

**A GUIDE TO YOUR BENEFITS
FROM THE
SEAFARERS HEALTH AND BENEFITS PLAN
LEVEL S**



October 2008

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INTRODUCTION

This booklet describes the benefits available to you from the Seafarers Health and Benefits Plan-Level S. It was written for you and other workers who are participants in the Plan.

The Seafarers Health and Benefits Plan is a multi-employer employee benefit plan. It provides benefits to employees of employers who have collective bargaining agreements with the Seafarers Entertainment and Allied Trades Union and Seafarers International Union, Atlantic, Gulf, Lakes, and Inland Waters District-National Maritime Union, AFL-CIO. 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 book 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-Level S
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-Level S. 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-Level S 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. The members of the Board of Trustees are:

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

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-Level S is Margaret R. Bowen.

You can contact the Board of Trustees and the Plan Administrator at:
Seafarers Health and Benefits Plan-Level S
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.

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 medical claim.

Eligible employee—A person who is, or was working for a signatory employer and who is eligible for benefits.

Plan—Seafarers Health and Benefits Plan-Level S

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—The generally accepted amount charged for a medical treatment or service as determined by the Plan. The Plan arrives at the reasonable and customary charge in your geographic area by following guidelines that are accepted within the medical community.

Signatory employer—An employer who has signed a contract with the Seafarers Entertainment and Allied Trades Union, or any affiliated union and has agreed to make contributions 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 are and where you can be contacted. It also tells the Plan to whom you want your death benefit paid. For you to receive benefits, the Plan must have a record of this important information.

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

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

WHEN DO I FIRST BECOME ELIGIBLE TO RECEIVE BENEFITS?

Upon beginning work as a new employee with an employer who pays into the Seafarers Health and Benefits Plan-Level S 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. 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. If you reach your 75th day of employment between July 1 and December 31 of a calendar year, you will be eligible to receive benefits for the remainder of that year and the following calendar year. However, you must have credit for at least one day of covered employment either in the six calendar months just before the date of your claim, or in the same month as your claim, as long as it is before the actual date of your claim.

WHAT MUST I DO TO REMAIN ELIGIBLE FOR BENEFITS?

To maintain your eligibility, you must have credit for at least 125 days of covered employment in the calendar year before the date of your claim. In addition, 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.

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 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. A year of service is a calendar year during which you worked at least 125 days for a signatory employer.

YEARS OF SERVICE	CREDITED DAYS
15 years or more	80 days
At least 10 years but less than 15	55 days
At least 5 years but less than 10	40 days
At least 2 years but less than 5	20 days
Less than 2 years	10 days

You may build up a reserve of as much as 40 S&A days or days of state disability as long as they were not used to extend your eligibility. This reserve may be saved for up to three years from the year in which the S&A or state disability benefits were paid. This reserve can be used only once regardless of how many days are needed to maintain your eligibility. In this way, you may use S&A benefits or state disability benefits you received to extend your eligibility in the future. However, you cannot use S&A days or days of state disability to qualify for additional Sickness and Accident benefits.

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

You can extend your eligibility to receive health care benefits through C.O.B.R.A. continuation coverage. Under certain conditions and for a limited time, you can extend your eligibility by paying premiums yourself. The amount of these premiums is set by the Plan. If certain events have happened, you can extend your eligibility. These events include:

- You quit your job.
- You were laid off or fired from your job.
- You retire from your job before you are eligible for Medicare.
- You become disabled and are unable to work, but you are not yet eligible for Medicare.

A special notice describing your right to C.O.B.R.A. continuation coverage appears at the end of this booklet. For more information concerning your right to extend your eligibility by paying premiums yourself, contact the Plan at:

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

WHAT IS AN ANNUAL DEDUCTIBLE AND HOW DOES IT WORK?

You are responsible for paying the first \$100 of certain health care costs you have each calendar year. This amount that you are responsible for paying is called the annual deductible. Charges for Outpatient Doctor's Visits and Outpatient Diagnostic Tests such as lab work, X-rays, scans, etc., are subject to the annual deductible.

Even before you have accumulated \$100 worth of medical bills, it is important to file a claim promptly, since no bills will be paid until you have received credit for paying the deductible amount. Never hold medical bills. Unless your claim is filed within 180 days of the date the claim accrued, it will not be paid. File a claim immediately to avoid any chance of your claim being denied.

WHAT HEALTH CARE BENEFITS ARE AVAILABLE TO ELIGIBLE EMPLOYEES?

The Seafarers Health and Benefits Plan-Level S will pay toward the cost of health care services that are needed to treat your illness or injury. The Plan also pays benefits for certain services that are needed to maintain your health. **Your spouse and dependent children are not covered by the Plan.** The following health care benefits are covered by the Plan:

HOSPITAL COSTS

Hospital Room and Board

The Plan will pay toward the cost of semi private room and board, while you are confined in a hospital. 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.

Confinements of up to 31 days are covered by the Plan. The Plan will pay a maximum of \$50,000 for all hospital charges during each confinement.

Intensive Care Units

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 100 percent of the Network allowed charge for confinement in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge.

The Plan will pay for 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. Confinements of up to 31 days are covered by the Plan. The Plan will pay a maximum of \$50,000 in combined hospital charges during each confinement.

Hospital Extras

The Plan will pay toward the cost of hospital extras while you are confined. Hospital extras include such things as: X-rays, oxygen, dressings, and drugs. 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. The Plan will pay a maximum of \$50,000 in combined hospital charges during each confinement.

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.

The Plan will pay 100 percent of the Network allowed emergency room facility charge when a Network facility is used. When a non-network facility is used, the Plan will pay 70 percent of the reasonable and customary emergency room facility charge. The Plan will pay 70 percent of the Network allowed charge for doctor's fees and other expenses 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. The Plan will pay a maximum of \$5,000 for all charges resulting from an emergency room visit.

Surgery

The Plan will pay toward the cost of surgical procedures performed in a hospital or on an outpatient basis. The Plan will pay 70 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

Visits by Doctors While in the Hospital

The Plan will pay toward the cost of doctor's visits in the hospital. The Plan will pay 70 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

Outpatient Visits at the Doctor's Office

The Plan will pay toward the cost of doctor's office visits. The Plan will pay 70 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

Outpatient Diagnostic Tests and X-rays

The Plan will pay toward the cost of outpatient diagnostic tests and X rays. The Plan will pay 70 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Benefits are payable only after you have paid the annual deductible.

Maternity Benefit

The Plan will pay toward the cost of childbirth services. The Plan will pay 70 percent of the Network allowed charge when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. Your newborn child is not covered by the Plan. To claim the maternity benefit, you must meet all eligibility requirements at the time of delivery. You may remain in the hospital for up to 48 hours following a normal delivery. After a delivery by cesarean section, you may remain in the hospital for up to 96 hours.

Elective Abortion

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

WHAT BENEFITS ARE AVAILABLE FOR THE TREATMENT OF SUBSTANCE ABUSE?

The Plan will pay toward the cost of up to five days of inpatient detoxification. The Plan will pay 100 percent of the Network allowed charge for confinement in a Network facility. If confined in a non-network facility, the Plan will pay 70 percent of the reasonable and customary charge.

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

The Plan does not pay for follow-up treatment, or provide any other substance abuse benefits for Plan Level S participants.

IS THERE ANY LIMIT ON THE AMOUNT OF BENEFITS I CAN RECEIVE FROM THE PLAN?

The total amount of benefits that you can receive from the Plan is limited to \$250,000 during your lifetime. In addition, the total benefit payable for hospital room and board, hospital extras, and intensive care, during each confinement, is limited to 31 days or \$50,000, whichever is reached first. All benefits payable for combined hospital expenses are counted toward the \$250,000 lifetime limitation.

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, and complications resulting from a mastectomy, including lymphedema. The same limitations and deductibles that apply to other benefits apply to these mastectomy-related services. For more information, call the Plan at 1 (800) 252-4674.

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

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

If you are successful in having the bill corrected, you should contact the Plan office. After verifying the correction, the Plan will pay you a bonus. The bonus is equal to 25 percent of the amount you saved the Plan, up to a maximum bonus of \$500.

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 there is any question concerning coverage or eligibility, call the Plan at: 1-800-252-4674.

- 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 provider yourself, obtain a copy of the itemized bill. To receive benefits you must send this itemized bill to the Plan. Make certain that the bill includes: employee's Social Security number, patient's name, provider's name, address, and I.D. number, date of service, diagnosis, description of treatment, supplies provided, and itemized costs. The Plan will process your claim within 30 days after receiving it. However, your claim will not be paid unless it is filed within 180 days of the date the claim accrued.

Send claims to:

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

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

Eligible 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 125 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 \$8 per day. In addition, the Plan will pay the FICA taxes due on the benefit to the Internal Revenue Service, on your behalf.

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

Sickness and Accident 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 Sickness

and Accident 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 Sickness and Accident Benefits end when you are no longer disabled and can return to work. Although you may receive eligibility credit for days during which you were receiving Sickness and Accident benefits, you cannot use days credited in this way to receive additional Sickness and Accident benefits.

HOW DO I APPLY FOR SICKNESS AND ACCIDENT BENEFITS?

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

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

WHAT IS THE DEATH BENEFIT?

Your beneficiary can receive a Standard Death Benefit upon your death. The amount of the Standard Death Benefit is \$5,000. However, if your death is the result of an accident, your beneficiary can receive an additional \$5,000 for a combined death benefit of \$10,000.

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

The beneficiaries of employees who do not meet the requirements for 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 is eligible to receive a \$500 death benefit.

WHO CAN BE MY BENEFICIARY?

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

Spouse	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 listed relative, the maximum amount he or she can receive as a Death Benefit is \$1,000 if you qualified for the standard death benefit or \$500 if you do not meet those requirements. If you do not name a beneficiary, a maximum of \$1,000 will be paid to your estate.

WHAT IS THE FUNERAL EXPENSE DEDUCTION?

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

HOW DOES MY BENEFICIARY APPLY FOR MY DEATH BENEFIT?

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

Your beneficiary must include with the application an itemized funeral bill, paid or unpaid, and an official Certificate of Death. Your beneficiary must also provide the Plan with official documents that show how he or she is related to you. 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.

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.

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 pay for up to 20 visits per year for podiatric services, up to a maximum of \$1,000 per year for all such services. This \$1,000 maximum includes podiatric surgery.
- 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 \$25,000 in covered expenses resulting from congenital anomalies.
- Except for inpatient detoxification, the Plan will not pay benefits for substance abuse treatment.
- The Plan will not pay benefits for the treatment of an illness or injury that began while you were employed on board a vessel.
- Any benefit not specifically provided for in the Plan's Rules and Regulations is not covered by the Plan.

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

If your application for benefits is denied, you have the right to appeal the decision to the Plan's Board of Trustees.

If the Plan denies your application, a written explanation will be sent to you. If you believe that the Plan should have approved your application, you can request a review by the Trustees. You must make your request in writing and you must send it within 180 days of the date your application was denied. You may include any documents or information that support your position.

Your application will be reviewed by the Trustees. They will look at all documents or information that they receive from you and any other information that they need to make a decision. 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-Level S
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-Level S 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-Level S
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 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.

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 if you believe that the Trustees of the Plan have not done their job.
- The right to have your questions answered by the Plan, and if you are not satisfied, the right to ask the U.S. Department of Labor.

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

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you are covered under a group health plan, the Seafarers Health and Benefits Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you, and 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. 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.” After a qualifying event, COBRA continuation coverage must be offered to you as a “qualified beneficiary.” You could become a qualified beneficiary 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.

As an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happen:

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, or insufficient covered employment, the employer must notify the Plan Administrator of the qualifying event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to you. When the qualifying event is the end of employment, or insufficient covered employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

If you are determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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 rights, you should keep the Plan Administrator informed of any changes in your address. 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

