IMPORTANT NOTICE

October, 2009

Dear Participant:

If you plan to retire in the near future, please consult the “Guide to Your Benefits from the Seafarers Health and Benefits Plan for Participants who are Receiving Retirement Benefits from the Seafarers Pension Plan” for information about pensioners’ eligibility for health benefits.

Sincerely,

Margaret R. Bowen
Administrator
May 28, 2008

Dear Participant:

We are pleased to announce that the Seafarers Health and Benefits Plan Trustees, at a recent board meeting, have decided to change the eligibility rules. **Beginning January 1, 2008, to be eligible for benefits, you must have 125 days of covered employment in calendar year 2007.** The one (1) day in six (6) months rule is still in effect.

This change is a result of many factors. The Plan has experienced a positive change in its financial situation over the past two years due to the benefit changes instituted in 2005, the use of a medical and dental network, and the stabilization of medical costs. The Trustees also took into consideration the appeals that participants have made indicating that due to shipping rotations they were unable to achieve the 150 days needed to maintain their eligibility.

If you had at least 125 days of covered employment during 2007 and had claims denied due to lack of eligibility, please resubmit them to the claims office. If you have any questions please call 1-800-252-4674.

Sincerely,

BOARD OF TRUSTEES
A GUIDE TO YOUR BENEFITS
FROM THE
SEAFARERS HEALTH AND BENEFITS PLAN
FOR PARTICIPANTS AT THE
BASIC, CORE, AND
CORE - PLUS
BENEFIT LEVELS

August 2006
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INTRODUCTION

This booklet describes the benefits available to you from the Seafarers Health and Benefits Plan. It was written for you and others who are participants in the 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, Atlantic, Gulf, Lakes, and Inland Waters District-National Maritime Union 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 always 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.

For disabled participants, this booklet is also available in large print and audiocassette 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

The information in this booklet is very important. Make sure you completely understand this information.

This booklet is only a summary of the Seafarers Health and Benefits Plan. 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

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  Michael DiPrisco
Ambrose Cucinotta  Todd Johnson
David Heindel  Thomas Murphy
Nicholas Marrone  Anthony Naccarato
Thomas Orzechowski  William Pagendarm
Joseph Soresi  Robert Rogers
George Tricker  Jordan Truchan

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.
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.

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 unmarried child is a covered dependent, if he or she is your natural, adopted, foster, or step-child, and is under the age of 19. Your dependent child must receive most of his or her support from you and your spouse. If your dependent child is not your natural or adopted child, he or she must have lived with you for the 12 months before you applied for dependent benefits. If he or she is a full time student in a college program that leads to a baccalaureate or higher degree, your dependent child will remain covered by the Plan until he or she reaches age 25. Even if your child does not receive all of his or her support from you, your child may be your dependent if they are under the age of 19, and the Plan has received a Qualified Medical Child Support Order.

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

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

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

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

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

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.

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?

The enrollment beneficiary card tells the Plan who you and your dependents are. It also tells the 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.

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. 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
P.O. Box 380
Piney Point, Maryland 20674

WHEN DO I FIRST BECOME ELIGIBLE TO RECEIVE BENEFITS?

Upon beginning work as a new employee with an employer who pays into the Seafarers Health and Benefits Plan on your behalf, you will become eligible for benefits after you have gained initial eligibility.

Initial eligibility requirements are met after you have completed 75 days of covered employment in a calendar year or after you have completed 75 days of continuous covered employment. In meeting initial eligibility requirements, covered employment means only the days that you work for an employer who pays into the Plan for your benefits. You may use initial eligibility to qualify for benefits only once during your lifetime when you are a new employee.

If you reach your 75th day of employment on or before June 30 of a calendar year, you will be eligible to receive benefits for the remainder of that year. If you reach your 75th day of employment between July 1 and December 31 of a calendar year, you will be eligible to receive benefits for the remainder of that year and the following calendar year. However, you must have credit for at least one
day of covered employment either in the six calendar months just before the date of your claim, or in
the same month as your claim, as long as it is before the actual date of your claim.

**WHAT MUST I DO TO REMAIN ELIGIBLE FOR BENEFITS?**

Effective January 1, 2008, in order to maintain your eligibility, you must have credit for at least 150
days of covered employment in the calendar year before the date of your claim.

Effective January 1, 2006 and during calendar year 2007, to maintain your eligibility, you must have
credit for at least 125 days of covered employment in the calendar year before the date of your claim. Also,
you must have credit for at least one day of covered employment either in the six calendar months just before
the date of your claim, or in the same month as your claim, as long as it is before the actual date of your claim.

During 2006 and 2007, to be eligible for prescription coverage you must have credit for at least 125 days
of covered employment in the calendar year before the date of your claim.

Effective January 1, 2008, to be eligible for prescription drug coverage, you must have credit for at
least 150 days of covered employment in the calendar year before the date of your claim.

**TO MAINTAIN MY ELIGIBILITY, WHAT DAYS CAN BE COUNTED AS COVERED EMPLOYMENT?**

To maintain your eligibility, the following days can be counted as covered employment:

- Days you worked for an employer who is 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 eligi-
  ble for Seafarers Health and Benefits Plan benefits at the time your disability began and your
  employer must be paying the appropriate contribution rate to the Plan.
- One half of the days you attended an approved 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. Beginning with 2007, a year of service is a calendar year during which
  you worked at least 150 days for a signatory employer. During 2005 and 2006, a year of serv-
  ice is a calendar year during which you worked for at least 125 days for a signatory employer.
  For years before 2005, a year of service is a calendar year during which you worked for at least
  120 days for a signatory employer.

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You may build up a reserve of as much as 90 S&A days or days of state disability as long as they were not used to extend your eligibility. This reserve may be saved for up to three years from the year in which the S&A or state disability benefits were paid. This reserve can be used only once regardless of how many days are needed to maintain your eligibility. In this way, you may use S&A benefits or state disability benefits you received to extend your eligibility in the future. However, you cannot use S&A days or days of state disability to qualify for additional Sickness and Accident benefits.

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

You can extend your eligibility to receive health care benefits through C.O.B.R.A. 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. 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 were laid off or fired from your job.
- 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 19 and is no longer able to get benefits from the Plan.
- You get divorced or legally separated, 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 eligibility by paying premiums yourself, contact the Plan at:

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

When your health coverage from the Plan ends for one of the reasons listed above, you are entitled to receive a Certificate of Creditable Coverage. The Plan will automatically send the Certificate to you if it is aware that your coverage ended. If you wish to request a Certificate, you may contact the Plan office.
WHAT IS THE ANNUAL DEDUCTIBLE AND HOW DOES IT WORK?

At all plan levels 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.

At the Basic and Core benefit levels, the amount of the annual deductible is $750 per person, but not more than $2,250 per family.

At the Core-Plus Level, the amount of the annual deductible is $500 per person, but not more than $1,500 per family.

All benefits are subject to the deductible except:
• Death benefits
• Accidental Dismemberment benefits
• Sickness and Accident benefits
• Inpatient Detoxification treatment
• 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 ARE BENEFIT LEVELS AND WHICH ONE WILL I RECEIVE?

The Plan pays benefits at three different benefit levels. These benefit levels are referred to as Basic, Core, and Core-Plus.

The level of benefits that you receive depends on the number of days of covered employment you have with certain employers in the calendar year before your claim. If you meet all the requirements for more than one benefit level you will receive the highest benefit level for which you qualify.

• Effective January 1, 2008, you will receive coverage at the Core-Plus Benefit level if you worked at least 150 days during the previous year for employers paying the contribution rate for either Core or Core-Plus benefits and at least 90 of these days were for employers paying the contribution rate for Core-Plus benefits. In 2006 and 2007, you will receive coverage at the Core-Plus benefit level if you worked at least 125 days during the previous year for employers paying the contribution rate for either Core or Core-Plus benefits and at least 90 of these days were for employers paying the contribution rate for Core-Plus benefits.

• Effective January 1, 2008, you will receive coverage at the Core Benefit level if you worked at least 150 days during the previous year for employers paying the contribution rate for either Core or Core-Plus benefits and less than 90 of these days were for employers paying the con-
tribution rate for Core-Plus benefits. In 2006 and 2007, you will receive coverage at the Core benefit level if you worked at least 125 days during the previous year for employers paying the contribution rate for either Core or Core-Plus benefits and less than 90 of these days were for employers paying the contribution rate for Core-Plus benefits.

- Effective January 1, 2008, you will receive coverage at the Basic Benefit level if you worked at least 150 days during the previous year for employers paying the contribution rate for Basic, Core or Core-Plus benefits and the majority of these days were for employers paying the contribution rate for Basic benefits. In 2006 and 2007, you will receive coverage at the Basic benefit level if you worked at least 125 days during the previous year for employers paying the contribution rate for Basic, Core, or Core-Plus benefits and the majority of these days were for employers paying the contribution rate for Basic benefits.

- If you are a new employee and you meet the initial eligibility requirement of 75 days, the level of benefits that you will receive is determined by the contribution rate paid by the employers for which you worked the majority of these days.

- If you are working for an inland employer, the rules above apply; except that if your level of benefits increase due to a change in the contract between the Union and your employer, you will immediately receive the higher level of benefits.

- You will receive coverage at benefit Level N if you were an eligible participant in the NMU Welfare Plan on June 30, 2001. If you were not eligible to receive benefits from either the Seafarers Health and Benefits Plan or the NMU Welfare Plan on June 30, 2001, but you were a participant in the NMU Welfare Plan on June 30, 2000, you are a participant in the NMU Welfare Plan. You also are a participant in Plan Level N if the NMU Plan was the first plan under which you established eligibility for benefits. Level N benefits are not described in this booklet. To obtain a booklet describing Level N benefits you should contact the Plan office.

**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 following health care benefits are covered by the Plan:

**Hospital Room and Board**

The Plan will pay toward the cost of semi private room and board, while you are confined in a hospital. At the Basic, Core, and Core-Plus benefit levels, payments for hospital charges are subject to a $450 admission deductible. You are only required to pay this $450 deductible once for an entire hospital stay.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 100% of the Network allowed charge for confinement in a Network facility. If confined in a non-network facility, the Plan will pay 70% of the reasonable and customary charge.

**Intensive Care**

The Plan will pay toward the cost of confinement in an intensive care unit. Intensive care units include: cardiac care units, burn units, and other special care units. Also, the Plan will pay for inten-
sive care confinements of up to 15 days. Beginning with the 16th day, confinements are covered in the same way as hospital room and board. At the Basic, Core, and Core-Plus benefit levels, payments for hospital charges are subject to a $450 admission deductible, unless this deductible was already satisfied by paying other hospital charges.

At the Basic, Core, and Core-Plus benefit levels, 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.

**Hospital Extras**

The Plan will pay toward the cost of hospital extras while you are confined to a hospital. Hospital extras include such things as: operating room charges, x-rays, oxygen, dressings, and drugs. At the Basic, Core, and Core-Plus benefit levels, payments for hospital charges are subject to a $450 admission deductible, unless this deductible was already satisfied by paying other hospital charges.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 100 percent of the Network allowed charge for hospital extras while confined in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge.

**Surgery**

The Plan will pay toward the cost of a surgeon and other members of the surgical team. 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.

At the Basic, Core, and Core-Plus benefit levels, 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% of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

**Visits by Doctors and Specialists in the Hospital**

The Plan will pay toward the cost of doctor’s visits while you are in the hospital.

At the Basic, Core, and Core-Plus benefit levels, 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.

**Emergency Treatment**

The Plan will pay toward the cost of emergency treatment. 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.

At the Basic, Core, and Core-Plus benefit levels, 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% of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.
Outpatient Doctor’s Visits and Services
The Plan will pay toward the cost of outpatient doctor's visits. This benefit includes such services as: X-rays, lab work, immunizations and physical examinations.

At the Core and Core-Plus benefit levels both you and your dependents are covered for outpatient services. Only you are covered for outpatient services at the Basic benefit level. There is no dependent coverage at the Basic benefit level.

At the Basic, Core, and Core-Plus benefit levels, 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.

Physical Therapy
For employees only, the Plan will pay toward the cost of physical therapy. There is no dependent coverage for physical therapy. Payments for physical therapy are limited to twenty visits during a calendar year.

At the Basic, Core, and Core-Plus benefit levels, 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.

Maternity Benefit
The Plan will pay toward the cost of childbirth for you or your eligible spouse. This benefit is to pay the doctor's charge for delivery. Charges for hospital room and board, hospital extras, and emergency 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.

At the Basic, Core, and Core-Plus benefit levels, 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.

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
At the Basic, Core, and Core-Plus benefit levels, the Plan will pay toward the cost of an elective abortion. If you or your spouse choose to have an abortion, and it is not medically necessary, the Plan will pay for no more than one such abortion during a 12-month period. After you have paid the annual deductible, the Plan will pay the cost of an elective abortion up to a maximum of $300 including all related charges. 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.
Transportation by Ambulance

The Plan will pay toward the cost of transportation by ambulance when medically necessary. When an air ambulance is used, the Plan will pay no more than the cost of transporting the patient the same number of miles by ground ambulance.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 80 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

Home Health Care

The Plan will pay toward the cost of health care services that you or your dependents receive at home. To receive this benefit, home care must begin within 14 days following a hospital confinement of at least two days. Services must be provided by an approved home health agency and they must be medically necessary.

At the Core and Core-Plus benefit levels both you and your dependents are covered for home health care. Only you are covered for home health care at the Basic benefit level. There is no dependent coverage at the Basic benefit level.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 100 percent of the daily reasonable and customary cost for home care, but not more than the average cost of a semi-private hospital room plus $50 per day. Benefits are payable only after you have paid the annual deductible.

The Plan will pay no more than $10,000 in combined home health care and hospice care services for you and also for each of your dependents (at the Core and Core-Plus benefit levels) during each of your lifetimes. Included in this lifetime limitation is a $2,000 per year limit on payments for private duty nursing.

Hospice Care

The Plan will pay toward the cost of hospice care if you or your dependent is not expected to live for more than six months. Services must be provided by an approved hospice provider.

At the Core and Core-Plus benefit levels, both you and your dependents are covered for hospice care. Only you are covered for hospice care at the Basic benefit level. There is no dependent coverage at the Basic benefit level.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 80 percent of the daily reasonable and customary cost for hospice care.

The Plan will pay no more than $10,000 in combined home health care and hospice care services for you and also for each of your dependents (at the Core and Core-Plus benefit levels) during each of your lifetimes. Included in this lifetime limitation is a $2,000 per year limit on payments for private duty nursing.

Durable Medical Equipment

For employees only, the Plan will pay toward the reasonable and customary charge for durable medical equipment. There is no dependent coverage for durable medical equipment. Durable medical equipment includes such things as prosthetic devises, medical appliances and other durables. However, the Plan will not pay to maintain or repair durable medical equipment.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 70 percent of the reasonable and customary charge for durable medical equipment after you have paid the annual deductible. However, if your illness or injury was caused by your job, the Plan will pay only 50 percent of the reasonable and customary cost of durable medical equipment. The Plan also will pay toward the cost of a hearing aid. Payments for hearing aids are limited to $350 every five years. Benefits are payable only after you have paid the annual deductible.
paid the annual deductible.

Durable medical equipment benefits over $1,000 if purchased or over $500 per month if rented, must first be approved by the Board of Trustees. 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 also must include the estimated cost of the equipment.

**Vision Care**

The Plan will pay toward the actual cost of vision care. Vision care services include eye examinations, eyeglasses, and contact lenses. Vision care benefits are available once every 24 months.

There may be a medical reason for you or your dependent to get new eyeglasses more often than every 24 months. If you send the Plan written proof of this reason, you or your dependent can get eyeglasses more often.

For employees and dependents at the Core-Plus benefit level, the Plan will pay a maximum of $200 in vision care charges during a 24-month period. For eligible employees at the Basic and Core benefit levels, the Plan will pay a maximum of $125 in vision care charges during a 24-month period. For dependents at the Basic and Core benefit levels, the Plan will pay a maximum of $40 in vision care charges during a 24-month period.

**Annual Physical Examinations**

For each employee and dependent the Plan will pay toward the cost of a routine physical examination once every twelve months.

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay 100 percent of the cost of a routine physical examination when it is performed at a clinic that is contracted to the Plan. When not performed at a Plan clinic, 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.

To arrange for a routine 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?**

At the Core-Plus benefit level, both you and your dependents receive prescription drug coverage. Only you receive prescription drug coverage at the Basic and Core benefit levels. There is no dependent coverage at these levels.

The Plan provides prescription drug coverage through an arrangement with a Pharmacy Benefit Manager. 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 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.

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. At the Core-Plus benefit level the prescription drug annual deductible is limited to $200 per family.
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 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

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<thead>
<tr>
<th>PURCHASE</th>
<th>CO-PAY AMOUNT</th>
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<tbody>
<tr>
<td>Generic Drugs Retail</td>
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<tr>
<td>Generic Maintenance Drugs Retail (beginning with 3rd 30-day supply)</td>
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<tr>
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<tr>
<td>Brand-name Maintenance Drugs Retail included on Formulary (beginning with 3rd 30-day supply)</td>
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<tr>
<td>Brand-name Drugs Retail not included on Formulary</td>
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<td>Brand-name Maintenance Drugs Retail not included on Formulary (beginning with 3rd 30-day supply)</td>
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<tr>
<td>Generic Maintenance Drugs Mail Order (90-day supply)</td>
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<td>Brand-name Maintenance Drugs Mail Order included on Formulary (90-day supply)</td>
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</tr>
<tr>
<td>Brand-name Maintenance Drugs Mail Order not included on Formulary (90-day supply)</td>
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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, or check the Member Benefits and Resources section of the Seafarers website at www.seafarers.org.
DOES THE PLAN PAY FOR DENTAL CARE?

At the Basic, Core, and Core-Plus benefit levels, the Plan will pay toward the cost of dental care. 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.

At the Basic benefit level, dental benefits are limited to $350 for each employee during a calendar year; the Plan does not provide dependent benefits at this level. There is no coverage for orthodontia at the Basic benefit level.

At the Core benefit level, dental benefits are limited to $350 for each employee or dependent during a calendar year. Payments for orthodontia are limited to $500 for each employee or dependent during his or her lifetime.

At the Core-Plus benefit level, dental benefits are limited to $750 for each employee or dependent during a calendar year. Payments for orthodontia are limited to $1,000 for each employee or dependent during his or her lifetime.

For information about the dental services that are covered by the Plan, or to request a copy of the 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 PSYCHIATRIC BENEFITS ARE AVAILABLE FROM THE PLAN?

Psychiatric Hospitalization
For employees only, the Plan will pay toward the cost of confinement in a psychiatric facility. This benefit is limited to 30 days in a 12-month period. At the Basic, Core, and Core-Plus benefit levels, payments for psychiatric facility charges are subject to a $450 admission deductible.

At the Basic, Core, and Core-Plus benefit levels, 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.

Outpatient Psychiatric Services
At the Basic, Core, and Core-Plus benefit levels, the Plan will pay toward the cost of outpatient psychiatric services for employees only. This benefit is limited to 10 visits in a 12-month period.

When a Network provider is used, the Plan will first determine 40 percent of the Network allowed charge and then pay 80% of that amount. When a non-Network provider is used, the Plan will first determine 40 percent of the reasonable and customary charge and then pay 65 percent of that amount. Benefits are payable only after you have paid the annual deductible.
WHAT BENEFITS ARE AVAILABLE FOR THE TREATMENT OF SUBSTANCE ABUSE?

For employees only, the Plan will pay toward the cost of up to five days of inpatient detoxification. At the Basic, Core, and Core-Plus benefit levels, payments for inpatient detoxification charges are subject to a $450 admission deductible.

At the Basic, Core, and Core-Plus benefit levels, 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.

The Plan will pay for inpatient detoxification on only one occasion. However, if you enter follow-up treatment within seven days of completing the initial detoxification you will be eligible for one additional inpatient detoxification. The Plan will only pay for a second inpatient treatment if you enter follow-up treatment within seven days of completing the second inpatient detoxification. In addition, at least twelve months must pass between the first and second inpatient detoxification treatments.

The Plan also provides for group treatment in a residential setting at the Seafarers Addictions Rehabilitation Center in Valley Lee, Maryland. Treatment at the SARC is available free of charge to eligible employees. To arrange for substance abuse treatment at the SARC in Valley Lee, Maryland, including transportation arrangements, contact your local Plan representative.

WHAT IS THE LONG TERM DISABILITY BENEFIT?

If you remain disabled after your eligibility for benefits has ended, you can continue to receive medical benefits for the injury or illness that disabled you. This coverage can continue for up to 26 weeks following your last day of eligibility.

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 lymph edema. These benefits are provided to both employees and dependents. The same limitations and deductibles that apply to other benefits apply to these mastectomy-related services. For more information, call the Plan at 1-800-252-4674.

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

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

If you are successful in having the bill corrected, you should contact the Plan office. After verifying the correction, the Plan will pay you a bonus. The bonus is equal to 25 percent of the amount you saved the Plan, up to a maximum bonus of $500.
WHAT IF MY SPOUSE HAS 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 Seafarers Health and Benefits Plan first. 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, file a claim with the Seafarers Health and Benefits Plan. 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 a participant is eligible for Medicare, the Seafarers Health and Benefits Plan will pay benefits first, as long as the employee is engaged in covered employment.

HOW CAN I REDUCE MY OUT OF POCKET COST?

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. In the case of hospital facility charges, the Plan pays a lower percentage for non-network providers. You can reduce your out of pocket cost by using network providers. For more information about the Network, you may contact the Plan office or check the Member Benefits and Resources section of the Seafarers website at www.seafarers.org.

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 information, you may contact the Plan office or check the Member Benefits and Resources section of the Seafarers website at www.seafarers.org.

**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 and Resources section of the Seafarers website at www.seafarers.org.

- 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.
- 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: employee'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.

Send claims to: Seafarers Health and Benefits Plan
P. O. Box 380
Piney Point, Maryland 20674

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

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

- The Plan will not pay benefits if your illness or injury is due to your involvement in a riot or 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.
- The Plan will not pay benefits if your illness or injury is due to behavior that showed you didn't care if you became sick or injured.
- 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.
- At the Basic benefit level the Plan will not pay benefits for organ and tissue transplants. At the Core benefit level the Plan will pay a maximum of $50,000 for autologous bone marrow transplants during the lifetime of a participant. No other organ or tissue transplants are covered at the Core benefit level. At the Core-Plus benefit level the Plan will pay a maximum of $150,000 for organ and tissue transplants during the lifetime of a participant. This $150,000 limit includes any benefits for autologous bone marrow transplants.
- The Plan will not pay benefits for bariatric surgery, gender orientation surgery, or any related treatment.
- 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.
- 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.
- 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.
- **Pre-Existing Conditions**—Until you have been a participant for at least 12 months, 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. 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. For more information concerning your right
to coverage you can contact the Plan at: 1-800-252-4674.

- During the lifetime of a participant, the Plan will pay no more than $50,000 in covered expenses resulting from congenital anomalies.
- The Plan will pay no more than $2,000 per year for cardiac rehabilitation.

**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 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 BENEFITS CAN I RECEIVE FROM THE PLAN IF I BECOME DISABLED AND CAN NO LONGER WORK?**

At the Basic, Core, and Core-Plus benefit levels, employees who are unable to work because of illness or injury can receive Sickness and Accident (S&A) Benefits from the Plan.

You can receive S&A benefits for up to 273 days during any 12-month period. The 12-month period begins with the first day of your disability. The amount of the S&A Benefit is $25. In addition, the Plan will pay the FICA taxes due on the benefit to the Internal Revenue Service, on your behalf.

You can receive S&A Benefits only if you are not receiving Workers' Compensation, state disability payments, or Maintenance and Cure payments. You also cannot receive S&A Benefits if you are receiving wages or vacation pay from your employer.

S&A payments will start on the first day of your disability if your disability begins while you are in the hospital. If you are not in the hospital when your disability begins, your S&A payments will start on the fifth day of your disability. However, you must first be disabled for at least eight days to claim benefits.

Your S&A Benefits end when you are no longer disabled and can return to work. Your S&A benefits also will end if you begin receiving a pension from the Seafarers Pension Plan.

Although you may receive eligibility credit for days during which you were receiving S&A benefits, you cannot use days credited in this way to receive additional S&A Benefits.

**HOW DO I APPLY FOR SICKNESS AND ACCIDENT BENEFITS?**

To receive S&A Benefits, you must file an application form with the Plan. These forms can be obtained from your local representative or from the Plan's main office. You must also provide the Plan with written proof of your disability such as a letter from your doctor.

To receive S&A benefits, you must file an application within 60 days after your disability begins. If you are hospitalized, you must file your application within 60 days after you leave the hospital.
What Is the Standard Death Benefit?

Upon your death, your beneficiary can receive a Standard Death Benefit. At the Basic, Core, and Core-Plus benefit levels, the amount of the Standard Death Benefit is $5,000.

For your beneficiary to receive the Standard Death Benefit, you must have met the Plan’s requirements for maintaining eligibility (as described on page 5) during the two calendar years before your death.

The beneficiaries of employees who do not meet the requirements of the Standard Death Benefit may still receive a payment from the Plan. If you die within twelve months after your last day of covered employment, your beneficiary can receive a $500 death benefit.

A Standard Death Benefit is also available to the beneficiaries of pensioners. Information about this Pensioner Death Benefit can be found in the summary booklet for the Seafarers Pension Plan.

What Is the Graduated Death Benefit?

At the Basic, Core, and Core-Plus benefit levels, your beneficiary may receive a Graduated Death Benefit in addition to the Standard Death Benefit.

At the Basic and Core benefit levels, your beneficiary can receive a Graduated Death Benefit of $5,000 if you met the Plan’s requirements for maintaining eligibility (as described on page 5) during each of the three calendar years before your death. For each additional year during which you met the Plan’s eligibility requirements, $2,500 is added to your Graduated Death Benefit. At the Basic and Core benefit levels, your beneficiary can receive a maximum Graduated Death Benefit of $15,000. Your beneficiary can receive up to $20,000 when the Graduated Death Benefit is paid together with the Standard Death Benefit.

At the Core-Plus benefit level, your beneficiary can receive a Graduated Death Benefit of $10,000, if you met the Plan’s requirements for maintaining eligibility (as described on page 5) during each of the three calendar years before your death. For each additional year during which you met the Plan’s eligibility requirements, $5,000 is added to your Graduated Death Benefit. At the Core-Plus benefit level, your beneficiary can receive a maximum Graduated Death Benefit of $45,000. Your beneficiary can receive up to $50,000 when the Graduated Death Benefit is paid together with the Standard Death Benefit.

Who Can Be My Beneficiary?

To claim the full amount of your death benefit, the beneficiary you have named must be a close relative. Your beneficiary may be any of the relatives from the following list:

- Spouse
- Child
- Grandchild
- Grandfather
- Grandmother
- Stepchild
- Mother
- Father
- Stepmother
- Stepfather
- Half sister
- Half brother
- Brother
- Sister
- Stepsister
- Stepbrother
- Nephew*
- Niece*

*Niece and nephew are defined as the children of the brother or sister of a deceased employee.
If the beneficiary you have named is not a listed relative, the maximum amount he or she can receive as a Death Benefit is $1,000. If you do not name a beneficiary, a maximum of $1,000 will be paid to your estate.

**WHAT IS THE FUNERAL EXPENSE DEDUCTION?**

If someone other than the government has paid for your funeral, the Plan will pay that person for the funeral expenses. The amount of this payment will be subtracted from the amount of the Death Benefit that your beneficiary will receive. The amount of funeral expenses that the Plan will pay is limited to $1,000. However, if you are buried at a Seafarers Health and Benefits Plan Cemetery, the maximum funeral expense deduction will be $5,000.

**HOW DOES MY BENEFICIARY APPLY FOR MY DEATH BENEFIT?**

To receive your death benefit, your beneficiary must file an Application for Death Benefits with the Plan. Your beneficiary can obtain an application from the Plan's main office.

They must include with the application an itemized funeral bill, paid or unpaid, and an official Certificate of Death.

Your beneficiary must apply for your death benefit within one year following your date of death.

If your beneficiary is not of legal age, your beneficiary's legal guardian must apply for your death benefit.

**WHAT BENEFITS CAN I RECEIVE IF I LOSE A LIMB OR MY EYESIGHT?**

The Plan provides an Accidental Dismemberment Benefit for eligible employees. Your loss must happen within 90 days of your injury and cannot be caused by an illness or be work related.

At the Basic, Core, and Core-Plus benefit levels you can receive a $2,500 benefit if you lose a hand, foot or the sight of an eye. If you lose any two, the Plan will pay you a maximum benefit of $5,000.

**HOW DO I APPLY FOR ACCIDENTAL DISMEMBERMENT BENEFITS?**

To receive this benefit you must file an Application for Dismemberment Benefits with the Plan. You can obtain an application from the Plan's main office. In addition to your application, you must send the Plan a doctor's statement as proof of your loss.
WHAT EDUCATIONAL BENEFITS DOES THE PLAN PROVIDE?

Each year the Plan awards a limited number of scholarships for use at colleges or vocational schools. At the Basic, Core, and Core-Plus benefit levels you, your spouse, and your dependent children may receive this benefit. Information about this important benefit can be found in the summary booklet for the Seafarers Scholarship Program.

To obtain a booklet you can contact the Plan at:
Seafarers Health and Benefits Plan
Attn: Scholarship
5201 Auth Way
Camp Springs, Maryland 20746
(301) 899-0675

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

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

A written explanation will be sent to you if the Plan denies your claim. If you believe that the Plan should have paid your claim, you 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. 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.

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:

- 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

WHAT RIGHTS DO I HAVE IF I LEAVE COVERED EMPLOYMENT TO PERFORM MILITARY SERVICE?

If you leave covered employment to perform military service, you have the right to continue health care coverage for you and your dependents for up to 24 months by paying premiums yourself.

Even if you choose not to continue coverage during your military service, you have the right to be reinstated in the Plan if you return to covered employment after your military service ends. However, you must return to covered employment within 90 days following a period of military service of not more than five years.

Upon returning to covered employment, your eligibility to receive benefits will be the same as it was when you left covered employment. Except for service-related illnesses and injuries, which are excluded from coverage, you will not be subject to the Plan’s waiting period for pre-existing conditions.

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
P.O. Box 380
Piney Point, Maryland 20674
1-800-252-4674

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:
• 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
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you are covered under a group health plan, the Seafarers Health and Benefits Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this booklet or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happen:

• Your days of covered employment are insufficient, or
• Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

• Your spouse dies;
• Your spouse’s days of covered employment are insufficient;
• Your spouse’s employment ends for any reason other than his or her gross misconduct;
• You become divorced.

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

• The parent-employee dies;
• The parent-employee’s days of covered employment are insufficient;
• The parent-employee’s employment ends for any reason other than his or her gross misconduct;
• The parents become divorced; or
• The child stops being eligible for coverage under the plan as a “dependent child.”
When is COBRA 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. When the qualifying event is the end of employment, or insufficient covered employment, or the death of the employee, the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce 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 notify the Plan at:

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

How is COBRA 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. When the qualifying event is the death of the employee, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment, or insufficient covered employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment, or insufficient covered employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.
Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. 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 nearest Regional or District Office of 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. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.

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 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

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