

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



August 2006

TABLE OF CONTENTS

INTRODUCTION	1
INFORMATION YOU SHOULD BE AWARE OF	2
WORDS YOU NEED TO UNDERSTAND.....	3
WHAT IS THE ENROLLMENT BENEFICIARY CARD AND WHY IS IT IMPORTANT?	4
HOW DO I BECOME ELIGIBLE FOR BENEFITS?.....	4
WHAT IS THE ANNUAL DEDUCTIBLE AND HOW DOES IT WORK?	5
WHAT HEALTH CARE BENEFITS ARE PAID FOR BY THE PLAN?	6
DOES THE PLAN PAY FOR PRESCRIPTION DRUGS?	10
DOES THE PLAN PAY FOR DENTAL CARE?.....	11
WHAT IS THE PENSIONER NURSING HOME BENEFIT?	11
WHAT BENEFITS DOES THE PLAN PROVIDE FOLLOWING A MASTECTOMY?.....	12
WHAT SHOULD I DO IF I FIND A MISTAKE ON MY HEALTH CARE BILL?	12
WHAT IF I HAVE OTHER HEALTH INSURANCE?	12
HOW CAN I REDUCE MY OUT OF POCKET COST?	12
DO I NEED TO OBTAIN PRE-CERTIFICATION WHEN USING NETWORK PROVIDERS?	13
HOW DO I APPLY FOR HEALTH CARE BENEFITS?	13

ARE THERE ANY REASONS WHY THE PLAN MAY NOT PAY BENEFITS?.....	13
IS THERE ANY WAY I CAN LOSE MY RIGHT TO BENEFITS?.....	15
WHAT RIGHTS DO I HAVE IF THE PLAN DENIES MY CLAIM?	15
WHAT PRIVACY RIGHTS DO I HAVE?.....	15
WHAT OTHER RIGHTS DO I HAVE?	16
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA	17

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 retirees 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.

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.

coinsurance amount—The amount that you are responsible for paying after Medicare has paid benefits.

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

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

dependent child—Your 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.

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.

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

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

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 by writing to the Plan office at:

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

HOW DO I BECOME ELIGIBLE FOR BENEFITS?

You can receive health care benefits after you retire if you meet either of the following requirements:

- You retire during 2006 or 2007 on a Regular Normal or Early Normal Pension from the Seafarers Pension Plan and you have credit for at least 5,475 days of covered employment with at least 125 days of covered employment in the calendar year before you applied for pension. If you retire during 2008 or any year thereafter, you must have at least 150 days of covered employment in the calendar year before you apply for a pension.
- You retire during 2006 or 2007 on a Disability Pension from the Seafarers Pension Plan and you have credit for at least 4,380 days of covered employment with at least 125 days of covered employment in the calendar year before your disability began. If you retire during 2008 or any year thereafter, you must have at least 150 days of covered employment in the calendar year before you apply for a pension.

Eligibility is determined without reference to reciprocity agreements. Covered employment does not include extra service days, service credit, past service credit, or other service that is used to qualify you for a pension.

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

You can arrange to have these premium payments deducted from your monthly pension benefit.

Upon becoming eligible for Medicare, you must enroll in Medicare Part A and Part B coverage. However, you need not enroll in Medicare Part D. The Seafarers Health and Benefits Plan will then become the secondary payer to Medicare. If you fail to enroll in Medicare, you will not be eligible to receive benefits from the Plan.

WHAT IS THE ANNUAL DEDUCTIBLE AND HOW DOES IT WORK?

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

If you and your spouse are not eligible for Medicare, the amount of the annual deductible is \$750 per person, but not more than \$1,500 per family. If you and your spouse are eligible for Medicare, the amount of the annual deductible is \$250 per person, but not more than \$500 per family.

All benefits are subject to the deductible except:

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

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

WHAT HEALTH CARE BENEFITS ARE PAID FOR BY THE PLAN?

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.

For pensioners and their dependants who are not eligible for Medicare, 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 hospital charges are subject to a \$450 admission deductible for pensioners who are not eligible for Medicare. You are only required to pay this \$450 deductible once for an entire hospital stay.

For pensioners and their dependants who are eligible for Medicare, you will be required to pay \$300 of the Medicare co-insurance amount, and the Plan will pay the remainder after Medicare benefits have been paid.

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. The Plan will pay for intensive care confinements of up to 15 days. Beginning with the 16th day, confinements are covered in the same way as hospital room and board.

For pensioners and their dependants who are not eligible for Medicare, 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 hospital charges are subject to a \$450 admission deductible for pensioners who are not eligible for Medicare, unless this deductible was already satisfied by paying other hospital charges.

For pensioners and their dependants who are eligible for Medicare, you will be required to pay \$300 of the Medicare co-insurance amount, and the Plan will pay the remainder after Medicare benefits have been paid.

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.

For pensioners and their dependants who are not eligible for Medicare, the Plan will pay 100 percent of the network-allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 70 percent of the reasonable and customary charge. Payments for hospital charges are subject to a \$450 admission deductible for pensioners who are not eligible for Medicare, unless this deductible was already satisfied by paying other hospital charges.

For pensioners and their dependants who are eligible for Medicare, you will be required to pay \$300 of the Medicare co-insurance amount and the Plan will pay the remainder after Medicare benefits have been paid.

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.

For pensioners and their dependants who are not eligible for Medicare, the Plan will pay 80 percent of the network allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

For pensioners and their dependants who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid. Benefits are payable only after you have paid the annual deductible.

Visits by Doctors and Specialists in the Hospital

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

For pensioners and their dependants who are not eligible for Medicare, the Plan will pay 80 percent of the network-allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

For pensioners and their dependants who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid. Benefits are payable only after you have paid the annual deductible.

Emergency Treatment

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.

For pensioners and their dependants who are not eligible for Medicare, the Plan will pay 80 percent of the network-allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

For pensioners and their dependants who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid. Benefits are payable only after you have paid the annual deductible.

Outpatient Doctor's Visits and Services

For pensioners only, the Plan will pay toward the cost of outpatient doctor's visits. There is no dependent coverage for outpatient doctor's visits. This benefit includes such services as: X-rays, lab work, immunizations and physical examinations.

For pensioners who are not eligible for Medicare, the Plan will pay 80 percent of the network-allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

For Medicare eligible pensioners, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid. Benefits are payable only after you have paid the annual deductible.

Physical Therapy

For pensioners 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.

For pensioners who are not eligible for Medicare, the Plan will pay 80 percent of the network-allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

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

For pensioners and their dependants who are not eligible for Medicare, the Plan will pay 80 percent of the network-allowed charge when a network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

For pensioners and their dependants who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid. Benefits are payable only after you have paid the annual deductible.

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

Elective Abortion

The Plan will pay toward the cost of an elective abortion. 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.

For pensioners and their dependants who are not eligible for Medicare, the Plan will pay 80 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

For pensioners and their dependants who are eligible for Medicare, the Plan will pay 50 percent of the Medicare coinsurance amount after Medicare benefits have been paid. Benefits are payable only after you have paid the annual deductible.

Home Health 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 health 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.

For all pensioners and their dependents, the Plan will pay 100 percent of the daily reasonable and customary cost for home health 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 each of your dependents 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.

For all pensioners and their dependents, 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 each of your dependents 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 pensioners 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 devices, medical appliances and other durables. However, the Plan will not pay to maintain or repair durable medical equipment.

The Plan will pay 70 percent of the reasonable and customary charge for durable medical equipment after you have paid the annual deductible. 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.

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 must also 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 examina-

tions, eyeglasses and contact lenses. For each pensioner and dependent, the Plan will pay a maximum of \$40 in vision care charges during a 24-month period.

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.

DOES THE PLAN PAY FOR PRESCRIPTION DRUGS?

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

The Pharmacy Benefit Manager will issue you a prescription card. You must present this card when you fill your prescription.

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

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

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

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

Maintenance drugs 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

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

For more information about the Pharmacy Benefit Manager, call the phone number on your prescription card. If you do not have a prescription card, you may contact the Plan office at 1-800-252-4674.

DOES THE PLAN PAY FOR DENTAL CARE?

For all pensioners, the Plan will pay toward the cost of dentures and extractions. Dental benefits are paid using a schedule. The dental schedule is a list of services that includes the amount the Plan will pay for each service. The Plan will pay the scheduled amount for dentures once every five years. In addition, the Plan will pay the scheduled amount for extractions. There is no dependent coverage for dental care.

WHAT IS THE PENSIONER NURSING HOME BENEFIT?

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

WHAT BENEFITS DOES THE PLAN PROVIDE FOLLOWING A MASTECTOMY?

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

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

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 I HAVE OTHER HEALTH INSURANCE?

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

HOW CAN I REDUCE MY OUT OF POCKET COST?

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: pensioner's Social Security number, patient's name, provider's name, address, and I.D. number, date of service, diagnosis, description of treatment, supplies provided and itemized costs. The Plan will process your claim within 30 days after receiving it. However, your claim will not be paid unless it is filed within 180 days of the date the claim accrued.

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 did not 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.
- The Plan will not pay benefits for organ and tissue 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 does not pay 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 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 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 ***For Pensioners and their Dependents***

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 the spouse of a pensioner, 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;
- 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 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 death of the pensioner, the pensioner’s spouse or dependent 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 pensioner 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 pensioner, 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.

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