A GUIDE TO YOUR BENEFITS

FROM THE

SEAFARERS HEALTH AND BENEFITS PLAN

FOR PARTICIPANTS AT THE

UNLICENSED APPRENTICE PHASE 2

BENEFIT LEVEL

FEBRUARY 2016

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INTRODUCTION

This booklet describes the benefits available to you and your dependents from the Seafarers Health and Benefits Plan.

The Seafarers Health and Benefits Plan is a multi-employer employee benefit plan. It provides benefits to employees 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 employees. The Plan is funded through contributions made by these employers. The assets of the Plan are held in trust for the participants. As a participant in the Plan, you can depend on your benefits being there when you need them.

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

Apprentice—a participant in the Unlicensed Apprentice Program at the Seafarers Harry Lundeberg School of Seamanship.

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.

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 a dependent if the Plan has received a Qualified Medical Child Support Order which requires you to provide health coverage to your 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. If you get a divorce, your spouse is no longer eligible for coverage.

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.

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 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.

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.

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

The enrollment beneficiary card tells the Plan who you and your dependents are and where you can be contacted. 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 representative or from the Plan office at:

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

WHEN DO I FIRST BECOME ELIGIBLE TO RECEIVE BENEFITS?

You will become eligible for benefits when you begin your apprenticeship on board a vessel during Phase 2 of the Unlicensed Apprentice Program at the Seafarers Harry Lundeberg School of Seamanship.

Before you begin Phase 2 of the Unlicensed Apprentice Program, the Plan will send you an ID card. You should bring this card with you whenever you seek medical service. If you do not receive an ID card, please contact the Plan at 1-800-252-4674 to request a card.

WHEN WILL MY ELIGIBILITY FOR BENEFITS END?

Your eligibility for benefits will end when you complete Phase 2 of the Unlicensed Apprentice Program (time when you work as an apprentice on board a vessel). Phase 2 lasts approximately 90 days.

CAN I EXTEND MY ELIGIBILITY TO RECEIVE BENEFITS BY PAYING THE PREMIUMS MYSELF?

You can extend your eligibility to receive health care benefits through COBRA continuation coverage. Under certain conditions, and for a limited time, you can extend your eligibility for benefits by paying premiums yourself. The amount of these premiums is set by the Plan. The health benefits that you receive through COBRA will be identical to the benefits that you received as an apprentice.

You, your spouse, or dependent children, can extend eligibility to receive benefits, if certain events have happened.

These events include:

- You quit your job.
- You complete your time as an apprentice.
- You were laid off or fired from your job, unless you were fired for gross misconduct.

- You retire from your job before you are eligible for Medicare.
- You become disabled and are unable to work, but you are not yet eligible for Medicare.
- Your dependent child reached the age of 26.
- You get divorced and your spouse or dependent wants to continue receiving benefits.
- Upon your death, your spouse or dependent wants to continue receiving benefits.

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 your 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

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 that begins on the following page is a summary of the health care benefits covered by the Plan for you, your dependent spouse and your dependent children. For more details, please review the appropriate benefit description listed after the chart.

SEAFARERS HEALTH AND BENEFITS PLAN SUMMARY FOR APPRENTICES AND THEIR DEPENDENTS	
DESCRIPTION	**Benefit**
Hospital Room and Board	**Pre-certification required** In-network 100% Out-of-network 70% R&C Maximum of 31 days or $50,000 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.
Hospital Miscellaneous Extras	In-network 100% Out-of-network 70% R&C
Surgical, Inpatient	In-network 70% Out-of-network 65% R&C
Surgical, Outpatient	In-network 70% Out-of-network 65% R&C
Diagnostic Tests and X-rays, Inpatient Facility Fees	In-network 100% Out-of-network 70% R&C
Diagnostic Tests and X-rays, Professional Fees Inpatient/Outpatient	In-network 70% Out-of-network 65% R&C
Doctor's Visits, Inpatient	In-network 70% Out-of-network 65% R&C
Doctor's Visits, Outpatient	In-network 70% Out-of-network 65% R&C
Emergency Room Treatment	In-network 100% * Out-of-network 70% R&C $300 co-pay if treated for illness and not admitted to hospital Maximum of $5,000 for all charges per emergency room visit
Home Health/Home Nursing Care	Non-covered
Hospice Care	Non-covered
Physical Therapy	Non-covered
Organ and Tissue Transplants	Non-covered

SEAFARERS HEALTH AND BENEFITS PLAN SUMMARY FOR APPRENTICES AND THEIR DEPENDENTS - continued	
DESCRIPTION	**Benefit**
Vision Care	Non-covered
Dental Care	Non-covered
Prescription Drugs	70% of cost for Generic drugs @ Retail * 75% of cost for Generic drugs @ mail order *Generic prescriptions only; The Plan does not provide any benefits for the purchase of brand name drugs.* * *For 30 day supply*
Psychiatric Inpatient	Non-covered
Psychiatric Outpatient	Non-covered
Substance Abuse Detox	In-network 100%* Out-of-network 70% R&C* *For Apprentice Only; no coverage for dependents
Lifetime Limitation	None

The following health care benefits are covered by the Plan:

Hospital Room and Board

The Plan will pay 100 percent of the Network allowed charge for hospital room and board, for a maximum of 31 days, or $50,000 per illness (whichever comes first) if you or your eligible dependent is confined 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 31 days or $50,000 per illness, whichever comes first. Once you reach the limit of 31 days or $50,000 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

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.

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

The Plan will pay 100 percent of the Network allowed charge for hospital extras if you or your eligible dependent is confined in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge.

Once you reach the maximum of 31 days, or $50,000 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 for additional fees for hospital extras for the same illness.

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

Surgery

The Plan will pay 70 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.

Visits by Doctors and Specialists in the Hospital

The Plan will pay 70 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.

Emergency Room Treatment

The Plan will pay 100 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 70 percent of the reasonable and customary charge.

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.

The Plan will pay a maximum of $5,000 for all charges resulting from an emergency room visit.

Outpatient Doctor's Visits and Services

The Plan will pay 70 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. This benefit includes such services as: X-rays, lab work, and physical examinations. This Plan does not provide benefits for immunizations.

Podiatric Services

The Plan will pay for up to 20 visits per year for podiatric services, up to a maximum of $1,000 per year for all such services. This $1,000 maximum includes podiatric surgery.

Maternity Benefit

The Plan will pay 70 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.

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 benefits 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 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).

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. The Plan does not provide abortion benefits to the child of an apprentice.

WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?

The Plan provides benefits for generic prescription drugs to eligible apprentices and their dependents. 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.

The Plan provides prescription drug coverage through an arrangement with a Pharmacy Benefit Manager (PBM). 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 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-insurance payment each time you purchase prescription drugs. When you purchase a generic prescription at a retail pharmacy, you will be responsible for a co-insurance of 30% of the cost. You will save money if you purchase generic prescriptions through the mail order service. When you purchase through mail order, you will be responsible for co-insurance of 25% of the cost.

Although the Plan will not pay anything towards the cost of brand-name drugs, you will receive a discounted rate on these drugs when you use your prescription card. The discount will be greater when you use the mail order service.

Please note, this Plan does not provide benefits for specialty drugs. Specialty drugs are high cost medications that are used to treat chronic or life threatening conditions, and require special handling, monitoring or administration.

For more information about placing mail orders, or 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.

WHAT BENEFITS ARE AVAILABLE FOR THE TREATMENT OF SUBSTANCE ABUSE?

Inpatient Detoxification

The Plan will pay for inpatient detoxification in the same manner as all other hospital stays. The Plan will pay 100 percent of the Network allowed charge 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. This benefit is limited to $50,000 per hospital stay. This benefit is for apprentices only. **The Plan does not cover inpatient detoxification for dependents of apprentices.**

The Plan does not pay for follow-up treatment, or provide any other substance abuse benefits, for apprentices or their dependents.

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. 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 OR CHILD HAS OTHER HEALTH INSURANCE?

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

- If you were the patient, send the claim to the Network address listed on the back of your Network ID card. After your claim has been paid by the Seafarers Health and Benefits Plan, send the claim to your spouse's insurer. Be sure to include the Explanation of Benefits Statement you received when your claim was processed.

- If your spouse was the patient, send the claim to your spouse's insurer first. Once your spouse's insurer has processed the claim, send the claim to the Network at the address listed on the back of your Network ID card. Be sure to include the Explanation of Benefits Statement that was sent to you by your spouse's insurer.

- If your child was the patient, the insurer that should get the claim first is the insurer of the parent whose birthday comes earliest in the year. After an Explanation of Benefits statement has been received from the first insurer, you should then file a claim under the other parent's coverage. This rule may not apply if coverage is provided for under a Qualified Medical Child Support Order.

EXAMPLE: You are covered by the Seafarers Health and Benefits Plan and your spouse also has health insurance. Your birthday is May 3 and your spouse's birthday is April 4. Claims for your dependent children should first be sent to your spouse's insurance, since your spouse's birthday is earlier in the year.

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.

If your child has health benefits through his or her employment, that insurance coverage will be the primary payer for your child. After that insurance pays the claim, the claim may be submitted to this Plan for secondary payment, by sending the claim to the Network at the address on the back of your ID card.

If your spouse or child is eligible for Medicare, Medicare is the usually the primary payer for them. After Medicare pays the claim, it should be submitted to the Plan for secondary payment. However, if you (the employee) are eligible for Medicare, the Seafarers Health and Benefits Plan will pay benefits first for you and your dependents as long as you meet the Plan's eligibility requirements and you are actively engaged in covered employment.

HOW CAN I REDUCE MY OUT OF POCKET COST?

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-insurance. 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-insurance. 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. **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 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.

Send **all** 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 many 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: employee's Social Security number, patient's name, provider's name, address, and ID 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.**

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 reasons listed below.

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 you didn't 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 substance abuse treatment except for inpatient detoxification for apprentices;

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

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

- for organ and tissue transplants;

- for chemotherapy and radiation therapy;

- for the diagnosis or treatment of infertility;

- for sterilization;

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

- on a claim if the medical records 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 weight loss drugs or nutritional counseling, except it will pay for nutritional counseling for diabetics;

- for cardiac rehabilitation;

- for occupational, rehabilitative, or speech therapy;

- for chiropractic treatment or physical therapy;

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

- for acupuncture;

- for any benefit not specifically provided for in this booklet.

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 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, 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?

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. These rights include:

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 Privacy Notice. If you do not already have a copy of the Privacy Notice, 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. These rights include:

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 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 his/her 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 dependents will have to pay for this coverage. Review the section of this booklet about COBRA continuation coverage for more information.
- 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

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.

Note: The Notice below refers to the "employee" losing coverage. The "employee" in this case is the Apprentice.

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