A MISTAKE ON MY HEALTH CARE BILL?

When you receive a bill from a health care provider, look it over carefully. If the bill includes charges for services you did not receive, you should contact the doctor or hospital and have the mistake corrected.

If you are successful in having the bill corrected, you should contact the Plan office. After verifying the correction, the Plan will pay you a bonus. The bonus is equal to 25 percent of the amount you saved the Plan, up to a maximum bonus of $500.

WHAT IF MY SPOUSE, CHILD, OR I HAVE OTHER HEALTH INSURANCE?

If you, your spouse, or your child has other insurance, you must file a coordinated claim. The proper way to file a coordinated claim depends on who the patient was:

- If you, your spouse, or your child are covered under **employer provided health insurance**, that insurer must pay benefits before the Plan will pay benefits.
- If you or your spouse is covered under Medicare and are the patient, Medicare must pay benefits before the Plan will pay benefits.
- If you or your spouse are covered under both employer provided health insurance and Medicare, the Plan will pay benefits only after all other insurers have paid benefits.

Once the other insurer has processed the claim, send the claim to the address listed on the back of your ID card. Be sure to include the Explanation of Benefits Statement that was sent to you by the other insurer.

When the Seafarers Health and Benefits Plan is the second payer, the date the claim accrued is the date on which the first insurer made a payment. You must apply to the Seafarers Health and Benefits Plan for benefits within 180 days following that date.

HOW CAN I REDUCE MY OUT OF POCKET COST?

If you are not eligible for Medicare, you can reduce your out of pocket cost by using Network providers. The Plan pays a non-Network provider based on the Plan's determination of the reasonable and customary charge. The reasonable and customary charge is usually less than the actual charge. The Plan pays a lower percentage for non-Network providers. In addition, in-Network providers have agreed to accept the Network allowed amount as payment in full, after you have paid any required co-payments and deductibles. For more information about the Network, you may contact the Plan office, check the Network website listed on your Plan ID card, or call the Network at the telephone number on your ID card.

In addition, if a Network provider is not available, **and you are not eligible for Medicare,** you may be able to reduce your out of pocket costs by using a provider that participates in CIGNA's Out-of-Network Savings Program. Health care providers who participate in this program have agreed to accept discounted rates as payment in full, except for applicable co-payments and deductibles. For more information about this program, call the telephone number on your ID card.

DO I NEED TO OBTAIN PRE-CERTIFICATION WHEN USING NETWORK PROVIDERS?

The Plan has arranged for you to receive services through a Network of preferred providers **if you are not eligible for Medicare. Pre-certification from the Network is required prior to any surgery or hospitalization. You also must notify the Network within 48 hours following emergency surgery or emergency hospitalization. Benefits will not be paid if you fail to notify the Network.** If you have asked the provider to notify the Network for you, make certain they have done so by contacting the Network yourself. **Remember, it is your responsibility to notify the Network.**

If you are not eligible for Medicare, you must also obtain pre-certification from the Network for outpatient high technology radiology services, such as a CT scan, PET scan or MRI. **If you do not obtain approval from the Network before you receive these services, the Plan will not pay benefits.** You do not need pre-certification when these tests are performed in the emergency room.

For more information, you may contact the Plan office at 1-800-252-4674 or call the Network at the telephone number on your ID card.

HOW DO I APPLY FOR HEALTH CARE BENEFITS?

Before filing a claim, make sure you have an **enrollment beneficiary card** on file with the Plan. If the patient is your spouse, be sure that you have sent the Plan an official copy of your **marriage certificate and your spouse's Social Security card**. Before the Plan will pay benefits for your dependent children, you must send the Plan an official copy of **each child's birth certificate and Social Security card**.

If there is any question concerning coverage or eligibility, call the Plan at: 1-800-252-4674. For information about the Network, you may contact the Plan office or check the Member Benefits section of the Seafarers website at www.seafarers.org.

If you are <u>not</u> eligible for Medicare, send **all** claims, except for vision and dental claims, to the address on the back of the ID card that you have received from the Plan. **Both in-Network and out-of-Network claims must be sent to this address.** If you lose this card, please contact the Plan at 1-800-252-4674. **Claims must be filed within 180 days of the date of service.**

- When you use a Network provider you usually do not have to file a claim yourself. The provider will file the claim for you. They can either file the claim electronically or by mail.

- In order to permit the Plan to pay the health care provider instead of you, the provider will ask you to sign a document assigning your benefits to them. If the Plan receives proof that you have paid the provider in full, the Plan will pay you directly.

- When using a non-Network provider, ask if the provider will accept direct payment from the Plan. In most cases the provider will file the claim for you. If the provider wants to file a claim electronically, have them contact the Plan at: 1-800-252-4674.

- If you must pre-pay a non-Network provider yourself, obtain a copy of the itemized bill. To receive benefits you must send this itemized bill to the Network at the address on the back of your ID card. Make certain that the bill includes: pensioner's Social Security number, patient's name, provider's name, address, and I.D. number, date of service, diagnosis, description of treatment, supplies provided and itemized costs. The Plan will process your claim within 30 days after receiving it. **However, your claim will not be paid unless it is filed within 180 days of the date the claim accrued.**

If you are eligible for Medicare, send claims to:

Seafarers Health and Benefits Plan
P.O. Box 380
Piney Point, Maryland 20674

All vision and dental claims, regardless of whether or not you are eligible for Medicare, should also be sent to the Plan's address listed above.

ARE THERE ANY REASONS WHY THE PLAN MAY NOT PAY BENEFITS?

Benefits will be paid only if the treatment was received in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, or other U.S. territories or Canada.

Your claim for benefits may be *denied or limited* for any of the following reasons:

The Plan will not pay benefits:

- if your illness or injury is due to alcohol or drug use;

- if your illness or injury occurred while committing a crime;

- if your illness or injury is due to something you knew, or should have known, was dangerous to your health or safety unless your injury was caused by an act of domestic violence;

- if your illness or injury is due to behavior that showed that you did not care if you became sick or injured, unless your illness or injury was the result of a medical condition such as depression;

- if your illness or injury is due to the actions of someone else who can be held legally responsible. However, the Plan may pay benefits if you agree to assign payment to the Plan from any money you recover. This means that the Plan is entitled to full payment from any money you recover regardless of your legal expenses. If you do not repay the Plan, money may be deducted from any future benefits you might be entitled to receive;

- for treatment which is not approved for use in the United States or is considered to be experimental;

- for organ and tissue transplants;

- for bariatric surgery, gender orientation surgery, or any related treatment;

- for weight loss drugs;

- for nutritional counseling unless you are a diabetic or a pensioner that has a BMI of 40, or has a BMI over 35, along with a complication of type 2 diabetes, cardiovascular disease, hypertension, chronic obstructive sleep apnea, or other conditions caused by being overweight such as joint pain, mobility problems. The Plan will pay for up to three (3) sessions of nutrition counseling in the same way it pays for all other professional fees.

- for the diagnosis or treatment of infertility;

- for sterilization;

- to obtain any records or paperwork needed to pay a claim;

- if the medical records related to your claim are insufficient, or if the records appear to be altered or fraudulent;

- if they can be paid under Workers' Compensation or another health and safety law;

- for treatment in a government hospital, where by law, the Plan is not required to pay;

- for treatment that is needed because of war, an act of war, or because you were in the military;

- for treatment which is cosmetic. However, the Plan will pay for breast reconstruction following cancer treatment;

- for custodial care. Confinement in a hospital or nursing facility is considered custodial care if adequate treatment could be rendered in an outpatient setting; **or** care consists of services and supplies that are provided primarily to train or assist in personal hygiene or activities of daily living rather than therapeutic treatment; **or** the care consists of health services that do not seek to cure and which are provided during a period when the medical condition of the patient is not changing.

- for treatment that is not medically necessary. This includes treatment that is required because of conditions that develop during the course of a hospital stay that could reasonably have been prevented;

- for occupational, rehabilitative, or speech therapy, except when these therapies are required to recover from a catastrophic illness or injury;

- for chiropractic treatment;

- for more than $1,500 per year for pain management services;

- for acupuncture;

IS THERE ANY WAY I CAN LOSE MY RIGHT TO BENEFITS?

You may lose your right to receive benefits if you don't seek medical treatment when you know you should, or if you don't follow your doctor's advice.

If you accept an overpayment from the Plan, or a payment to which you are not entitled, and you refuse to return it, you may lose your right to benefits. You also may lose your right to benefits if you fail to repay money that has been assigned to the Plan.

WHAT WILL HAPPEN TO MY BENEFITS IF I RETURN TO WORK IN THE MARITIME INDUSTRY?

If you are a Pensioner and you decide to go back to work in the maritime industry for more than 60 days, in a calendar year, either for an employer who contributes to the Plan, or for any employer in which you perform a job similar to the types of jobs covered by collective bargaining agreements with the SIU, **you may lose your pensioner's health benefits**. **If the Seafarers Pension Plan suspends your pension benefits because you have returned to work, your pensioner's health benefits will also be suspended.** During the period that your benefits are suspended, you will be eligible to purchase COBRA continuation coverage from the Plan. For more information about COBRA continuation coverage, see page 36 of this booklet.

You will reestablish eligibility for the benefits of an active employee once you have 90 days of continuous covered employment. **See the Guide to Benefits for Employees at the Core and Core-Plus Benefit level for more information about how to maintain eligibility for the benefits of an active employee.** When you decide to stop working again, and resume receiving your pension, your pensioner's health benefits will be reinstated.

WHAT EDUCATIONAL BENEFITS DOES THE PLAN PROVIDE?

Each year the Plan awards a limited number of scholarships for use at colleges or vocational schools. **Your dependent children may receive this benefit.** Information about this important benefit can be found in the summary booklet for the Seafarers Scholarship Program.

To obtain a booklet, you can contact the Plan at:

Seafarers Health and Benefits Plan
Attn: Scholarship
5201 Auth Way
Camp Springs, Maryland 20746
(301) 899-0675

WHAT RIGHTS DO I HAVE IF THE PLAN DENIES MY CLAIM?

If your application for benefits is denied, or you believe your claim was paid incorrectly, you have the right to appeal the Plan's decision.

A written explanation will be sent to you if the Plan denies your claim. If you believe that the Plan should have paid your claim, you may call the Plan at 1-800-252-4674 to discuss this matter. If you want to request a review by the Board of Trustees, you must make your request in writing and you must send it within 180 days of the date your claim was denied. You should include any supporting documentation you have when making your request. Your doctor, hospital, or other medical provider may also submit an appeal on your behalf.

Your claim will be reviewed by the Trustees. They will look at all proof that they receive from you or anyone else. After completing their review, the Trustees will make their final decision. The Trustees will notify you of their decision in writing within 30 days of receiving your appeal, unless the Trustees decide that they need additional information to make a decision. In certain emergency circumstances, your appeal will be handled in a shorter amount of time. If additional information is needed, the Plan will send you a request for this information, and give you at least 45 days to provide the requested documentation.

Your written appeal should be sent to:

Board of Trustees
Seafarers Health and Benefits Plan
P.O. Box 380
Piney Point, MD 20674

Any legal action based upon the Plan’s denial of benefits must be commenced no later than two (2) years after your appeal is denied by the Plan’s Board of Trustees.

CAN I APPEAL TO HAVE A CLAIM APPROVED BEFORE I RECEIVE A MEDICAL SERVICE?

If you or your doctor would like a claim considered for approval before you receive medical treatment, the Plan will consider your pre-service appeal. If it is not urgent, please send the appeal and all supporting information to the Board of Trustees at the address listed above. The Plan will consider your appeal and notify you of a decision within 15 calendar days of receiving your request and all supporting documentation.

If your appeal involves a request for approval of **urgent** care before you receive treatment, the Plan will make a decision more quickly. A request will be considered to be **urgent** if your health would be threatened if the Plan took the normal amount of time to consider your appeal. The Plan will decide urgent care appeals within 72 hours.

If the Plan needs more information to decide an urgent care appeal, it will notify you within 24 hours, and give you at least 48 hours to respond. Once the Plan receives this information, it will make a decision within 48 hours. If you do not supply the information requested, the Plan will make a decision within 48 hours after the time it gave you to provide the information has elapsed. If you wish to submit an urgent appeal, please contact the Plan at 1-800-252-4674.

HOW WILL THE PLAN NOTIFY ME IF THERE ARE ANY CHANGES IN MY BENEFITS?

If the Trustees decide to make any changes to your benefits, the Plan will notify you by mailing a notice to your home address.

WHAT PRIVACY RIGHTS DO I HAVE?

The Seafarers Health and Benefits Plan is committed to safeguarding the privacy of its participants. The Plan discloses protected health information only when it is necessary for medical treatment, payment of claims, or normal health care operations. As a participant in the Plan, you have certain privacy rights.

You have the right to:

- request restrictions on certain uses and disclosures of your protected health information;
- receive confidential communications of your protected health information;
- inspect and copy your protected health information;
- amend your protected health information;
- an accounting of disclosures of your protected health information;

In addition, you have the right to receive a printed copy of the Plan's Notice of Privacy Practices. If you do not already have a copy of the Notice of Privacy Practices, you can obtain a copy online at www.seafarers.org under the Member Benefits section, from your local Plan representative, or from the Plan at:

Seafarers Health and Benefits Plan
Attn: Privacy Officer
5201 Auth Way
Camp Springs, MD 20746

CAN THE PLAN TREAT ME DIFFERENTLY BECAUSE I HAD A GENETIC TEST THAT SHOWS THAT I AM MORE LIKELY TO GET A CERTAIN ILLNESS?

No. The Plan will not request information about any genetic test that you or a family member may have had, and the Plan will not use genetic information to make any decisions about your benefits.

WHAT OTHER RIGHTS DO I HAVE?

As a participant in the Plan, you have certain rights under the Employee Retirement Income Security Act of 1974.

You have the right to:

- receive information about the Plan;
- inspect Plan documents at the Plan's office;
- receive copies of Plan documents for a small copying fee;
- receive a listing of signatory employers when requested in writing;
- receive a summary of the Plan's financial report;
- not to be penalized or discriminated against by the Trustees of the Plan when you are applying for benefits;
- hire a lawyer, if you believe that your application for benefits was incorrectly turned down, or that a Trustee of the Plan has not done their job;
- continue health care coverage for you, your spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse will have to pay for this coverage. Review the section of this booklet about COBRA continuation coverage for more information;

- The right to have your questions answered by the Plan, and if you are not satisfied, to ask the U.S. Department of Labor.

  U.S. Department of Labor
  Employee Benefits Security Administration
  Room N5619
  200 Constitution Avenue, N.W.
  Washington, DC 20210

NOTICE OF CONTINUATION COVERAGE
RIGHTS UNDER COBRA

The following is a notice that describes your COBRA continuation coverage rights in the event that you or a family member loses health coverage from this plan. If you lose eligibility, and do not receive your COBRA Election Notice, please contact the Plan immediately at: 1-800-252-4674.

Seafarers Health and Benefits Plan

General Notice Of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan - Seafarers Health and Benefits Plan ("the Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator at:

Seafarers Health and Benefits Plan
Attn: Administrator
5201 Auth Way
Camp Springs, MD 20746

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an **employee**, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the **spouse of an employee**, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your **dependent children** will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Due to the nature of the maritime industry, an employer may not always be aware when these events occur, because you may work for multiple employers. **Therefore, the Plan suggests that you or a family member also notify the Plan of these events.**

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Seafarers Health and Benefits Plan
Attn: COBRA
PO Box 380
Piney Point, MD 20674

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

You may obtain more information about your COBRA rights from the Seafarers Health and Benefits Plan by calling the Plan at 1-800-252-4674, and asking to speak with the COBRA Representative; or by writing to:

Seafarers Health and Benefits Plan
Attn: COBRA
PO Box 380
Piney Point, Maryland 20674