

A GUIDE TO YOUR BENEFITS
FROM THE
SEAFARERS HEALTH AND BENEFITS PLAN
FOR PARTICIPANTS AT THE
CORE-PLUS AND CORE BENEFIT LEVELS



July 2011

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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 District-NMU 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.

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	Gerald Carbiener
Ambrose Cucinotta	Michael DiPrisco
David Heindel	Todd Johnson
Nicholas Marrone	Thomas Murphy
Thomas Orzechowski	Anthony Naccarato
Joseph Soresi	William Pagendam
Chester Wheeler	Robert Rogers

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

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

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

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

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

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

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

WORDS YOU NEED TO UNDERSTAND

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

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

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

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

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

dependent child—Your child up to age 26 is a covered dependent if he or she is your natural, adopted, foster, or step-child. However, a child who is 19 or older will only be eligible for coverage if the child is not offered insurance through his or her employer. Your child may also be your dependent if the Plan has received a Qualified Medical Child Support Order which requires you to provide health coverage to the child.

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

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

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

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

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

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

preferred provider network—Doctors, hospitals, dentists and other health care providers that have agreed to provide Plan participants with health care services at a reduced cost. This Plan currently participates in the CIGNA network for all participants except for participants who reside in Puerto Rico. If you reside in Puerto Rico, please contact the Plan for information about your network. The Network logo is on your Plan ID card. You

must use this card whenever you visit an in-network health care provider in order to receive services at the reduced cost.

pharmacy benefits manager (PBM) – A company that provides pharmacy benefits either through a card that is used at a pharmacy, or through mail order. The Plan currently uses Prescriptions Solutions as its pharmacy benefits manager.

reasonable and customary charge—The amount allowed by the Plan for a medical treatment or service for a non-network provider. These amounts are determined by comparing amounts charged by other providers for the same service in the same area of the country.

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

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

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 that you want to enroll in the Plan. **If your dependent is between ages 19 and 26, you must also complete and return the “Enrollment Form and Affidavit for Dependent Child”.** This form is available at www.seafarers.org under the Member Benefits section, or you can contact the Plan to request a copy of this form.

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

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

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

Before the Plan will pay benefits for your dependent children, you must send the Plan an official copy of each child's birth certificate. For adopted children, the Plan will

need a copy of the adoption papers. For stepchildren, a copy of the custody award or other written proof will be required.

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

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

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.

Once you become eligible for benefits, the Plan will send you an ID card. You should bring this card with you whenever you seek medical service. If you think you are eligible for benefits, but have not received an ID card, please contact the Plan at: 1-800-252-4674 to request a card.

WHAT MUST I DO TO REMAIN ELIGIBLE FOR BENEFITS?

In order to maintain your eligibility for medical benefits, you must have credit for at least 125 days of covered employment in the calendar year before the date of your claim, and at least one day of covered employment any time in the six calendar months just before the date of your claim, as long as it is before the actual date of your claim.

In order to be eligible for prescription benefits, you must meet the same eligibility requirements described above with regard to the number of days needed in the previous year; **except that during the first six months of the calendar year only** there is a different requirement. During the period from January 1 through June 30, you will be eligible for prescription coverage if you have at least 90 days of covered employment by September 30 of the previous calendar year. You are not required to have one day of covered employment during the six months immediately before your claim in order to be eligible for prescription drug coverage. However, if you die while you are still an active employee, your dependents will remain eligible for prescription coverage for the same period of time as they remain eligible for medical coverage.

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 eligible for Seafarers Health and Benefits Plan benefits at the time your disability began based upon actual days of employment, and **your employer must be paying the appropriate contribution rate to the Plan.** Days when you receive Maintenance and Cure payments only count as covered employment at the Core-Plus benefit level. At the Core level, these days only count if your employer is remitting contributions on your behalf during this period. These days do not count to establish eligibility for Sickness and Accident benefits unless your employer makes contributions to the Plan on your behalf while you are receiving Maintenance and Cure or other disability payments described in this section.

- One half of the days you attended a qualified upgrading course at the Seafarers Harry Lundeberg School of Seamanship, as long as you successfully completed the course and met Seafarers Health and Benefits Plan eligibility requirements when you began attending the school.
- Days you received a Seafarers Scholarship Award.
- Days you received Sickness and Accident Benefits or state disability benefits. However, the maximum number of S&A days or days of state disability you can be credited with depends on your years of service.

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

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 at a time when you did not have enough days of actual employment. 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 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 active employee. However, individuals receiving COBRA are not eligible for Sickness & Accident benefits or scholarship benefits; and time when a former employee is receiving COBRA does not count towards qualifying for the graduated death benefit.

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, 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 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.

The following are the annual deductible amounts:

At the Core-Plus benefit level, the amount of the annual deductible is \$250 per person, but not more than \$750 per family.

At the Core benefit level, the amount of the annual deductible is \$375 per person, but not more than \$1,125 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 (including psychiatric inpatient), which have a separate co-payment
- 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?

This booklet describes two different benefit levels, Core-Plus and Core.

The level of benefits that you and your family will 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.

- You and your dependents 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-Plus or Core benefits and at least 90 of these days were for employers paying the contribution rate for Core-Plus benefits.
- You and your dependents will receive coverage at the Core benefit level if you worked at least 125 days during the previous year for employers paying contributions at the Core-Plus or Core rate, and **less than** 90 of these days were for employers paying the contribution rate for Core-Plus 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 increases due to a change in the contract between the Union and your employer, you will receive the higher level of benefits as of the effective date in the contract.

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 chart is a summary of the health care benefits covered by the Plan. For more details, please review the appropriate benefit description listed after the chart.

SEAFARERS HEALTH AND BENEFITS PLAN SUMMARY FOR CORE-PLUS AND CORE BENEFITS		
EFFECTIVE JUNE 1, 2011		
DESCRIPTION	Core-Plus	Core
Annual Deductible	\$250 Individual \$750 Family	\$375 Individual \$1,125 Family
Hospital Room and Board	In-network 100% Out-of-network 70% R&C \$450 in or out of network admission copayment Maximum of 180 days or \$1,000,000 per illness (whichever comes first) per hospitalization Intensive care - maximum of 15 days at the hospital's intensive care rate. Beginning with 16 th day, paid at semi-private room rate	In-network 100% Out-of-network 70% R&C \$450 in or out of network admission copayment Maximum of 180 days or \$1,000,000 per illness (whichever comes first) per hospitalization Intensive care - maximum of 15 days at the hospital's intensive care rate. Beginning with 16 th day, paid at semi-private room rate

*Subject to annual deductible

DESCRIPTION	Core-Plus	Core
Hospital Miscellaneous Extras	In-network 100% Out-of-network 70% R&C	In-network 100% Out-of-network 70% R&C
Surgical, Outpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Diagnostic Tests and X-rays, Inpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Diagnostic Tests and X-rays, Outpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Doctor's Visits, Inpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Doctor's Visits, Outpatient	In-network 80% * Out-of-network 65% R&C *	In-network 80% * Out-of-network 65% R&C *
Emergency Treatment	In-network 80% * Out-of-network 65% R&C * \$300 co-pay if treated for illness and not admitted to hospital	In-network 80% * Out-of-network 65% R&C * \$300 co-pay if treated for illness and not admitted to hospital
Home Health/Home Nursing Care Hospice Care	Home Health/Home Nursing: 100% R&C* Combined maximum of 60 visits a year (a visit is defined as 2 hours or less) with a maximum allowable charge of \$75 per hour for nurse or home health aide Hospice Care: 80% R&C	Home Health/Home Nursing: 100% R&C * Combined maximum of 60 visits a year (a visit is defined as 2 hours or less) with a maximum allowable charge of \$75 per hour for nurse or home health aide Hospice Care: 80% R&C
Physical Therapy	In-network 80% * Out-of-network 65% R&C * Limit 20 visits per year (Employee only)	In-network 80% * Out-of-network 65% R&C * Limit 20 visits per year (Employee only)
Organ and Tissue Transplants	In-network 80%* Out-of-network 65% R&C*	In-network 80%* for autologous bone marrow transplant only Out-of-network 65% R&C* for autologous bone marrow transplant only
Vision Care	\$200 Employee max in 24 months \$200 dependent max in 24 months	\$125 Employee max in 24 months \$40 dependent max in 24 months

*Subject to annual deductible

DESCRIPTION	Core-Plus	Core
Dental Care	\$750 dental maximum per year \$750,000 maximum per year for pediatric preventive dental care only \$1,000 orthodontia lifetime	\$350 dental maximum per year \$750,000 maximum per year for pediatric preventive dental care only \$500 orthodontia lifetime
Prescription Drugs	\$10-Generic @ Retail; \$25-Brand Name on Formulary @ Retail; \$50-Brand Name Not on Formulary @ Retail; for 30 day supply. <i>(Mail order also available at different co-pays).</i> \$100 deductible	\$10-Generic @ Retail; \$25-Brand Name on Formulary @ Retail; \$50-Brand Name Not on Formulary @ Retail; for 30 day supply. <i>(Mail order also available at different co-pays).</i> \$100 deductible <i>(Employee only)</i>
Sickness and Accident	39 weeks @ \$25 per day <i>(Employee only)</i>	39 weeks @ \$25 per day <i>(Employee only)</i>
Death Benefit	\$5,000 to \$50,000; <i>(\$1,000 maximum if you don't name a beneficiary or beneficiary is not in Plan's close relative category.)</i> <i>(Employee only)</i>	\$5,000 to \$20,000 <i>(\$1,000 maximum if you don't name a beneficiary or beneficiary is not in Plan's close relative category.)</i> <i>(Employee only)</i>
Accidental Dismemberment	\$2,500 to \$5,000 <i>(Employee only)</i>	\$2,500 to \$5,000 <i>(Employee only)</i>
Psychiatric Inpatient	Facility charge only - In-network 100% and Out-of-network 70% R&C \$450 admission co-payment 30 days maximum in 12 months <i>(Employee only)</i>	Facility charge only - In-network 100% and Out-of-network 70% R&C \$450 admission co-payment 30 days maximum in 12 months <i>(Employee only)</i>
Psychiatric Outpatient	In-network 80% of 40% of allowable* Out-of-network 65% of 40% of R&C * 10 visit maximum per year <i>(Employee only)</i>	In-network 80% of 40% of allowable* Out-of-network 65% of 40% of R&C * 10 visit maximum per year <i>(Employee only)</i>

*Subject to annual deductible

DESCRIPTION	Core-Plus	Core
Substance Abuse Detox	In-network 100%, Out-of-network 70% R&C 5 days inpatient (payable one time) \$450 admission co-payment <i>(Employee only; Benefit is for Detox only.)</i>	In-network 100%, Out-of-network 70% R&C 5 days inpatient (payable one time) \$450 admission co-payment <i>(Employee only; Benefit is for detox only.)</i>
Scholarship Program	Seafarers - 2-two year scholarships \$6,000 each, 1-four year scholarship \$20,000 Dependents - 5-four year scholarships \$20,000 each	Seafarers- 2-two year scholarships \$6,000 each, 1-four year scholarship \$20,000 Dependents - 5-four year scholarships \$20,000 each
Lifetime Limitation	None	None

*Subject to annual deductible

The following health care benefits are covered by the Plan:

Hospital Room and Board

At the Core-Plus and Core benefit levels, the Plan will pay 100 percent of the Network allowed charge for hospital room and board, for a maximum of 180 days, or \$1,000,000 per illness (whichever comes first) for confinement in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge for a maximum of 180 days, or \$1,000,000 per illness, whichever comes first. Once you reach the limit of 180 days or \$1,000,000 in benefit payments, you must be out of the hospital for at least 60 days before the Plan will pay additional hospital facility fees for your care for this illness. This limit applies to all facility-related fees, including hospital extras, described below.

Both you and your dependents have coverage for hospital room and board. Payments for hospital charges are subject to a \$450 admission co-payment. You are only required to pay this \$450 co-payment once for an entire hospital stay.

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

At the Core-Plus and Core benefit levels, 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.

Both you and your dependents have intensive care coverage. Payment for intensive care is subject to a \$450 admission co-payment, unless this payment was already satisfied by paying other hospital charges.

Hospital Extras

At the Core-Plus and Core 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. Once the maximum of 180 days, or \$1,000,000 in benefits per illness for all hospital facility-related fees (including hospital extras), you must be out of the hospital for at least 60 days before the Plan will pay for additional fees for hospital extras for this illness.

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

Both you and your dependents have coverage for hospital extras. Payment for hospital extras is subject to a \$450 admission co-payment, unless this payment was already satisfied by paying other hospital charges.

Surgery

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

Both you and your dependents have coverage for surgical benefits. Surgical benefits are payable only after you have paid the annual deductible.

Visits by Doctors and Specialists in the Hospital

At the Core-Plus and Core benefit levels, the Plan will pay 80 percent of the Network allowed charge for a doctor's visit in the hospital when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

Both you and your dependents have coverage for doctor's visits in the hospital. Benefits are payable only after you have paid the annual deductible.

Organ and Tissue Transplants

At the Core-Plus benefit level, the Plan will pay benefits for organ and tissue transplants. At the Core benefit level, the Plan only provides benefits for autologous bone marrow transplants. The Plan does not cover other organ and tissue transplants at the Core benefit level.

Both you and your dependents have coverage for organ and tissue transplants. Benefits are payable only after you have satisfied the annual deductible.

Emergency Treatment

At the Core-Plus and Core benefit levels, the Plan will pay 80 percent of the Network allowed charge for emergency treatment when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

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.

Both you and your dependents have coverage for emergency treatment. Benefits are payable only after you have paid the annual deductible.

Outpatient Doctor's Visits and Services

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

Both you and your dependents are covered for outpatient services. Benefits are payable only after you have paid the annual deductible.

Physical Therapy

The Plan will pay toward the cost of physical therapy for employees only. There is no dependent coverage for physical therapy. At the Core-Plus and Core 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. Payments for physical therapy are limited to twenty visits during a calendar year.

Maternity Benefit

At the Core-Plus and Core benefit levels, the Plan will pay 80 percent of the Network allowed charge for maternity benefits when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

This benefit is to pay the doctor's charge for delivery of a child born to **you or your spouse only**. The Plan does not provide maternity coverage to your child if she becomes pregnant. Charges for hospital room and board, hospital extras, and 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.

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).

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

Elective Abortion

At the Core-Plus and Core benefit levels, the Plan will pay toward the cost of an elective abortion for you or your spouse, up to a maximum of \$300, including all related charges. If the abortion is not medically necessary, the Plan will pay for no more than one such abortion during a 12-month period. If an abortion is needed to preserve the health of the mother, the Plan will pay in the same way as for any other medical condition. Benefits are payable only after you have paid the annual deductible.

Transportation by Ambulance

At the Core-Plus and Core benefit levels, the Plan will pay 80 percent of the Network allowed charge when a Network provider is used to transport a patient to the hospital, and transportation by ambulance is medically necessary. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for transportation by ambulance.

Both you and your dependents have coverage for ambulance transportation. Benefits are payable only after you have paid the annual deductible.

Home Health and Home Nursing Care

At the Core-Plus and Core benefit levels, the Plan will pay for a combined total of up to 60 visits per year for either home health care and/or home nursing care. A "visit" equals up to two hours of home health or home nursing services provided by a nurse or home health aide. The Plan will pay the cost for the services of a home health aide or nurse, up to a maximum of \$75.00 per hour. Other home health care services such as drugs and supplies are paid for at 100 percent of the reasonable and customary charge, up to the maximum daily rate. The maximum daily rate is the average daily rate of your prior hospital stay, plus \$50.

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

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

Hospice Care

At the Core-Plus and Core benefit levels, the Plan will pay 80 percent of the daily reasonable and customary cost for hospice care for you and your dependents. In order to be eligible for this benefit, a doctor must certify that you or your dependent is not expected to live for more than six months. Services must be provided by an approved hospice provider.

Durable Medical Equipment

At the Core-Plus and Core benefit levels, the Plan will pay 70 percent of the reasonable and customary charge for durable medical equipment for you. 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. Durable medical equipment includes such things as prosthetic devices, medical appliances, and other durables. The Plan will not pay to maintain or repair durable medical equipment.

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

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.

This benefit is for employees only. There is no dependent coverage for durable medical equipment. Benefits are payable only after you have paid the annual deductible.

Vision Care

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 Core benefit level, the Plan will pay a maximum of \$125 in vision care charges during a 24-month period. For dependents at the Core benefit level, the Plan will pay a maximum of \$40 in vision care charges during a 24-month period.

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 your dependent child who is under age 19 to receive vision services more often than every 24 months. If you send the Plan written proof of this reason, your child under age 19 may be eligible for this benefit more often.

Annual Physical Examinations

At the Core-Plus and Core 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 that provides this service. When not performed at a Plan clinic, the Plan will pay 80 percent of the Network allowed charge for an annual physical when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. For each employee and dependent, the Plan will pay toward the cost of a routine physical examination once every twelve months.

Both you and your dependents are eligible to receive this benefit. 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.

WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?

At the Core-Plus benefit level, both you and your dependents are entitled to receive prescription drug coverage. Only **you** receive prescription drug coverage at the Core benefit level. There is no dependent coverage for prescriptions at the Core benefit level.

The annual prescription deductible is \$100 per person, up to a maximum of \$200 per family at the Core-Plus benefit level. The annual prescription deductible is \$100 at the Core benefit level since there is no dependent coverage. This deductible is in addition to the health care annual deductible.

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

When your prescription is filled, you will receive a generic drug. Generic drugs are medications that are not a brand name medication, but by law must have the same active ingredients as the brand name medication, and are subject to the same standards as their brand name counterpart. Generic drugs usually cost less. If a generic drug is not available, your prescription will be filled with a brand-name drug. If you choose to buy a brand-name drug when a generic is available, the Plan will only pay the benefit it would have paid for the generic drug. Certain brand-name drugs are included on the "formulary" which is a list of drugs specified by the Pharmacy Benefit Manager. Drugs included on the formulary are widely available and reasonably priced. Drugs not included on the formulary are generally more expensive than those on the list, so your co-payment will be higher.

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

PRESCRIPTION DRUG CO-PAYMENT AMOUNTS

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

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

DOES THE PLAN PAY FOR DENTAL CARE?

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 Core-Plus benefit level, dental benefits are limited to \$750 for each employee or dependent during a calendar year, except for children under the age of 19. **During calendar year 2011, there is an annual limit of \$750,000 on pediatric preventive services for children until the child's 19th birthday.** According to law, this limit on pediatric preventive dental services will be increased to \$1,250,000 in 2012, and to \$2,000,000 in 2013. Beginning in 2014, there will be no limit on pediatric preventive dental services, unless there is a change in the law. The following services are considered to be **preventive** dental services:

- Periodic Oral Examination (includes soft tissue/oral cancer screening).
- Prophylaxis (teeth cleaning).
- Topical Fluoride Treatment.
- Fluoride Supplementation.
- Oral Health Education (includes tooth brushing/flossing instruction).
- Sealants.

Payments for orthodontia are limited to \$1,000 for each employee or dependent during his or her lifetime.

At the Core benefit level, dental benefits are limited to \$350 for each employee or dependent during a calendar year, except for children under the age of 19. **During calendar year 2011, there is an annual limit of \$750,000 on pediatric preventive services for children until the child's 19th birthday.** According to law, this limit on pediatric preventive dental services will be increased to \$1,250,000 in 2012, and to \$2,000,000 in 2013. Beginning in 2014, there will be no limit on pediatric preventive dental services, unless there is a change in the law. The following services are considered to be **preventive** dental services:

- Periodic Oral Examination (includes soft tissue/oral cancer screening).
- Prophylaxis (teeth cleaning).
- Topical Fluoride Treatment.
- Fluoride Supplementation.
- Oral Health Education (includes tooth brushing/flossing instruction).
- Sealants.

Payments for orthodontia are limited to \$500 for each employee or dependent during his or her lifetime.

Many dentists participate in the Network. If you receive dental services from a dentist that is in-Network, your out-of pocket charges will be lower in most cases. For more information about participating dentists, contact the Network at the phone number or website on your dental ID card.

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

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

WHAT PSYCHIATRIC BENEFITS ARE AVAILABLE FROM THE PLAN?

Psychiatric Hospitalization

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

This benefit is for employees only. The benefit is limited to 30 days in a 12-month period. Payments for psychiatric facility charges are subject to a \$450 admission co-payment.

Outpatient Psychiatric Services

At the Core-Plus and Core benefit levels, the Plan will pay toward the cost of outpatient psychiatric services that you receive. When a Network provider is used, the Plan will first determine 40 percent of the Network allowed charge and then pay 80 percent 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. This benefit is for employees only. The benefit is limited to 10 visits per calendar year.

If you require outpatient psychiatric services because you were a victim of piracy, please contact the Plan, as additional benefits may be available.

WHAT BENEFITS ARE AVAILABLE FOR THE TREATMENT OF SUBSTANCE ABUSE?

Inpatient Detoxification

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

The Plan will pay for inpatient detoxification on only one occasion. However, if you enter follow-up treatment at an accredited treatment facility within seven days of completing the initial detoxification, you will be eligible for payment for one additional inpatient detoxification.

The Plan will only pay for a second inpatient detoxification if you enter follow-up treatment within seven days of completing this 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.

There is no dependent coverage for substance abuse treatment.

Note: Federal law may require a modification of the Plan's psychiatric benefits and substance abuse benefits in the future. The Plan will advise you of any changes in these benefits.

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 lymphedema. 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 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 a participant is eligible for Medicare, the Seafarers Health and Benefits Plan will pay benefits first, as long as the employee meets the Plan's eligibility requirements and is 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-payments and deductibles. For more information about the Network, you may contact the Plan office, check the Network website listed on your Plan ID card, or call the Network at the telephone number on your ID card.

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

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

The Plan has arranged for you to receive services through a network of preferred providers. **Pre-certification from the Network is required before 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, 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 your dependent is between ages 19 and 26, you must also complete and return the "Enrollment Form and Affidavit for Dependent Child".** This form is available at www.seafarers.org under the Member Benefits section, or you can contact the Plan to request a copy of this form.

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

Send **all** claims, except for vision and dental claims, to the address on the back of the ID card that you have received from the Plan. **Both in-Network and out-of-Network claims must be sent to this address.** If you lose this card, please contact the Plan at 1-800-252-4674.

- 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 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.

Send **vision and dental claims only** to the following address:

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 for the treatment of any condition for which you sought treatment within six months before you were covered by the Plan until you have been a participant for at least 12 months. However, this 12-month period will be reduced if you had other health care coverage immediately before you become a participant in the Plan with a break of 63 days or less between coverage. This pre-existing condition exclusion does not apply to children under the age of 19. Beginning in 2014, this exclusion will no longer apply to any participants. For more information concerning your right to coverage you can contact the Plan at: 1-800-252-4674.
- The Plan will not pay benefits if your illness or injury occurred while committing a crime.
- The Plan will not pay benefits if your illness or injury is due to something you knew, or should have known was dangerous to your health or safety unless your injury was caused by an act of domestic violence.
- The Plan will not pay benefits if your illness or injury is due to behavior that showed 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.
- The Plan will not pay benefits if your illness or injury is due to alcohol or drug use.

- The Plan may not pay benefits if your illness or injury is due to the actions of someone else who can be held legally responsible. However, the Plan may pay benefits if you agree to assign payment to the Plan from any money you recover. This means that the Plan is entitled to full payment from any money you recover regardless of your legal expenses. If you do not repay the Plan, money may be deducted from any future benefits you might be entitled to receive.
- The Plan will not pay benefits for treatment which is not approved for use in the United States or is considered to be experimental.
- The Plan 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. This includes treatment that is required because of conditions that develop during the course of a hospital stay that could reasonably have been prevented.

- The Plan 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 weight loss drugs or nutritional counseling, except it will pay for nutritional counseling for diabetics.
- The Plan does not pay for occupational, rehabilitative, or speech therapy.
- The Plan does not pay for chiropractic treatment.
- The Plan will pay no more than \$1,500 per year for pain management services.
- The Plan does not pay for acupuncture.
- During 2011, the Plan will pay no more than \$750,000 per year for cardiac rehabilitation for employees and dependents. In accordance with the Patient Protection and Affordable Care Act, this amount will increase to \$1,250,000 in 2012, and to \$2,000,000 in 2013. There will be no limit on this benefit in 2014; unless there is a change in the law. The Plan does not cover cardiac rehabilitation for pensioners or their dependents.

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

At the Core-Plus and Core 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 a day. In addition, the Plan will pay the FICA and Medicare 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, unemployment benefits, 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, from the Plan's main office or download the form from www.seafarers.org under the Member Benefits section. 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 may receive a Standard Death Benefit if he or she is a relative listed in the paragraph titled "Who Can Be My Beneficiary" on page 31 of this booklet. At the Core and Core-Plus benefit levels, the amount of the Standard Death Benefit is \$5,000. This benefit is subject to the Funeral Expense deduction, which is described below.

For your beneficiary to receive the Standard Death Benefit, you must have met the Plan's requirements for maintaining eligibility (as described on page 6) 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. If you did not name a beneficiary, or your named beneficiary died before you, then the Plan will pay your estate a death benefit of \$1,000.

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

WHAT IS THE GRADUATED DEATH BENEFIT?

At the Core-Plus and Core benefit levels, your beneficiary may receive a Graduated Death Benefit in addition to 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 6) 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. The maximum Graduated Death Benefit is \$45,000 at the Core-Plus benefit level. Your beneficiary can receive up to \$50,000 when the Graduated Death Benefit is paid together with the Standard Death Benefit.

At the Core benefit level, 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 6) 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. The maximum Graduated Death Benefit is \$15,000 at the Core benefit level. Your beneficiary can receive up to \$20,000 when the Graduated Death Benefit is paid together with the Standard Death Benefit.

If your death is self-inflicted, is directly or indirectly caused by alcohol or drugs, or is a result of engaging in an activity that you knew or should have known could cause serious injury, the Plan will not pay the full Graduated Death Benefit. In this circumstance the Plan will pay a Graduated Death Benefit up to a maximum of \$10,000.

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	Mother	Brother
Child	Father	Sister
Grandchild	Stepmother	Stepsister
Grandfather	Stepfather	Stepbrother
Grandmother	Half-sister	Nephew*
Stepchild	Half-brother	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 relative on this list, 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.

It is extremely important to keep your beneficiary information up to date to ensure that all the benefits you have earned will be paid to your beneficiary.

WHAT IS THE FUNERAL EXPENSE DEDUCTION?

If someone other than the government has paid for your funeral, the Plan will pay that person towards 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 the 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, from your local representative, or online at www.seafarers.org under the Member Benefits section.

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 for 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 Core-Plus and Core 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, contact the Plan's main office at 1-800-252-4674 for more information. You will be required to 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 Core-Plus and Core 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 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. If you prefer to receive notices from the Plan by email, you must give the Plan permission to communicate with you by email, and provide your email address. A form is available at www.seafarers.org under the Member Benefits section which you can fill out and return to the Plan, or you can contact the Plan to request a copy of this form.

WHAT PRIVACY RIGHTS DO I HAVE?

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 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

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

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:

- 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 his/her job.
- The right to continue health care coverage for you, your spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse will have to pay for this coverage. Review the section of this booklet about COBRA continuation coverage for more information.
- The right to have your questions answered by the Plan, and if you are not satisfied, to ask the U.S. Department of Labor.

U.S. Department of Labor
 Employee Benefits Security Administration
 Room N5619
 200 Constitution Ave. N.W.
 Washington, D.C. 20210

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

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

What is continuation coverage?

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

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

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

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

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or loss of eligibility, coverage generally may be continued for up to 18 months. In the case of loss of coverage due to an employee's death, divorce, or the employee becomes entitled to Medicare benefits or a dependent child ceases to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. The first page of the COBRA notice you will receive if you experience a qualifying event will show the maximum period of continuation coverage available to the listed qualified beneficiaries.

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

How can you extend the length of continuation coverage?

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

Disability

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

Second Qualifying Event

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

How can you elect continuation coverage?

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

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

qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

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

When and how must payment for continuation coverage be made?

First payment for continuation coverage

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

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

Your first payment for continuation coverage should be sent to:

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

Periodic payments for continuation coverage

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

Grace periods for periodic payments

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

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

Your first payment and all periodic payments for continuation coverage should be sent to:

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

For more information

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

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

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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