GUIDE TO YOUR BENEFITS

FROM THE

SEAFARERS HEALTH AND BENEFITS PLAN

FOR PARTICIPANTS RESIDING IN

PUERTO RICO

May 2024

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INTRODUCTION

This booklet applies to all participants in the Seafarers Health and Benefits Plan who reside in Puerto Rico, except for pensioners who are eligible for Medicare. It describes the benefits available to you and your dependents from the Plan. The Plan has contracted with MCS, a local company in Puerto Rico, to provide most medical and dental benefits to you and your family. The website for MCS is: www.mcs.com.pr. MCS participates in the United Healthcare network.

There are certain benefits that are provided directly by the Plan. You must apply to the Plan's office in Maryland to receive COBRA continuation coverage, vision benefits, Sickness and Accident benefits, accidental dismemberment benefits, scholarship benefits, long term disability benefits, funeral expenses, and death benefits. Your pharmacy benefits are provided through OptumRx.

If you are a non-Medicare Pensioner who receives health benefits from this Plan, you will receive all of the benefits described in this booklet, except for Sickness and Accident benefits and the Graduated Death Benefit. If you are a participant at Plan Level S or at the Apprentice benefit level, you will receive all the benefits described in this booklet except for the Graduated Death Benefit.

The Seafarers Health and Benefits Plan is a multi-employer employee benefit plan. It provides benefits to employees of employers who have collective bargaining agreements with the Seafarers International Union of North America, Atlantic, Gulf, Lakes, and Inland Waters ("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 Benefits 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
(301) 899-0675

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.

IMPORTANT INFORMATION ABOUT THE PLAN

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	Ira Douglas
Nicholas Marrone	Edward Hanley
Thomas Orzechowski	Todd Johnson
Bryan Powell	Damon Mote
Joseph Soresi	Anthony Naccarato
Mario Torrey	Scott Winfield
George Tricker	Eunice Young

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 enrollment beneficiary card.

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

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

Coinsurance—Your share of the costs of a covered health care service, calculated as a percentage. *For example*, coinsurance for certain professional fees, diagnostic tests and outpatient care is 10%.

Copayment—A fixed amount that a participant must pay for certain covered health care services. *For example,* the Plan has a $450 copayment for hospital stays, a $300 copayment for emergency room treatment unless the patient is injured or admitted to the hospital, a $7 copayment for general doctor's visits, and various copayments 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, or step-child. 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.

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.

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 MCS network for all participants who reside in Puerto Rico. 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. If you have an emergency while in the continental U.S., United Healthcare is the preferred provider network.

Qualifying Payment Amount (QPA)—The amount used to calculate the payment for out-of-Network emergency services, or out-of-network ancillary services performed at in-Network facilities. The QPA will be determined based upon a formula set by the federal government.

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. For you to receive benefits, you must have an enrollment form on file with the Plan. The form must include the names of 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 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

To be properly enrolled in the Plan, 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 and a new enrollment form. MCS will not provide benefits to an individual who does not provide a Social Security number or ITIN number. 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 be responsible for any claims paid on their behalf and 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 at www.seafarers.org under the Benefits tab, from your local Plan representative or from the Plan's Claims Department at:

Seafarers Health and Benefits Plan
45353 St. George's Avenue
Piney Point, MD 20674
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. Eligibility is determined according to the rules of the Seafarers Health and Benefits Plan; it is not determined by MCS.

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 in 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 notify MCS, and MCS will send you an ID card. You should bring this card with you whenever you seek medical services. If you think you are eligible for benefits, but have not received an ID card, please contact the MCS Client Service Center at 787-281-2800 or 1-888-758-1616. Individuals with auditory impairments may call 1-866-627-8182 (TTY).

There are special eligibility rules that apply to Apprentices. If you are an **Apprentice**, you are eligible for the benefits described in this booklet when you are employed on board a vessel during Phase II and Phase III of the Unlicensed Apprentice Program only. After that, you will become eligible for benefits again when you meet the requirements described above and below.

WHAT MUST I DO TO REMAIN ELIGIBLE FOR BENEFITS?

For eligibility purposes, the Plan divides the calendar year into two 6 month eligibility periods. The eligibility periods are 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 for the **next** 6 month period; OR a total of 125 days of covered employment distributed between the two eligibility periods immediately preceding the date of the claim.

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.

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 OR 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 Worker's 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 covered employment.

- 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.

  The following chart applies to employees at the Core-Plus at Core Benefit levels:

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

If you are at the Core-Plus or Core benefit levels, you may build up a reserve of as much as 90 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. The 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.

If your employer contributes to the Plan at the Plan S benefit level, you may build up a reserve of up to 40 days when you are receiving S&A benefits or state disability benefits to extend your eligibility. These days may be saved for up to 3 years from the date in which the benefits were paid. Once you use any of these days, the reserve is no longer available.

Apprentices and non-Medicare Pensioners do not receive S&A benefits, so they cannot extend their eligibility in this way.

WILL I CONTINUE TO RECEIVE HEALTH BENEFITS FROM THIS PLAN IF I RETIRE ON A PENSION FROM THE SEAFARERS PENSION PLAN?

In order to be eligible for pensioner health benefits, you must meet the following eligibility 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 2024, you will need at least 60 days of covered employment during the eligibility period from January 1, 2024 through June 30, 2024; and 60 days of covered employment during the eligibility period from July 1, 2023 through December 31, 2023; **OR** 125 days of covered employment during 2023 (previous calendar year).

Covered employment includes all days that count as covered employment for purposes of maintaining your eligibility for health benefits (described on page 6). However, covered employment does not include "Extra Service Credit" or "Supplemental Service Credit" earned under the Seafarers Pension Plan. These days do not count for eligibility for health benefits. In addition, days for which you receive more than one day's credit for one day worked and/or credit received for Vacation days are not counted towards eligibility for health benefits.

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 - 7 of this booklet.

Other reasons you can lose health coverage:

- If you are an employee and 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 QMSCO 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 or scholarship benefits; and, time when a former employee is receiving COBRA does not count towards qualifying for the graduated death benefit.

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

- You quit your job.
- You were laid off or fired from your job, unless you were fired for gross misconduct.
- You retire from your job before you are eligible for Medicare.
- You become disabled and are unable to work, but you are not yet eligible for Medicare.
- Your dependent child reached the age of 26.

- You get divorced and your spouse or dependent wants to continue receiving benefits.
- Upon your death, your spouse or dependent wants to continue receiving benefits.

There are special rules that apply to this extension of eligibility. A complete notice of your coverage continuation rights under COBRA appears in Appendix A 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

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 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. For the purpose of tracking the deductible, the year begins on October 1, and ends September 30 of the following calendar year,

The annual deductible amount is $250 per person, but not more than $750 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 health benefits are subject to the deductible except:

- Death benefit
- Accidental Dismemberment benefit
- Sickness and Accident benefit
- Inpatient hospital facility charges, which has a $450 copay
- Hospice care
- Prescription drug benefit, which has a separate deductible
- Dental benefit
- Vision care benefit

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

The Plan has an out-of-pocket maximum of $2,700 for an individual, and $5,500 for a family of two or more per year. **This means that once you spend this amount on deductibles, copayments and co-insurance in a year, the Plan will then pay 100% of the Network-allowed amount for you and your family (if applicable) for the remainder of the year.** For the purpose of tracking the out-of-pocket maximum, the year begins on October 1, and ends September 30 of the following calendar year.

The following claims count towards the out-of-pocket maximum: all in-Network claims, claims for out-of-network emergency room treatment, out-of-network claims for ancillary services at an in-Network facility and air ambulance claims.

WHAT HEALTH CARE BENEFITS ARE COVERED 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 chart below and on the following pages is a brief summary of the health care benefits covered by the Plan. For more details, and additional benefit information, please review the appropriate benefit descriptions listed after the chart. You will also receive additional information about your medical and dental benefits directly from MCS.

SEAFARERS HEALTH AND BENEFITS PLAN – BENEFITS SUMMARY FOR PUERTO RICO **These services are subject to deductible.* *All in-patient facilities require pre-certification. Contact MCS at phone number on ID card.*	
DESCRIPTION	**Payment Amount** (applies to all Plan levels, unless noted)
Annual Deductible	$250 Individual (medical) $750 Family (medical)
Out of pocket maximum	$2,700 Individual (medical) $5,500 Family (medical)
Hospital Room and Board And Hospital Miscellaneous Extras	**Pre-certification required** Plan pays 100% $450 admission copay
Inpatient Rehabilitation (at skilled nursing facility or acute rehabilitation facility)	**Pre-certification required** Paid in the same manner as Hospital Room and Board above.
Surgery, Inpatient (professional fee)	**Pre-certification required** Plan pays 100% in network *
Surgery, Outpatient (professional fee)	Plan pays 100% in-network *

DESCRIPTION	**PAYMENT AMOUNT** (all Plan levels, unless noted)
Doctor's Visits – inpatient Outpatient: Generalist Specialist Sub-specialist	Plan pays 100% in-network, 90% out-of-network * $10 copay * $15 copay * $18 copay *
Diagnostic Tests and X-rays, Inpatient	Plan pays 100% *
Diagnostic Tests and X-rays, Outpatient	Plan pays 90% * **Pre-certification required for CT scan, PET scan and MRI**
Annual Physical Well baby care	Plan pays 100% Plan pays 100%
Cancer Treatment (chemotherapy and radiation) Inpatient or Outpatient	Plan pays 90% *
Emergency Treatment (in emergency room)	Plan pays 100% * $300 copay if treated for illness and not admitted to hospital
Cardiac Rehabilitation	$7 copay * Limit 40 visits per year
Physical/Occupational/ Speech/Pulmonary/ Cognitive Therapies	$7 copay * Limit 60 visits per year (for all services combined)
Mental health, Inpatient	Facility charge: Plan pays 100% $450 admission copay
Mental health, Outpatient (includes substance use counseling)	$15 copayment *
Substance Use Detox and Inpatient Substance Use Disorder treatment	Facility charge: Plan pays 100% $450 admission copay
Organ and Tissue Transplants	Plan pays100% up to $2 million through MCS, if over $2 million contact Plan *
Home Health/ Home Nursing Care	Plan pays 90% * Combined maximum of 60 visits a year
Hospice Care	Plan pays 90%

SEAFARERS HEALTH AND BENEFITS PLAN SUMMARY FOR PUERTO RICO **These services are subject to deductible.* *All in-patient facilities require pre-certification. Contact MCS at phone number on ID card.*	
DESCRIPTION	**PAYMENT AMOUNT** (all Plan levels, unless noted)
Prescription Drugs	Coverage depends on your employer's contribution rate. See detailed description on pages 22 - 25
Vision Care (must apply through Plan's Claims department in Maryland)	**Seafarer:** Core-plus - $400 maximum in 24 months; Core - $250 maximum in 24 months **Pensioner**: $80 maximum in 24 months **Dependent:** Core-Plus - $400 maximum in 24 months *Core*-$80 max in 24 months, Pensioner dependent - $80 max in 24 months. *No coverage for Apprentices or Plan S*
Hearing Aids	$3,000 maximum every 3 years for one or two hearing aids*
Dental Care	$2,000 maximum per year $4,000 orthodontia lifetime maximum no limit on pediatric preventive dental care
Sickness and Accident	39 weeks @ $25 per day for Core-Plus and Core $8 per day for Plan S *(seafarer only, not available at Apprentice and Pensioner benefit levels)*
Death Benefit	$5,000 to $50,000 *($1,000 maximum if you don't name a beneficiary or beneficiary is not in Plan's close relative category.)* *(Applies to death of seafarer only)*
Accidental Dismemberment	$2,500 to $5,000 *(seafarer only)*
Scholarship Program	***Seafarers:*** 2 - two year scholarships @ $6,000 each; 1 - four year scholarship @ $20,000. ***Dependents:*** 5 - four year scholarships @ $20,000 each
Vaccines	Plan pays 100% for preventive vaccines.

The following is a detailed description of the health care benefits covered by the Plan. Please note, these descriptions apply when you receive services from a health care provider that is in-network with MCS. **If you visit an out-of-network provider, you must pay the full amount, and request reimbursement from MCS. You will be reimbursed based upon the amount that would be allowed for an in-network provider.**

Hospital Room and Board

The Plan will pay 100 percent of the MCS contracted amount for hospital room and board. ***All in-patient facilities require pre-certification. Contact MCS at the phone number on your ID card.***

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

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

Hospital Extras

The Plan will pay 100 percent of the MCS contracted amount for hospital extras. ***All in-patient facilities require pre-certification from MCS.***

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

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

Intensive Care

The Plan will pay 100 percent of the MCS contracted amount for confinement in an intensive care unit.

Intensive care units include cardiac care units, burn units, and other special care units. ***All in-patient facilities require pre-certification. Contact MCS at the phone number on your ID card.***

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

Inpatient Rehabilitation

The Plan will pay benefits for inpatient rehabilitation. Types of rehabilitation covered are physical therapy, occupational, speech, pulmonary, and cognitive therapies.

Once you reach maximum medical improvement, the Plan will no longer pay for inpatient rehabilitation. The Plan will not pay benefits for custodial care. ***All in-patient facilities***

require pre-certification. Contact MCS at the phone number on your ID card.

Payment for inpatient rehabilitation is subject to a $450 admission copayment. You are only required to pay this $450 copayment once for the entire confinement in the rehabilitation facility. Both you and your dependents have coverage for inpatient rehabilitation following a catastrophic illness or injury.

Surgery

The Plan will pay 100 percent of the MCS contracted amount for the surgeon. If you are in an in-Network hospital and the surgery is performed by an out-of-network surgeon, the Plan will pay 100 percent of the qualifying payment amount.

The Plan will pay an assistant surgeon (a physician) 80 percent of the MCS contracted amount.

All in-patient surgeries require pre-certification. Contact MCS at the phone number on your ID card.

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

Anesthesia

The Plan will pay 100 percent of the MCS contracted amount for the professional fee for anesthesia. However, if you go to an in-Network hospital and the anesthesiologist is out-of-network, the Plan will pay 100 percent of the Qualifying Payment Amount, and the provider should not balance bill you.

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 90 percent of the MCS contracted amount for a doctor's visit in the hospital when a Network provider is used. If you are treated by an out-of-network doctor while you are a patient at an in-Network facility the Plan will pay up to 90% of the Qualifying Payment Amount, and the doctor should not bill you for the balance.

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

Outpatient Doctor Visits and Services

You will be required to pay a set copayment when you visit a doctor. The copayment amount depends on the type of doctor you see. The copayment is $10 for a generalist, $15 for a specialist, and $18 for a sub-specialist. The Plan will pay the remainder of the MCS contracted amount.

Both you and your dependents are covered for outpatient doctor's visits. Benefits are payable only after you have satisfied the annual deductible.

Outpatient Diagnostic Tests and X-rays

The Plan will pay 90% of the MCS contracted amount for most outpatient diagnostic tests. This benefit includes services such as lab tests, X-rays, PET scan, CT scan, and MRI. x-rays, sonograms, MRIs, and CT scans. **Prior authorization from MCS is required for MRI and CT scans.** Contact MCS for information.

The Plan will pay 100% of the MCS contacted amount for mammograms.

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

Annual Physical Examinations

The Plan will pay 100% of the MCS contracted amount for an annual physical exam. For **seafarers**, this exam may either be performed at a clinic that is contracted with the Plan **(fit for duty exam)** or by your own physician.

For each seafarer and dependent, the Plan will pay toward the cost of a routine physical examination once every twelve months.

Emergency Treatment

The Plan will pay 100 percent of the MCS contracted amount for treatment of an emergency medical condition in an emergency room when an in-Network provider is used. When a non-network provider is used, the Plan will pay 100 percent of the Qualifying Payment Amount for treatment in an emergency room and hospital until the emergency medical condition is stabilized. **The emergency room should not bill you for the balance.**

An **emergency medical condition** is a medical condition, including a mental health condition or a substance use disorder, that is so severe that it would be reasonable for you to expect that your health would be in jeopardy if you did not receive immediate medical attention. If you receive emergency treatment in a hospital emergency room 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.

You may also seek treatment for many emergency conditions at an Urgent Care center operated by MCS. There are 19 MCS Urgent Care Centers conveniently located throughout Puerto Rico. There is a copayment of $35 for treatment at an MCS Urgent Care Center.

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

Transportation by Ambulance

The Plan will pay will pay up to $75 per trip, for up to 4 trips per year when transportation by ambulance is medically necessary due to a medical emergency.

The Plan will pay 90% of the MCS contracted amount for transportation by an **air**

ambulance within Puerto Rico when an air ambulance is medically necessary. The Plan will pay 80% of the United Healthcare contracted amount for transportation by air ambulance in the continental U.S. The Plan will cover one trip per year for air ambulance transportation.

Both you and your dependents have coverage for ambulance transportation. The annual deductible does not apply if it is a true emergency.

Maternity Benefit

The Plan will pay 100 percent of the MCS contracted charge for maternity benefits. 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. If the office visits for medical conditions related to your pregnancy are not included in your doctor's global fee, you will pay a $15 copayment for each office visit, and the Plan will pay the remainder of the MCS contracted charge.

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

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

Infertility Benefit

The Plan will pay up to $10,000 per **eligible seafarer or their spouse** to diagnose or treat infertility. In order to qualify for this benefit, you must meet the Plan's criteria for infertility. Please contact the Plan for more information at (800) 252-4674.

The Plan will pay 90 percent of the MCS contracted amount for infertility benefits. Once the $10,000 limit is reached, the Plan will not provide any additional benefits to diagnose or treat infertility.

The cost of infertility prescriptions is included in the $10,000 limit.

Sterilization Benefit

The Plan will pay benefits for a tubal ligation or for a vasectomy for an **eligible seafarer or the spouse of an eligible seafarer.** the Plan will pay 90 percent of the MCS contracted amount for a tubal ligation or a vasectomy. The Plan does not cover the reversal of these procedures.

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

Elective Abortion

The Plan will pay toward the cost of an elective abortion for an **eligible seafarer or the spouse of an eligible seafarer,** 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.

Cancer Treatment

The Plan will pay 90 percent of the MCS contracted amount for cancer treatment. This benefit includes such services as chemotherapy and radiation.

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

Genetic Testing

The Plan will pay for genetic testing if it meets the Plan's criteria for medical necessity. Types of testing that may be covered includes:

- **Prenatal testing** - when recommended by the patient's physician due to maternal age, ethnic background, or family history of a particular condition; carrier screening prior to a pregnancy when medically indicated based upon race, ethnicity, family history or other risk factors, amniocentesis or Chorionic Villus Sampling when medically indicated due to increase of chromosomal disorder.

- **Genetic testing for hereditary conditions** – when the patient has symptoms of the condition and has a direct risk factor based on family history, the results of the test will affect the patient's treatment, and the test is considered scientifically valid.

- **Genetic testing for hereditary cancer susceptibility** – when the results will impact the medical management, the treatment is not experimental and the testing meets the Plan's additional criteria for medical necessity.

- **Genetic testing to target cancer treatment** – provided that the targeted therapy is approved by the FDA, and the treatment is not experimental.

- **Genetic testing for Individuals with Autism spectrum disorder –** testing for fragile X syndrome and chromosomal microarray analysis for the purpose of targeting education and treatment.

The Plan will pay 90 percent of the MCS contracted amount for genetic testing.

For more information about the criteria for medical necessity for genetic testing, please contact MCS.

Cardiac Rehabilitation

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.

There is a copayment of $7 per visit for cardiac rehabilitation. The Plan will pay the remainder of the MCS contracted amount. Benefits are payable only after you have satisfied the annual deductible.

Physical, Occupational, Pulmonary, Speech, and Cognitive Therapies

Payments for physical, occupational, pulmonary, speech, and cognitive therapy are limited to **sixty visits for all therapies combined during a calendar year.** The Plan provides these benefits to both you and your dependents.

There is a copayment of $7 per visit for physical, occupational, pulmonary speech or cognitive therapy. The Plan will pay the remainder of the MCS contracted amount. Benefits are payable only after you have satisfied the annual deductible.

Organ and Tissue Transplants

The Plan will pay 100% of the MCS contracted amount for organ and tissue transplants, up to a maximum of $2,000,000, when the transplant is performed by a provider contracted with MCS. If the transplant costs more than $2,000,000, the Plan will pay the remainder of the reasonable and customary charges. If you have a transplant with costs that exceed the MCS' $2,000,000 maximum payment amount, please contact the Plan at 800-252-4674.

There is a 90 day waiting period for all transplants, except for bone, skin and cornea transplants.

Transplant benefits include the costs of compatibility testing, the costs related to finding a bone marrow or stem cell donor, the cost of removing the organ from the donor, and the cost of transporting the organ to the recipient's location. If the donor is alive, the benefit includes the donor's hospital costs.

Both you and your dependents have coverage for organ and tissue transplants.

Bariatric Surgery

The Plan provides bariatric surgery benefits for seafarers who are significantly overweight and meet certain medical criteria. Some examples of bariatric surgery include gastric bypass, gastroplasty, and gastric stapling. The Plan will pay 90% of the charge for bariatric surgery for an eligible seafarer.

To be eligible for this benefit, you must have a Body Mass Index (BMI) of at least 40 **OR** a BMI over 35 and a two year history one or more of the following conditions:

- Type 2 diabetes
- Cardiovascular disease
- Hypertension

- Obstructive sleep apnea
- Or other obesity induced conditions such as chronic joint pain, mobility problems, or interference with the ability to maintain employment.

In addition, you must be evaluated by a mental health specialist and obtain prior authorization from MCS.

This benefit is for eligible seafarers only. The Plan does not provide bariatric surgery benefits for dependents. Benefits are payable only after you have satisfied the annual deductible.

Telehealth Benefits

Telehealth benefits are available 24 hours a day, 7 days a week through **Medilinea**. The phone number for Medilinea is **1.866.727.6271**. You can call Medilinea from anywhere to receive a medical consultation over the phone for many medical conditions. A $10 copayment applies to a telephone consultation.

Nutritional Counseling

The Plan provides nutritional counseling benefits to seafarers and their dependents. A $15 copayment applies to each visit for nutritional counseling.

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

Treatment of Gender dysphoria

The Plan provides benefits to treat gender dysphoria, including gender reassignment surgery, for eligible seafarers and their dependents who are age 18 or older. The Plan will pay 90% of the network-allowed charges for services related to gender dysphoria or gender reassignment, including surgery and hormonal treatment, when this treatment is medically indicated. You must meet the criteria established by the MCS Life Clinical Sex Reassignment Guide. Contact MCS to receive this document.

This benefit includes behavioral therapy, diagnostic tests, specialized tests (MRTI, CT SCAN , Pet Scan, Pet CT MRA, SPECT), surgery for sex reassignment, which may include genital reconstruction surgery and breast / thorax surgery. All procedures related to this diagnosis require preauthorization.

Surgery for sex reassignment is covered for individuals eighteen (18) years of age or older diagnosed with gender dysphoria, duly documented by two (2) referral letters by qualified mental health professionals. The insured must have received twelve (12) months of continuous hormone therapy (unless the person has a medical contraindication or cannot or does not want to take hormones).

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

Home Health and Home Nursing Care

The Plan will pay the MCS contracted amount for a total of up to 60 visits per year for either home health care and/or home nursing care. The Plan will pay the cost for the services of a home health aide or nurse, and other home health care services such as physical, speech, occupational, respiratory and cardiovascular therapy; drugs and supplies.

Generally, in order to be eligible for this benefit, the home care must begin within 14 days following a hospital confinement of at least three days. The services must be provided by an approved home health care organization, and must be prescribed by a doctor.

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

Hospice Care

The Plan will pay 90 percent of the MCS contracted amount for hospice care for you or your dependents.

In order to be eligible for this benefit, a doctor must certify that you or your dependent is not expected to live for more than six months. Services must be provided by a licensed health care provider that is a Medicare approved hospice provider.

Durable Medical Equipment

The Plan provides benefits for durable medical equipment to both you and your dependents. The Plan will pay 90 percent of the charge for durable medical equipment.

Durable medical equipment includes such things as prosthetic devices, medical appliances, and other durables. The Plan will not pay to maintain or repair durable medical equipment.

Benefits for durable medical equipment are payable only after you have satisfied the annual deductible.

Hearing Aids

The Plan provides benefits for hearing aids to **seafarers** only. 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.

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

Vaccines

The Plan will pay 100% of the charge for preventive vaccines administered at a pharmacy or doctor's office. The recommended preventive vaccines depend on the

patient's age and medical condition, but include Covid, flu, tetanus, measles, mumps, pertussis (whooping cough), rubella, MMR, shingles, tetanus and hepatitis A and B. If you receive a vaccine at the doctor's office, it will be covered by MCS. If you receive a vaccine at a pharmacy, it will be covered through OptumRx.

The Plan does not pay for travel vaccines, except when a seafarer requires a particular vaccine for work.

DO I HAVE HEALTH COVERAGE IN THE MAINLAND UNITED STATES?

In general, your MCS ID card is only valid for medical services in Puerto Rico. **Under the following circumstances only,** residents of Puerto Rico may use their MCS 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 MCS to show that the service is not available in Puerto Rico.
- **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.
- **Your child is attending elementary, high school or college in the mainland United States.** You must send proof of your child's enrollment to MCS. If your child is a college student, you must provide certification from the college or university that your child's course of study is at least 12 credits per semester.

In all of these situations, except for an emergency, you should seek treatment from a health care provider that is in the **United Healthcare** network. If you go to a provider that is not in the United Healthcare 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 United Healthcare network.

Vision Care

If your employer contributes to the Plan at the Core-Plus benefit level, the Plan will pay a maximum of $400 in vision care charges during a 24-month period for eligible seafarers and their dependents. If your employer contributes to the Plan at the Core benefit level, the Plan will pay a maximum of $250 in vision care charges for eligible seafarers, and a maximum of $80 for each dependent during a 24-month period. If you are a pensioner, the Plan will pay a maximum of $80 in vision care charges during a 24-month period for you or your dependent.

You must pay for these services, and submit a receipt for reimbursement to the Plan's **Claims Department** in Maryland. The address is: **Claims Department, 45353 St. Georges Avenue, Piney Point, MD 20674.**

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

The Plan does not provide vision care benefits to you or your dependents if you are an apprentice or your employer contributes to the Plan at the Plan S benefit level.

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. 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.

You must submit the Nicotine Replacement Therapy Reimbursement Form with receipts to the Plan's Claims Department in Maryland (address listed on page 21) in order to obtain reimbursement. The form is available online at www.seafarers.org/plans: under "Seafarers Health and Benefits Plan," "Core-Plus and Core Benefits," "Applications and Forms;" or you may contact the Plan at 1-800-252-4674 to request the form.

WHAT IS THE PLAN'S PRESCRIPTION DRUG BENEFIT?

The Plan provides prescription drug coverage through an arrangement with a Pharmacy Benefit Manager (PBM). This Plan currently uses OptumRx as its PBM. The PBM will issue you a prescription card. You must present this card when you fill your prescription.

Both you and your dependents are entitled to receive prescription drug coverage, unless you are a pensioner. The dependents of pensioners are not eligible for prescription coverage. If your employer contributes at the Plan S level or you are an Apprentice, you have prescription coverage for generic drugs only.

The annual prescription deductible for Core-Plus and Non-Medicare Pensioners is $100 per person, up to a maximum of $200 per family. The annual prescription deductible for Plan S is $100 for each person. The prescription deductible is in addition to the health care annual deductible. Apprentices do not have a separate prescription deductible.

Your coverage 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 copayment each time you purchase prescription drugs. Generic drugs have the lowest copayment amounts, while brand-name drugs have the highest. In addition, there is an especially high copayment 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 your employer contributes at the Core-Plus level, or you are a non-Medicare Pensioner, brand name drugs are also included in your coverage.** In that case, 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 copayment will be higher. A copy of the formulary for this Plan is available at www.optumrx.com or via a link on the Seafarers website: www.seafarers.org or you may call SHBP or OptumRx to request a paper copy.

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 copayment will increase, beginning with the prescription for the third month.

PRESCRIPTION DRUG COPAYMENT AMOUNTS FOR CORE-PLUS EMPLOYEES AND DEPENDENTS AND NON-MEDICARE PENSIONERS

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
Generic *Maintenance* Drugs *(beginning with 3rd 30-day supply)*	$30
Brand Name *Maintenance* Drugs Included on Formulary *(beginning with 3rd 30-day supply)*	$75
Brand-name *Maintenance* Drugs Not Included on Formulary *(beginning with 3rd 30-day supply)*	$150
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

PRESCRIPTION DRUG COPAYMENT AMOUNTS FOR PLAN S EMPLOYEES, APPRENTICES AND THEIR DEPENDENTS

If your employer contributes to the Plan at the Plan S level, or if you are an apprentice, you and your dependents have generic prescription coverage only. When you purchase a generic prescription at a retail pharmacy, you will be responsible for a copayment 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 paying 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, Plan S participants and apprentices do not have coverage for specialty drugs, unless they are generic.** Specialty drugs are high cost medications that are used to treat chronic or life threatening conditions, and require special handling, monitoring or administration.

Prior Authorization

Certain medications will require prior authorization from the PBM. 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 is available on the online provider portal at www.optumrx.com or you may also call OptumRx or SHBP to request a paper copy.

Quantity Limits

A quantity limit is the largest amount of a medication that you can receive per copayment, or in a certain time period. The PBM 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.

However, if you need a larger quantity of medication because you will be on a vessel for an extended period, SHBP will be able to approve your request to exceed the quantity limit. Please contact SHBP at 1-800-252-4674.

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.

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 the PBM. After the drug is approved, the PBM will decide whether it will be paid for as a formulary or non-formulary drug (non-formulary drugs have a higher copayment).

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.

Weight Loss Drugs

The Plan provides benefits for weight loss drugs to seafarers and their dependents at the Core-Plus level and to Non-Medicare Pensioners who meet certain criteria. You must receive prior authorization from the PBM for these drugs. For more information about the criteria to qualify for weight loss prescriptions, please have your doctor contact the PBM. Plan Level S participants and Apprentices do not have coverage for weight loss drugs.

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.

DOES THE PLAN PAY FOR DENTAL CARE?

The Plan will pay up to $2,000 per calendar year in dental benefits for each seafarer or dependent. There is no dollar limit on preventive dental services for children under age 19. Preventive dental services will count towards the annual maximum of $2,000.

The Plan will pay 100% of the MCS contracted amount for preventive services. The Plan will pay 80% of the MCS allowed amount for most other dental services, except that the Plan will pay 50% of the MCS allowed amount for crowns or prosthesis; until the $2000 annual maximum is reached.

Payments for orthodontia are limited to $4,000 for each seafarer or dependent during

his or her lifetime.

The following services are considered to be **preventive** dental services for children under age 19:

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

WHAT MENTAL HEALTH BENEFITS ARE AVAILABLE FROM THE PLAN?

Mental Health Hospitalization

The Plan will pay 100 percent of the MCS contracted amount for room and board and hospital extras if you or your dependent is hospitalized at an in-Network mental health facility. The Plan will pay professional fees in the same manner as for any other hospital stay.

Payments for mental health facility charges are subject to a $450 admission copayment. Seafarers and their dependents are both eligible for this benefit.

Outpatient Mental Health Services

There is a $15 copayment for outpatient mental health services. The Plan will pay the remainder of the MCS contracted amount.

Benefits are payable only after you have satisfied the annual deductible. Seafarers and their dependents are both eligible for this benefit.

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 MCS contracted amount for the hospital costs for inpatient detoxification. The Plan will pay professional fees in the same manner as for any other hospital stay.

Payments for inpatient detoxification are subject to a $450 admission copayment. Seafarers and their dependents are both eligible for this benefit.

Inpatient Substance Use Disorder Treatment

The Plan will pay for inpatient treatment for a substance use disorder in the same manner as all other hospital stays. The Plan will pay 100 percent of the MCS contracted amount for the hospital costs for inpatient substance use disorder treatment.

Payments for inpatient substance use disorder treatment are subject to a $450 admission copayment. Seafarers and their dependents are both eligible for this benefit.

Treatment at the Seafarers Addictions Rehabilitation Center

The Plan also provides for group substance use treatment for seafarers in a residential setting at the Seafarers Addictions Rehabilitation Center (SARC) in Valley Lee, Maryland. **Treatment at the SARC is available free of charge to eligible seafarers if your employer is contributing at the Core Plus or Core benefit levels.** This program is specially designed just for seafarers. The staff members at the SARC are familiar with the unique problems that mariners face, and are knowledgeable about Coast Guard regulations and procedures that apply when a seafarer fails a drug or alcohol test. **The Plan will pay for the cost of transportation to the SARC from anywhere in the U.S.**

To arrange for substance use disorder treatment at the SARC in Valley Lee, Maryland, including transportation arrangements, contact your Port Agent or Patrolman. If you would like additional information about the SARC, you may contact them directly at (301) 994-0010, ext. 5330. All phone calls are confidential.

Participants at Plan Level S, Non-Medicare Pensioners, and dependents are **not** eligible to attend the SARC.

Outpatient Substance Use Disorder Treatment

There is a $15 copayment for outpatient substance disorder treatment. The Plan will pay the remainder of the MCS contracted amount.

Benefits are payable only after you have satisfied the annual deductible. Seafarers and their dependents are both eligible for this benefit.

The Plan will only pay for substance use disorder treatment that is provided at a facility or program that is licensed or certified in Puerto Rico.

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 seafarers and dependents. The same limitations and deductibles that apply to other benefits apply to these mastectomy-related services.

WHAT IS THE LONG-TERM DISABILITY BENEFIT?

If you remain disabled after your eligibility for benefits has ended, you can continue to receive medical benefits for the injury or illness that disabled you only. This coverage can continue for up to 26 weeks following your last day of eligibility. For more information about this benefit, call the Plan at 1-800-252-4674.

WILL THE PLAN PAY BENEFITS FOR ME IF I AM INJURED OR BECOME ILL WHILE WORKING ON BOARD A VESSEL?

If you are injured or become ill while you are working for a signatory employer, the Plan will pay benefits for your medical care if you meet the Plan's eligibility requirements at the time you receive treatment. However, the Plan does not pay for treatment that you receive in a foreign country.

You may wish to talk to your employer about the costs for your co-insurance, copayments and other charges that are not covered by the Plan.

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 and/or dependent child 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 MCS. After your claim has been paid, send the claim to your spouse's insurer. Be sure to include the MCS 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 MCS. 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 (QMCSO).**

- 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 MCS.

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 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.**

If you, your spouse, or child is eligible for Medicare, contact the Plan at 1-800-252-4674 regarding coordination of benefits.

HOW CAN I REDUCE MY OUT OF POCKET COST?

You can reduce your out of pocket cost by using Network providers. The Plan pays a non-network provider based upon MCS's contracted amount. This amount is usually less than the actual charge. For more information about MCS providers, please go to their webpage at https://mcs.com.pr/es/Paginas/Inicio.aspx, or call the MCS customer service center at 787-281-2800.

DO I NEED TO OBTAIN PRE-CERTIFICATION FOR CERTAIN SERVICES?

Pre-certification from MCS is required prior to any surgery or hospitalization. You also must notify MCS within 48 hours following emergency surgery or emergency hospitalization. Benefits may not be paid if you fail to notify MCS.

You must also obtain pre-certification from MCS outpatient high technology radiology services, such as a CT scan, PET scan or MRI. If you do not obtain approval from MCS before you receive these services, the Plan may 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.

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 MCS network or other questions about benefits, please see their network at https://mcs.com.pr/es/Paginas/Inicio.aspx, or call MCS customer service at: 787-281-2800

A claim for benefits must be filed within 180 days of the date of service or it will be denied for late filing.

- When you use an in-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.

- When using a non-network provider, you initially you must pay the claim yourself, and then apply to MCS to receive reimbursement. Be sure to obtain a copy of the itemized bill. To receive benefits, you must send this itemized bill to MCS at the address on the back of your ID card. Make certain that the bill includes: seafarer'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. **However, your claim will not be paid unless it is filed within 180 days of the date the claim accrued.**

Send **vision claims and claims for sickness and accident benefits only** to the following address:

Seafarers Health and Benefits Plan
Attn: Claims Department
45353 Saint Georges 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 Puerto Rico or the mainland U.S.

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 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;

- to obtain any records or paperwork needed to pay a claim;
- for 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 prescription drugs when there is evidence that the drugs are being abused;

- 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?

Seafarers who are unable to work because of illness or injury 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 pages 11 - 12.

You can receive S&A benefits for up to 273 days during any 12-month period. The 12-month period begins with the first day of your disability. The amount of the S&A Benefit is $25 a day for employees at the Core Plus and Core benefit levels, and $8 a day for employees at the Plan S benefit level. 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 only receive S&A benefits if you are not receiving Workers' Compensation, state disability payments, unemployment benefits, sick pay 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. Your S&A benefits also will end if you begin receiving a pension from the Seafarers Pension Plan.

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

HOW DO I APPLY FOR SICKNESS AND ACCIDENT BENEFITS?

To receive S&A benefits, you must file an application form with the Plan. These forms can be obtained from your local representative, from the Plan's main office or download the form at: www.seafarers.org/plans under "Seafarers Health and Benefits Plan," "Core-Plus and Core Benefits," "Applications and Forms." You must also provide the Plan with written proof of your disability, such as a letter from your doctor.

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

Pensioners and apprentices are not eligible for S&A benefits.

WHAT IS THE STANDARD DEATH BENEFIT?

Upon your death, your beneficiary may receive a Standard Death Benefit if he or she is a relative listed in the paragraph titled "Who Can Be My Beneficiary" on pages 39 - 40 of this booklet. At the Core-Plus, Core, Non-Medicare Pensioner and Plan S benefit levels, the amount of the Standard Death Benefit is $5,000. This benefit is subject to the Funeral Expense deduction, which is described below. 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 credit for at least 125 days of covered employment in each of the two calendar years immediately preceding the year of your death.

The beneficiaries of seafarers 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.

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

WHAT IS THE ACCIDENTAL DEATH BENEFIT?

If your employer is contributing to the Plan at the **Plan S** benefit level, and you die as a result of an **accidental injury that did not occur during the course of your employment**, your beneficiary may receive an Accidental Death Benefit in addition to the Standard Death Benefit. A benefit of $5000 is payable to your beneficiary if he or she is a relative listed in the section below entitled "Who Can Be My Beneficiary." If you do not designate a beneficiary, no benefit is payable.

In order to qualify for this benefit, you must have met the requirements for maintaining eligibility (described on page 12) during the two calendar years before you death.

WHAT IS THE GRADUATED DEATH BENEFIT?

If your employer(s) are contributing to the Plan at the **Core-Plus or Core benefit level**, your beneficiary may receive a Graduated Death Benefit in addition to the Standard

Death Benefit.

At the Core-Plus benefit level, your beneficiary can receive a Graduated Death Benefit of $10,000, if you have at least 125 days of covered employment during each of the three calendar years before your death. For each additional year during which you met the Plan's eligibility requirement of 125 days of covered employment, $5,000 is added to your Graduated Death Benefit. The maximum Graduated Death Benefit is $45,000 at the Core-Plus benefit level. Your beneficiary can receive up to $50,000 when the Graduated Death Benefit is paid together with the Standard Death Benefit.

At the Core benefit level, your beneficiary can receive a Graduated Death Benefit of $5,000 if you have at least 125 days of covered employment during each of the three calendar years before your death. For each additional year during which you met the Plan's eligibility requirement of 125 days of covered employment, $2,500 is added to your Graduated Death Benefit. The maximum Graduated Death Benefit is $15,000 at the Core benefit level. Your beneficiary can receive up to $20,000 when the Graduated Death Benefit is paid together with the Standard Death Benefit.

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

If you are a pensioner, an Apprentice or a participant at Plan Level S, you are not eligible for the graduated death benefit.

WHO CAN RECEIVE MY DEATH BENEFIT?

To claim the full amount of your death benefit, the beneficiary you name 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 seafarer.*

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, and the beneficiary will not qualify for the graduated death benefit. If you do not name a beneficiary, a maximum of $1,000 will be paid to your estate.

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

WHAT IS THE FUNERAL EXPENSE DEDUCTION?

If someone other than the government or insurance has paid for your funeral, the Plan will pay that person up to $1,000 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?

Your beneficiary must file an Application for Death Benefits with the Plan to receive your death benefit, your beneficiary can obtain an application from the Plan's main office, from your local representative, or online at www.seafarers.org/plans, under "Seafarers Health and Benefits Plan," "Core-Plus and Core Benefits," "Applications and Forms." They can also request an application by calling the Plan at 1-800-252-4674. They must include an itemized funeral bill, paid or unpaid, and an official Certificate of Death with the application.

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

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

WHAT BENEFITS CAN I RECEIVE IF I LOSE A LIMB OR MY EYESIGHT?

The Plan provides for an Accidental Dismemberment Benefit for eligible seafarers. Your loss must happen within 90 days of your injury and cannot be caused by an illness or be work related.

If your employer is contributing to the Plan at the Core-Plus or Core benefit level, you can receive a $2,500 benefit if you lose a hand, foot, or the sight of an eye. If you lose any two, the Plan will pay you a maximum benefit of $5,000.

HOW DO I APPLY FOR ACCIDENTAL DISMEMBERMENT BENEFITS?

This benefit is to is available to eligible employees at the Core-Plus or Core benefit levels. To apply for this benefit, contact the Plan at 1-800-252-4674 for more information.

You will be required to send the Plan a doctor's statement as proof of your loss.

WHAT EDUCATIONAL BENEFITS DOES THE PLAN PROVIDE?

Each year the Plan awards a limited number of scholarships for use at colleges or vocational schools. At the Core-Plus and Core benefit levels, you, your spouse, and your dependent children may receive this benefit. Information about this important benefit can be found in the summary booklet for the Seafarers Scholarship Program.

To obtain a booklet, you can contact the Plan at:
Seafarers Health and Benefits Plan
Attn: Scholarship
5201 Capital Gateway Drive
Camp Springs, Maryland 20746
(301) 899-0675

OR, you can download the booklet at www.seafarers.org/plans under "Seafarers Health and Benefits Plan," "Core-Plus and Core Benefits," "Applications and Forms," "Scholarship Application."

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 decision.

A written explanation will be sent to you if MCS denies your claim. Once you have exhausted your appeals to MCS, if you still believe that the Plan should have paid your claim, you may call the Plan at 1-800-252-4674 to discuss the claim. If you want to request a review of MCS's decision 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 by MCS. 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. You have the right to ask MCS for copies of any documents it relied on when they made the decision about your claim.

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 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 Saint Georges 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. Before you bring legal action against the Plan, you are required to notify the Plan of your complaint in writing, either in person or by certified or registered mail. The Trustees will respond to your letter within 60 days. If you are still not satisfied with the Trustees' response, you can file a lawsuit in the U.S. District Court for the District of Maryland.

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 MCS at 1-888-758-1616.

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. An electronic consent form is available at www.seafarers.org/plans, under "Core-Plus and Core Benefits," "Applications and Forms;" or you can contact the Plan to request a copy of this form. You must fill out this form and return it to the Plan if you want to receive notices electronically.

Participant notices are also available online at: www.seafarers.org/plans, under "Seafarers Health and Benefits Plan." in the sections labeled "SHBP Participants Who Reside

in Puerto Rico."

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/plans, under "HIPAA Privacy Rules," or 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

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

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

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

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

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

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
  Telephone (866) 444-3272

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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 Georges 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/portal/lobby.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.

Language Translation Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-252-4674

Arabic:
ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-252-4674

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-252-4674

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-252-4674

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-252-4674

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-252-4674

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-252-4674

Indonesian: PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-800-252-4674

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-252-4674

Croatian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-252-4674

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-252-4674

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-252-4674。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-252-4674 번으로 전화해 주십시오.

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-252-4674

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-252-4674

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

Introduction

You're getting this notice because you recently gained coverage under a group health 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.

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 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).

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, Claims Department, COBRA Processor, 45353 St. 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. Please send information about the disability to: **Seafarers Health and Benefits Plan, Claims Department, COBRA Processor, 45353 St. George's Avenue, Piney Point, MD 20674.**

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 period[1] 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

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

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

Plan contact information

Seafarers Health and Benefits Plan
Claims Department
COBRA Processor
45353 St. George's Avenue
Piney Point, MD 20674
Telephone: (800) 252-4674