

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



July 2020

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INTRODUCTION

This booklet describes the benefits available to you and your dependents from the Seafarers Health and Benefits Plan. It was written for those who are receiving pension benefits from the Seafarers Pension Plan and who are participants in the Seafarers Health and Benefits Plan.

The Seafarers Health and Benefits Plan is a multi-employer employee benefit plan. It provides benefits to employees and former employees of employers who have collective bargaining agreements with the Seafarers International Union of North America, Atlantic, Gulf, Lakes, and Inland Waters ("SIU" or "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.

This booklet contains important information about your benefits. Read it carefully and keep it for future use. You may also view the booklet online at www.seafarers.org in the Health and Benefits Plan section. In the event of any changes to these benefits, the Plan will mail you a notice of the changes; or if you have consented, will email notices to you. Notice of benefit changes will also be posted online at www.seafarers.org .

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 Capital Gateway Drive
Camp Springs, Maryland 20746
1-800-252-4674

Language translation services are available for participants who need assistance with English. See the Appendix of this booklet for more information or call 1-800-252-4674.

This booklet is referred to as the Summary Plan Description or SPD. 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.

The Seafarers Health and Benefits Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (also referred to as the "Affordable Care Act" or "ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to

a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 5201 Capital Gateway Drive, Camp Springs, MD 20746. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a chart summarizing which protections do and do not apply to grandfathered health plans.

INFORMATION YOU SHOULD BE AWARE OF

The Seafarers Health and Benefits Plan is directed by a group of people called the Board of Trustees. The Board of Trustees has the absolute authority to make changes to the Plan. As of the date of this booklet, the members of the Board of Trustees are:

| | |
|--------------------|-------------------|
| Dean Corgey | William Cole |
| David Heindel | Ira Douglas |
| Kate Hunt | Edward Hanley |
| Nicholas Marrone | Todd Johnson |
| Thomas Orzechowski | Damon Mote |
| Joseph Soresi | Anthony Naccarato |
| George Tricker | Scott Winfield |

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 Capital Gateway Drive
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

catastrophic illness or injury—An illness with an acute onset, or a medical condition resulting from an injury that will require extensive rehabilitation and/or nursing care. Examples include: a stroke, heart attack, or severe injuries received in a serious accident. The Plan does not consider chronic conditions (such as diabetes or multiple sclerosis) to be catastrophic illnesses.

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.

coinsurance—Your share of the costs of a covered health care service, calculated as a percentage. *For example*, if you are a non-Medicare pensioner, co-insurance for in-Network professional fees, diagnostic tests, and outpatient care is 10% of the allowed amount for the service. The co-insurance is the amount that you are responsible for paying after Seafarers Health and Benefits Plan or Medicare has paid benefits.

copayment—A fixed amount that a participant must pay for certain covered health care services. *For example*, the Plan has a \$450 co-payment for hospital stays, a \$300 co-payment for emergency room treatment if the patient is not admitted to the hospital, and various co-payments for prescription drugs (depending upon whether the drug is generic or brand name).

covered employment—Days that you worked for a signatory employer and certain other days described in this booklet. Covered employment does not include “extra service credit” or “supplemental service credit” earned under the Seafarers Pension Plan or days for which you received vacation pay.

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 biological, adopted, foster, step-child, or you are the child's court appointed guardian. Your child may also be your dependent if the Plan has received a Qualified Medical Child Support Order (QMCSO) which requires you to provide health coverage to the child.

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

employee—A person who is, or was working for a signatory employer and is, or was covered by the Plan (also referred to as “seafarer”).

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-insurance when you visit a provider that participates in this program, there will be no additional balance billing. This program only applies to pensioners and their dependents who are not eligible for Medicare, and it does not apply to Humana participants.

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

Pharmacy Benefits Manager (PBM)—A company that provides prescription drugs through both retail pharmacies and mail order. The Plan currently uses OptumRx as its pharmacy benefits manager for pensioners who are not eligible for Medicare and Retiree RxCare for pensioners who are eligible for Medicare.

Plan—the Seafarers Health and Benefits Plan (also referred to as "SHBP").

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. The Plan currently participates in the CIGNA Network for all participants who reside in the United States, except for participants who reside in Puerto Rico. If you reside in Puerto Rico, the Plan currently participates in the Humana Network. The Network logo is on your Plan ID card if you are not eligible for Medicare. You must use this card whenever you visit an in-Network health care provider in order to receive services at the reduced cost. **If you are eligible for Medicare, you do not participate in a preferred provider network.**

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 FORM AND WHY IS IT IMPORTANT?

The enrollment form tells the Plan who you and your dependents are and where you can be contacted. Since you were already enrolled in the Plan before you became a pensioner, there is no need to re-enroll unless you wish to add a new dependent.

The information on your enrollment form must be accurate and up-to-date. You should complete a new enrollment form if:

- Your home address changes
- Your number of dependent children changes
- You get married, divorced, or your spouse dies

If you get married or wish to add dependent children, you must send the Plan copies of their Social Security cards and a new enrollment form. The Plan will need a copy of an official marriage certificate before a claim will be paid for your spouse. If you are married under common law, you must prove that your marriage is legally recognized in the state where you live. **It is also important that you immediately notify the Plan if you get a divorce so that the Plan may update its records. Your spouse's coverage will end as of the date of divorce. 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. If you are divorced, the Plan will require a copy of the divorce decree and/or Qualified Medical Child Support Order (QMCSO). For adopted children, the Plan will need a copy of the adoption papers. For stepchildren, the Plan requires a copy of the divorce decree and/or QMCSO, or other written proof that no one else is responsible for providing health coverage.

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

Seafarers Health and Benefits Plan
5201 Capital Gateway Drive
Camp Springs, Maryland 20746
Telephone: 1-800-252-4674

HOW DO I BECOME ELIGIBLE FOR BENEFITS?

You will be eligible for health care benefits after you retire if you meet the following requirements:

- You retire 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 Seafarers Health and Benefits Plan (SHBP);**

OR

- You retire on a Disability Pension from the Seafarers Pension Plan and you have credit for at least **4,380 days of covered employment with Seafarers Health and Benefits Plan (SHBP);**

AND

- At least 60 days of covered employment in each of the two 6 month eligibility periods immediately preceding the date you become eligible for and apply for a pension, **OR** at least 125 days of covered employment during the calendar year immediately preceding the year in which you become eligible for and apply for a pension.

*For example, if you retire in August 2019, you will need at least 60 days of covered employment during the eligibility period from January 1, 2019 through June 30, 2019 and 60 days of covered employment during the eligibility period from July 1, 2018 through December 31, 2018; **OR** 125 days of covered employment during 2018 (previous calendar year).*

Eligibility is determined without reference to reciprocity agreements. Covered employment does not include "extra service credit", "supplemental service credit", or other time that is used to qualify you for a pension from the Seafarers Pension Plan. This means that you may only receive one day's credit for each day actually worked in covered employment. Credit received for Vacation days are not counted towards eligibility for health benefits.

If you do not have enough days of covered employment to qualify for health benefits when you begin receiving pension benefits from the Seafarers Pension Plan, you cannot later qualify for pensioner's health benefits by returning to covered employment and working additional days. However, if you qualify for pensioner's health benefits and you return to covered employment, your pensioner's health benefits will resume as soon as you stop working and your pension benefits are reinstated.

WHAT DAYS CAN BE COUNTED AS COVERED EMPLOYMENT?

To establish your eligibility for health benefits when you become a pensioner, the following days can be counted as covered employment:

- Days you worked for an employer who was obligated to pay into the Plan for your benefits.
- Days you received Maintenance and Cure, Longshore and Harbor Workers' compensation, or Workers' Compensation 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. Days when you received Maintenance and Cure payments count as covered employment if you were at the Core-Plus benefit level. At the Core benefit level, these days only count if your employer was making contributions on your behalf during the period you were receiving these payments.
- 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 the School's eligibility requirements when you began attending the School.
- Days you received a Seafarers Scholarship Award.
- Days you received Sickness and Accident Benefits (S&A) or state disability payments. 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 |

WHEN WILL I BEGIN TO RECEIVE PENSIONER'S BENEFITS?

You will begin to receive pensioner's health benefits when your eligibility for health benefits as an active employee runs out.

There are differences between the health benefits that you and your family received when you were an active employee and the benefits you will receive when you are a pensioner. If you wish, you may elect COBRA continuation coverage at the time you become eligible for pensioner's benefits, which will allow you to continue to receive the same health benefits that you received when you were an active employee for a certain period of time. You must pay a monthly premium for this coverage. The amount of the COBRA premium depends on the level of benefits that you received before you retired. 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
45353 Saint Georges Avenue
Piney Point, Maryland 20674
1-800-252-4674

If you elect COBRA, you will begin to receive pensioner's health benefits when the COBRA period is over. Once you begin to receive pensioner's health benefits, you can continue to use the same ID card that you already have, unless you are eligible for Medicare. In that case, you should contact the Plan to request a new ID card.

DOES THE PLAN CHARGE A PREMIUM FOR PENSIONER'S HEALTH COVERAGE?

If you are not eligible for Medicare at the time you retire, you must pay a monthly premium to the Plan for your health coverage. 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. The Seafarers Pension Plan will deduct this amount from your monthly pension if you give the Pension Plan written permission.

Upon becoming eligible for Medicare, you must immediately enroll in Medicare Part A and Part B coverage in order to receive retiree coverage from this Plan. **If you fail to enroll in Medicare, you will not be eligible to receive benefits from the Plan.**

If you retire before you are Medicare eligible, it is important that you remember to

enroll in Medicare Part A and B when you reach age 65. Once you are Medicare eligible, the Seafarers Health and Benefits Plan will become the secondary payer to Medicare. If you are over 65 at the time you retire, you may still be eligible for primary coverage from this Plan as an active employee for six more months, until your eligibility as an active employee runs out. **Please be aware that once you are Medicare primary, if you choose to seek treatment from a health care provider that does not accept Medicare, the Plan will still process the claim as though Medicare had paid as the primary payer, and you will be responsible for paying the balance of the remaining charges.**

However, you should not enroll in Medicare Part D as the Plan provides prescription coverage to you in a Medicare Part D plan through Retiree RxCare. **If you decide to enroll in another Medicare Part D plan, you will lose your prescription coverage from this Plan and cannot re-enroll in the future.**

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.

The following are the annual deductible amounts:

If you and your spouse are not eligible for Medicare, the amount of the annual deductible is \$375 per person, but not more than \$750 per family.

If you and your spouse are eligible for Medicare, the amount of the annual deductible is \$125 per person, but not more than \$250 per family.

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 satisfying 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.**

All benefits are subject to the deductible except:

- Inpatient hospital facility charges, which has a copayment
- Hospice care
- Prescription drug benefit, which has a separate deductible
- Dental benefit
- Vision care benefit

DOES THE PLAN HAVE AN OUT-OF-POCKET MAXIMUM?

If you are **not** eligible for Medicare, the Plan's out-of-pocket maximum is \$2,700 for an individual and \$5,500 for a family of two or more. This means that once you spend this amount on deductibles, co-payments, and co-insurance in a calendar year, the Plan will pay 100 percent of the remaining Network allowed amount for you and your family (if applicable) for the remainder of that year. **The out-of-pocket maximum applies to in-Network claims only.**

If you **are** eligible for Medicare, this section does not apply to you as there is no out-of-pocket maximum.

IF I LIVE IN PUERTO RICO, DO I HAVE HEALTH COVERAGE IN THE MAINLAND UNITED STATES?

If you are a resident of Puerto Rico, you will receive the benefits described in this booklet, but if you are a non-Medicare pensioner, you will receive your medical coverage through Humana of Puerto Rico. In general, your Humana ID card is only valid for medical services in Puerto Rico. **Under the following circumstances only**, residents of Puerto Rico who are **not** eligible for Medicare may use their Humana ID card to receive health benefits in the mainland United States:

- **You or a family member require a medical service that is not available in Puerto Rico.** Your health care provider must send information to Humana to show that the service is not available in Puerto Rico.
- **Your child is attending high school or college in the mainland United States.** You must send proof of your child's enrollment in school to Humana's enrollment department.
- **In an emergency.** If you (or an eligible family member) are in the mainland United States and experience a serious medical emergency in which your life or health is in jeopardy, you are eligible for benefits for emergency treatment.

In all of these situations, except for an emergency, you should seek treatment from a health care provider that is in the Humana network. If you go to a provider that is not in the Humana network, the claim will be processed at the out-of-network rate for Puerto Rico, which will result in a larger out-of-pocket cost to you. In a medical emergency, you will receive benefits at the in-Network rate, even if you go to a provider that is not in the Humana network. If you have questions, please call the Humana Customer Service department at 1-800-314-3121. If you are eligible for Medicare, you may use your Medicare card anywhere in the United States.

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 brief summary of the health care benefits covered by the Plan **for Pensioners and dependents who are not eligible for Medicare**. For more details, and additional benefit information, please review the appropriate benefit descriptions listed after the chart.

| SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS | | |
|---|---|---|
| <i>*These services are subject to deductible.</i> | | |
| <i>All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.</i> | | |
| DESCRIPTION | Pensioner Non-Medicare | Pensioner Dependent Non-Medicare |
| Annual Deductible | \$375 Individual (medical) \$750 Family (medical) | \$375 Individual (medical) \$750 Family (medical) |
| Out of pocket maximum | \$2,700 Individual (medical) \$5,500 Family (medical) | \$2,700 Individual (medical) \$5,500 Family (medical) |
| Hospital Room and Board and Hospital Miscellaneous Extras | Pre-certification required In-network 100% Out-of-network 70% R&C \$450 admission co-payment 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. | Pre-certification required In-network 100% Out-of-network 70% R&C \$450 admission co-payment 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. |
| Inpatient Rehabilitation (at skilled nursing facility or acute rehabilitation facility) | Pre-certification required Paid in the same manner as Hospital Room and Board above. | Pre-certification required Paid in the same manner as Hospital Room and Board above. |

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS

**These services are subject to deductible.*

All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.

| DESCRIPTION | Pensioner Non-Medicare | Pensioner Dependent Non-Medicare |
|---|---|--|
| Surgical, Inpatient | Pre-certification required In-network 90% * Out-of-network 65% R&C * | Pre-certification required In-network 90% * Out-of-network 65% R&C * |
| Surgical, Outpatient | In-network 90% * Out-of-network 65% R&C * | In-network 90% * Out-of-network 65% R&C * |
| Doctor's Visits, Inpatient | In-network 90% * Out-of-network 65% R&C * | In-network 90% * Out-of-network 65% R&C * |
| Doctor's Visits, Outpatient | In-network 90% * Out-of-network 65% R&C * | Non-covered |
| Diagnostic Tests and X-rays, Inpatient | In-network 90% * Out-of-network 65% R&C * | In-network 90% * Out-of-network 65% R&C * |
| Diagnostic Tests and X-rays, Outpatient | In-network 90% * Out-of-network 65% R&C * Pre-certification required for high tech radiology services | Non-covered |
| Annual Physical | 100% at Comprehensive Health Services (CHS) clinics <i>OR at other providers:</i> In-network 90%* Out-of-network 65% R&C * | In-network 100% * Out-of-network 65% R&C * |
| Cancer Treatment (chemotherapy and radiation) | In-network 90% * Out-of-network 65% R&C * | In-network 90% * Out-of-network 65% R&C * |
| Emergency Treatment | In-network 90% * Out-of-network 65% R&C * \$300 co-pay if treated for illness and not admitted to hospital | In-network 90% * Out-of-network 65% R&C * \$300 co-pay if treated for illness and not admitted to hospital |

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS

*These services are subject to deductible.

All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.

| DESCRIPTION | Pensioner Non-Medicare | Pensioner Dependent Non-Medicare |
|---|--|---|
| Cardiac Rehabilitation | In-network 90% * Out-of-network 65% R&C * Limit 40 visits per year | In-network 90% * Out-of-network 65% R&C * Limit 40 visits per year |
| Physical Therapy (for non-catastrophic illnesses or injuries) | In-network 90% * Out-of-network 65% R&C * Limit 20 visits per year | Non-covered |
| Physical/Occupational/ Speech/Pulmonary/ Cognitive Therapies (following catastrophic illnesses or injuries) | In-network 90%* Out-of-network 65% R&C* Limit 40 visits per year (for all therapies combined) | In-network 90%* Out-of-network 65% R&C* Limit 40 visits per year (for all therapies combined) |
| Home Health/ Home Nursing Care | 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 | 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 | In-network 90% Out-of-Network 80% R&C | In-network 90% Out-of-Network 80% R&C |
| Prescription Drugs | \$10-Generic @ Retail** \$25-Brand Name on Formulary @ Retail** \$50-Brand Name Not on Formulary @ Retail** **For 30 day supply. (Mail order also available at different co-pays). \$100 deductible | Non-covered |

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR NON-MEDICARE PENSIONERS

**These services are subject to deductible.*

All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.

| DESCRIPTION | Pensioner Non-Medicare | Pensioner Dependent Non-Medicare |
|--|---|---|
| Hearing Aids | \$3,000.00 maximum every 3 years for one or two hearing aids * | Non-covered |
| Vision Care | \$40 maximum in 24 months | \$40 maximum in 24 months |
| Dental Care | Dentures and related services only: 80% R&C; Limited to once every 5 years Oral surgery and anesthesia only: 100% R&C The Plan covers the following surgeries: Pulpotomy, apicoectomy, alveoloplasty and surgical extractions | Oral Surgery and anesthesia only: 80% R&C See list of covered surgeries for pensioner. |
| Scholarship Program | | Dependents - 5-four year scholarships @ \$20,000 each |
| Organ and Tissue Transplants | Non-covered | Non-covered |
| Sickness and Accident | Non-covered | Non-covered |
| Death Benefit | Non-covered | Non-covered |
| Accidental Dismemberment | Non-covered | Non-covered |
| Mental Health Inpatient and Outpatient | Non-covered | Non-covered |
| Substance Abuse Detox | Non-covered | Non-covered |
| Lifetime Limitation | None | None |
| <i>*Subject to deductible</i> | | |

The following chart is a summary of the health care benefits covered by the Plan, including the co-payment and co-insurance amounts. **This chart is for Pensioners and dependents who are eligible for Medicare.** For more details, please review the appropriate benefit description listed after the chart.

| SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS | | |
|---|--|--|
| <i>*These services are subject to deductible.</i> | | |
| DESCRIPTION | Pensioner Medicare | Pensioner Dependent Medicare |
| Annual Deductible | \$125 Individual \$250 Family | \$125 Individual \$250 Family |
| Hospital Room and Board and Hospital Miscellaneous Extras | \$300 copay then 100% of Medicare co-insurance and deductible 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. | \$300 copay then 100% of Medicare co-insurance and deductible 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. |
| Inpatient Rehabilitation (at skilled nursing facility or acute rehabilitation facility) | Paid in the same manner as Hospital Room and Board above. | Paid for in the same manner as Hospital Room and Board above |
| Surgical, Inpatient | 50% of Medicare co-insurance and deductible * | 50% of Medicare co-insurance and deductible * |
| Surgical, Outpatient | 50% of Medicare co-insurance and deductible * | 50% of Medicare co-insurance and deductible * |

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS

**These services are subject to deductible.*

| DESCRIPTION | Pensioner Medicare | Pensioner Dependent Medicare |
|---|---|--|
| Doctor's Visits, Inpatient | 50% of Medicare co-insurance and deductible * | 50% of Medicare co-insurance and deductible * |
| Doctor's Visits, Outpatient | 50% of Medicare co-insurance and deductible * | Non-covered |
| Diagnostic Tests and X-rays, Inpatient | 50% of Medicare co-insurance and deductible * | 50% of Medicare co-insurance and deductible * |
| Diagnostic Tests and X-rays, Outpatient | 50% of Medicare co-insurance and deductible * | Non-covered |
| Annual Physical | 100% at Comprehensive Health Services (CHS) clinics <i>OR at other providers:</i> 50% of Medicare co-insurance and deductible * | 100% of Medicare co-insurance and deductible * |
| Cancer Treatment (chemotherapy and radiation) | 50% of Medicare co-insurance and deductible * | 50% of Medicare co-insurance and deductible * |
| Emergency Treatment | 50% of Medicare co-insurance and deductible * \$300 copay if treated for illness and not admitted to hospital | 50% of Medicare co-insurance and deductible * \$300 copay if treated for illness and not admitted to hospital |
| Cardiac Rehabilitation | 50% of Medicare co-insurance and deductible * Limit 40 visits per year | 50% of Medicare co-insurance and deductible * Limit 40 visits per year |
| Physical Therapy (for non-catastrophic illnesses or injuries) | 50% of Medicare co-insurance and deductible * Limit 20 visits per year | Non-covered |

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS

**These services are subject to deductible.*

| DESCRIPTION | Pensioner Medicare | Pensioner Dependent Medicare |
|---|--|--|
| Physical/Occupational/ Speech/Pulmonary/ Cognitive Therapies (following catastrophic illnesses or injuries) | 50% of Medicare co insurance and deductible * Limit 40 visits per year (for all therapies combined) | 50% of Medicare co insurance and deductible * limit 40 visits per year (for all therapies combined) |
| Home Health/ Home Nursing Care | 50% of Medicare co-insurance and deductible * Combined maximum of 60 visits a year (<i>a visit is defined as 2 hours or less</i>) with a maximum allowable charge of \$75 per hour for nurse or home health aide | 50% of Medicare co-insurance and deductible * *Combined maximum of 60 visits a year (<i>a visit is defined as 2 hours or less</i>) with a maximum allowable charge of \$75 per hour for nurse or home health aide |
| Hospice Care | 50% of Medicare co-insurance and deductible | 50% of Medicare co-insurance and deductible |
| Prescription Drugs | \$10-Generic @ Retail;** \$25-Brand Name on Formulary @ Retail** \$50-Brand Name not on Formulary @ Retail** <i>**For 30 day supply.</i> <i>(Mail order also available at different copays).</i> \$100 deductible | Non-covered |
| Hearing Aids | \$3,000.00 maximum every 3 years for one or two hearing aids * | Non-covered |
| Vision Care | \$40 maximum in 24 months | \$40 maximum in 24 months |

SEAFARERS HEALTH & BENEFITS PLAN SUMMARY FOR MEDICARE PENSIONERS

**These services are subject to deductible.*

| DESCRIPTION | Pensioner Medicare | Pensioner Dependent Medicare |
|---|--|---|
| Dental Care | Dentures and related services only: 80% R&C; Limited to once every 5 years; Oral surgery and anesthesia only: 100% R&C The Plan only covers the following surgeries: Pulpotomy, apicoectomy, alveoloplasty and surgical extractions | Oral Surgery and anesthesia only: 80% R&C See list of covered surgeries for pensioners |
| Scholarship Program | Non-covered | Dependents - 5-four year scholarships @ \$20,000 each |
| Organ and Tissue Transplants | Non-covered | Non-covered |
| Sickness and Accident | Non-covered | Non-covered |
| Death Benefit | Non-covered | Non-covered |
| Accidental Dismemberment | Non-covered | Non-covered |
| Mental Health Inpatient and Outpatient | Non-covered | Non-covered |
| Substance Abuse Detox | Non-covered | Non-covered |
| Lifetime Limitation | None | None |

The following health care benefits are covered by the Plan:

Hospital Room and Board

For pensioners and their dependents who are **not** eligible for Medicare, 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 fees for your care for the same illness. This limit applies to all facility related fees, including hospital extras, described below. **All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.**

Payments for hospital charges are subject to a \$450 admission co-payment for pensioners and their dependents who are **not** eligible for Medicare. You are only required to pay this \$450 payment once for an entire hospital stay.

For pensioners and their dependents who **are** eligible for Medicare, you will be required to pay a \$300 admission co-payment. You are only required to pay this \$300 payment once for an entire hospital stay. The Plan will pay the remainder of the Medicare allowed amount after Medicare benefits have been paid. However, payment is limited to 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 the same illness. This limit applies to all facility related fees, including hospital extras, described below.

Payment for hospital room and board is based upon the hospital's semi-private room rate, unless a private room is medically necessary.

Hospital Extras

For pensioners and their dependents who are **not** eligible for Medicare, 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. Payment for hospital extras is subject to a \$450 admission co-payment, unless this payment was already satisfied by paying other hospital charges. **All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.**

For pensioners and their dependents who **are** eligible for Medicare, you will be required to pay a \$300 admission co-payment, unless this payment was already satisfied by paying other hospital charges. The Plan will pay the remainder after Medicare benefits have been paid.

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

Once you reach the maximum of 180 days, or \$1,000,000 in benefits per illness (whichever comes first) for all hospital facility related fees (including hospital extras and room and board), you must be out of the hospital for at least 60 days before the Plan will pay additional fees for hospital extras for the same illness.

Intensive Care

For pensioners and their dependents who are not eligible for Medicare, 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. Payment for intensive care is subject to a \$450 admission co-payment for pensioners who are not eligible for Medicare, unless this payment was already satisfied by paying other hospital charges. ***All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.***

For pensioners and their dependents who are eligible for Medicare, you will be required to pay a \$300 admission co-payment unless this payment was already satisfied by paying other hospital charges. The Plan will pay the remainder of the Medicare allowed amount after Medicare benefits have been paid.

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.

Inpatient Rehabilitation

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay benefits for inpatient rehabilitation. Types of rehabilitation covered are physical therapy, occupational, speech, pulmonary, and cognitive therapies. ***All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.***

The Plan will pay 100 percent of the Network allowed charge for a maximum of 180 days or \$1,000,000 per illness, or until you reach maximum medical improvement (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, or until you reach maximum medical improvement (whichever comes first).

Once you reach the limit of 180 days or \$1,000,000 in benefit payments, you must be out of the rehabilitation facility for at least 60 days before the plan will pay additional

benefits for your care. **The Plan will no longer pay for inpatient rehabilitation once you reach maximum medical improvement.** These limits apply to all facility-related fees. The Plan will not pay benefits for custodial care.

Payments for inpatient rehabilitation are subject to a \$450 admission co-payment for pensioners and their dependents who are not eligible for Medicare. You are only required to pay this \$450 payment once for the entire confinement in the rehabilitation facility.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay benefits for inpatient rehabilitation. Types of rehabilitation covered are physical therapy, occupational, speech, pulmonary, and cognitive therapies.

The Plan will pay 100 percent of the Medicare co-insurance and deductible amounts for a maximum of 180 days or \$1,000,000 per illness, or until you reach maximum medical improvement (whichever comes first) for confinement in a rehabilitation facility.

Once you reach the limit of 180 days or \$1,000,000 in benefit payments, you must be out of the rehabilitation facility for at least 60 days before the Plan will pay additional benefits for your care. **The Plan will no longer pay for inpatient rehabilitation once you reach maximum medical improvement.** These limits apply to all facility-related fees. The Plan will not pay benefits for custodial care.

Payments for inpatient rehabilitation are subject to a \$300 admission co-payment for pensioners and their dependents who **are** eligible for Medicare. You are only required to pay this \$300 payment once for the entire confinement in the rehabilitation facility.

Surgery

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 percent of the Network allowed charge for the surgeon when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for the surgeon. The Plan will pay an assistant surgeon (a physician) 20 percent of the amount allowed for the surgeon. The Plan will pay surgical assistants who are not physicians 10 percent of the amount allowed for the surgeon. If more than one surgical procedure is performed during the same session, payments for all but the first procedure will be reduced by 50 percent of the allowed charge. Payments for anesthesia are calculated using a formula for out-of-network claims. This formula is available from the Plan upon request. **All in-patient facilities require pre-certification. Contact your Network (CIGNA or Humana) at the phone number on your ID card.**

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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

Anesthesia

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 percent of the Network allowed charge for anesthesia when a Network provider is used. When a non-network provider is used, the Plan will pay 65 percent of the allowable amount under a formula established by the Plan. For a copy of this formula, please contact the Plan.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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

Visits by Doctors and Specialists in the Hospital

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 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.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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

Outpatient Doctor's Visits and Services

For pensioners who are not eligible for Medicare, the Plan will pay 90 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.

For pensioners who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

This benefit includes such services as: lab work, immunizations, and physical examinations.

There is no dependent coverage for outpatient doctor's visits (except for annual physical exam), or other services performed on an outpatient basis.

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

Outpatient Diagnostic Tests and X-Rays

For pensioners who are not eligible for Medicare, the Plan will pay 90 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, PET scan, CT scan, and MRI. ***Pre-certification is required for high tech radiology services such as PET Scan, CT Scan, MRI, heart catheterization and echocardiography with stress test.***

For pensioners who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

There is no dependent coverage for these services.

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

Annual Physical Examination

For all pensioners, both non-Medicare eligible and those eligible for Medicare, the Plan will pay 100% of the cost of an annual physical exam **when it is performed at a clinic that is contracted by the Plan.**

For pensioners who are not eligible for Medicare, if the exam is not performed at a contracted clinic, the Plan will pay 90 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 dependents who are not eligible for Medicare, the Plan will pay 100% 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 pensioners who are eligible for Medicare, the Plan will pay 50% of the Medicare co-insurance amount for an annual physical exam that is **not** performed at a Plan-contracted clinic.

For dependents who are eligible for Medicare the Plan will pay 100% of the Medicare co-insurance amount for an annual physical exam.

Pensioners who wish to arrange for an annual physical exam at a Plan-contracted clinic should contact the local Plan office.

This benefit is available once every twelve months and is subject to the annual deductible, unless it is performed at a Plan-contracted clinic.

Cancer Treatment

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 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 chemotherapy and radiation.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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

Emergency Treatment

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 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.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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.

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

Cardiac Rehabilitation

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 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.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

The Plan provides cardiac rehabilitation benefits to both you and your dependents. Payments for cardiac rehabilitation are limited to 40 visits during a calendar year.

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

Physical Therapy

The Plan offers two types of physical therapy benefits for pensioners: benefits for therapy required following a **non-catastrophic illness or injury** (such as a broken leg) and benefits for therapy required following a **catastrophic illness or injury** (such as a stroke). Pensioners' dependents have benefits for physical therapy required following a catastrophic illness or injury (such as a stroke). **There is no dependent coverage for physical therapy following a non-catastrophic condition.**

For pensioners who are not eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 90 percent of the Network allowed charge for physical therapy 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 pensioners who are eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

Payments for physical therapy for pensioners following a non-catastrophic condition are limited to **twenty visits** during a calendar year.

For pensioners and their dependents, following a catastrophic illness or injury, the Plan provides physical therapy, occupational therapy, pulmonary therapy and cognitive therapy benefits to aid in rehabilitation. **In order to qualify for these benefits, the pensioner or dependent must be expected to improve to a certain level of recovery.**

For pensioners and their dependents who are not eligible for Medicare, following a catastrophic illness or injury, the Plan will pay 90 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.

For Medicare eligible pensioners and their dependents, following a catastrophic illness or injury, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

These benefits are limited to 40 visits per calendar year for any combination of therapies. For pensioners only, these benefits are in addition to the physical therapy benefits for non-catastrophic conditions.

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

Home Health and Home Nursing Care

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.

For pensioners and their dependents who are not eligible for Medicare, 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.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount, for up to 60 visits a year.

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.

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

Hospice Care

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 percent of the Network-allowed amount when the care is provided at an in-Network facility. When a non-network is facility used, the Plan will pay 80 percent of the reasonable and customary charge for hospice care.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 80 percent of the Medicare co-insurance and deductible for hospice care.

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 a licensed health care provider that is a Medicare-approved hospice provider. The Plan will pay for hospice care in the same manner if the hospice care is provided in the patient's home, rather than in a facility.

Transportation by Ambulance

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 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 80 percent of the reasonable and

customary charge for transportation by ambulance. When an air ambulance is required, the Plan will pay for air transportation in the same manner.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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

Maternity Benefit

For pensioners and their dependents who are not eligible for Medicare, the Plan will pay 90 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.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

This benefit is to pay the *doctor's charge for delivery of a child* born to you, your spouse, or your dependent daughter who is under the age of 26. **However, the Plan does not provide any medical coverage, other than the delivery, for your dependent daughter's child.**

Charges for hospital room and board, hospital extras, and surgery, are paid in the same way as any other medical condition. To receive maternity benefits, you must be eligible for benefits at the time of delivery.

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

Elective Abortion

For pensioners and their dependents who are not eligible for Medicare, 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.

For pensioners and their dependents who are eligible for Medicare, the Plan will pay

toward the cost of an elective abortion for **you or your spouse**, at 50 percent of the Medicare co-insurance amount after Medicare benefits have been paid, 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 satisfied the annual deductible.

Nutritional Counseling

The Plan provides nutritional counseling benefits for pensioners and their dependents. To receive this benefit, you or your dependent must either have diabetes, or have a Body Mass Index (BMI) of at least 40, or a BMI over 35 and one or more of the following conditions:

- Type 2 diabetes
- Cardiovascular disease
- Hypertension
- Obstructive sleep apnea

The Plan will pay for up to three (3) sessions of nutritional counseling in the same way it pays for all other professional fees.

Both you and your dependents have coverage for nutritional counseling. Benefits are payable only after you have satisfied the annual deductible.

Gender Reassignment Surgery

The Plan provides gender reassignment surgery benefits for pensioners and their dependents who are age 18 or older. The Plan will cover services related to gender reassignment, including surgery and hormonal treatment, when this treatment is medically indicated. These benefits are paid in the same manner as other surgical services. For more information about the Plan's criteria for eligibility for these services, please contact the Claims Department at 1-800-252-4674.

Both you and your dependents are covered for gender reassignment surgery. Benefits are payable only after you have satisfied the annual deductible.

Durable Medical Equipment

Only pensioners are eligible for durable medical equipment benefits for a non-catastrophic illness or injury, or a chronic medical condition. The Plan does not provide coverage to dependents for durable medical equipment required due to a non-catastrophic illness or injury or chronic medical condition.

Both pensioners and their dependents are covered for durable medical equipment benefits when it is required to assist with rehabilitation following a catastrophic illness or injury.

For pensioners who are not eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 90 percent of the Network allowed charge for durable medical equipment from a Network provider. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for durable medical equipment.

For pensioners who are eligible for Medicare, following a non-catastrophic illness or injury, the Plan will pay 70 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

For pensioners and their dependents who are not eligible for Medicare, following a catastrophic illness or injury, the Plan will pay 90 percent of the Network allowed charge for durable medical equipment from a Network provider. When a non-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge for durable medical equipment.

For pensioners and their dependents who are eligible for Medicare, following a catastrophic illness or injury, the Plan will pay 70 percent of the Medicare co-insurance amount after Medicare benefits have been paid.

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 Board of Trustees must approve all durable medical equipment benefits over \$1,000 if purchased or over \$500 per month if rented.

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.

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

Hearing Aids

For all pensioners, the Plan will pay the actual charges, up to a total of \$3,000, for the purchase of hearing aids. The total benefit amount is \$3,000 regardless of whether you require one or two hearing aids. The \$3,000 hearing aid benefit is payable once every three years.

Dependents are not eligible for hearing aid benefits.

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

Vision Care

The Plan will pay a maximum of \$40 in vision care charges during a 24-month period for each pensioner and dependent. This benefit is not subject to the annual deductible.

Vision care services include eye examinations, eyeglasses, and contact lenses. Vision care services are available once every 24 months. There may be a medical reason for your dependent child (who is under age 19 only) 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.

Tobacco Cessation

The Plan provides tobacco cessation benefits for you, your spouse, and your dependent children over age 18 who are eligible to receive benefits.

You must contact CIGNA/CareAllies at 866-417-7848 to enroll in CIGNA's tobacco cessation program. Once you enroll, you will receive a 12 weeks supply of nicotine gum or an 8 weeks supply of nicotine patches (your choice), as well as resource materials and telephone coaching to support your efforts to quit using tobacco.

For residents of Puerto Rico, the Plan will directly reimburse you up to a maximum of \$175 which should provide you with a 12 week supply of nicotine gum or an 8 week supply of nicotine patches. Puerto Rico residents must submit the Nicotine Replacement Therapy Reimbursement Form with their receipts to the Plan in order to obtain reimbursement. The form is available online at: www.seafarers.org: *About / Health and Benefits Plan / Applications*; or you may contact the Plan at 1-800-252-4674 to request the form.

Both you and your dependents over age 18 are covered for the tobacco cessation program.

Telehealth

Telehealth is the delivery of health-related services through your smartphone, tablet, computer or other electronic device.

For pensioners who are not eligible for Medicare, the Plan will pay 90 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.

There is no dependent coverage for telehealth; and this benefit is not available to pensioners eligible for Medicare.

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

WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?

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

For pensioners who are not eligible for Medicare, you will receive prescription coverage through OptumRx, which is the same PBM that provided your coverage when you were an active employee.

For pensioners who are Medicare eligible, you will receive your prescription coverage from Retiree RxCare. This is a Medicare Part D Employer Group Waiver Plan. If you are eligible for Medicare, SHBP will automatically enroll you in this program, unless you notify us that you have decided to enroll in another Medicare Part D plan. **IMPORTANT: If you enroll in another Medicare Part D prescription plan, you will lose your prescription coverage from SHBP and you will not be able to re-enroll in the future.**

IRMAA for Certain Medicare Recipients

SHBP is paying Retiree RxCare for your prescription coverage if you are Medicare eligible. However, Medicare requires individuals with incomes above a certain level to pay an income-related monthly adjusted amount (IRMAA), which is deducted from your monthly Social Security check. You will receive a notice from Social Security if this applies to you. If you are required to pay IRMAA, the Plan will reimburse you for the monthly IRMAA payment if you send a copy of the Social Security notice or proof of IRMAA payment to the Plan. *Mail address:* Seafarers Pension Plan, 5201 Capital Gateway Drive, Camp Springs, MD 20746.

The annual prescription deductible is \$100. This prescription deductible is in addition to the health care annual deductible.

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 based upon the drugs’ safety and effectiveness, 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.

A copy of the formulary for **non-Medicare participants** is available at the following link: or you may call SHBP or OptumRx to request a paper copy. **If you are eligible for Medicare**, the formulary that applies to you is available from Retiree RxCare: www.retireerxcare.amwins.com.

Maintenance drugs, which are 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-PAY AMOUNTS

| PURCHASED AT RETAIL: 30 DAYS SUPPLY | CO-PAY AMOUNT |
|--|----------------------|
| Generic Drugs | \$10 |
| Brand-name Drugs included on Formulary | \$25 |
| Brand-name Drugs not included on Formulary | \$50 |
| <hr/> | |
| Generic Maintenance Drugs <i>(beginning with 3rd 30-day supply)</i> | \$30 |
| Brand-name Maintenance Drugs included on Formulary <i>(beginning with 3rd 30-day supply)</i> | \$75 |
| Brand-name Maintenance Drugs Retail not included on Formulary <i>(beginning with 3rd 30-day supply)</i> | \$150 |
| <hr/> | |
| PURCHASED AT MAIL ORDER: 90 DAYS SUPPLY | CO-PAY AMOUNT |
| Generic Maintenance Drugs | \$20 |
| Brand-name Maintenance Drugs included on Formulary | \$50 |
| Brand-name Maintenance Drugs not included on Formulary | \$100 |

“Specialty” drugs are drugs that are high cost (more than \$670 per month), may require special handling or storage, and are sometimes administered by injection. Specialty drugs are limited to a 30 day supply. The copayment amount for a 30 day supply of a specialty drug is \$50.

Prescription Policies for Non-Medicare Pensioners

Prior Authorization

Certain medications will require prior authorization from OptumRx. Your doctor must show that you have a medical necessity for that particular drug. These medications require prior approval because they are drugs that:

- have only been approved or found effective for treating certain conditions but are being prescribed for a different condition; or
- are prescribed for conditions for which their safety and effectiveness have not been proven; or
- cost more than other medications that are used to treat the same or similar conditions.

If your doctor is prescribing a medication for the first time, you or your doctor can check the PBM's list of drugs that require prior authorization. The prior authorization form and list of drugs requiring prior authorization is available on the online provider portal at www.optumrx.com or you may also call OptumRx to request a paper copy.

Quantity Limits

A quantity limit is the largest amount of a medication that you can receive per co-payment, or in a certain time period. OptumRx has quantity limits on certain medications to help to ensure that patients take the appropriate dosage of these drugs. These limits are based upon FDA recommendations for medication dosage, clinical guidelines or usage patterns.

Opioid Management Program

Certain limits apply to prescriptions for opioid medications. If you are currently taking a prescription opioid, or are prescribed an opioid, contact OptumRx for more information.

Exclusion for Compound Drugs

A compound drug is a customized medicine that is made to order by a pharmacist or doctor, or someone under their supervision, by combining, mixing, or altering ingredients of a drug to create a medication tailored to the needs of an individual patient. Compounded drugs are not approved by the FDA; therefore, their safety, quality and effectiveness have not always been established. In most cases there are safe, effective,

and lower-cost alternatives to compounded medications. This Plan will not pay for compounded drugs, unless your doctor provides a reason why there is not a suitable alternative. Your doctor may provide this information either by calling OptumRx at the phone number on the back of your ID card, faxing them a prior authorization form, or submitting the information to their online provider portal at www.optumrx.com.

New High Cost Drugs

The pharmaceutical industry is constantly introducing new, high cost drugs. In many cases, there already is an existing medication that successfully treats the same condition. This Plan will not pay benefits for a new drug for up to six months, until its effectiveness has been established by OptumRx. After the drug is approved, OptumRx will decide whether it will be paid for as a formulary or non-formulary drug (non-formulary drugs have a higher co-payment).

General Information

For more information about placing mail orders, or about your prescription coverage, call the phone number on your prescription card. If you do not have a prescription card, you may contact the Plan office at 1-800-252-4674.

Prescription Policies for Medicare Pensioners

If you are eligible for Medicare, you will receive more information from Retiree RxCare about the policies that apply to your prescription coverage. The phone number for the Retiree RxCare Customer Care Center is 855-693-3921. Upon initial coverage and every year thereafter, you will receive an Evidence of Coverage (“EOC”) booklet and an Annual Notice of Change (ANC).

DOES THE PLAN PAY FOR DENTAL CARE?

For all pensioners, the Plan will pay 80% of the reasonable and customary cost of dentures required by a pensioner, once in five years. In addition, the Plan will pay 80% of the reasonable and customary cost to repair such dentures. **Dependents of pensioners are not eligible for denture benefits.**

For all pensioners, the Plan will pay 100% of the reasonable and customary cost of surgical extractions, certain oral surgeries (pulpotomy, apicoectomy, and alveoloplasty), and related anesthesia for pensioners. For the dependents of pensioners, the Plan will pay 80% of the reasonable and customary cost of surgical extractions, certain oral surgeries (pulpotomy, apicoectomy, and alveoloplasty), and related anesthesia. If you require oral surgery, check with the Plan to find out whether the procedure is covered.

Neither pensioners nor their dependents are covered for routine dental care.

WHAT IS THE PENSIONER NURSING HOME BENEFIT?

The Plan can help pay the cost of nursing home care **for eligible pensioners. There is no nursing home benefit for dependents.** To be eligible to receive this benefit, you must meet certain requirements. You must first exhaust your Social Security, pension benefits, and Medicare benefits (if applicable). The Plan will then pay up to \$100 per week toward the remaining nursing home cost. Please contact the Plan at 1-800-252-4674 for more information.

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, CHILD, OR I HAVE OTHER HEALTH INSURANCE?

If you, your spouse, or your dependent child has other insurance, you must file a coordinated claim. The proper way to file a coordinated claim depends on who the patient was:

- If you, your spouse, or your child, are covered under **employer provided health insurance**, that insurer must pay benefits before the Plan will pay benefits.
- If you or your spouse is covered under Medicare and are the patient, Medicare must pay benefits before the Plan will pay benefits. However, if you are eligible for Medicare, but return to covered employment and are eligible for benefits

from the Plan as an active employee, the Plan will pay benefits first.

- 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.

Once the other insurer(s) has processed the claim, send the claim to the address listed on the back of your ID card. Be sure to include the Explanation of Benefits Statement that was sent to you by the other insurer(s).

When the Seafarers Health and Benefits Plan is the secondary 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.**

HOW CAN I REDUCE MY OUT OF POCKET COST?

If you are **not** eligible for Medicare, 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, co-insurances and deductibles. For more information about the Network, you may contact the Plan office or call the Network at the telephone number on your ID card.

In addition, if you are **not** eligible for Medicare and 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, coinsurances and deductibles. For more information about this program, call the telephone number on your ID card. **The out-of-network savings program does not apply to Humana participants.**

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

If you are **not** eligible for Medicare, 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.**

If you are not eligible for Medicare, you must also obtain pre-certification from the

Network for outpatient high technology radiology services, such as a CT scan, PET scan, MRI, heart catheterization, and echocardiography with stress test. If you do not obtain approval from the Network before you receive these services, the Plan will not pay benefits. You do not need pre-certification when these tests are performed in the emergency room or while you are an inpatient in the hospital.

If you are eligible for Medicare, this Plan does not require you to obtain pre-certification.

For more information, you may contact the Plan office at 1-800-252-4674, or call the Network at the telephone number on your ID card.

HOW DO I APPLY FOR HEALTH CARE BENEFITS?

Before filing a claim, make sure you have an **enrollment form** 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**. Before the Plan will pay benefits for your dependent children, you must send the Plan an official copy of **each child's birth certificate**. **The Plan also requests that you send a copy of each dependent's 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 Health and Benefits Plan section of the Seafarers website at www.seafarers.org.

If you are **not** eligible for Medicare, send **all** claims, except for vision, dental, and hearing aid claims, to the address on the back of the ID card that you have received from the Plan. **Both in-Network and out-of-network claims must be sent to this address.** If you lose this card, please contact the Plan at 1-800-252-4674. **Claims must be filed within 180 days of the date of service or they will be denied for late filing.**

If you **are** eligible for Medicare, you or your health care provider must file your claim with Medicare first. Once Medicare has processed your claim, your provider should submit the claim to the Plan, along with the Medicare Explanation of Benefits (EOB). **Send the claim, along with the Medicare EOB** to the Plan at the following address:

Seafarers Health and Benefits Plan
45353 Saint George's Avenue
Piney Point, Maryland 20674

The claim must be filed with the Plan within 180 days of the date that Medicare issued its Explanation of Benefits.

In most cases you 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. If the provider wants to file a claim electronically, they should refer to the back of your Medical ID card for information, or they may contact the Plan at 1-800-252-4674.

- 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.
- If you are **not** eligible for Medicare and you use 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, they should refer to the back of your Medical ID card for information, or they may contact the Plan at 1-800-252-4674.
- If you must pre-pay a non-network provider yourself, obtain a copy of the itemized bill. To receive benefits, you must send this itemized bill to the Network at the address on the back of your ID card. Make certain that the bill includes: pensioner's Social Security number, patient's name, provider's name, address, 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, dental, and hearing aid claims** to the following address:

Seafarers Health and Benefits Plan
 45353 Saint George's Avenue
 Piney Point, Maryland 20674

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

Benefits will be paid only if the treatment was received in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, or other U.S. territories or Canada.

Your claim for benefits may be *denied or limited* for any of the reasons listed below.

The Plan will not pay benefits:

- if your illness or injury is due to alcohol or drug use, unless you have a history of a substance abuse disorder;
- if your illness or injury occurred while committing a crime;
- if your illness or injury is due to something you knew, or should have known, was dangerous to your health or safety, unless your injury was caused by an act of domestic violence;

- if your illness or injury is due to behavior that showed you didn't care if you became sick or injured, unless your illness or injury was the result of a medical condition such as depression;
- if your illness or injury is due to the actions of someone else who can be held legally responsible. However, the Plan may pay benefits if you agree to assign payment to the Plan from any money you recover. This means that the Plan is entitled to full payment from any money you recover regardless of your legal expenses. If you do not repay the Plan, money may be deducted from any future benefits you might be entitled to receive.
- for treatment which is not approved for use in the United States or is considered to be experimental;
- for mental health treatment, including visits to a psychiatrist, psychologist or social worker;
- for the diagnosis or treatment of infertility;
- for sterilization;
- for bariatric surgery;
- to obtain any records or paperwork needed to pay a claim;
- on a claim if the medical records are insufficient, or if the records appear to be altered or fraudulent;
- if they can be paid under Workers' Compensation or another health and safety law;
- for treatment in a government hospital, where by law the Plan is not required to pay;
- for treatment that is needed because of war, an act of war, or because you were in the military;
- for treatment which is cosmetic. However, the Plan will pay for breast reconstruction following cancer treatment.
- for custodial care. Confinement in a hospital or nursing facility is considered custodial care if adequate treatment could be rendered in an outpatient setting;
 - **or** care consists of services and supplies that are provided primarily to train or assist in personal hygiene or activities of daily living rather than therapeutic treatment;
 - **or** the care consists of health services that do not seek to cure and which are

provided during a period when the medical condition of the patient is not changing. However, in certain circumstances, the Plan does provide a limited benefit for nursing home care for pensioners only (see description of Nursing Home Benefit on page 30).

- for treatment that is not medically necessary. This includes treatment that is required because of conditions that develop during the course of a hospital stay that could reasonably have been prevented.
- for routine visits to a podiatrist, unless the Plan determines such services are medically necessary;
- for weight loss drugs;
- for nutritional counseling; except it will pay for nutritional counseling for diabetics OR if you meet certain other criteria (see description of nutritional counseling on page 27).
- for chiropractic treatment;
- for acupuncture;
- for any benefit not specifically provided for in this booklet.

IS THERE ANY WAY I CAN LOSE MY RIGHT TO BENEFITS?

You may lose your right to receive benefits if:

- you don't seek medical treatment when you know you should, or if you don't follow your doctor's advice;
- you accept an overpayment from the Plan or a payment to which you are not entitled and you refuse to return it;
- if you fail to repay money that has been assigned to the Plan.

WHAT WILL HAPPEN TO MY BENEFITS IF I RETURN TO WORK IN THE MARITIME INDUSTRY?

If you are a pensioner and you decide to go back to work in the maritime industry for more than 60 days in a calendar year, either for an employer who contributes to the Plan, or for any employer in which you perform a job similar to the types of jobs covered by collective bargaining agreements with the SIU, **you may lose your pensioner's health benefits. If the Seafarers Pension Plan suspends your pension benefits because you have returned to work, your pensioner's health benefits will also be suspended.** During the period that your benefits are suspended, you will be eligible to purchase COBRA continuation coverage from the Plan.

You will reestablish eligibility for the benefits of an active employee once you have 90 days of continuous covered employment. **See the Guide to Benefits for Employees at the Core and Core-Plus Benefit level for more information about how to maintain eligibility for the benefits of an active employee.** When you decide to stop working again, and resume receiving your pension, your pensioner's health benefits will be reinstated.

WHAT EDUCATIONAL BENEFITS DOES THE PLAN PROVIDE?

Each year the Plan awards a limited number of scholarships for use at colleges or vocational schools. Information about this important benefit can be found in the summary booklet for the Seafarers Scholarship Program at: www.seafarers.org, in the Health and Benefits Plan section.

OR, to obtain a booklet, you can contact the Plan at:

Seafarers Health and Benefits Plan
Attn: Scholarship
5201 Capital Gateway Drive
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 a subcommittee of the Board of Trustees. They will look at all proof that they receive from you or anyone else. After completing their review, the subcommittee 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. If the subcommittee decision is unfavorable, and you have new and pertinent information, you may appeal to the full Board of Trustees for further consideration within 60 days of receiving the subcommittee 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
Attn: Claims Department
45353 Saint George's Avenue
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 e-mail, you must give the Plan permission to communicate with you by e-mail and provide your e-mail address. A form is available at www.seafarers.org in the Health and Benefits Plan section, which you can fill out and return to the Plan, or you can contact the Plan to request a copy of this form. Participant notices are also available online at: www.seafarers.org in the Health and Benefits Plan section.

WHAT PRIVACY RIGHTS DO I HAVE?

The Seafarers Health and Benefits Plan is committed to safeguarding the privacy of its participants. The Plan discloses protected health information only when it is necessary for medical treatment, payment of claims, or normal health care operations. As a participant in the Plan, you have certain privacy rights. These rights include:

You have the right to:

- request restrictions on certain uses and disclosures of your protected health information;
- receive confidential communications of your protected health information;
- inspect and copy your protected health information;
- amend your protected health information;
- an accounting of disclosures of your protected health information.

In addition, you have the right to receive a printed copy of the Plan's Privacy Notice. The current Privacy Notice is in Appendix A of this booklet. You can also obtain a copy online at www.seafarers.org in the Health and Benefits Plan section, from your local Plan representative, or from the Plan at:

Seafarers Health and Benefits Plan
Attn: Privacy Officer
5201 Capital Gateway Drive
Camp Springs, MD 20746

CAN THE PLAN TREAT ME DIFFERENTLY BECAUSE I HAD A GENETIC TEST THAT SHOWS THAT I AM MORE LIKELY TO GET A CERTAIN ILLNESS?

No. The Plan will not request information about any genetic test that you or a family member may have had, and the Plan will not use genetic information to make any decisions about your benefits.

WHAT OTHER RIGHTS DO I HAVE?

As a participant in the Plan, you have certain rights under the Employee Retirement Income Security Act of 1974. These rights include:

You have the right to:

- receive information about the Plan;
- inspect Plan documents at the Plan's office;
- receive copies of Plan documents for a small copying fee;
- receive a listing of signatory employers when requested in writing;
- receive a summary of the Plan's financial report;
- not be penalized or discriminated against by the Trustees of the Plan when you are applying for benefits;
- hire a lawyer, if you believe that your application for benefits was incorrectly turned down, or that a Trustee of the Plan has not done his/her job;
- continue health care coverage for you, your spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your spouse will have to pay for this coverage. Review the section of this booklet about COBRA continuation coverage for more information.
- have your questions answered by the Plan, and if you are not satisfied, to ask the U.S. Department of Labor.

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

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APPENDIX

- Notice of Nondiscrimination and Language Translation Services
- Notice of Privacy Practices
- Notice of Continuation Coverage Rights Under COBRA

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NOTICE OF NONDISCRIMINATION

The Seafarers Health and Benefits Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan will provide free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters,
- Written information in other formats (large print, audio, accessible electronic format, other formats).

The Plan provides free language services to people whose primary language is not English, in order to help you apply for benefits, or understand your benefits and eligibility. These services include:

- Qualified interpreters;
- Information written in other languages.

If you need assistance, tell any Plan representative that you speak with that you need translation services or information in another format, and the Plan will arrange for a qualified interpreter or provide information to you in an accessible format.

If you believe that the Seafarers Health and Benefits Plan has failed to provide these services or discriminated in any way against you on the basis of race, color, national origin, age, disability or sex, you can file a grievance/appeal to the Board of Trustees within 180 days of the day you became aware of the alleged discrimination. Your written appeal should be sent to:

Board of Trustees
Seafarers Health and Benefits Plan
45353 Saint George's Avenue
Piney Point, Maryland 20674

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

SEAFARERS HEALTH AND BENEFITS PLAN NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information found at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We share general claims information with the Plan's actuary in order to design Plan benefits.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
Example: We share information about your claims with your spouse's health plan in order to coordinate benefits.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
Example: We will share your claim information with the Board of Trustees if you submit an appeal.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address law enforcement, and other government requests

We can use or share health information about you:

- For Jones Act Claims upon receipt of a subpoena or authorization

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

If you attend the Seafarers Addictions Rehabilitation Center (ARC) we will never share any substance abuse treatment records without your written permission, unless we receive a valid subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- We will *never* share your information for marketing purposes, and we will not sell your information.

For more information, see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

For more information, contact the Privacy Officer at: privacyofficer@seafarers.org

Or by mail to: Seafarers Health and Benefits Plan, 5201 Capital Gateway Drive, Camp Springs, MD 20746

Telephone: (301) 899-0675; Website: www.seafarers.org

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following is a notice that describes your COBRA continuation coverage rights in the event that you or a family member loses health coverage from this plan. If you lose eligibility, and do not receive your COBRA Election Notice, please contact the Plan immediately at: 1-800-252-4674.

Seafarers Health and Benefits Plan

General Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan - Seafarers Health and Benefits Plan ("the Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator at:

Seafarers Health and Benefits Plan
Attn: Administrator
5201 Capital Gateway Drive
Camp Springs, MD 20746

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for

another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The parents become divorced or legally separated;

- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Due to the nature of the maritime industry, an employer may not always be aware when these events occur, because you may work for multiple employers. **Therefore, the Plan suggests that you or a family member also notify the Plan of these events.**

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Seafarers Health and Benefits Plan
Attn: COBRA
45353 Saint George's Avenue
Piney Point, MD 20674

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial

period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

You may obtain more information about your COBRA rights from the Seafarers Health and Benefits Plan by calling the Plan at 1-800-252-4674, and asking to speak with the COBRA Representative; or by writing to:

Seafarers Health and Benefits Plan
Attn: COBRA
45353 Saint George's Avenue
Piney Point, Maryland 20674

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