

# ***SEAFARERS HEALTH AND BENEFITS PLAN***

5201 Auth Way  
Camp Springs, Maryland 20746-4275  
(301) 899-0675

Margaret R. Bowen  
Administrator

July, 2012

Dear Pensioner:

Enclosed is a revised Summary Plan Description (SPD) Booklet, which describes your benefits from the Seafarers Health and Benefits Plan. This booklet contains up-to-date information about the benefits available from the Plan. You may wish to discard previous versions of this booklet, which are now out of date. Keep this booklet in a convenient place so that you may refer to it when necessary.

If you have any questions about your benefits, please call our toll-free telephone number, 1-800-252-4674 (1-800-CLAIMS4), or, write to: Seafarers Health and Benefits Plan, P.O. Box 380, Piney Point, MD 20674.

Sincerely,

BOARD OF TRUSTEES

Enclosure

A GUIDE TO YOUR HEALTH BENEFITS  
FROM THE  
SEAFARERS HEALTH AND BENEFITS PLAN  
FOR PARTICIPANTS WHO ARE RECEIVING  
RETIREMENT BENEFITS FROM  
THE SEAFARERS PENSION PLAN



July 2012

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## INTRODUCTION

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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 District-NMU (SIU) or affiliated unions and to the families of those employees. 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](http://www.seafarers.org) under the Member Benefits section.**

The Seafarers Health and Benefits Plan believes that this 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, grand-fathered 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 the address below. 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](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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.**

## INFORMATION YOU SHOULD BE AWARE OF

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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	Ed Hanley
Ambrose Cucinotta	Michael DiPrisco
David Heindel	Norm Gauslow
Kermett Mangram	Thomas Murphy
Thomas Orzechowski	Anthony Naccarato
Joseph Soresi	William Pagendam
Jim McGee	Robert Rogers

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

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

**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 SHBP 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. However, a child who is 19 or older will only be eligible for coverage if the child is not offered insurance through his or her employer. 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 considered legally married in the state where you reside. 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.

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

**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. 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.

**pharmacy benefits manager (PBM)**—A company that provides pharmacy benefits either through a card that is used at a pharmacy, or through mail order. The Plan currently uses OptumRx (formerly known as "Prescription Solutions") as its pharmacy benefits manager.

**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.

**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?

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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. **If your dependent child is between the ages of 19 and 26, you must also complete and return the “Enrollment Form and Affidavit for Dependent Child.”** This form is available at [www.seafarers.org](http://www.seafarers.org) under the Member Benefits section, or you can contact the Plan to request a copy of this form.

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 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 should complete one and send it to the Plan as soon as possible. Enrollment beneficiary cards are available from your local 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?

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You will be eligible for health care benefits after you retire if you meet either of 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) and at least **125 days of covered employment** with SHBP in the calendar year before you applied for pension.
- 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 at least **125 days of covered employment** with SHBP in the calendar year before your disability began.

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?

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

There are some differences between the health benefits that you 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 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. When the COBRA period is over, you will begin to receive pensioner's health benefits.

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?

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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. 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 the Plan.

## WHAT DAYS CAN BE COUNTED AS COVERED EMPLOYMENT?

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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, Workers' Compensation, Longshore and Harbor Workers' compensation, or state disability 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, and **your employer must have been paying the appropriate contribution rate to the Plan.** Days when you received Maintenance and Cure payments only count as covered employment if you were at the Core-Plus benefit level. At the Core benefit level, these days only counted 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 or state disability benefits. However, the maximum number of S&A days or days of state disability you can be credited with depends on your years of service.

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?

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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.

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 paying 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?

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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 following chart is a summary of the health care benefits covered by the Plan, including the co-payment and co-insurance amounts. For more details, please review the appropriate benefit description listed after the chart.

<b>SEAFARERS HEALTH AND BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS</b>		
<b>DESCRIPTION</b>	<b>Pensioner Medicare</b>	<b>Pensioner Dependent Medicare</b>
Annual Deductible	\$125 Individual \$250 Family	\$125 Individual \$250 Family
Hospital Room and Board	\$300 co pay then 100% of Medicare co insurance 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 16 <sup>th</sup> day, paid at semi-private room rate	\$300 co pay then 100% of Medicare co insurance 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 16 <sup>th</sup> day, paid at semi-private room rate
Hospital Miscellaneous Extras	\$300 co pay then 100% of Medicare co insurance and deductible	\$300 co pay then 100% of Medicare co insurance and deductible
Surgical, Outpatient	50% of Medicare co insurance and deductible *	50% of Medicare co insurance and deductible *
Diagnostic Tests and X-rays, Inpatient	50% of Medicare co insurance and deductible *	50% of Medicare co insurance and deductible *
Diagnostic Tests and X-rays, Outpatient	50% of Medicare co insurance and deductible *	Non-covered
Doctor's Visits, Inpatient	50% of Medicare co insurance and deductible *	50% of Medicare co insurance and deductible *
Doctor's Visits, Outpatient	50% of Medicare co insurance and deductible *	Non-covered
Emergency Treatment	50% of Medicare co insurance and deductible * \$300 co-pay if treated for illness and not admitted to hospital	50% of Medicare co insurance and deductible * \$300 co-pay if treated for illness and not admitted to hospital

\*Subject to annual deductible

DESCRIPTION	Pensioner Medicare	Pensioner Dependent Medicare
Home Health/Home Nursing Care	50% of Medicare co insurance 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 co insurance 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	Hospice Care: 50% of Medicare co insurance and deductible	Hospice Care: 50% of Medicare co insurance and deductible
Physical Therapy	50% of Medicare co insurance and deductible * limit 20 visit per year	Non-covered
Organ and Tissue Transplants	Non-covered	Non-covered
Vision Care	\$40 max in 24 months	\$40 max in 24 months
Dental Care	Allowance per code on dental grid; exceptions = dentures and related services 50% of Medicare co insurance and deductible, oral surgery and anesthesia 50% of Medicare co insurance and deductible	Oral Surgery and anesthesia 50% of Medicare co insurance and deductible
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

**SEAFARERS HEALTH AND 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	In-network 100% Out-of-network 70% R&C \$450 in or out of network 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 16 <sup>th</sup> day, paid at semi-private room rate	In-network 100% Out-of-network 70% R&C \$450 in or out of network 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 16 <sup>th</sup> day, paid at semi-private room rate
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 *	Non-covered
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

\*Subject to annual deductible

DESCRIPTION	Pensioner Non-Medicare	Pensioner Dependent Non-Medicare
Home Health/Home Nursing Care	Home Health/Home Nursing: 100% R&C*	Home Health/Home Nursing: 100% R&C *
Hospice Care	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: 80% 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: 80% R&C
Physical Therapy	In-network 80% * Out-of-network 65% R&C * Limit 20 visits per year	Non-covered
Organ and Tissue Transplants	Non-covered	Non-covered
Vision Care	\$40 max in 24 months	\$40 max in 24 months
Dental Care	Allowance per code on dental grid; exceptions = dentures and related services 80% of R&C, oral surgery and anesthesia 100% R&C	Surgery and anesthesia 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 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 this illness. This limit applies to all facility related fees, including hospital extras, described below.

Payments for hospital charges are subject to a \$450 admission co-payment 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 this 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. Payments for hospital charges are 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 16<sup>th</sup> 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 when a Network provider is used. When a non-network provider is used, 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 the maximum of 180 days in the hospital, or \$1,000,000 per illness is reached, 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 a 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. Payments for anesthesia are calculated using a formula. 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 paid 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 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 a visit by a doctor or specialist in the hospital.

**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 paid 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 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 paid the annual deductible.

## 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 performed on an outpatient basis.

**There is no dependent coverage for outpatient doctor's visits.** Benefits are payable only after you have paid the annual deductible.

## Physical Therapy

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% of the Medicare coinsurance amount after Medicare benefits have been paid.

Payments for physical therapy are limited to twenty visits during a calendar year. Benefits are payable only after you have paid the annual deductible.

**There is no dependent coverage for physical therapy.**

## Podiatric Surgery

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.

## Maternity Benefit

For pensioners and their spouses 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. Benefits are payable only after you have paid the annual deductible.

For pensioners and their spouses 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 paid the annual deductible.

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

Group health plans and health insurance issuers 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 or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **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 paid 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 65% 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 paid 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% 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 paid 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

For pensioners who are **not** eligible for Medicare, the Plan will pay 80 percent of the Network allowed charge when the durable medical equipment is purchased or rented from a Network provider. 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, 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 Board of Trustees must approve all payments over \$1,000 for the purchase of durable medical equipment, or over \$500 per month for rental of equipment. 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.

The Plan also will pay toward the cost of a hearing aid for a pensioner. Payments for hearing aids are limited to \$350 every five years.

The durable medical equipment benefit is only payable after you have paid the annual deductible.

**This benefit is for pensioners only.** There is no dependent coverage for durable medical equipment or hearing aids.

## Vision Care

The Plan will pay a maximum of \$40 for 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 to get new eyeglasses more often than every 24 months. If you send the Plan written proof of this reason, your child may be eligible for the benefit more often.

## Annual Physical Examinations

For all pensioners and their dependents, the Plan will pay 100 percent of the cost of a routine annual physical examination when it is performed at a clinic contracted to the Plan that provides this service. There is no dependent coverage for annual physical exams performed at any other location. When the exam is not performed at a Plan-contracted clinic, the Plan will pay for annual physical examinations for pensioners in the same way it pays for other outpatient services.

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

## DOES THE PLAN PAY FOR PRESCRIPTION DRUGS?

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

The Pharmacy Benefit Manager 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 the mail order service. 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, and will not pay for certain prescriptions if it determines there is a pattern of abuse. 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.

Before you can receive prescription drug benefits, you must first pay a \$100 annual deductible. This deductible is in addition to the health care annual deductible.

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-pay 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. For more information about placing mail orders you should contact the Pharmacy Benefit Manager.

### **PRESCRIPTION DRUG CO-PAY AMOUNTS**

<b>PURCHASE</b>	<b>CO-PAY AMOUNT</b>
Generic Drugs Retail	\$10
Generic Maintenance Drugs Retail (beginning with 3 <sup>rd</sup> 30-day supply)	\$30
Generic Maintenance Drugs Mail Order ( <i>90-day supply</i> )	\$20
Brand-name Drugs Retail included on Formulary (30-day supply)	\$25
Brand-name Drugs Retail not included on Formulary (30-day supply)	\$50

PURCHASE	CO-PAY AMOUNT
Brand-name Maintenance Drugs Retail included on Formulary (beginning with 3 <sup>rd</sup> 30-day supply)	\$75
Brand-name Maintenance Drugs Retail not included on Formulary (beginning with 3 <sup>rd</sup> 30-day supply)	\$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 the Pharmacy Benefit Manager, 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.

## DOES THE PLAN PAY FOR DENTAL CARE?

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For all pensioners, the Plan will pay toward the cost of dentures and extractions. 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 once every five years. In addition, the Plan will pay the scheduled amount for extractions. Many dental providers participate in the Network. You may save money by using an In-Network provider. **There is no dependent coverage for dental care.**

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?

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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?

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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 lymph edema. 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?

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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 HAPPENS IN THE EVENT OF AN OVERPAYMENT OF A CLAIM?

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In the event that the Plan inadvertently pays a health care provider more than they are entitled to under the rules of the Plan for a service that you received, the Plan will ask the provider for a refund. If the provider refuses to refund the overpayment, the Plan has the right to deduct the overpaid amount from a future payment to the same provider for services provided to you.

## WHAT IF MY SPOUSE OR I HAVE OTHER HEALTH INSURANCE?

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- If you or your spouse are covered under employer provided health insurance, that insurer must pay benefits before the Plan will pay benefits.
- If you or your spouse is a patient covered under Medicare, 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.

## HOW CAN I REDUCE MY OUT OF POCKET COST?

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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 copayments 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, 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 contact the telephone number on your ID card.

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

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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. For information, you may contact the Plan office or call the Network at the telephone number on your ID card.

## HOW DO I APPLY FOR HEALTH CARE BENEFITS?

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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 your child is between the ages of 19 and 26, you must also complete and return the "Enrollment Form and Affidavit for Dependent Child." This form is available at [www.seafarers.org](http://www.seafarers.org) under the Member Benefits section, or you can contact the Plan to request a copy of the form.

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](http://www.seafarers.org)

If you are **not** 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.

- When you use a Network provider you do not have to file a claim with the Plan. The provider will file the claim for you.
- 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 Plan. 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 this address.**

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

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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 occurred while committing a crime.
- The Plan will not pay benefits 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.
- The Plan will not pay benefits 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 for which you were not responsible.
- The Plan will not pay benefits if your illness or injury is due to alcohol or drug use.
- The Plan may not pay benefits 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.

- The Plan will not pay benefits for treatment which is not approved for use in the United States or is considered to be experimental.
- The Plan does not provide benefits for organ and tissue transplants for pensioners or their dependents.
- The Plan will not pay benefits for bariatric surgery, gender orientation surgery, or any related treatment.
- The Plan will not pay benefits for prescriptions for weight loss or for services of a dietician except it will pay for nutritional counseling for diabetics.
- The Plan will not pay benefits for the diagnosis or treatment of infertility.
- The Plan will not pay benefits for sterilization or for contraceptives.
- 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.
- The Plan will not pay to obtain any records or paperwork needed to pay a claim.
- The Plan will not pay benefits on a claim if the medical records are insufficient, or if the records appear to be altered or fraudulent.
- Benefits will not be paid by the Plan if they can be paid under Workers' Compensation or another health and safety law.
- Benefits will not be paid for treatment in a government hospital, where by law, the Plan is not required to pay.
- Benefits will not be paid for treatment that is needed because of war, an act of war, or because you were in the military.
- Benefits will not be paid for treatment which is cosmetic. However, the Plan will pay for breast reconstruction following cancer treatment.
- Benefits will not be paid for custodial care. Confinement in a hospital or nursing facility is considered custodial care if the confinement is not medically necessary.
- Benefits will not be paid 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.
- The Plan does not pay for occupational, rehabilitative, or speech therapy.
- The Plan does not pay for chiropractic treatment.
- The Plan will pay no more than \$1,500 per year for pain management services.
- The Plan does not pay for acupuncture.
- Pre-Existing Conditions—The Plan will not pay for the treatment of any condition for which you sought treatment within six months before you were covered by the Plan until you have been a participant for at least 12 months. However, this 12-month period will be reduced if you had other health care coverage immediately before you become a participant in the Plan with a break of 63 days or less between coverage. This pre-existing condition exclusion does not apply to children under the age of 19. Beginning in 2014, this exclusion will no longer apply to any participants. For more information concerning your right to coverage you can contact the Plan at: 1-800-252-4674.
- The Plan does not pay for cardiac rehabilitation.

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

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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 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?

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If you are a Pensioner and you decide to go back to work in the maritime industry, 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 26 of this booklet.

You will re-establish eligibility for the benefits of an active employee once you have 125 days of covered employment within 12 months. If you do not work at least 125 days within your first 12 months after returning to covered employment, in order to become eligible for benefits you will need 125 days of covered employment in the previous calendar year, and one day of covered employment in the 6 months before the date of your medical service. 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?

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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?

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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 can request a review by the Plan. 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 claim will be reviewed by the Trustees. They will look at all proof that they receive from you or anyone else. If medical review is necessary to make a decision about your claim, the Trustees will refer your appeal to an appropriate specialist for a medical opinion. After completing their review, the Trustees will make their final decision. Your written appeal should be sent to:

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

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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?

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If the Trustees decide to make any changes to your benefits, the Plan will notify you by mailing a notice to your home address. If you prefer to receive notices from the Plan by e-mail, you must give the Plan permission to communicate with you by e-mail, and provide your e-mail address. A form is available at [www.seafarers.org](http://www.seafarers.org) under the Member Benefits section which you can fill out and return to the Plan, or you can contact the Plan to request a copy of this form.

## WHAT PRIVACY RIGHTS DO I HAVE?

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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. These rights include:

- The right to request restrictions on certain uses and disclosures of your protected health information.
- The right to receive confidential communications of your protected health information.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to an accounting of disclosures of your protected health information. In addition, you have the right to receive a printed copy of the Plan's Privacy Notice. If you do not already have a copy of the Privacy Notice, you can obtain one 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?

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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?

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As a participant in the Plan, you have certain rights under the Employee Retirement Income Security Act of 1974 and other laws that govern employee benefit plans. These rights include:

- The right to receive information about the Plan.
- The right to inspect Plan documents at the Plan's office.
- The right to receive copies of Plan documents for a small copying fee.
- The right to receive a listing of signatory employers when requested in writing.
- The right to receive a summary of the Plan's financial report.
- The right not to be penalized or discriminated against by the Trustees of the Plan when you are applying for benefits.
- The right to 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.
- The right to continue health care coverage for yourself, 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 C.O.B.R.A. 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 Ave. N.W.  
Washington, D.C. 20210

**The following is a copy of the notice that you or your dependent will receive if a qualifying event occurs that results in the loss of health coverage. If you lose eligibility, and do not receive a copy of this COBRA notice please contact the Plan immediately at: 1-800-252-4674.**

## NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

### **What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage (COBRA) is the same health coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. (However, individuals receiving continuation coverage are not eligible for sickness and

accident benefits or scholarship benefits. Also, time when a former employee is receiving continuation coverage does not count as "covered employment" to qualify for death benefits.) Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from:

Seafarers Health and Benefits Plan  
5201 Auth Way  
Camp Springs, Maryland 20746

### **How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or loss of eligibility, coverage generally may be continued for up to 18 months. In the case of loss of coverage due to an employee's death, divorce, or the employee becomes entitled to Medicare benefits or a dependent child ceases to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### **How can you extend the length of continuation coverage?**

If you elect continuation coverage and the maximum period is less than 36 months, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Seafarers Health and Benefits Plan of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

#### *Disability*

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify Seafarers Health and Benefits Plan of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Seafarers Health and Benefits Plan of that fact within 30 days of SSA's determination.

## *Second Qualifying Event*

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee or divorce from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify Seafarers Health and Benefits Plan within 60 days after a second qualifying event occurs.

### **How can you elect continuation coverage?**

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children. Continuation coverage may be elected for only one, several or for all dependent children who are qualified beneficiaries. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

### **How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

## **When and how must payment for continuation coverage be made?**

### *First payment for continuation coverage*

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Seafarers Health and Benefits Plan to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:  
Seafarers Health and Benefits Plan  
P.O. Box 380  
Piney Point, Maryland 20674

### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

### *Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:  
Seafarers Health and Benefits Plan  
P.O. Box 380  
Piney Point, Maryland 20674

### **For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from:

Membership Assistance Program  
Seafarers Health and Benefits Plan  
5201 Auth Way  
Camp Springs, Maryland 20746

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.

### **Plan Contact Information:**

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