

**A GUIDE TO YOUR BENEFITS
FROM THE
SEAFARERS HEALTH AND BENEFITS PLAN
FOR PARTICIPANTS AT BENEFIT LEVEL S**



January 2022

TABLE OF CONTENTS

INTRODUCTION	1
INFORMATION YOU SHOULD BE AWARE OF.....	2
WORDS YOU NEED TO UNDERSTAND.....	3
WHAT IS THE ENROLLMENT BENEFICIARY CARD AND WHY IS IT IMPORTANT?	4
WHEN DO I FIRST BECOME ELIGIBLE TO RECEIVE BENEFITS?	5
WHAT MUST I DO TO REMAIN ELIGIBLE FOR BENEFITS?	6
TO MAINTAIN AND RE-ESTABLISH MY ELIGIBILITY, WHAT DAYS CAN BE COUNTED AS COVERED EMPLOYMENT?	6
WHEN WILL MY COVERAGE END?	7
CAN I EXTEND MY ELIGIBILITY TO RECEIVE BENEFITS BY PAYING THE PREMIUMS MYSELF?	8
WHAT IS THE ANNUAL DEDUCTIBLE AND HOW DOES IT WORK?	9
WHAT HEALTH CARE BENEFITS ARE PAID FOR BY THE PLAN?	10
WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?	15
WHAT BENEFITS ARE AVAILABLE FOR THE TREATMENT OF SUBSTANCE ABUSE?	16
WHAT BENEFITS DOES THE PLAN PROVIDE FOLLOWING A MASTECTOMY?	17
WHAT SHOULD I DO IF I FIND A MISTAKE ON MY HEALTH CARE BILL?	17

WHAT IF MY SPOUSE OR CHILD HAS OTHER HEALTH INSURANCE? 17

HOW CAN I REDUCE MY OUT OF POCKET COST? 18

DO I NEED TO OBTAIN PRE-CERTIFICATION WHEN USING NETWORK PROVIDERS? 18

HOW DO I APPLY FOR HEALTH CARE BENEFITS? 19

ARE THERE ANY REASONS WHY THE PLAN MAY NOT PAY BENEFITS? 20

IS THERE ANY WAY I CAN LOSE MY RIGHT TO BENEFITS? 22

WHAT BENEFITS CAN I RECEIVE FROM THE PLAN IF I BECOME DISABLED AND CAN NO LONGER WORK? 22

HOW DO I APPLY FOR SICKNESS AND ACCIDENT BENEFITS? 23

WHAT IS THE STANDARD DEATH BENEFIT? 23

WHAT IS THE ACCIDENTAL DEATH BENEFIT? 23

WHO CAN BE MY BENEFICIARY? 24

WHAT IS THE FUNERAL EXPENSE DEDUCTION? 24

HOW DOES MY BENEFICIARY APPLY FOR MY DEATH BENEFIT? 24

WHAT RIGHTS DO I HAVE IF THE PLAN DENIES MY CLAIM? 25

CAN I APPEAL TO HAVE A CLAIM APPROVED BEFORE I RECEIVE A MEDICAL SERVICE? 26

HOW WILL THE PLAN NOTIFY ME IF THERE ARE ANY CHANGES IN MY BENEFITS? 26

WHAT PRIVACY RIGHTS DO I HAVE? 26

WHAT RIGHTS DO I HAVE IF I LEAVE COVERED
EMPLOYMENT TO PERFORM MILITARY SERVICE? 27

CAN THE PLAN TREAT ME DIFFERENTLY BECAUSE I HAD A
GENETIC TEST THAT SHOWS THAT I AM MORE LIKELY TO
GET A CERTAIN ILLNESS? 28

WHAT OTHER RIGHTS DO I HAVE? 28

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA..... 29

INTRODUCTION

This booklet describes the benefits available to you and your family from the Seafarers Health and Benefits Plan.

The Seafarers Health and Benefits Plan is a multi-employer employee benefit plan. It provides benefits to employees of employers who have collective bargaining agreements with the Seafarers Entertainment and Allied Trades Union, Seafarers International Union of North America, Atlantic, Gulf, Lakes, and Inland Waters, or affiliated unions, and to the families of those employees. The Plan is funded through contributions made by these employers. The assets of the Plan are held in trust for the participants. As a participant in the Plan, you can depend on your benefits being there when you need them.

This booklet contains important information about your benefits. Read it carefully and keep it for future use. You may also view the booklet online at www.seafarers.org in the Health and Benefits Plan section, under Plan Level S. 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
(301) 899-0675

Language translation services are available for participants who need assistance with English. Call 800-252-4674 for more information.

This booklet is only a summary of the Seafarers Health and Benefits Plan. This booklet is referred to as the Summary Plan Description (SPD). The Rules and Regulations of the Plan and the Trust Agreement, together with laws that apply to benefit plans, control the payment of benefits.

The Seafarers Health and Benefits Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, 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 Affordable Care Act 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 Affordable Care Act, 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 table 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
David Heindel
Nicholas Marrone
Thomas Orzechowski
Joseph Soresi
George Tricker
Bryan Powell

William Cole
Ira Douglas
Edward Hanley
Todd Johnson
Damon Mote
Anthony Naccarato
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

beneficiary – The person or persons that you choose to have your death benefit paid to as shown on your beneficiary form.

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 are no longer eligible for coverage.

coinsurance – Your share of the costs of a covered health service, calculated as a percentage. For example, coinsurance for in-Network surgery is 30% of the allowed amount for the cost of the surgery. The co-insurance is the portion of the Plan's allowed amount that you are responsible for paying.

copayment – A fixed amount that you must pay for certain covered health care services. For example, the plan has a \$450 copayment for hospital stays and a \$300 copayment for emergency room treatment of an illness if the patient is not admitted to the hospital.

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

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

dependent child – Your child up to age 26 is a covered dependent if he or she is your natural, adopted, foster or stepchild. Your child may also be your dependent if the Plan receives a Qualified Medical Support Order which requires you to support the child.

dependent spouse – Your husband or wife is a covered dependent if you are legally married. The Plan will recognize your common law marriage, if the state where you live considers you married. If you get a divorce, your spouse is no longer eligible for coverage.

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

Formulary – A list of brand name drugs specified by the Pharmacy Benefits Manager.

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

out-of-network savings program – This program provides discounts for many health care providers that are not in the primary network. While you are still required to pay the out-

of-network co-payment when you visit a provider that participates in this program, there will be no additional balance billing.

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

pharmacy benefits manager (PBM) – A company that provides pharmacy benefits either by presenting a card at a pharmacy, or through mail order. The Plan currently uses OptumRx as its pharmacy benefits manager.

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. This Plan currently participates in the CIGNA network for all participants except for participants who reside in Puerto Rico. If you reside in Puerto Rico, the Plan participates in the Humana network. The Network logo is on your Plan ID card. You must use this card whenever you visit an in-network health care provider in order to receive services at the reduced cost.

qualifying payment amount – The amount that the Plan uses to determine the payment amount for out-of-network emergency services and out-of-network ancillary services at an in-network facility. The qualifying payment amount is usually determined based upon the Plan's median contracted rate for a given service in the same geographic region within the same insurance market.

reasonable and customary charge – The amount allowed by the Plan for a medical treatment or service for an out-of-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. You must have an enrollment form on file with the Plan in order to receive benefits. The form must include information about each of your dependents that you want to enroll in the Plan:

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

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

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

Before the Plan will pay benefits for your dependent children, you must send the Plan an official copy of each child's birth certificate. For adopted children, the Plan will need a copy of the adoption papers. For stepchildren, a copy of the custody award or other written proof will be required.

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

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

WHEN DO I FIRST BECOME ELIGIBLE TO RECEIVE BENEFITS?

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

You must complete 90 days of continuous covered employment in order to attain initial eligibility. Employment is considered to be continuous as long as there is a break of less than 90 days between jobs. In meeting initial eligibility requirements, "covered employment" means only the days that you work for an employer who pays into the Plan for your benefits.

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

WHAT MUST I DO TO REMAIN ELIGIBLE FOR BENEFITS?

For eligibility purposes, the Plan divides the calendar year into two 6 month eligibility periods, January 1 through June 30, and July 1 through December 31. Once you establish initial eligibility, you will be eligible for benefits for the remainder of that 6 month period. After that, you must have at least 60 days of covered employment during a 6 month eligibility period in order to remain eligible in the **next** 6 month period; OR a combined total of 125 days distributed between the 2 prior consecutive 6 month periods.

For example, once you establish initial eligibility:

- If you become eligible for benefits on February 1, you will be eligible for benefits until June 30. However, if you have 60 days of covered employment any time between January 1 and June 30, you will remain eligible for benefits through December 31.
- Alternatively, if you had only 50 days of covered employment between January 1 and June 30, but you had 75 days of covered employment from July 1 through December 31 of the prior year (a total of 125 in the 2 prior eligibility periods), then you will still remain eligible through December 31 of the current year.

If you lose eligibility, you must have 90 days of continuous covered employment to re-establish eligibility for benefits. **The Plan will begin counting your days of covered employment to re-establish on the day after you lose eligibility.** The Plan will consider your covered employment to be continuous if there is a break of less than 90 days between jobs or other covered employment.

If your 90th day of covered employment falls during the last month of an eligibility period (June or December) then you will be eligible until the end of the **following** 6 month period, as long as you accrue at least 30 days of covered employment in the 6 month period in which you reached your 90th day.

TO MAINTAIN AND RE-ESTABLISH MY ELIGIBILITY, WHAT DAYS CAN BE COUNTED AS COVERED EMPLOYMENT?

To maintain or re-establish your eligibility, the following days can be counted as covered employment:

- Days you worked for an employer who is obligated to pay into the Plan for your benefits.
- Days you received Maintenance and Cure, Longshore and Harbor Workers' compensation, or Workers' Compensation payments up to a maximum of 125 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 covered employment, and your employer must be remitting contributions to the Plan on your behalf during the period you are 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 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 upon your years of service.

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

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

NOTE: Even if your employer contributes to the Plan while you are unable to work due to illness or injury, you will still not be eligible for benefits for the treatment of an injury or illness that was incurred while you were employed on board a vessel. However, if you meet the Plan's eligibility requirements for health benefits, you will be eligible for all other health benefits that are not work related.

WHEN WILL MY COVERAGE END?

You, and any covered dependents, will lose health coverage when you no longer meet the eligibility requirements that are described on pages 5 – 6 of this booklet.

Other reasons you can lose health coverage:

- If you die at a time when you were eligible for benefits, your dependents' eligibility will end based upon your last day of covered employment under these same eligibility requirements.
- Your children's coverage will end at the end of the month in which they turn age 26.
- If you get divorced, your spouse will lose coverage as of the date of the divorce.
- After a divorce, in most instances, the Plan will continue to cover your children. However, if you have a Qualified Medical Child Support Order (QMCSO), you must submit the QMCSO to the Plan in order for the Plan to properly determine coverage and Coordination of Benefits (which parent's plan pays as primary and secondary). A QMCSO may state that you are responsible for your children's health care expenses, which would make this Plan primary, or it may state that your spouse has to provide primary health coverage, which would make this Plan secondary coverage. Please contact the Plan at 1-800-252-4674 for questions in regards to your specific situation.

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

You can extend your eligibility to receive health care benefits through COBRA continuation coverage. Under certain conditions, and for a limited time, you can extend your eligibility for benefits by paying premiums yourself. The amount of these premiums is set by the Plan. The health benefits that you receive through COBRA will be identical to the benefits that you received as an active employee. However, individuals receiving COBRA are not eligible for Sickness & Accident benefits.

You, your spouse or dependent children can extend eligibility to receive benefits, if certain events have happened.

These events include:

- You quit your job.
- You were laid off or fired from your job, unless you were fired for gross misconduct.
- You retire from your job before you are eligible for Medicare.

- You become disabled and are unable to work, but you are not yet eligible for Medicare.
- Your dependent child reached age 26.
- You get divorced and your spouse wants to continue receiving benefits.
- Upon your death your spouse or dependent child wants to continue receiving benefits.

There are special rules that apply to this extension of eligibility. A complete notice of your coverage continuation rights under COBRA appears at the end of this booklet. For more information concerning your right to extend your 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

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. The amount that you are responsible for paying each year is called the annual deductible. At the Plan S benefit level, the amount of the annual deductible is \$100 per person, up to a maximum of \$300 per family.

All benefits are subject to the deductible except:

- Death benefits
- Sickness and Accident benefits
- Inpatient Detoxification treatment
- Inpatient charges
- Prescription drug benefits, which have a separate deductible

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.**

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 your illness or injury. The Plan also pays benefits for certain services that are needed to maintain your health.

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

NOTE: Benefits not specifically listed in this booklet are not covered by this Plan.

SEAFARERS HEALTH AND BENEFITS PLAN SUMMARY FOR PLAN S BENEFIT LEVEL	
DESCRIPTION	Plan S Benefit
Annual Deductible	\$100 per individual/ \$300 per family for outpatient medical services \$100 per individual for prescriptions
Hospital Room and Board	Pre-certification required In-network 100% Out-of-network 70% R&C Maximum of 31 days or \$50,000 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.
Hospital Miscellaneous Extras	In-network 100% Out-of-network 70% R&C
Surgical, Inpatient	In-network 70% Out-of-network 65% R&C
Surgical, Outpatient	In-network 70% * Out-of-network 65% R&C *
Diagnostic Tests and X-rays, Inpatient	In-network 100% Out-of-network 70% R&C
Diagnostic Tests and X-rays, Outpatient	In-network 70% * Out-of-network 65% R&C *
Doctor's Visits, Inpatient	In-network 70% Out-of-network 65% R&C

Doctor's Visits, Outpatient	In-network 70% * Out-of-network 65% R&C *
Emergency Treatment	In-network 100% * Out-of-network 100% of the qualifying payment amount or the billed amount, whichever is less \$300 co-pay if treated for illness and not admitted to hospital Maximum of \$5,000 for all charges per emergency room visit
Home Health/Home Nursing Care	Non-covered
Hospice Care	Non-covered
Physical Therapy	Non-covered
Organ and Tissue Transplants	Non-covered
Vision Care	Non-covered
Dental Care	Non-covered
Prescription Drugs	70% of cost for Generic drugs @ Retail ** 75% of cost for Generic drugs @ mail order Generic prescriptions only; The Plan does not provide any benefits for the purchase of brand name drugs. ** For 30 day supply \$100 deductible per person
Sickness and Accident Benefit (employee only)	\$8 per day 125 days max
Death Benefit (for employee only)	\$5,000 to \$10,000; <i>(\$1,000 maximum if you don't name a beneficiary or beneficiary is not in Plan's close relative category.)</i>
Accidental Dismemberment	Non-covered
Psychiatric Inpatient	Non-covered
Psychiatric Outpatient	Non-covered
Substance Abuse Detox (employee only)	In-network 100%, Out-of-network 70% R&C <i>(Benefit is for Detox only.)</i>
Lifetime Limitation	None

*Subject to annual deductible

The following is more detailed information about the health care benefits that are covered by the Plan:

Hospital Room and Board

The Plan will pay 100 percent of the Network allowed charge for hospital room and board, for a maximum of 31 days, or \$50,000 per illness (whichever comes first) for confinement in a Network facility. If confined in an out-of-network facility, the Plan will pay 70 percent of the reasonable and customary charge for a maximum of 31 days or \$50,000 per illness, whichever comes first. Once you reach the limit of 31 days or \$50,000 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. **All inpatient facilities require pre-certification unless it is an emergency. Contact your Network (Cigna or Humana) at the phone number on your ID card.**

Both you and your dependents have coverage for hospital room and board. Payment for hospital room and board is based upon the hospital's semi-private room rate, unless a private room is medically necessary.

Intensive Care

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 an out-of-network facility, the Plan will pay 70 percent of the reasonable and customary charge.

The Plan will pay for intensive care confinements based upon the hospital's intensive care rate for up to 15 days. Beginning with the 16th day, the Plan will pay for intensive care at the hospital's semi-private room rate. Intensive care units include cardiac care units, burn units, and other special care units.

Both you and your dependents have intensive care coverage.

Hospital Extras

The Plan will pay 100 percent of the Network allowed charge for hospital extras while confined in a Network facility. If confined in an out-of-network facility, the Plan will pay 70 percent of the reasonable and customary charge.

Once you reach the maximum of 31 days, or \$50,000 in benefits per illness for all hospital facility-related fees (including hospital extras), you must be out of the hospital for at least 60 days before the Plan will pay for additional fees for hospital extras for the same illness.

Hospital extras include such things as: operating room charges, x-rays, oxygen, dressings, and drugs. Both you and your dependents have coverage for hospital extras.

Surgery

The Plan will pay 70 percent of the Network allowed charge for the surgeon when a Network provider is used. When an out-of-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 inpatient surgeries require pre-certification. Contact your Network (Cigna or Humana) at the phone number on your ID card.

Outpatient surgical benefits are payable only after you have satisfied the annual deductible. The deductible does not apply to the inpatient surgical benefit. Both you and your dependents have coverage for surgical benefits.

Anesthesia

The Plan will pay 80 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.

Both you and your dependents have coverage for anesthesia benefits. Anesthesia benefits are payable only after you have satisfied the annual deductible.

Visits by Doctors and Specialists in the Hospital

The Plan will pay 70 percent of the Network allowed charge for a doctor's visit in the hospital when a Network provider is used. When an out-of-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. This benefit applies to you and your dependents.

Emergency Treatment

The Plan will pay 100 percent of the Network allowed charge for emergency treatment provided to you or your dependent when a Network provider is used. When an out-of-network provider is used, the Plan will pay 100 percent of the qualifying payment amount or the billed amount, whichever is less.

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 or is not due to an injury, you are responsible for paying the first \$300 in charges. The Plan may deny payment for emergency treatment where a medical emergency did not exist.

The Plan will pay a maximum of \$5,000 for all charges resulting from an emergency room visit. Benefits are payable only after you have satisfied the annual deductible.

Out-of-Network Ancillary Services at an In-Network Facility

Sometimes you are treated at an in-Network facility, and some of the health care providers that treat you (such as the anesthesiologist, radiologist, surgeon or emergency room doctor) may be out-of-network. In this situation, the Plan will pay for these services at the percentage that would be allowed for an in-Network provider, based upon the qualifying payment amount or the billed amount, whichever is less. For example, for an out-of-network surgeon at an in-Network hospital, the Plan will pay 70% of the qualifying payment amount or the billed amount, whichever is less. For out-of-network anesthesia at an in-network facility, the Plan will pay 80% of the qualifying payment amount or the billed amount, whichever is less. For an out-of-network emergency room physician at an in-Network hospital, the Plan will pay 100% of the qualifying payment amount, or the billed amount, whichever is less, until the emergency room maximum is met.

Outpatient Doctor's Visits and Services

The Plan will pay 70 percent of the Network allowed charge when a Network provider is used. When an out-of-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge. This benefit includes such services as: X-rays, lab work, and physical examinations. The Plan does not provide benefits for outpatient treatment such as chemotherapy, radiation and dialysis. The Plan does not cover immunizations, unless such coverage is federally mandated.

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

Podiatric Services

The Plan will pay for up to 20 visits per year for podiatric services, up to a maximum of \$1,000 per year for all such services. This \$1,000 maximum includes podiatric surgery.

Maternity Benefit

The Plan will pay 70 percent of the Network allowed charge for maternity benefits when a Network provider is used. When an out-of-network provider is used, the Plan will pay 65 percent of the reasonable and customary charge.

This benefit is to pay the doctor's charge for delivery of a child born to you or your spouse only. The Plan does not provide maternity coverage to your child if she becomes pregnant. Charges for hospital room and board, hospital extras, and surgery are paid in the same way as any other medical condition. To receive maternity benefits, you must be eligible for benefits at the time of delivery.

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

Elective Abortion

The Plan will pay toward the cost of an elective abortion for **you or your spouse**, up to a maximum of \$300, including all related charges. If the abortion is not medically necessary, the Plan will pay for no more than one such abortion during a 12-month period. If an abortion is needed to preserve the health of the mother, the Plan will pay in the same way as for any other medical condition. The Plan does not provide abortion benefits to the child of an employee.

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

Continuity of Care

If you are being treated by an in-Network provider for a serious illness or for pregnancy, or have scheduled surgery with an in-Network provider, and that provider leaves the Network, the Plan will continue to pay at the in-Network rate for up to 90 days.

WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?

The Plan provides benefits for **generic** prescription drugs to participants in Plan Level S. 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.

The Plan provides prescription drug benefits to both you and your eligible dependents. The annual prescription deductible is \$100 per person. This deductible is in addition to the health care annual deductible. Once the prescription deductible is satisfied, the Plan will pay for generic prescriptions as described below

The Plan provides prescription drug coverage through an arrangement with a Pharmacy Benefit Manager (PBM). The PBM will issue you a prescription card. You must

present this card when you fill your prescription.

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

You will be expected to make a co-payment each time you purchase prescription drugs. When you purchase a generic prescription at a retail pharmacy, you will be responsible for a co-payment of 30% of the cost. You will save money if you purchase generic prescriptions through the mail order service. When you purchase through mail order, you will be responsible for 25% of the cost.

Although the Plan will not pay anything towards the cost of brand-name drugs, you will receive a discounted rate on these drugs when you use your prescription card. The discount will be greater when you use the mail order service. **Please note, this Plan does not provide benefits for specialty drugs.** Specialty drugs are high cost medications that are used to treat chronic or life threatening conditions, and require special handling, monitoring or administration.

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.

WHAT BENEFITS ARE AVAILABLE FOR THE TREATMENT OF SUBSTANCE ABUSE?

Inpatient Detoxification

The Plan will pay for inpatient detoxification in the same manner as all other hospital stays. The Plan will pay 100 percent of the Network allowed charge for confinement in a Network facility. If confined in an out-of-network facility, the Plan will pay 70 percent of the reasonable and customary charge. This benefit is limited to \$50,000 per hospital stay. This benefit is for employees only.

The Plan does not pay for follow-up treatment, or provide any other substance abuse benefits, for participants at the Plan S benefit level. Dependents are not eligible for substance abuse treatment benefits.

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. 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 OR CHILD HAS OTHER HEALTH INSURANCE?

If your spouse has insurance through his or her employer, you must file a coordinated claim. The proper way to file a coordinated claim depends on who the patient was:

- If you were the patient, send the claim to the Network address listed on the back of your Network ID card. After your claim has been paid by the Seafarers Health and Benefits Plan, send the claim to your spouse's insurer. Be sure to include the Explanation of Benefits Statement you received when your claim was processed.
- If your spouse was the patient, send the claim to your spouse's insurer first. Once your spouse's insurer has processed the claim, send the claim to the Network at the address listed on the back of your Network ID card. Be sure to include the Explanation of Benefits Statement that was sent to you by your spouse's insurer.
- If your child was the patient, the insurer that should get the claim first is the insurer of the parent whose birthday comes earliest in the year. After an Explanation of Benefits statement has been received from the first insurer, you should then file a claim under the other parent's coverage. This rule may not apply if coverage is provided for under a Qualified Medical Child Support Order.

EXAMPLE: You are covered by the Seafarers Health and Benefits Plan and your spouse also has health insurance. Your birthday is May 3 and your spouse's birthday is April 4.

Claims for your dependent children should first be sent to your spouse's insurance, since your spouse's birthday is earlier in the year.

When the Seafarers Health and Benefits Plan is the second payer, the date the claim accrued is the date on which the first insurer made a payment. You must apply to the Seafarers Health and Benefits Plan for benefits within 180 days following that date.

If your child has health benefits through his or her employment, that insurance coverage will be the primary payer for your child. After that insurance pays the claim, the claim may be submitted to this Plan for secondary payment, by sending the claim to the Network at the address on the back of your ID card.

If your spouse or child is eligible for Medicare, Medicare is the usually the primary payer for them. After Medicare pays the claim, it should be submitted to the Plan for secondary payment. However, if you (the employee) are eligible for Medicare, the Seafarers Health and Benefits Plan will pay benefits first for you and your dependents as long as you meet the Plan's eligibility requirements and you are actively engaged in covered employment.

HOW CAN I REDUCE MY OUT-OF-POCKET COST?

You can reduce your out-of-pocket cost by using Network providers. The Plan pays an out-of-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 out-of-network providers. In addition, in-Network providers have agreed to accept the Network allowed amount as payment in full, after you have paid any required co-payments and deductibles. For more information about the Network, you may contact the Plan office, check the Network website listed on your Plan ID card, or call the Network at the telephone number on your ID card.

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

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

The Plan has arranged for you to receive services through a network of preferred providers. **Pre-certification from the Network is required prior to any surgery or hospitalization. You also must notify the Network within 48 hours following emergency**

surgery or emergency hospitalization. Benefits will not be paid if you fail to notify the Network. If you have asked the provider to notify the Network for you, make certain they have done so by contacting the Network yourself. **Remember, it is your responsibility to notify the Network.**

For 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 Member Benefits section of the Seafarers website at www.seafarers.org.

Send **all** 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.**

- When you use a network provider you usually do not have to file a claim yourself. The provider will file the claim for you. They can either file the claim electronically or by mail.
- In order to permit the Plan to pay the health care provider instead of you, the provider will ask you to sign a document assigning your benefits to them. If the Plan receives proof that you have paid the provider in full, the Plan will pay you directly.
- When using an out-of-network provider, ask if the provider will accept direct payment from the Plan. In many cases, the provider will file the claim for you. If the provider wants to file a claim electronically, have them contact the Plan at 1-800-252-4674.
- If you must pre-pay an out-of-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: employee's Social Security number, patient's name, provider's name, address, and ID number, date of service, diagnosis, description of treatment, supplies provided, and itemized costs. The Plan will process your claim within 30 days after

receiving it. **However, your claim will not be paid unless it is filed within 180 days of the date the claim accrued.**

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.

Certain conditions or services are not covered by this Plan. 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 the treatment of an illness or injury that began while you were employed on board a vessel;
- for substance abuse treatment except for inpatient detoxification;
- for treatment which is not approved for use in the United States or is considered to be experimental;
- for bariatric surgery, gender orientation surgery, or any related treatment;
- for organ and tissue transplants;

- for dialysis;
- for chemotherapy or radiation therapy;
- for the diagnosis or treatment of infertility;
- for birth control or sterilization;
- for immunizations, unless coverage is mandated by federal regulations;
- for transportation by ambulance;
- 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.
- 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 weight loss drugs or nutritional counseling, except it will pay for nutritional counseling for diabetics;
- for cardiac rehabilitation;
- for occupational, rehabilitative, or speech therapy;

- for chiropractic treatment or physical therapy;
- for more than \$1,500 per year for pain management services;
- 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.

If you accept an overpayment from the Plan or a payment to which you are not entitled and you refuse to return it, you may lose your right to benefits. You also may lose your right to benefits if you fail to repay money that has been assigned to the Plan.

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

If you are unable to work because of illness or injury that did not occur at your job, you can receive Sickness and Accident (S&A) benefits from the Plan. In order to be eligible for S&A benefits, you must meet the Plan's eligibility requirements described on page 5. This benefit only applies to employees. Dependents are not eligible for S&A benefits.

You can receive S&A benefits for up to 125 days during any 12-month period. The 12-month period begins with the first day of your disability. The amount of the S&A Benefit is \$8 a day. In addition, the Plan will pay the FICA and Medicare taxes due on the benefit to the Internal Revenue Service, on your behalf. You can receive S&A benefits only if you are not receiving Workers' Compensation, state disability payments, unemployment benefits, or Maintenance and Cure payments. You also cannot receive S&A Benefits if you are receiving wages or vacation pay from your employer.

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

Your S&A benefits end when you are no longer disabled and can return to work, or if you begin receiving SSI disability benefits.

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

HOW DO I APPLY FOR SICKNESS AND ACCIDENT BENEFITS?

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

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

WHAT IS THE STANDARD DEATH BENEFIT?

Upon your death, your beneficiary may receive a Standard Death Benefit if he or she is a relative listed in the paragraph titled "Who Can Be My Beneficiary" that appears below. The amount of the Standard Death Benefit is \$5,000. This benefit is subject to the Funeral Expense deduction, which is described below. If you did not name a beneficiary, or your named beneficiary died before you, then the Plan will pay your estate a death benefit of \$1,000.

For your beneficiary to receive the Standard Death Benefit, you must have met the Plan's requirements for maintaining eligibility (as described on page 5) during the two calendar years before your death. The beneficiaries of employees who do not meet the requirements of the Standard Death Benefit may still receive a payment from the Plan. If you die within twelve months after your last day of covered employment, your beneficiary can receive a \$500 death benefit.

WHAT IS THE ACCIDENTAL DEATH BENEFIT?

Upon your death, if it was the result of an accidental injury that did not occur during, or arise out of the course of employment, your beneficiary may receive an Accidental Death Benefit of \$5,000 if he or she is a relative listed in the paragraph titled "Who Can Be My Beneficiary" below. This will be in addition to the Standard Death Benefit listed on page 23 of this booklet. If no beneficiary has been designated, no benefit shall be payable.

For your beneficiary to receive the Accidental Death Benefit, you must have met the Plan's requirements for maintaining eligibility (as described on pages 5 and 6) during the two calendar years before your death.

WHO CAN BE MY BENEFICIARY?

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

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

*Niece and Nephew are defined as the children of the brother or sister of a deceased employee.

If the beneficiary you have named is not a relative on this list, the maximum amount he or she can receive as the Standard Death Benefit is \$1,000. If you do not name a beneficiary, a maximum of \$1,000 will be paid to your estate.

It is extremely important to keep your beneficiary information up to date to ensure that all the benefits you have earned will be paid to your beneficiary. The death benefit is only provided to the beneficiary of an employee; there is no benefit upon the death of a dependent.

WHAT IS THE FUNERAL EXPENSE DEDUCTION?

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

HOW DOES MY BENEFICIARY APPLY FOR MY DEATH BENEFIT?

To receive your death benefit, your beneficiary must file an Application for Death Benefits with the Plan. Your beneficiary can obtain an application from the Plan's main office, from your local representative, online at www.seafarers.org under the "About" section, or by calling the Plan at 1-800-252-4674.

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

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

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

WHAT 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's 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's 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
45353 St. 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 email, you must give the Plan permission to communicate with you by email, and provide your email address. A form is available at www.seafarers.org under the "About" section which you can fill out and return to the Plan, or you can contact the Plan to request a copy of this form.

WHAT PRIVACY RIGHTS DO I HAVE?

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

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. If you do not already have a copy of the Privacy Notice, you can obtain a copy online at www.seafarers.org under the "About" 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, Maryland 20746

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

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

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

Upon returning to covered employment, your eligibility to receive benefits will be the same as it was when you left covered employment, except for service-related illnesses and injuries, which are excluded from coverage.

For more information concerning your right to extend your eligibility by paying premiums yourself, contact the Plan at:

Seafarers Health and Benefits Plan
Attn: COBRA
45353 Saint George's Avenue
Piney Point, Maryland 20674
1-800-252-4674

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

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

WHAT OTHER RIGHTS DO I HAVE?

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

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 if there is a loss of coverage under the plan as a result of a qualifying event. You 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 Ave. N.W.
Washington, D.C. 20210

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following is a notice that describes your COBRA continuation coverage rights in the event that you lose 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.

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);
- The parents become divorced or legally separated; or
- 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 employee 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).

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 health 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

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

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

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