INTRODUCTION

If you have any questions about the Masters, Mates and Pilots Health and Benefit Plan, please send your inquiry in writing to:

The Administrator
Masters, Mates and Pilots
Health and Benefit Plan
700 Maritime Boulevard, Suite A
Linthicum Heights, MD 21090

ABOUT YOUR SUMMARY PLAN DESCRIPTION

This Summary Plan Description covers the major provisions of your Plan which should be easier to read than the Plan's complete Rules and Regulations. There have been changes to the Plan, and we have kept you apprised of all these amendments through the Master, Mate and Pilot magazine.

Please be assured that **NONE** of your medical, dental, life or accidental benefits have been eliminated just because they are not covered in detail in this Summary Plan Description. All your medical, dental, life and accidental benefits are still set forth in the Health and Benefit Plan Rules and Regulations. However, in the interest of providing you with an easy-to-read Summary Plan Description, we have not detailed all of the Plan's benefits.

This Summary Plan Description does not change or interpret the terms of the Health and Benefit Plan documents, such as the Trust Agreement or the Rules and Regulations. Your rights can be determined only by referring to these official documents which are available for your inspection as described in the Administrative Information section of this Handbook.

Please note that nobody other than the Board of Trustees has any authority to interpret the Health and Benefit Plan Rules and Regulations (or other official Plan documents) or to make any promises to you about your benefits.

This Summary Plan Description itself does not override the Health and Benefit Plan Rules and Regulations. Only the Rules and Regulations, and the other official Plan documents, govern the administration of the Health and Benefit Plan and the benefits to which you may be entitled. This Summary Plan Description is provided solely for the purpose of assisting you in understanding the scope and meaning of the Plan, not to replace or amend it. If any of the information contained in this Summary Plan Description is inconsistent with the official Health and Benefit Plan documents, the provisions of the official documents will govern in all cases. THE BOARD OF TRUSTEES RESERVES THE RIGHT TO AMEND, MODIFY OR TERMINATE THE HEALTH AND BENEFIT PLAN AND THE RULES AND REGULATIONS (IN WHOLE OR IN PART) AT ANY TIME AND FROM TIME TO TIME.

Medical Coverage

The Plan's medical claim coverage reimburses you for all or part of a broad range of medical expenses you or your qualified dependents may incur.

In order to counter the rising costs of medical benefits, the Plan utilizes two Preferred Provider Organizations (PPOs), CIGNA and MultiPlan. If you utilize providers within the PPO network you will be reimbursed at higher rates, and both you and the Plan will benefit from discounts. The Plan also utilizes a Prescription Benefit Manager ("PBM") to reduce the cost of prescription drug coverage while providing you with responsive service. CVS/Caremark is the Plan's PBM.

Dental Coverage

Maintaining good dental health is important to your overall health and wellbeing. Therefore, the Plan also provides dental coverage – to defray the cost of dental services for you and your qualified dependents.

The Plan's dental coverage has been provided by Delta Dental of Pennsylvania. Delta Dental operates the nation's largest network of participating dentists. Treatment you receive from network dentists costs you a 20% co-pay of a contract amount. If you wish, you may receive treatment from out-of-network dentists. If you do, Delta Dental will reimburse you 70% on the reasonable and customary charge for the services performed, and your co-pay would be the difference between the total charge and what was reimbursed.

Life, Accidental Death and Accidental Dismemberment Coverages

Peace of mind is not something you can come by easily especially when you try to plan for the uncertainties of the future. The Plan provides Life, Accidental Death and Accidental Dismemberment Benefits that can help by providing valuable benefits for you and your family if you die, or if you're seriously injured in an accident.

ADDITIONAL INFORMATION

The previous description of the medical, dental, life and accidental benefits under the Plan provides only a brief summary of the benefits available. Please refer to the Plan Rules and Regulations for more details.

ACTIVE ELIGIBLE GROUPS

Offshore Employees

As a new participant in the Plan, you are covered under the Plan on the date you complete 30 days of shipboard Covered Employment (excluding Port Relief, Disability and Vacation days) with one or more Employers within any period of six (6) consecutive calendar months. PRO hours can be used to extend coverage once you complete your 30 days (as outlined above) by one calendar month for each 40 hours of employment while you are still eligible. Extended eligibility is limited to a maximum of 6 calendar months. PRO employment performed during a period not to exceed 60 days immediately following your last day of shipboard Covered Employment. You have a co-pay requirement of one and one-half percent (1-½%) co-pay contribution deducted on a pre-tax basis from all earnings from your employment and vacation with an Employer without any maximum earnings limit.

Officers of the Organization and Office Employees of the Organization and Plan Office

You will become eligible for benefits on the date you complete one month of continuous service unless you were previously eligible under the Plan, and your Employer pays one month contribution. As an Eligible Employee, coverage starts on the date you commence employment. You have a co-pay requirement of one and one-half percent (1-½%) co-pay contribution deducted on a pre-tax basis from all earnings from your employment and vacation with an Employer without any maximum earnings limit.

Shoreside Employees and Employees of the Atlantic and Gulf Membership and Great Lakes Groups

Once your Employer pays one month contribution, and you complete 30 days with one or more Employers within any period of 6 consecutive months, you will become eligible for benefits under the Plan.

Pilot Groups

A member, employee, dependent, retiree or surviving spouse of a retiree of a Branch of the Pilots Membership Group that signs an M.M.&P. Health & Benefit Plan Agreement and Declaration of Trust, and agrees to maintain the minimum participation requirements and to pay a monthly contribution established by the Trustees, may be eligible for benefits on the day he completes one month of employment. If a new employee wants to join and a Branch is already participating in the Plan, there are certain requirements to establish coverage. You should contact the Plan Office regarding open enrollment.

Pacific Maritime Region Employees – Regular Employees

Depending on what Employer you work for, contributions received on a monthly basis provides you eligibility as follows:

Contributions received in January provides eligibility for March
February provides eligibility for April
March provides eligibility for May

Employers paying contributions bi-monthly on your behalf provide you with eligibility as follows:

Contributions for January/February provides eligibility for April/May
Contributions for March/April provides eligibility for June/July

If you are a Casual Employee, please contact the Plan Office regarding contribution requirements.

Alaska Marine Highway System Group Employees

Employees with the Alaska Marine Highway System Group ("AMHS") as of July 1, 2001 who were eligible for health coverage provided by the employer immediately prior to that date are eligible for benefits under the Plan. For new employees after July 1, 2001, your coverage will begin on this first day of the month, after one month of employment, for which the employer has made contributions.

TERMINATION OF ELIGIBILITY FOR ALL GROUPS

- According to each group's Collective Bargaining Agreement for extended eligibility;
- The date you are granted a withdrawal card from the Organization, or, if earlier, you are 6 months delinquent in Union dues;
- The date you cease to be a member of the Organization;
- The date you become eligible for benefits under another health plan established by the Organization;
- The date you enter military, naval or air forces of any country, state or union. However, if you had extended coverage before being recalled, coverage will be reinstated in accordance with the Uniformed Services, Employment and Reemployment Rights Act;
- The date you retire, unless benefits are provided for Pensioners and Dependents;
- The date you accept employment with an employer operating vessels that are not a party to the Health & Benefit Plan, except upon approval by the Trustees;
- The date you become a Pilot unless you are a Member of a Pilot's Branch that is participating in the Plan;
- The date you commence employment elsewhere;
- Death;
- The date the Employer/Branch ceases contributions on your behalf;
- The date the Pilot Branch ceases to maintain minimum participation requirements; and/or
- Casual employees who should contact the Plan Office

Dependent Coverage

While you are covered by the Plan, your qualified dependents are also covered for medical and dental benefits. Your qualified dependents are:

- Effective 1/1/14 the term Spouse means the person to whom our Eligible Employee or Pensioner is legally married under applicable law.
- Your spouse (coverage for your spouse ends on the date of divorce, legal separation or when you and your spouse enter into a written agreement to live separately);
- For AMHS, eligible dependents shall include a person who meets the requirements of Alaska Administrative Code Title 2, Section 38.010 (2006), only so long as the person meets those requirements;

- Each natural child, adopted child, child placed for adoption or step-child or each child for whom you have been named legal guardian by court order who is under 26 years of age;
- Children for whom you are obligated to provide medical coverage under a Qualified Medical Child Support Order;
- Your dependent parents if you do not have a spouse or children who qualify as dependents, your parents are principally dependent on you for support, and they are claimed as dependents on your federal income tax return.

Coverage for your qualified dependents ends when your coverage ends, or when they cease to be qualified dependents as defined above. If you die while covered, coverage for your qualified dependents may continue. Please contact the Plan Office for additional information.

FORMS YOU NEED TO COMPLETE

To have Plan coverage you must submit a Permanent Data Form ("PDF" or "Form") to the Plan Office. Your dependents' coverage will begin at the same time as your coverage or as soon as a dependent becomes qualified, whichever occurs later.

Your qualified dependents are not covered under the Plan unless this Form has been completed, signed and submitted to the Plan Office, and they are listed on the Form. If there is any change to your dependent's status (e.g. birth, death, change in marital status, etc.), you need to submit a new Permanent Data Form. The Plan Office may require additional documentation in order to establish health coverage for your dependents, including IRS Form 1040, adoption papers, divorce decree, marriage certificate or birth certificate.

If your dependent is 19 years of age, you must request a Coordination of Benefits Form for Eligible Adult Children Age 19-26 from the Plan Office prior to them being eligible for coverage. If you are adding a dependent, you must request an enrollment form/PDF from the Plan Office in writing within 60 days of the event (e.g., marriage, birth of a child, adoption of a child, legal guardianship, loss of group health insurance). No coverage will be provided without appropriate forms and notification within 60 days of an event. Otherwise, coverage will not be provided to the dependent until the next open enrollment period during November and December for coverage effective January 1.

Coverage for your dependents begins when your coverage starts or, if later, when an individual becomes your dependent.

Dependent coverage ends when your coverage ends. Coverage for your spouse ends if you are legally separated, or if a decree dissolves or ends your marriage. Effective 1/1/14 Dependents between ages 19 and 26 must complete Coordination of Benefits Form for Eligible Adult Children Age 19-26, and Spouses must complete a different Coordination of Benefits Form.

COBRA Coverage

COBRA allows employees and qualified dependents to continue temporarily their medical and dental coverage under the Plan by making a self-payment premium in certain instances after regular employee coverage under the Plan would otherwise end. COBRA also allows qualified dependents of Pensioners to continue temporarily their medical coverage under the Plan in certain instances after

their Pensioner coverage under the Plan would otherwise end. Even if you do not elect COBRA continuation coverage for yourself, each of your qualified dependents has an independent right to elect COBRA coverage. COBRA coverage does *not* include any Life, Accidental Death or Accidental Dismemberment benefits. This section provides a summary of your rights and obligations under COBRA.

Only persons who are actually covered by the Plan on the date regular employee or pensioner coverage would otherwise end may continue coverage under COBRA. However, if you adopt a child while you are on COBRA continuation coverage, you may add that child to your COBRA coverage. To do so, you must notify the Plan Office within 30 days after the date of birth or adoption.

Duration of COBRA Coverage

You and your qualified dependents can elect COBRA coverage for up to 24 months after the date that regular employee coverage ends because you did not work enough days in Covered Employment to maintain eligibility. However, there is no right to COBRA coverage if your failure to work enough days was due to termination of your employment because of gross misconduct on your part.

The 24-month period can be extended to up to 29 months if you or any of your qualified dependents are determined by Social Security to have been disabled at any time during the first 60 days of COBRA coverage. To receive the extension, you must provide the Plan Office with notice of the Social Security determination within the initial 24-month period and within 60 days after the date of the determination. You must also notify the Plan Office within 30 days of any final determination by Social Security that you or your qualified dependents are no longer disabled.

Your qualified dependents may elect COBRA coverage for up to 36 months if their regular employee or pensioner coverage ends because of one of the following qualifying events:

- you die; or
- you get divorced, legally separated or enter into a written agreement to live separately from your spouse.

In addition, your qualified dependent children may elect COBRA coverage for up to 36 months if your regular employee or pensioner coverage ends or because they no longer meet the Plan's eligibility requirements for qualified dependent children.

Please note that loss of pensioner coverage for failure to pay the required contribution does *not* entitle anyone to elect COBRA.

If, while your qualified dependents are on COBRA coverage for a 24 or 29 month period, one of the above qualifying events occurs that would otherwise allow your dependents to elect 36 months of COBRA coverage, they may extend their COBRA coverage for the balance of the 36 month period from the start of the initial 24 or 29 month period. In no event will COBRA coverage extend beyond 36 months from when such coverage first started.

Your and your dependents' right to COBRA coverage will terminate before the end of the periods described above if:

- the required self-payment premium is not received on time;
- after COBRA coverage is elected, a person on COBRA coverage becomes covered by another group health plan that does not contain an exclusion or limitation affecting any pre-existing condition of that person;
- the Plan no longer provides coverage for any persons;
- after COBRA coverage is elected, a person on COBRA coverage becomes entitled to Medicare; or
- coverage was extended for up to 29 months due to disability, and there has been a final determination that the person is no longer disabled.

Your Responsibility to Provide Notice

You and your qualified dependents must notify the Plan Office in writing of a divorce, legal separation (including a written agreement to live separately), or a child's loss of qualified dependent status, within 60 days after the date the event occurs. *If notice of these events is not sent to the Plan Office within that 60 days, the right to elect or extend COBRA coverage is permanently lost.*

Required Self-Payments

It is also your or your dependents' responsibility to make self-payment premiums on a timely basis. Self-payment premiums are due on the first day of each month for which COBRA coverage is to be in effect. *If the self-payment premiums for a month is not received within 30 days after the due date, COBRA coverage will automatically terminate as of the last day of the preceding month. Termination of COBRA coverage for failure to make self-payment premiums on time is permanent and coverage cannot be reinstated.*

Procedures and Elections for COBRA Coverage

The Plan Office will notify you by letter when your name appears on the "lapse of coverage" listing. The letter will state that there is a possibility that your regular employee coverage has lapsed and will ask for your assistance in updating your employment records or confirming that regular employee coverage has actually lapsed.

If you are aware that your regular employee coverage will run out and you would like information concerning COBRA in advance, please contact the Plan Office prior to losing your regular employee coverage. As stated in the previous section, it is your responsibility to notify the Plan Office concerning divorce, legal separation (including a written agreement to live separately), or a dependent child's loss of eligibility under the Plan. This notice obligation applies in all situations. If the Plan Office is timely notified that one of the above events has occurred, it will notify you and/or your qualified dependents of the right to elect COBRA coverage and will provide COBRA information and a COBRA election form.

Deadline for Election of Coverage and First Self-Payment

You and your qualified dependents have 60 days after the later of (i) the date that notice of your right to elect COBRA is sent by the Plan, or (ii) the date you or your dependents lose coverage, to return the completed COBRA election form to the Plan Office.

The initial self-payment premium may be mailed with the COBRA election form. If it is not mailed with the election form, the Plan Office must receive the initial self-payment premium within 45 days after the date the COBRA election form is mailed to the Plan Office.

If either the COBRA election form or the initial self-payment premium is not received on time by the Plan Office, all rights to COBRA coverage are permanently lost and cannot be reinstated.

COBRA coverage starts as of the date your regular employee or pensioner coverage ends. You cannot elect to have it start later. If the election of COBRA coverage is made after the date that your regular employee or pensioner coverage ends, then COBRA coverage will take effect retroactively to that date and the first self-payment premium must be sufficient to pay for that retroactive coverage. In no event will any claims be paid until the required self-payment premium is received. Therefore, it is advisable to include the first self-payment premium with the COBRA election form to ensure prompt processing of any claims for benefits.

Subsequent monthly self-payment premiums are due on the first day of the month for which COBRA coverage is in effect. If monthly self-payment premiums are not received by the Plan Office within 30 days after the due date, COBRA coverage will be permanently lost.

BENEFITS WHILE ON COBRA COVERAGE

Self-Payment Rates

COBRA self-payment rates depend on the number of people covered, whether you have regular employee or pensioner coverage, and for employees whether you choose core plus non-core or core only benefits. COBRA self-payment rates are reviewed and updated annually. You will be advised by the Plan Office of any changes in the rates while you are on COBRA coverage.

Certificate of Coverage

Certificates of coverage are written documents provided by the Plan Office to show the type of coverage a person had (e.g., employee only, employee plus spouse, etc.) and how long the coverage lasted. Under federal law, the Plan must provide these certificates automatically when a person's coverage terminates. One of the goals of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was to make it easier for people changing jobs to keep health insurance, regardless of their health status. The primary purpose of the certificates is to show the amount of creditable coverage a person had under a prior group plan or other health insurance coverage, because this can reduce or eliminate the length of time that any pre-existing condition clause in a new plan otherwise might apply to you.

The Plan Office will automatically provide you with a certificate after you lose coverage (whether regular coverage or COBRA continuation of coverage) under the Plan and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered. If you are entitled to elect COBRA coverage, you will receive your certificate no later than when a notice is required to be provided for a qualifying event. Otherwise, you will receive your certificate within a reasonable time after coverage ceases.

If you are a qualified beneficiary and you have elected continuation coverage, you will receive an additional certificate within a reasonable time after cessation of such coverage or, if applicable, after the expiration of any grace period for the payment of premiums. In addition, the Plan will provide a certificate for you (or your dependents) upon request if you make the request within two years (24 months) after your coverage terminates.

ACTIVE PARTICIPANT MEDICAL BENEFITS
IMPORTANT HIGHLIGHTS

Your medical benefits are provided under a comprehensive major medical program. After you meet your deductible, the Plan pays for a percentage of your Allowable Expenses.

HOW THE DEDUCTIBLE WORKS

Once an individual reaches his or her individual $250 deductible, the deductible is considered satisfied for that individual for the remainder of the calendar year. Once covered individuals reach the $500 family deductible, the deductible is considered satisfied for the calendar year. After the deductible is satisfied this Plan pays a percentage of either the contract amount if you used a Preferred Provider Organization ("PPO") network or the Reasonable and Customary Charge determined by the Plan Office. There is a $150 per inpatient admission deductible and a $150 annual out-of-pocket network (non-PPO) deductible for a primary care physician visit ("PCP").

WHAT IS A PPO?

A PPO is a network of doctors, hospitals and other health care professionals and facilities that have agreed to charge discounted rates for their services. They are referred to as "preferred providers". The PPO networks used by the Plan are provided through CIGNA and Multi-Plan. There are several advantages to using a PPO provider for covered expenses because:

- Lower costs, save both you and the Plan money; and
- You do not have to pay any charges above the Reasonable and Customary Charge.

Simply show your ID card which has the CIGNA and Multi-Plan logos (which you will receive when you begin Plan coverage).

"Reasonable And Customary Charge" means the prevailing charge in the geographical area of the provider for the same or similar service or supply, as determined by the Plan Office.

"Covered Expenses" means the types of medical services and supplies covered by the Plan. The services and supplies must be performed or prescribed by a qualified provider and, except for preventive care, must be medically necessary for the treatment of an illness or injury.

"Out-of-Pocket Costs" means all out-of-pocket expenses for the annual deductible, inpatient deductibles and $150 out-of-network annual deductible which are credited towards the $3,000 (individual) or $10,000 (family) out-of-pocket limits. Expenses for charges in excess of the Reasonable and Customary Charge, non-covered expenses and individual out of pockets for PPO physician visits or penalties for failure to get a required pre-certification are not credited toward the out-of-pocket limit.

Precertification Requirements

The Plan requires you to get precertification of an in-patient hospitalization. These requirements apply to both PPO and non-PPO providers, and it is your responsibility to get any required precertification for emergency and nonemergency stays.

Precertification of Hospitalization

You must precertify your (or your dependent's) admission to a hospital. This precertification is intended to help you and your qualified dependents make informed decisions when facing hospitalization.

If a doctor recommends that you stay overnight in a hospital, simply contact CIGNA prior to your non-emergency admission, or as soon as possible following an emergency admission, toll free number 1-800-768-4695.

If a hospital admission is not precertified, payment for covered hospital expenses will be reduced according to the rules of the Plan. You will be responsible for paying the remaining expenses, and they will not be credited toward either the deductible or the out-of-pocket limit.

Second Surgical Opinion

A second surgical opinion is optional. The medical provider performing the second opinion cannot perform the surgery.

Prior to Turning 65 Years Old

You should contact Social Security three months prior to turning age 65 with respect to Medicare registration in order to avoid any penalties. The Plan Office will notify you one month prior to your 65th birthday. If you continue as an active employee, the Plan will remain your primary carrier.

WHAT IS AN ALLOWABLE EXPENSE?

An "Allowable Expense" is an expense that must be necessary for the care and treatment of an injury or illness that is not job related. (The Plan excludes Worker's Compensation claims as well as claims for injuries aboard a vessel.) The person receiving treatment must be eligible at the time of the treatment. Treatment/service must be recommended, approved and administered by a physician for a

valid course of medical treatment, which is not experimental as determined by Medicare. The Plan may obtain and rely upon an independent medical opinion to determine whether services or supplies are necessary for such medical treatment.

The illness/injury must be responsive to treatment and expected to lead to a cure. All services/treatment supplies must be medically necessary. Expenses must also be a Covered Charge as listed in the Summary Plan Description and not subject to any Exclusions under the Plan.

Lifetime Maximum Benefit

There is no lifetime maximum benefit.

COVERED EXPENSES FOR ACTIVE EMPLOYEES

Hospital Room and Board

The Plan covers charges for a semi-private room.

Hospital Services and Supplies

The Plan covers services and supplies furnished in a hospital in which the covered individual is confined.

Outpatient Hospital-Type Services

The Plan covers, as hospital charges, outpatient hospital-type services related to surgical procedures performed at an approved ambulatory surgical center.

Physician and Surgical Charges

The Plan covers physician and surgical charges for services rendered by a legally qualified Physician which includes a Doctor of Medicine (MD), Psychiatrist (MD, PhD), Osteopath (DO), Chiropractor (DC), Dentist (DDS), Certified Social Worker, Master of Social Work, Certified Registered Nurse, Anesthesiologist who perform services in lieu of a physician, or certain non-physician practitioners who are licensed to perform services in the state in which they practice and whose services would otherwise be covered by this Plan if performed by a physician. Non-physician services are covered only by Medicare. No coverage is provided for physician care provided by the patient's spouse, brother, sister, children or parents.

Nursing Care

The Plan covers private duty nursing care by a Registered Nurse (RN), or, if an RN is unavailable, by a Licensed Practical Nurse (LPN), provided in a hospital in which the covered individual is confined. The Plan also covers private duty nursing care by an RN or LPN provided in a setting other than a hospital during the first 30 days following discharge from a hospital. No coverage is provided for nursing care provided by the patient's spouse, brother, sister, children or parents.

Mental and Nervous Disorders

If you are confined in a hospital for the care and treatment of a mental or nervous disorder, the Plan will treat that as a covered expense for up to a maximum of 30 days during a two consecutive calendar year period or a maximum of 50 days at a PPO facility in a two consecutive calendar year period. All days must be approved by CIGNA.

Outpatient expenses for the treatment of a mental or nervous disorder are covered for 200 visits during a two (2) consecutive calendar year period.

Alcohol, Drug and Other Substance Abuse

Effective January 1, 2014, there are no maximum annual benefits in connection with the treatment of alcoholism or substance abuse. All care received at a Hospital or qualified Substance Abuse Rehabilitation Facility shall mean a facility licensed by the State in which it is located, or certified or approved as an alcohol or other drug dependency treatment program or center by any other state agency that has the legal authority.

Charges incurred in connection with the treatment of alcoholism on an out-patient basis shall be payable as long as the following is provided:

1. the treatment facility is licensed by the State in which it is located or certified or approved as an alcohol treatment program or center by any other state agency that has the legal authority to do so, or

2. such treatment is required by the State Division of Motor Vehicles in connection with the resolution of a DUI or DWI charge.

Maternity Benefits

The Plan covers maternity-related expenses incurred by you or your covered spouse if the pregnancy begins while coverage is in effect or if the expenses are incurred while coverage is in effect. Effective January 1, 2012, charges for the pregnancy and delivery of a newborn child of an Eligible Employee's Dependent Child are covered.

In accordance with Federal law, the Plan does not restrict benefits for any covered hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan 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).

Hospital Audit Reward

If you discover a billing error made by the hospital in which you are an in-patient and you have the error corrected, you will receive a reward equal to 50% of the error, up to a maximum of $1,000.

Anesthesia Charges for either the physician or the C.R.N. Anesthetist are payable but not both, unless the state medical society or standard medical practice requires the service of both.

Surgeon's Charges are covered including surgical procedures and post-operative treatment. Any OT/PT surgical procedure with a procedure code of experimental/investigational or gastric bypass must be approved by CIGNA.

Chiropractor's Services
The maximum reimbursement per Covered Individual is $2,100 per calendar year. Such services are also limited to a maximum of 30 visits per calendar year.

Durable Medical and Surgical Equipment are covered on a rental basis, or a purchase basis if that equipment is for long range use and if it cannot be rented or if it is likely to cost less to buy than to rent. Please contact the Plan Office to pre-determine benefits. Any durable medical equipment purchased by the Plan is the property of the Plan.

Test and Services are covered including anesthesia and its administration; diagnostic x-rays and laboratory examinations; x-ray, radium and isotope treatment; unreplaced blood and blood plasma and its administration; prosthetic appliances; braces or crutches; and dressings.

Acupuncture is covered up to ten (10) acupuncture treatments. However, please consult the Health & Benefit Plan's Rules & Regulations for guidelines.

Educational Training is covered up to a maximum benefit of the lesser of $300 or three days of educational training per individual per calendar year. However, certain conditions must be met. Please contact the Plan Office for more details.

AMBULANCE SERVICE

Ground Ambulance – Usual, Customary and Reasonable charges for emergency services to or from the nearest facility able to provide appropriate emergency care for the patient's condition are covered.
Air Ambulance – Effective 1/1/14 services shall be payable but limited to $6,000 per instance.

INVESTIGATIONAL OR EXPERIMENTAL SURGERY/MEDICAL TREATMENTS

The Plan will only cover procedures which are covered and payable by Medicare.

Organ Transplant Program

The Trustees have implemented an Organ Transplant Program through CIGNA. Thus, the Plan now offers the following alternatives:

In-Network Program
Covers the following transplants for up to a maximum of $400,000 (except where noted):

Kidney (up to maximum of $300,000)
Heart – Heart/Lung – Lung

Liver – Kidney/Pancreas
Bone Marrow (Allogenic, Autologous)

Covered Charges are paid at 95/5% (100% after $3,000 Out-of-Pocket maximum is met).

Program also covers:
Donor Medical Expenses (up to $10,000)
*Travel and Lodging Expenses for Transplant
Facility for Covered Individual (up to $10,000) **if the facility** is 100 miles or more from your residence.

Certain conditions must be met – please call the Plan Office for details.

Out-of-Network Program

Transplants listed above and Cornea Transplant
(covered up to a maximum of $250,000)

No donor or travel expenses covered.

Covered charges are paid at 70%/30% (100% after $3,000 Out-of-Pocket maximum is met).

Multiple Surgeries are payable as follows:

Out-of-Network

70% of the Reasonable Charge for the 1st and highest cost procedure.

50% of the Reasonable Charge for the second highest cost procedure.

25% of the Reasonable Charge for all other procedures.

In-Network

90% of the Contracted Rate for all such procedures if performed by CIGNA or MultiPlan.

WHAT ARE YOUR PHYSICAL REHABILITATION, PHYSICAL THERAPY AND PHYSICAL MEDICINE BENEFITS?

These benefits are available to you and your eligible Dependents:

Heart Disease/Stroke

For a diagnosis of Heart Disease or Stroke, benefits relating to Physical Therapy, Physical Medicine or Rehabilitation are limited to an aggregate benefit of sixty (60) days of in-patient hospital and/or out-patient care per calendar year within six (6) months of either a hospital confinement or an out-patient procedure for Heart Disease or Stroke.

Other Rehabilitation

Physical therapy and physical medicine or rehabilitation benefits for diagnoses other than Heart Disease or Stroke are limited to ninety (90) days of in-patient hospital and/or out-patient care per calendar year, unless additional treatments are determined to be medically necessary by the treating physician and approved by the Plan's Medical Consultant.

All above benefits must be approved by the Plan's Review Organization and performed at a facility which is equipped to provide the required treatment.

WHAT IS NOT COVERED UNDER PHYSICAL THERAPY/ PHYSICAL MEDICINE AND REHABILITATION BENEFITS?

No benefits are paid for preventive care or physical exercise programs even if they are recommended or supervised by a physician.

WHAT ARE YOUR BENEFITS FOR COMPREHENSIVE ANNUAL PHYSICAL EXAMINATION & IMMUNIZATIONS?

Effective January 1, 2011, any charges above the $1,250 will be limited to Reasonable Charges and subject to the deductible amount or co-payments. Reimbursements for a child under age 19 for annual physical and immunizations are not subject to a deductible or co-payment.

An annual physical examination is a comprehensive examination by a physician for a covered individual for whom no specific diagnosis or symptoms led to the examination. It includes all diagnostic, x-ray and laboratory services related to the exam, as well as immunizations. It does not include x-rays or laboratory work related to an illness or injury.

A Covered Individual who is a Military Sealift Command job applicant is eligible to receive reimbursement for a pre-employment physical required by MSC, but not more than once per calendar year. Please contact the Plan Office for information concerning this program.

Effective January 1, 2012, 100% of the Reasonable Charge (which is the contract amount of a PPO provider or the Reasonable Charge as determined by the Plan) will be payable and not subject to any deductible amount, co-payment or part of the limit of $1,250 for colorectal cancer screening using sigmoidoscopy or colonoscopy starting at age 50 until 75 once every 5 years and a mammogram for women over age 40 every year and cervical cancer screening every three years.

Mastectomy/Mammoplasty

In accordance with Federal law, the Plan covers the following medical services in connection with coverage for a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- Treatment of physical complications in all stage of mastectomy, including lymphedema.

WHAT ARE SOME EXPENSES <u>NOT COVERED</u> UNDER THE <u>MEDICAL</u> PROGRAM OF BENEFITS?

The following are some of the expenses that are <u>not covered</u> by your comprehensive major medical plan:

- expenses resulting from or occurring during the commission of a crime or an illegal act, illegal occupation or felonious act, aggravated assault or inflicting harm to another person
- services which were not recommended, approved and certified by a physician as necessary for the care and treatment of an illness/injury
- hospital days that are not approved by the Plan's Review Organization
- dental care, unless it is necessary because of an accident that is not job-related and is a result of accidental bodily injury to sound natural teeth
- eye examinations, eyeglasses and hearing aids
- with the exception of breast reconstruction, cosmetic surgery and/or treatments unless they are necessary because of an accident that is not job-related
- treatment of congenital diseases that cannot be cured or improved
- stays in nursing homes, institutions, hospitals or other facilities after you are cured or if the illness is permanent and will not respond to further treatment
- treatment for a service-related illness or injury in a U.S. Government hospital or elsewhere at the expense of the federal government
- expenses payable by Worker's Compensation
- expenses payable by your employer for illness or injuries that occur while you are working. It is your employer's responsibility to pay for medical treatment. This includes overseas medical expenses and transportation back to the U.S. Pilots are exempted from this exclusion
- investigative or experimental surgery/medical treatment which is not payable by Medicare
- a physician's visit to the hospital on the same day that surgery is performed by the physician who performed the surgery
- transportation or travel other than ambulance in case of emergency only
- custodial care at home or in an institution when maximum cure has been reached
- for nursery, medical and related expenses of a newborn child of an Eligible Employee's Dependent Child
- tubal ligations/vasectomies and related expenses other than for female employees or male employees' covered spouses
- war injuries or diseases
- preventive care, physical exercise and weight control programs
- infertility treatments
- homeopathic/naturophic treatments or procedures
- smoking cessation treatments
- acupuncture (except as noted above) and acupressure
- charges made by a physician for travel time or expenses, broken appointments, or telephone or other telecommunication consultation
- corrective vision eye surgery, including, but not limited to laser and LASIK eye surgery

WHAT ARE YOUR VISION CARE BENEFITS?

You and each of your dependents are eligible for a maximum benefit of $360 during a two calendar year period (e.g., January 1, 2012 to December 31, 2013) toward the cost of eye examinations, eyeglasses, contact lenses, and effective 1/1/2012 corrective vision eye surgery which includes laser and Lasik eye surgery.

Effective January 1, 2011, the Plan will reimburse one eye exam per year for a child under age 19 and up to $280 for eyeglass frames or $200 for contact lenses every two years.

If you elect to go Out-of-Network:

- You pay for your eye examination and eyewear.
- You submit the bills to the Plan Office for reimbursement.

In-Network Benefits (EYEMED Program)

You and your Eligible Dependent(s) who elect to participate in the In-Network Program will be able to obtain optical benefits and services up to a maximum retail value of $485.00 (plus an administrative fee) at no cost during a two calendar year period (e.g., January 1, 2012 through December 31, 2013). If the eyewear and/or services exceed the negotiated Plan allowances, you will be required to pay for the difference at a discounted rate.

The Program covers a two calendar year period: Spectacle eye exam – contact lens exam (includes fitting fee)

Spectacle lenses – uncoated plastic lenses regardless of size or power.

Frames – any frame up to a regular retail cost of $200.00 for frames above $200.00 regular retail frames are available at an additional discounted cost.

Lens Options – a retail value allowance of $80.00.

Contact lenses – any pair of contact lenses in lieu of lenses and frames up to a regular retail cost of $200.00.

At the present time, there are more than 2,000 EYEMED Vision optical departments located nationwide including all Sears, JC Penney, Pearle Vision Centers and some Target stores in some cities.

For the nearest location call EYEMED INFO LINE 1-800-334-7591 (available six (6) days per week – Weekdays 9 a.m. to 9 p.m., Saturdays 9 a.m. to 5 p.m. EST).

It is recommended that you call in advance and make an appointment for an eye examination.

Identify yourself as a Masters, Mates & Pilots participant by using your EYEMED ID card or by providing them with your Social Security number.

The Plan Office has arranged with EYEMED for online eligibility verification and billing procedures.

You will not be required to pay the provider if you are within the Plan allowance. No need to submit for reimbursement to the Plan Office. The Plan will pay for your benefits directly to EYEMED. Please note that the Optical Benefit did not increase to $485.00. It remains at $360.00. The $485.00 is the retail value, which includes an $8.00 administration fee. This arrangement provides you with better value at less cost.

If you submit a claim for optical benefits, please specify if you used EYEMED. This will expedite reimbursement.

If both in-and out-of-network services are obtained, your expenses will be applied proportionately to both programs so that in combination 100% of the limits are provided.

Additional Savings

You can obtain discounts from Vision Services Plan (VSP) by logging on to www.vsp.com to select a VSP doctor in your area. You will be required to pay for your vision services and submit your receipts to the Plan Office for reimbursement. If you have exhausted your optical benefits, you are still entitled to the discounts.

What is Not Covered:

Some exclusions are

- Non-prescription sunglasses
- Non-prescription contact lenses
- Expenses above allowable maximums

WHAT ARE YOUR HEARING AID BENEFITS?

You and your eligible dependents may have expenses for hearing examinations or hearing aids. If you do, you are eligible for benefits as follows:

For a hearing examination the maximum benefit is $75 once in each 24 month period for adults and children 19 years of age and older. Dependents under 19 years of age have no maximum if treatment is medically necessary every 12 month period.

The maximum hearing aid benefit is $1,000 per ear once every 36 months for adults and children 19 years and older. Dependents under 19 years old have no maximum if treatment is medically necessary once every 36 months.

You are not required to have an otologist recommendation.

WHAT ARE YOUR DENTAL BENEFITS?

The Plan offers In and Out-of-Network Dental Benefits to eligible participants and dependents through Delta Dental located at One Delta Drive, Mechanicsburg, PA 17055-6999.

Out-of-Network

Under this program you and your covered dependents will be reimbursed for usual, customary and reasonable charges ("UCR") for dental expenses according to the geographical schedule of dental allowances. The dental services must be provided by a licensed dentist acting within the scope of his or her license. There is no deductible and the program reimburses 70% of Covered Dental Expenses.

The geographic dental schedule is updated from time to time. For more information about specific services, please contact the Plan Office.

In-Network

The Plan offers a national network of dental care providers through an arrangement with Delta Dental. Covered dental charges are paid at 80/20%, and there is no deductible. ID cards are not required but can be obtained from the Plan Office.

For information concerning providers, please call 1-800-932-0783.

Effective 6/1/2013 dental implants are covered.

Orthodontic is covered, up to a maximum lifetime benefit of $2,000 per Covered Individual except for dependents under age 19 when treatment is medically necessary. Orthodontic means the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids.

Treatment for TMJ is covered up to a maximum of $1,500. Effective January 1, 2011, there is no limit for a child under age 19.

A claim form is required for dental procedures. However, providers use a standardized form which is accepted by the Plan Office.

WHAT IS NOT COVERED?

Some of the dental expenses which are not covered by this Plan include:

- replacement of an unserviceable denture or bridge or a crown unless an abutment is necessary for a new bridge, more frequently than once every five years;
- services or supplies that are primarily cosmetic;
- precision or semi-precision attachments, surgical implants
- services and supplies not recognized as generally accepted dental practice
- more than two (2) oral examinations performed more frequently in any one calendar year;
- the performance of more than two dental prophylaxes in any one calendar year;
- more than one fluoride treatment in any one calendar year;
- anesthesia except when medically necessary and administered in connection with oral or dental surgery;
- periodontics treatment in excess of $2,000 per covered individual in any 12 consecutive month period. Effective January 1, 2011, no maximum for a child under age 19;

- orthodontic treatment in excess of $2,000 per covered individual over his or her lifetime;
- any duplicate prosthetic device or other appliance services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- any services or supplies payable under any other coverage provided by the Plan
- fissure sealants to permanent teeth more often than once every five years or for children over age 19;
- nitrous oxide;
- duplicate prosthetic devices.

Please remember that benefits are limited to the least costly professionally acceptable alternative as determined by the Plan Consultant.

There are a number of limitations. Please call Delta Dental at 1-800-932-0783 before engaging in a costly treatment.

For questions concerning coverage, please call the Plan Office.

WHAT ARE YOUR DISABILITY BENEFITS?

If you are an Offshore Employee and are physically or mentally disabled, unable to perform your duties and need the care of a licensed physician, you will receive a disability benefit of $50 a week to a maximum of 13 weeks or $650 for each disability period (less applicable Social Security taxes).

Benefits begin after seven days of disability; however, if you are hospitalized, benefits commence the day you are confined to a hospital. No benefits are paid if you are on the payroll of an employer or if you receive unearned wages. If the disability occurs while you are on payroll, including vacation time, these days of employment will count toward the seven-day waiting period. **You must apply for these benefits within 180 days after your disability starts.** Under certain conditions, days of disability during vacation time can be applied to periods after the vacation period (for Pension Credit only).

What is a Disability Period? A disability period begins after you are disabled for seven days, or on the day you are hospitalized. The Plan will accept as evidence of disability the “not fit-for-duty” certificate of any authorized physician. However, the Plan may require that you be examined by a physician selected by the Plan. Refusal to do this will disqualify you from receiving benefits.

If you register for employment after a period of disability and receive a “qualified fit-for-duty” certificate, any other disability that occurs after 14 days and one day of actual shipboard employment is considered a new disability period.

If you obtain a “qualified fit-for-duty “ certificate but there has been actual employment, subsequent disabilities are considered part of the same disability period.

If you do not obtain a “qualified fit-for-duty” certificate, any subsequent period of disability or hospitalization will be considered part of the same disability period.

The Trustees have the right to deny disability benefits to you if, within a period of six consecutive calendar months, you:

- apply twice for disability benefits, and don't obtain a "fit-for-duty" certificate, but
- register for employment at the Union Office or accept employment, or
- do not file a claim within 180 days from the onset of your disability.

By registering for employment, it is presumed that you are fully recovered from a disability.

Temporary Long-Term Disability Benefits

If you are an Eligible Offshore Employee and become totally disabled and are unable to work at any occupation, you may be eligible to receive temporary long-term disability benefits.

To be eligible for benefits, you must meet the following requirements at the time your disability starts:

- be under age 60,
- have at least 400 days of Covered Employment within the immediately preceding 36 consecutive months, and have been eligible for benefits from the Plan for at least five calendar years,
- have worked a minimum of 280 days of Covered Employment per year in five of the preceding ten years, and
- your condition must be of a temporary non-chronic nature, as determined by the Trustees.

You must apply to Social Security for a disability pension and provide proof to the Plan Office that you have made this application before benefits begin under the Plan. The Temporary Long-Term Disability benefit begins six calendar months after the month in which you are disabled. However, payment will not be made for any month before the month in which your claim is received by the Plan Office.

The amount of your benefit is equal to your average monthly earnings in employment covered by the Plan during the 36 months before your disability with a maximum monthly benefit of $1500. This benefit will be offset by any disability or pension benefits you receive from other M.M.&P. Plans or from Social Security. This benefit terminates the earlier of 60 months of payments or recovery from the disability.

WHAT ARE THE DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS?

There are several benefits available to eligible employees under this category of coverage, some of which are voluntary.

Available Benefits Include:

- death benefit
- accidental death and dismemberment benefit
- voluntary program of death benefits and accidental death and dismemberment benefits
- optional program of death benefits and accidental death and dismemberment benefits for pilots

These benefits are insured through an insurance company rather than being self-insured by the Plan. Therefore, you are required to submit proper documentation when filing a claim. Please contact the Plan Office for details.

Death Benefits for Active Employees (Except Pilots)

The amount of your death benefit depends upon the length of time you work in Covered Employment. If you do not have 400 days of Covered Employment (shipboard, vacation or paid disability) within the 36-month period before your death, your beneficiary will receive a $7,500 death benefit. If you have 400 days of Covered Employment (shipboard, vacation and paid disability) and are not eligible to receive an M.M.&P. Pension Plan benefit within the 36-month period before your death, your beneficiary will receive a $20,000 death benefit.

If you are an eligible, active Offshore Employee entitled to but not receiving a pension at the time of your death, your beneficiary will receive the following death benefit:

Your Age At The Time of Death	Death Benefit
Under age 55	$1,000
55-59	$10,000
60-64	$5,000
Age 65 or older	$1,500

Pensioners' death benefits are paid by the M.M.&P. Pension Plan.

What Happens If You Become Disabled? If you become totally and permanently disabled before age 60 and you are eligible for an M.M.&P. Pension, you can continue to be eligible for the $7,500 death benefit until you start receiving a pension from the M.M.&P. Pension Plan. If you receive benefits under a Seaman's War Risk Insurance Policy, you are not eligible for continuation of the coverage.

Total and permanent disability means that you are continuously unable to work at any job for compensation until your death.

You must send written proof to the Trustees that you are totally and permanently disabled after nine months of disability but within 12 months after eligibility ends. The Trustees will acknowledge receipt of proof. Nine months after the Trustees receive the first proof, you must again send proof that the disability continues. Each year you must send this proof to the Trustees. The Trustees will acknowledge receipt of the proof.

The Trustees have the right to have you examined by a physician designated by them.

If you die within one year after you become disabled, and before you send proof of your disability to the Trustees, your beneficiary must supply written proof of your disability before benefits are paid.

This Coverage Ends on the *Earliest* of the Following:

- you are no longer permanently and totally disabled,
- you work at any job for compensation,
- the last day of any 12-month period of continued coverage if you do not supply proof of disability to the Trustees, or
- the date you refuse to submit to an examination by a doctor selected by the Trustees.

Accidental Death Benefits

If you are an Eligible Employee and your death is accidental, your beneficiaries are eligible for accidental death and dismemberment benefits instead of the regular death benefits described above.

The amount of your benefit resulting from accidental death depends upon the length of time you work in Covered Employment. If you have 400 days of Covered Employment (including vacation and paid disability) within the three years before your death, your beneficiary will receive a $40,000 accidental death benefit. If you do not have 400 days of Covered Employment (including vacation and paid disability) within the three years before your death, your beneficiary will receive a $15,000 accidental death benefit.

NOTE: The benefit is $25,000 for Active Pilots who meet eligibility requirements. Retired Pilots and their surviving spouses are not eligible for this coverage.

Accidental Dismemberment Benefits

If you are injured in an accident, you are eligible to receive benefits from this coverage.

For Eligible Employees. The $40,000 death benefit described above will be paid if you lose both hands, both feet, one hand and one foot, the sight of both eyes, your speech and hearing, one hand and the sight of one eye or one foot and the sight of one eye. You will receive $20,000 if you lose one hand, one foot, the sight of one eye or your speech or hearing. If you lose your thumb and index finger on the same hand, you will receive $10,000.

If you are eligible for the $15,000 benefit (because you do not have 400 days of Covered Employment within the three years prior to your dismemberment), you will receive that amount if you lose both hands, both feet, one hand and one foot, the sight of both eyes, your speech and hearing, one hand and the sight of one eye, or one foot and the sight of one eye. You'll receive $7,500 if you lose one hand, one foot, the sight of one eye or your speech or hearing; $3,750 if you lose your thumb and index finger on the same hand.

For Active Pilots. $25,000 will be paid if you die an accidental death; or, if you lose both hands, both feet, one hand and one foot, the sight of both eyes, your speech and hearing, one hand and the sight of one eye or one foot and the sight of one eye. You'll receive $12,500 if you lose one hand, one foot, the sight of one eye, or your speech or hearing; $6,250 if you lose your thumb and index finger on the same hand.

Loss of hands means complete severance through or above the wrist joints; loss of feet at or above the ankle joint; loss of sight must be total and permanent; loss of speech and hearing must be total and permanent; and loss of thumb and index finger means complete severance through or above metatarsophalangeal joints.

The benefits are provided if the loss occurs within 365 days of the accident. No more than the full amount of coverage will be paid for all losses due to one accident.

WHAT IS NOT COVERED?

You and your beneficiaries will not receive AD&D benefits if death or dismemberment is caused by:

- disease, physical or mental illness, or medical or surgical treatment for illness or disease,
- ptomaines or bacterial infections, except infections in an accidental wound,
- suicide or intentionally self-inflicted injury, or war or any act of war.

Exclusions Which Apply To Your Death Benefits and Accidental Death Benefits

There are certain circumstances when your beneficiaries will not receive death benefits from the M.M.&P. Pension Plan. Benefits will not be provided if your death is from a cause for which benefits are paid because of shipping operations in the area of war, under wartime conditions or as a result of an act of war;

- under the policy provided for seamen by the United States government, or
- through a self-insurance program maintained by your employer.

This includes payment from a policy known as the War Risk Policy.

Naming A Beneficiary

You may designate a beneficiary for your coverage by filing a written notice with the Plan Office at any time.

You may name any person or persons you wish as your beneficiary for the death and accidental death benefits described above.

You can change your beneficiary at any time by filing a written form supplied for that purpose by the Trustees. This change is not valid until it is received by the Plan Office. Blank beneficiary forms are available at the Plan Office.

If you name more than one beneficiary, and you do not specify the one who should receive a larger interest than the other, the beneficiaries will each receive an equal share.

If you do not name a beneficiary, or if your beneficiary does not survive you, the benefit will be paid to your estate.

However, if your spouse or other members of your family are living, the Trustees may pay the benefit to these survivors.

If your beneficiary is a minor, the Trustees may pay a maximum of $200 a month to the person who has assumed custody and principal support.

To file a claim, your beneficiary should contact the Plan Office at:

700 Maritime Boulevard, Suite A
Linthicum Heights, MD 21090-1996

Transportation Expenses (Offshore Eligible Employees)

If your death occurs while outside the continental United States, the Trustees may reimburse your beneficiary or other member of your family up to $1,000 for transportation and incidental expenses required to return your body to the United States.

Local No. 90 Burial Benefit

In addition to the death benefits described in this section, the Trustees of the M.M.&P. Health and Benefit Fund administer the Burial Benefit Fund established by former Local 90. Former members of Local 90 are entitled to receive a burial benefit under the terms of the Local 90 by-laws. The program will be maintained so long as assets are available. Payments will be issued by the Plan Office.

WHAT ARE YOUR ADDITIONAL VOLUNTARY DEATH BENEFITS AND AD&D BENEFITS?

As a member of the I.O.M.M.&P., in addition to the death benefit coverage described in the preceding pages, which is covered by the Plan, you have the opportunity to purchase additional coverage.

You can purchase life insurance for yourself, accidental death and dismemberment insurance for yourself, or one of the two family plans which automatically cover you and your dependents for accidental death and dismemberment. If you elect to purchase one of the family plans, you cannot also purchase additional individual accidental death and dismemberment coverage. You must submit evidence of insurability for all individuals for whom you are purchasing coverage.

If you are a new applicant for Organization membership, you may enroll within six months after submitting your application. If you are a new member and decline to enroll when you are first eligible, you may enroll for this coverage only during an open enrollment period determined by the Trustees.

If you choose this coverage, you are covered as of the first of the month following the month your premium is received by the Plan Office. Your premium must cover the balance of the period covered. The next renewal date is January 1 of each year.

An active participant, who elects this coverage and then commences receiving a pension, will continue to have this coverage until the annual coverage period ends. Once this period of coverage ends, retired members cannot renew coverage.

Life insurance and accidental death and dismemberment coverage for you alone is available in the amount $25,000 or $50,000, or you can choose one of the two family plans – a high option plan or a low option plan.

Coverage is provided in the following amounts under the two options:

FAMILY PLAN		
	High Option	**Low Option**
Coverage for you:	$50,000	$25,000
Coverage for your spouse if you have no dependent children:	$25,000	$12,500
Coverage for each child if you have no spouse:	$5,000	$2,500
Coverage if you have a spouse and dependent children:		
Spouse	$20,000	$10,000
Each child	$2,500	$1,200

What Does This Coverage Cost?

If you choose life insurance coverage for you alone, the cost is based on the amount of the coverage chosen and your age at your birthday during the calendar year that coverage begins. The premium increases as you get older.

If you choose AD&D coverage for yourself only, the annual premium is based on the amount of coverage ($25,000 or $50,000). If you choose AD&D coverage for you and your family, the annual premium is based on the option you choose (high or low). These rates may vary year to year.

How Are The Benefits Paid?

If you have life insurance coverage for yourself, your beneficiary receives the full amount of your coverage at your death from any cause, except suicide.

If you and your family have AD&D insurance, benefits are paid in the following way. The beneficiary receives the full benefit amount if a covered family member dies as a result of an accident.

AD&D benefits will not be paid if you die or are injured as the result of:

- suicide or attempted suicide,
- bacterial infections, except pyogenic infections as a result of injury,
- hernia or illness,
- war, any act of war or accidents while serving on active military duty in the military service,
- injuries while in an airplane as a crew member, pilot or position other than a passenger, or
- any other exclusion listed in the policy.

OPTIONAL PROGRAM OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR PILOTS

If you are a Pilot, you may purchase accidental death and dismemberment protection in addition to the Voluntary Death Benefit and AD&D Benefits. Any coverage you purchase under this optional program is subject to the same terms and conditions that apply to the voluntary program.

For Pilots Only	Family Plan
$25,000	$25,000
$50,000	$50,000

If you choose to participate in this program, you must pay the premium established by the carrier providing this coverage.

WHAT IS YOUR INSURANCE FOR FAILURE OF WAGE PAYMENTS? (OFFSHORE ELIGIBLE EMPLOYEES ONLY)

This benefit is designed to protect you if your employer is unable to pay you for your employment and your only recourse is to commence legal, equitable or admiralty proceedings. You are not eligible to receive this benefit if you continue to work for an employer after the Plan advises you through the Organization that the employer is not making contributions to the Plan.

Your Benefit

The Benefit you will receive is 90% of the net amount of compensation determined to be due you. The remaining 10% is held in escrow and used to pay for legal and administrative expenses.

How To Apply For Benefits

To receive benefits, you must apply on forms provided by the Plan Office. In addition, you must submit proof of the amount of the compensation owed to you. A statement from the Master of the vessel or the Company is the best evidence. The Plan Office will assist in trying to establish the relevant facts from your employer.

Other Documents

In addition to these forms, before you receive payment from the Plan, you must assign your rights with respect to wages involved, including an assignment of your maritime lien, and authorize the Trustees to sue for these wages, either in your name or their names. You must also authorize the Plan to apply the 10% held in escrow for legal and administrative expenses.

VOLUNTARY LONG-TERM CARE INSURANCE

The Trustees have contracted with Prudential to provide Covered Individuals under the Plan with an opportunity to purchase long-term care insurance on a voluntary basis. For information please contact Prudential at 800-732-0416 or e-mail at ltc4me@prudential.com

VOLUNTARY DISABILITY INSURANCE PROGRAM

Under this voluntary program an Active Participant submits an application to the insurance broker. This insurance is through Lloyd's of London and the broker is Willis. For information please contact Angela Mitchell, at Willis, toll free 800-456-3162 ext. 3032.

WHAT IS THE LICENSE INSURANCE PROGRAM?

License insurance protects Offshore Employees and Pacific Maritime Region Employees who are members of the Organization against the loss of wages or salary if their license is revoked or suspended. You must apply for this coverage and pay the premium to the Plan. Coverage takes effect on the first day of the month after the Plan receives and accepts your application and premium.

Coverage is on an annual basis; rates are determined by the Board of Review of the M.M.&P. License Insurance Program which is appointed by the Trustees. Please contact the Plan Office for further information on the premium rates.

Covered Benefits

Covered Benefits include representation, payment for loss of wages, subsistence payments and property damage. You must be employed in Covered Employment aboard ocean-going vessels of 1,000 gross tons or over. This coverage is secondary to any other coverage including coverage for legal services under the Coast Guard Legal Aid Program of the Plan.

Representation from counsel selected by the Board of Review is covered in connection with administrative charges brought by the U.S. Coast Guard seeking suspension or revocation of your license. If the incident occurs within the jurisdiction of a foreign country, foreign counsel will be provided for up to $500 of covered services. The Board of Review will decide if counsel should be provided for an appeal.

This coverage does not include criminal proceedings or any type of civil suit or action. It also does not include payment of fines, penalties, judgments, awards or settlements.

Payment for losses of wages and subsistence is provided as follows:

- during an outright suspension, you will be paid the amount listed below for up to a maximum of 12 months; if your license is revoked, payment will be for a maximum of 12 months. If you can serve your suspension during a paid vacation, no payment will be made.
- $20.00 a day will be paid as subsistence during a period of suspension for up to a maximum of 12 months unless you can serve your suspension during a paid vacation. If your license is revoked, this payment is made for up to 12 months.

Grade	Amount of Monthly Wages Insured	Annual Premium
Master or Chief Engineer	$5,000	$162.50*
Chief Officer or 1st Asst. Engineer	$4,500	$78.75*
Second Officer or 2nd Asst. Engineer	$3,500	$57.75*
Third Officer or 3rd Asst. Engineer	$3,000	$49.50*

Property damage is paid for up to $2,000 for loss of personal effects, instruments and equipment if:

- the property was located on board the vessel to which you were officially assigned and the damage or loss resulted from an accidental standing, sinking, fire or explosion, collision, oil spill or grounding of the vessel during the time you were covered; and
- you report every loss of or damage to the property to the Plan Office within 90 days of the loss.

Reduced Rates

You are eligible for a 10% reduction in your rate if during the five years before your coverage starts, you meet the following "Safe Mariner" requirements described below:

- no administrative charges have been brought by the U.S. Coast Guard seeking the suspension or revocation of your license; and
- you (if you are a licensed officer) have successfully completed at the Maritime Institute of Technology and Graduate Studies at Linthicum Heights, Maryland, the Shiphandling Simulator Course, the ARPA course, or the Radar Observer or any other course authorized by the Trustees.

Limitations and Exclusions

This coverage does not provide benefits toward loss or damage to your property if:

1. it is not located on board the vessel to which you are officially assigned;
2. the loss is the result of theft or misplacement of the property; or
3. the loss arises from war, invasion, hostilities, rebellion, terrorist activity, insurrection, confiscation by any government or public authority, or risks, contraband or illegal transportation or trade.

Loss of earnings is based on the amount of premium that you pay which is keyed to your shipboard officer rating. **You should apply for coverage in the highest rating in which you expect to serve** during the policy period. If you become employed in a higher officer capacity than the one for which you have chosen coverage, your coverage will be suspended and will not be in effect during the time you are employed and not in effect during the time you are employed in the higher capacity. To be eligible for the "Safe Mariner" rate, you must meet the required conditions and submit a completed application.

Pilots are not eligible for this benefit. Officers who are performing pilot duties in the United States waters where pilots are available but not used by the vessel during the incident leading to license suspension or revocation proceedings will not be covered by this benefit.

Pensioners are not eligible for this benefit.

WHAT IS THE COAST GUARD LEGAL AID PROGRAM?

If you are an Offshore Eligible Employee and you are brought before the U.S. Coast Guard on charges, the Plan will provide legal representation at your request unless charges are brought for refusal to take a drug test.

Attorneys are available in major ports to provide these services. Your local Organization office or I.O.M.M.&P. headquarters can provide you with the name of an attorney in your area.

The Trustees at their discretion may grant further representation if you wish to appeal an unfavorable decision. If the decision following the hearing is revocation, legal representation shall be provided for an appeal of the decision unless the revocation is based upon a positive drug test result. In that case

your legal expenses for the appeal will be reimbursed only if the appeal results in a reversal of revocation. If the revocation order is affirmed, the granting of further representation will be at the discretion of the Board. The maximum number of times you can receive representation under this Plan is three separate occasions.

Upon request, the Plan provides legal representation for Eligible Offshore Employees whose license renewal has been denied, provided that the Eligible Offshore Employee has reasonably exhausted administrative appeal procedures except where the license renewal has been denied because the Eligible Offshore Employee has refused to take a drug test. Legal representation will be provided only by attorneys designated by the Plan.

SCHOLARSHIP PROGRAM FOR DEPENDENT CHILDREN OF ELIGIBLE OFFSHORE EMPLOYEES

What is the Scholarship Program?

The Scholarship Program was established to provide six college scholarships each year for the eligible sons and daughters of active or deceased Offshore Employees who meet Plan eligibility requirements and Co-Pay Pensioners under the M.M.&P. Pension Plan.

Each scholarship has a maximum value of $5,000 a year. It is renewable each year for a maximum total of $20,000 or until the student receives a bachelor's degree, whichever is earlier. This renewal is dependent on the student maintaining the standards required by the college and the Scholarship Committee.

Each scholarship winner and alternate is selected by an independent scholarship committee composed of educators from colleges and universities.

Candidates' Eligibility Requirements

To be eligible for the Scholarship Program, the candidate must be at the time of application:

- a high school senior who expects to graduate in January or June of the current school year; and
- under 19 years old, or under 23 and unmarried, a full-time student and dependent upon you for support; and
- the child, step-child or legally adopted child of an active or deceased eligible Offshore Employee of the Organization, or a Co-Pay Pensioner who meets the eligibility requirements described below.

Parent/Deceased Parent Eligibility Requirements

You must be:

- an Offshore Eligible Employee with 400 days of Covered Employment (including vacation and paid disability) under the Plan in the three years before the date of application for a scholarship and you must meet the normal eligibility requirements of the Plan the day the application is received by the Plan. <u>You must also be eligible for benefits from the Plan on September 1 of</u>

the academic year the scholarship is awarded and each September 1 for an additional three years for renewal of the award unless you retire or die before that date; or

- a deceased Offshore Employee, who was eligible for benefits from the Plan at the time of death and who had at least 400 days of Covered Employment (including vacation and paid disability) in the three years before his/her death; or
- a Co-Pay Pensioner receiving a regular, reduced, early retirement or disability retirement pension from the M.M.&P. Pension Plan who had at least 400 days of Covered Employment (including vacation and paid disability) in the three-year period before the effective date of his/her pension and your child was your Dependent at the time you went on pension.

How Winners Are Selected

An independent scholarship committee composed of educators from college and universities selects each winner and alternate. Candidates are selected on the basis of high school records, including extracurricular activities, College Entrance Examination Board Test results, and other indications of character, leadership and potential for success.

The scholarship award is renewable annually each September 1, until the completion of the four-year program or the student obtains a Bachelor's Degree, whichever comes first. The student must be enrolled at an accredited college or university on a full-time basis and must maintain the scholastic standards required by college officials and the Scholarship Committee.

Payment of Scholarship

The amount of the scholarship is deposited with the school at the beginning of each September during the school year in the name of the student, and is disbursed as needed to cover expenses.

Selection of Colleges

Scholarship winners may attend any accredited college or university granting a four-year or equivalent degree which does not permit discrimination based on sex, race, creed, color or national origin in:

- its overall enrollment policy for any part of its curriculum, or
- the use of any of its facilities.

Transferring from one accredited college to another is only permitted between academic years with written approval from the Scholarship Committee.

Obligations of Scholarship Winners

Scholarship winners must enter an accredited college or university no later than the fall of the year in which the scholarship is awarded.

They must continue their courses without interruption except for illness, military service or other exceptional circumstances.

The scholastic records of the winners will be reviewed each year by the Scholarship Committee. Each winner who maintains the required standards will continue to receive the scholarship award.

A scholarship winner may not accept any other scholarship except for honorary awards or grants or awards based entirely on financial need.

Military Service

If a scholarship winner's studies are delayed or interrupted by military service, the scholarship will be held for the winner. He or she should apply for reinstatement of the scholarship within three months after discharge and enroll in college no later than the next year.

Illness

An illness, accident, or other exceptional situation is accepted as a reason for holding the scholarship for the winner.

Scholarship winners who are prevented from starting or continuing their college courses for any of these reasons should promptly advise the Scholarship Committee.

If a scholarship winner is not eligible to receive the scholarship, the first alternate's records will be reviewed by the Scholarship Committee; and if found eligible, the scholarship will be awarded to the alternate. If the first alternate is not eligible, the second alternate will be considered.

Trustee approval is required.

WHAT ARE YOUR PRESCRIPTION DRUG BENEFITS?

In addition to your comprehensive major medical benefits, the Plan provides you with other types of benefits including a prescription drug benefit.

Prescription drugs will be dispensed, pursuant to the Federal Food, Drug and Cosmetic Act, upon a written or oral prescription of a physician licensed by law. They include, for purposes of this Plan, insulin and diabetic supplies, including syringes, needles and test material.

The following are some of the exclusions under the Plan:

- any prescription or medication for which there is a generic equivalent available in non-prescription form
- aspirin, vitamins (excluding pre-natal vitamins) and over-the-counter medications and supplies
- fertility drugs, naturopathic or homeopathic substances/devices
- smoking cessation substances
- controlled substances (Schedule II Drugs) are limited to a 30-day supply
- nutritional supplements, appetite suppressants/weight control substances/supplies
- hair growth treatments or drug/devices used for cosmetic purposes
- appliances and devices other than disposable syringes and needles for injection of a prescribed drug
- contraceptives or birth control

The Prescription Drug Program

The Prescription Drug Program is provided through CVS/Caremark.

THIS IS HOW THE PROGRAM WORKS:

Retail Program – Short-Term Medication

Under this program, Eligible Participants (Covered Individuals) will be able to purchase short-term medication at discounted prices from participating pharmacies.

When you and/or your eligible dependent(s) purchase short-term Prescription Drugs at a participating pharmacy, you are required to pay a minimum co-payment of $15.00 for brand name drugs and $7.50 for a generic equivalent. If a generic equivalent of a brand name drug is available and you or your eligible dependent(s) request the brand name version, you will also be responsible for paying the difference in cost between the brand name drug and the generic equivalent, in addition to these minimum co-payment amounts. The maximum that a member will be required to pay under these provisions is the total cost of the drug to the Plan.

Out-of-Network Claims for Prescriptions

Due to the high costs of Prescription Drugs and in order to be able to continue to offer the Prescription Drug benefit to Plan participants, the Trustees agreed to reimburse Out-of-Network claims the amount(s) the Plan would have paid had the claim been submitted In-Network through CVS/Caremark, subject to the minimum co-payment amounts described above.

If you obtain your medication at a **non-participating** pharmacy, submit a claim form which is included in your packet to the following or call the Plan Office:

CVS/CAREMARK
P.O. Box 52136
Phoenix, AZ 85072

For out-of-network claims, you must request reimbursement within three years after you incurred the expense. A minimum accumulation of $50 is required for these claims.

Mail Service Pharmacy Program

If you require chronic or maintenance type prescription drugs, you can order them through CVS/Caremark Direct. Through this program, you can order up to a 30-day supply of the drug for first-time prescriptions and a 90-day supply of the prescribed drug after the first time. The Mail Order Drug Program will send you generic drugs unless you and your physician specify brand name drugs or there are no generic equivalents. If you order a brand-name drug when a generic equivalent is available, you will have to pay the difference between the cost of the generic drug and the brand name drug directly to CVS/Caremark Direct mail service. The Plan will pay 80% for drugs obtained through the mail order program. The participant will be responsible for 20% of the balance (up to $75 per prescription maximum). This includes generic drugs and brand name drugs where there is no generic equivalent available.

To use the Mail Order Drug Program, please do the following:

Submit a Confidential Profile and Drug Allergy Information Form to CVS/CAREMARK, P.O. Box 94467, Palatine, IL 60094 and your prescription to the pharmacy. This form should be submitted once, unless you are reporting a change in the information. Forms are available at the Plan Office and the Port Offices.

The Mail Order Pharmacy will establish a record for you and your dependents to order your medication from home. It will be delivered by first-class mail or UPS within 14 days from the date you mail the prescription. You may call for a refill on a currently valid prescription. Be sure to allow enough time for delivery.

When your medication arrives, examine it carefully to make sure the prescription has been properly filled and the medication you ordered has been provided to you. If you have any questions about the prescription, do not take the medication and contact the mail order pharmacy.

CVS/CAREMARK – Mail Order for refills call 1-888-364-6815.

To locate a participating pharmacy call 1-888-364-6815.

NOTE: There is no Plan deductible under the Prescription Program.

COORDINATION OF BENEFITS

How Do You File a Claim for Benefits?

There are several things to remember when filing a claim for benefits. In general, you should know the following:

- if you are an active employee, this Plan pays first. If you are also covered by another plan, for example, Medicare or as a dependent under your spouse's plan, submit your claims to the plan after this Plan has paid benefits.
- if your spouse is working and is covered by a group plan, his or her expenses should first be submitted to the plan which covers your spouse as an employee. Remaining expenses can then be submitted to this Plan together with the medical bill and explanation of benefits from the other carrier.
- if you have dependent children, the plan covering the parent whose birthday falls on the earlier month and day during the year pays benefits first. So, if your birthday is on an earlier month and day than your spouse's, submit your children's claims to this Plan first and to your spouse's plan second. If you and your spouse have the same birthday, the plan that has covered one of you the longest pays benefits first.
- if insurance law in your state does not require health plans to coordinate benefits according to the above "birthday rule," the plan that covers the male employee pays benefits first. So, in this case, if you are male, submit your children's claims to this Plan first.

However, if you are separated or divorced, there are other rules regarding coverage for your children. If there is a court decree which establishes responsibility for the health care expenses of your

children, benefits are paid according to that decree. If there is no court decree, benefits are paid in the following order:

Parents Separated or Divorced and Not Remarried	Parents Separated or Divorced and Remarried
(1) Plan covering parent with custody **(2) Plan covering parent without custody**	**(1) Plan covering parent with custody** **(2) Plan covering step-parent with custody** **(3) Plan covering parent without or with lesser custody**

Effective 1/1/2014, if a dependent child ages 19-26 of an Eligible Employee or Pensioner is covered under another health plan as a participant or dependent of a participant spouse the other health plan pays first, and this Plan pays second.

Please remember that the Plan has the right to exchange information with any other organization for the purpose of coordinating benefits. **If this Plan makes an overpayment, it has the right to recover the overpayment from the party to whom it was made.**

The Plan is primary and will pay its full benefit if you or your dependent need kidney dialysis for end-stage renal disease for the first 30 months of Medicare coverage.

OTHER PLAN PROVISIONS

Subrogation

Each Covered Individual and his personal representative (which, for the purposes of this Article, shall include, but not be limited to, his attorney, as well his Executor or Administrator in the event he is deceased) agree, by filing a claim for benefits under the Plan and as consideration for payments received from the Plan, to reimburse the Plan for any and all payments made by the Plan on the Covered Individual's behalf to the full extent of any amount recovered from any third party by virtue of any claim or cause of action that has accrued or may accrue with respect to the injuries or conditions that resulted in the Plan's payments. Specifically, the Plan is entitled to reimbursement of any benefits paid in connection with an accident or injury caused directly or indirectly by a third party from any recovery received by or on behalf of the Covered Individual with respect to such accident or injury, regardless of how the recovery is characterized. For example, the Fund is entitled to reimbursement even if there is no recovery for medical expenses and the only recovery is for pain and suffering.

The Plan will not pay benefits related to any third party liability accident or injury to the extent of any payment or recovery previously received by or on behalf of the Covered Individual in connection with the accident or injury, unless the Plan's lien was repaid in full or the Plan agreed to accept a reduced payment.

In addition, and not by way of limitation, the Covered Individual and his personal representative agree, with regard to any such claim or cause of action, that –

1. the Plan will have the right to sue the third party directly in the place and stead of the Covered Individual;
2. no settlement will be made or release given without prior notification to the Plan;
3. the Covered Individual (or his personal representative) will not waive any of the Plan's right to recovery without the Plan's prior consent, and any settlement of the Covered Individual's claim that is less than the full amount of the Plan's lien cannot be accepted without the Plan's prior approval. If a settlement that compromises the Plan's lien is accepted without the Plan's prior approval, the Plan is entitled to reimbursement in full, even if the reimbursement amount is more than the settlement;
4. the Covered Individual and his personal representative will take such action, furnish such information and assistance, and execute and deliver such instruments as the Plan may require to facilitate the enforcement of its rights, including but not limited to the Covered Individual signing the Plan's Subrogation Agreement as a condition to receiving benefits. The Plan will suspend or deny all accident-related benefit claims and those claims will not be complete until the Plan receives properly executed copies of the foregoing documents. All required documents must be received by the Plan within the Plan's time limits for filing claims;
5. the Covered Individual and his personal representative will take no action that will dissipate the fund arising from the recovery or place it beyond the reach of the Plan; and
6. the Plan shall have a lien on any recovery received by the Covered Individual or his personal representative (including an attorney) in the full amount that is due to the Plan. Any such amount shall be held in trust by the Covered Individual or personal representative for the benefit of the Plan until paid to the Plan.

For the purposes of this Article, the amount recovered from the third party will be determined without any reduction for the costs of recovery, including but not limited to attorney's fees, court costs, and fees and expenses of expert witnesses, and without the application of the "common fund" doctrine. The Plan is entitled to reimbursement first and completely from any recovery, without regard to whether the recovery fully compensates the Covered Individual for the injury, expense or loss that he suffered, without regard to whether it is designated as a recovery of medical expenses, and without the application of the "make whole" doctrine. The Plan's right to first priority is not subject to reduction due to the Covered Individual's own negligence.

The Plan's right to recovery shall apply regardless of the source of the recovery. Moreover, the Plan's right to reimbursement applies to any type of accident or injury caused or contributed to, directly or indirectly, by a third party. This includes, but is not limited to, motor vehicle accidents, slip and fall cases, medical malpractice, and legal malpractice related to a third party liability case (i.e., an attorney's failure to file a third party liability case within the applicable statute of limitations).

The Trustees may disqualify an Employee and his Dependents from receiving future benefits under the Plan, if any Covered Individual receiving benefits in connection with the Employee fails to provide any necessary information to the Plan in a timely manner or fails to reimburse, or provide for the reimbursement of, the Plan in accordance with the requirements of this Article VI within four weeks after the payment of any recovery.

Family and Medical Leave

Any employee's eligibility for benefits will continue during any leave of absence approved by his Employer pursuant to the Family and Medical Leave Act.

Recovery of Benefit Overpayments

The Plan has the right to recover all overpayments from among the person(s) to or for whom payments were made – insurance companies, providers/organizations or you. Failure to reimburse the Plan within four weeks from the date of Plan Office demand may, at the Trustees discretion, disqualify the participant or dependent from receiving future benefits and could result in the pursuit of legal action.

IMPORTANT INFORMATION PRIOR TO TURNING AGE 65

If you continue to work in Covered Employment beyond age 65, coverage under the Plan will continue for you and your qualified dependents. Because you become Medicare eligible at age 65, you need to know some information about Medicare. Medicare is divided into three key components, – Part A is hospital insurance, Part B is supplementary medical insurance and Part D is prescription drug insurance. There's no cost to you for Medicare Part A (provided you apply for it on time – about three months before you reach age 65). Medicare Part B, on the other hand, requires you to pay a monthly premium. Medicare Part D also requires you to pay a monthly premium. Federal law provides for a penalty if you wait to enroll for Medicare Part B and Medicare Part D until after your 65th birthday, but that penalty can be waived if you are continuously covered under the Plan as your primary coverage.

While you are in Covered Employment with coverage under the Plan, you have the option of enrolling in Medicare Part A and rejecting Medicare Part B. While you are in Covered Employment, Medicare coverage (Parts A and B) is secondary to the coverage provided by the Plan. **However, because Medicare will become your primary coverage when you retire, if you don't enroll in Part B when you are first eligible, there may be a gap in coverage between your retirement and the date your Part B coverage becomes effective.**

Pensioners Eligibility for Benefits

It is important to remember that your benefits as an active employee **terminate as of the effective date of your pension**. Upon retirement you may be eligible to receive certain health benefits from the Plan beginning on the first day of the month in which your pension becomes effective. The types of benefits you may be eligible for depends on whether you elect to share the costs of coverage with the Plan, your age, your dependent's age and type of pension you are receiving from the MM&P Pension Plan.

Maximum Reimbursement under the Comprehensive Major Medical Benefit for Pensioners, Retired Pilots and each of their Eligible Dependents may not exceed 1/1/12 - $1,250,000 – 1/1/13 - $2,000,000.

Offshore Employees – In order to be eligible for health benefits as a retiree, you must have 400 days of Covered Employment in the last 3 years prior to your effective date of pension. You must also pay a monthly premium to either the Co-Pay Program or Continuation of Coverage Program.

Co-Pay Program

To be eligible for retiree benefits, you must be eligible to vote on union contracts, and you must agree to pay a premium to the Plan. You must authorize the Plan Office to deduct a contribution from your pension benefit equal to 3% of your gross adjusted monthly benefit with a minimum of $35 per month and a maximum of $175 a month. Your benefits are:

- comprehensive major medical
- prescription drugs
- comprehensive annual physical examination

- hearing aid benefit

Continuation of Coverage Program

If you do not participate in the Co-Pay Program, you are eligible to continue certain benefits for you and/or your dependents until June 30, 2013 (or a later date if extended by the Trustees) by paying the appropriate monthly premiums to the Plan. Your benefits are the same as a Co-Pay Pensioner **excluding the dental and optical benefits.**

The amount of the premium is determined annually by the Plan's actuary and adjusted each year on April 1. **The Trustees determine each year at the beginning of the year whether or not this coverage is to be continued.** The coverage period is July 1 to June 30 of the following year.

If you or your eligible dependents are entitled to Medicare, benefits from this Plan will be coordinated with Medicare. Medicare will be the primary insurer and will pay benefits first. The Plan will be the secondary carrier and will pay benefits after Medicare, subject to Plan rules and limitations.

Employees of the Organization, Plan Office, Mates Program, MIRAID or MM&P Federal Credit Union shall be eligible for benefits under the "Continuation of Coverage" provisions provided, before he retires, he meets all of the following:

- must have been an Office Employee of the Organization, the Plan Office, the MATES Program, MIRAID and/or MM&P Federal Credit Union for a total of at least 17 years
- the sum of his age and his years as an employee (for one of the above mentioned) must equal 75 or more, and he must elect coverage under the "Continuation of Coverage" provision prior to the earlier of his retirement date or his pension effective date and **may not** elect such coverage after such date.

Pilots

You should contact your Pilot Branch in order to continue your coverage as a retiree.

Pacific Maritime Region

In order to be eligible to health benefits as a retiree you must have been covered for health benefits as a result of Covered Employment for 24 calendar months in the last 36 calendar months prior to your effective date of retirement and you must have been in Covered Employment and eligible for benefits under this Plan or Columbia Northwest Marine Benefit Trust Plan for 3 calendar months preceding your effective retirement date.

Retired Organization Official of the United Inland Group or Retired Savannah Docking Pilots are eligible for retiree benefits under the Plan until 6/30/13 by paying the appropriate cost for coverage as determined by the Plan's actuary under Continuation of Coverage. Retirees who were eligible for benefits as of May 1, 2000 (date of the merger) will be eligible for health benefits under the Plan provided they pay the required contributions for such coverage. Effective February 1, 2012, a Pensioner who received health coverage under the Plan as an Eligible Employee immediately prior to his retirement and not eligible for health coverage as a Pensioner shall be eligible for coverage for

themselves and their eligible Dependent until June 30, 2013 under the Continuation of Coverage Program.

Termination of Coverage

Your Benefits and the Benefits of Your Dependent Spouse will end on the earlier of:

- the end of the second month after the month in which the Plan Office receives notice that you are revoking your co-pay authorization or continuation of coverage premiums, or
- immediately upon non-receipt by the Plan Office of your Continuation of Coverage premium or Co-Pay Contribution, or
- your death, or
- the date of suspension of your MM&P Pension, or
- the discontinuance of benefits for a class of pensioners of which you are a member, or
- the date you lose eligibility under the Plan as a result of application of the Cessation of Benefits provisions of the Plan, or
- the date you are granted a withdrawal card or if earlier, the date the Plan receives notice from the Organization that you are six (6) months delinquent in your Union dues.

CESSATION OF BENEFITS PROVISION

You will permanently lose eligibility to health benefits as a retiree if you are an active employee or a Pensioner who accepts employment for 30 or more days in the aggregate in any capacity relating to the operation or maintenance of a vessel operated by a company that does not participate in this Plan.

The above will not apply if:

such active employee subsequently resumes Covered Employment with an Employer that contributed to this Plan at a rate calculated to include Pensioners' health benefits for at least 400 days including vacation and disability days. The Trustees waive this provision due to the Employer of such employee becoming or regaining status as an Employer under the Plan, or if your employment is permissible under the MM&P Pension Plan and the Trustees have approved this employment.

WHEN CAN A PENSIONER TEMPORARILY LOSE ELIGIBILITY TO HEALTH BENEFITS?

A Pensioner under 65 years of age can lose eligibility for him/her and his/her Eligible Dependents if he or she earns more than the maximum allowed under the Plan and/or Social Security. What happens depends upon when you temporarily lose eligibility. In order to resume coverage under the Plan at a later date, you must continue to make Co-Pay Contributions during the periods of ineligibility. You can purchase COBRA Continuation of Coverage for you and your Eligible Dependents by contacting the Plan Office.
Earnings means all wages, earned income or remuneration or compensation for current, past or future services, including (i) taxable wages reportable by any employer on Form W-2, (ii) self-

employment income as defined in section 1402 of the Internal Revenue Code, (iii) the individual's share of the profits of any S corporation or undistributed net income of any C corporation in which he is a shareholder to the extent that his wages reportable on Form W-2 do not reflect the full value of his services; provided, however, "Earnings" do not include distributions from qualified pension, profit sharing or stock bonus plans or benefits received under government Social Security.

Benefits for Retired Employees (Pensioners) and Their Eligible Dependents

As a participant in the Plan you are offered a variety of benefits. If you meet the requirements previously outlined you will be provided benefits as described in this section. However, the Trustees reserve the right to amend, modify or terminate the Plan's benefits (in whole or part) at any time.

Retiree Health Benefits Under Age 65 and Not Entitled to Medicare

If you are retired and are under age 65, the Plan is the primary provider of health benefits for you and your eligible dependents. For a summary of how benefits are reimbursed, please go to pages 39-41 Summary of Benefits for Active Employees. Remember, you must comply with all Plan requirements.

Earnings Limitations Provisions Applicable to Pensioners under Age 65 (see definition of earnings in the glossary)

1. If you continue to work at any type of job for which you're paid, you retired with **less than 20 years** of pension credit and you earn more than the maximum allowed under Social Security during a calendar year, you and your dependents will not be eligible for health benefits, except the death benefit during that calendar year.

2. The Social Security maximum for 2012 is $14,640. If you did not earn more than the maximum allowed under Social Security, but your Spouse or your children earned over the allowable maximum, the individual who exceeded the earnings limitations will not be eligible for health benefits during that calendar year.

3. **Pensioners who retired with 20 or more years of pension credit** and/or their Dependents are permitted to earn up to $32,000 for 2012 and subsequent years, per calendar year, without losing their eligibility to health benefits. Effective 1/1/2014 you will be permitted to receive earnings of up to $35,000 per year, and an additional earnings of $1,000 per year effective each January 1 thereafter up to a maximum of $40,000 per year without losing eligibility to health benefits.

If a Dependent of a Pensioner under 65 years of age is gainfully employed and earning over the annual maximum, that individual will not be eligible to health benefits.

Effective January 1, 2011, a Pensioner or his dependents under age 65 must inform the Plan Office at the beginning of the year or at the time they expect they will exceed the Earnings Limitation for that year in which they will not be eligible for benefits for the remainder of the year. Furthermore, it will be presumed that you exceed the Earnings Limitation for the following year unless you can demonstrate to the Plan otherwise.

The Plan may request from Pensioners and/or their Dependents information such as Federal Income Tax Returns to verify they have not exceeded the Earnings Limitation. Effective January 1, 2005 the Plan may suspend benefits if this information is not provided.

WHAT TO DO IF YOU/YOUR DEPENDENT EXCEED THE ABOVE EARNINGS LIMITATIONS?

If you or your dependents temporarily lose eligibility for benefits because you earn more than the maximum allowed under Social Security, you/your dependent may purchase COBRA Continuation Coverage as described on page 6. You must also continue to make Co-Pay Contributions in order to continue health care benefits under this Plan when you/your dependent no longer earn more than the maximum allowed by Social Security or the Plan provisions.

Retiree Health Benefits Over Age 65 and Entitled to Medicare

If you are retired and are age 65 or over or under 65 but entitled to Medicare, Medicare is your primary insurer, and this Plan is your secondary provider of health coverage.

The Plan will reimburse you as though you have Medicare benefits even **if you do not apply** for Medicare coverage; that is, the Plan will only reimburse the difference between the amount Medicare would have paid had you applied for coverage and the Allowable Expense payable under this Plan.

Part A of Medicare, which covers hospital expenses, is free. When you apply for Social Security you are also applying for Part A. Medicare Part B covers medical expenses and has a monthly cost of $99.90 for 2012.

Offshore Co-Pay Pensioners who meet the following conditions will be reimbursed quarterly in arrears for their Medicare Part B Premium:

1. The Pensioner as of the later of January 1, 2001 or his/her effective date of Pension has a gross monthly MM&P Pension of $2,000 or less; and

2. Is receiving a Regular or Disability Pension.

Although you are eligible for benefits from Medicare and the Plan, Medicare pays benefits first. Accordingly, submit your claims first to Medicare. Once Medicare has paid benefits, submit the Medicare Explanation of Benefits (E.O.B.) form and bills indicating the type of procedure and diagnosis to the Plan Office.

Some examples on how the Plan reimburses Pensioners covered by Medicare are :

Example: Provider accepts Medicare Assignment				
Billed Amount	Medicare Approved	Medicare Paid	MM&P Plan Pays	Your Payment
$100.00	$80.00	$64.00	$16.00	0

Example: Provider does not accept Medicare Assignment				
Billed Amount	Medicare Approved	Medicare Paid	MM&P Plan Pays	Your Payment
$100.00	$80.00	$64.00	$36.00[1]	0

1. Both examples assume that you have met your Medicare deductible and also your Plan deductible.

2. The Plan will give you credit for the Medicare deductible.

The Plan Office pays the difference between what Medicare paid and the Plan's Allowable Expense.

If you go to a Non-Participating Medicare Provider, the Plan will only reimburse you 20% of the Plans UCR.

Important Drug Information for Retirees

Your prescription drug benefits as a Retiree is outlined on page 49. However, certain retired Participants may be eligible for coverage under a Medicare Part D Prescription Drug Plan (PDP). Information regarding Medicare Part D benefits was delivered to all Plan Participants in late 2005 and sent annually. Please contact the Plan Office for more information regarding Medicare Part D benefits.

In addition, for more information you can:

- Visit www.medicare.gov,
- Call your State Health Insurance Assistance Program, or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

Eligible Participants may wish to enroll in a PDP for prescription drug coverage, based on various factors. For example, individuals with limited income may be eligible for assistance in paying PDP premiums. The prescription medications covered by each PDP, as well as the deductibles, co-payments, and network of retail and mail pharmacies applicable for each PDP vary. You are not required to enroll in a PDP, and may choose not to do so if your coverage under the Plan is on average at least as good as standard PDP coverage. If you are eligible to enroll in a PDP, you can choose any one of the following options:

[1] **The maximum the doctor will receive is $100.00.**

(1) **Keep your current Plan coverage, and not enroll in a PDP.** If you choose this option, you may enroll in a PDP in the future, during Medicare's annual enrollment period (November 15 – December 31 of each year). You will not have to pay extra to enroll in Medicare PDP coverage later on, if you enroll in a timely manner, as described below.

(2) **Keep your current Plan coverage and enroll in a PDP.** If you choose this option, the Plan will pay for prescription drug benefits secondary to Medicare. When you fill a prescription, you should present your PDP card to the pharmacy, which will submit your prescription drug claims to Medicare for payment first. Ask your pharmacist for a computer printout (called a "screen shot") indicating that your prescription drug claim was submitted to your PDP, as well as how much money the PDP paid toward your claim. (If your pharmacy cannot provide this information, you should contact your PDP and ask them to send you an Explanation of Benefits (EOB).) Obtain a Medicare COB Direct Member Reimbursement form from the Plan Office. Attach the computer records to your form with the itemized receipts from the pharmacy that come with your prescription (not cash register receipts), and mail them to:

CAREMARK
P.O. BOX 52066
Phoenix, AZ 85072

The Plan Office cannot reimburse members directly for Medicare Part D coordination of benefit claims. Medicare collects certain payment information from CVS/Caremark (CAREMARK); therefore, payments for secondary coverage through the Plan must be performed manually.

(3) **Drop your current Plan coverage and enroll in a PDP.** If you choose this option, and you are a Retiree from a membership group other than a participating Pilot Branch, you **will not** be allowed to re-enroll in the Plan. If you drop your Plan coverage, you will lose coverage for both yourself and your Spouse and other Dependents.

If you drop or lose coverage and do not enroll in a PDP after your current coverage ends, you may have to pay more to enroll in a PDP later. Participants who wish to apply for coverage in a PDP should contact PDPs available in their state for more information. The deadline for enrolling in a PDP without penalty is May 15, 2006, for those individuals eligible for Medicare Part D coverage in 2006.

If you become eligible for Medicare Part D benefits in the future, you should contact PDPs in your state as soon as possible for enrollment information, to avoid potential penalties.

If you are not eligible for Medicare Part D, but are otherwise eligible to receive prescription drug benefits, your benefits will continue to be covered by the Plan.

WHO IS NOT ELIGIBLE FOR BENEFITS UNDER THE PLAN?

- Deferred Vesting Pensioners
- Pensioners who do not participate in either the Co-Pay Program or the Continuation of Coverage Program
- Pensioners who do not have 400 days of Covered Employment (Shipboard, Vacation or Paid Disability) during the last 3 years prior to the effective date of their pension
- The dependents of all above Pensioners

IMPORTANT: If you retire with a Deferred 10-Year Pension, you are not eligible for Dental or Hearing Aid benefits.

Coverage for Dependent Spouses After the Death of a Pensioner

1. Co-Pay Pensioners

- **Surviving Spouses**

Surviving Spouses of Co-Pay Pensioners eligible for health benefits at the time the Pensioner dies are offered the following options:

a) COBRA Continuation Coverage for up to the earlier of entitlement to Medicare or 36 months, or

b) Waive COBRA Continuation Coverage and purchase health coverage under the Plan's Continuation of Coverage Program which is subject to extension by the Trustees each year.

The Continuation of Coverage Program has been extended through June 30, 2013 and is subject to renewal and extension by the Trustees each year. If the Trustees decide not to extend this Coverage, the Surviving Spouses' coverage will terminate.

2. Continuation of Coverage Pensioners

- **Surviving Spouses of Continuation of Coverage Pensioners**

Surviving Spouses of Pensioners subscribing to the Continuation of Coverage Program at the time of death will be offered COBRA Continuation Coverage until the earlier of:

a) entitlement to Medicare, or

b) 36 months

Coverage Available to Dependent Children of Deceased Participants Eligible for an MM&P Pension

If you die while an Eligible Employee and you are entitled to a pension under the MM&P Pension Plan or you die while an eligible pensioner, your dependent children's coverage will continue until they marry or reach age 19, whichever is earlier, or reach age 26.

Dependent Spouses of Eligible Employees entitled to pension benefits under the MM&P Pension Plan on a deferred basis at the time of death will be offered COBRA Continuation Coverage until the earlier of 36 months or entitlement to Medicare.

WHAT OTHER INFORMATION SHOULD YOU KNOW?

Plan Amendments

Procedures followed by Trustees to Amend the Plan. The Plan documents are amended from time-to-time by the Trustees who have the right and the discretion to alter or terminate the amount or conditions with regard to any benefits described in this booklet or the Rules and Regulations of the Plan. These changes/amendments are communicated to the Participants through the Union Newspaper, The Master, Mate & Pilot.

Rules Governing Claims and Appeals

The following summary explains new rules under your group health plan for filing claims and appeals. The new rules streamline the claims and appeals process. We hope that the new rules will result in a faster and better claim and appeal determination.

CLAIMS

General Information

Claims for benefits under the Plan can be post-services, pre-services or concurrent. This summary explains how we process these different types of claims and how you can appeal a partial or complete denial of a claim.

The following Claims and Appeals procedures are designed to comply with the requirement of the **Employee Retirement Income Security Act of 1974 (ERISA)**.

You must act on your own behalf or through an authorized representative if you wish to exercise your right under this summary.

Post-Service Claims

Any claim for a benefit under the Plan that is not a Pre-Service Claim. Generally, these are claims for which medical services have already been rendered or supplies purchased.

What Constitutes a Claim?

For you to obtain benefits for a post-service claim, we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted with the appropriate information. Each claim for services should have: dates of services, CPT codes, diagnosis, and amounts charged for each service.

Additionally, if a claim is the result of an injury due to an accident, we will require an accident description form. This form will be sent to you after we receive a bill from the provider. It must be completed and returned prior to the payment of the claim for service.

If services are dental services, we will advise you of the procedure for filing with **Delta Dental** or you can call them at **1-800-932-0783**. If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of Post-Service Claims

Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether services or supplies were medically necessary. If we need this additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. In order to expedite our receipt of the information, we may request it directly from your provider. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you or your authorized representative of our decision with respect to a post-service (non-urgent) claim within 30 days after receipt of the claim by us. If it is necessary for us to ask for additional missing information, you will have 45 days to provide this information to us. We will then notify you of our decision within 15 days after we receive the requested information. If you do not provide us with the missing information, we will process your claim based on the information we have. This may result in a denial of your claim.

In some cases, due to matters beyond our control, we will need to extend the general 30-day period for up to an additional 15 days. If this is necessary, we will notify you or your authorized representative before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which we expect to render a decision.

Pre-Service Claims (Non-Urgent)

A pre-service claim is one in which you are required to obtain pre-approval from the Plan Office.

Example
You are required to obtain pre-certification for hospital admissions longer than 2 days through our Medical Review Organization, **CIGNA.** They can be contacted at **1-800-768-4695**. Hospital stays that are medically necessary will always be authorized.

Pre-certification procedures only apply to non-emergencies. CIGNA will only certify those days which are considered medically necessary. Please remember you must maintain your eligibility in order for the certified days to be paid under the Plan.

Example
You should always contact the Plan Office for approval of the purchase of durable medical equipment or supplies.

Processing of Pre-Service (Non-Urgent) Claims

Ordinarily, we will notify you or your authorized representative of our decision within 15 days of the date on which we receive your claim. If it is necessary for us to ask for additional missing information, you will have 45 days to provide this information to us. We will then notify you of our decision within 15 days after we receive the requested information. If you do not provide us with the requested information, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

In some cases, due to matters beyond our control, we will need to extend the general 15-day period for up to 15 days. If this is necessary, we will notify you or your authorized representative before the end of the initial 15-day period of the circumstances requiring the extension of time and date by which we expect to render a decision.

Urgent Pre-Service Claims

Urgent (pre-service) claims are those claims for medical care or treatment that require notification or approval prior to receiving medical care where applications of the time periods for making non-urgent care determinations could seriously jeopardize your life or health, the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Processing of Urgent Pre-Service Claims

With respect to urgent pre-service claims, you will receive notice of the benefit determination in writing or electronically as soon as possible taking into account the medical exigencies but not later than 72 hours after we receive your claim.

If you filed an urgent claim improperly or if more information is needed to process your claim, we will notify you of the improper filing and how to correct it as soon as possible but no more than 24 hours after the urgent claim was received. You then have a reasonable amount of time taking into account your circumstances, but not less than 48 hours, to file a proper claim or provide the requested information.

You will be notified of a determination as soon as possible, but in no event later than 48 hours after:

We receive the requested information, or

The end of the period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claim

If the Plan has approved an ongoing course of treatment to be provided over a period of time or for a specific number of treatments, any reduction or termination by the Plan of such treatment (other than by Plan amendments or termination) before the end of such period of time or number of treatments will be considered an adverse benefit determination. We will notify you sufficiently in advance to allow you to appeal before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend treatment is an urgent care claim, as defined earlier, your request will be decided and notice provided to you or your authorized representative as soon as possible taking into account the medical exigencies, but no later than 24 hours after receipt of your claim, provided that your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described for urgent care claims.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment under a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Example
For emergency care admissions our medical review Organization, CIGNA, will contact the medical section of the hospital or your physician in order to obtain a medical necessity determination for your continued stay. A concurrent review is done even on pre-approved days in case additional days are medically necessary.

Another example would be for services related to physical therapy/physical medicine/rehabilitation, if additional days are required and determined as medically necessary by the treating physician and approved by the Plan's Medical Review Organization.

Processing of Disability Claims

With respect to any disability claims you file, if your claim is denied, we will notify you of any adverse decision within a responsible period of time, but not later than 45 days after receiving the claim. This 45-day may be extended for up to 30 days, if we:

Determine the extension is necessary because of matters beyond our control, and

Notify you, before the end of the initial 45-day period, why the extension is needed and the expected decision date.

If, before the end of the first 30-day extension, we determine that, due to matters beyond our control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided we notify you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension will explain:

» The standards on which benefit entitlement is based,

» Any unresolved issues that prevent a claim decision, and

» The additional information needed to resolve the issues.

If any additional information is needed, you will have 45 days to provide the information.

Content of Claim Denial Notice

A claim denial notice will explain:

The specific reason or reasons for denial with reference to those specific plan provisions on which the denial is based;

A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary;

A description of the Plan's appeal procedures and timeframes, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse decision on appeal;

If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

APPEALS

General Information

Under the Rules & Regulations of the Plan you or your duly authorized representative may seek review to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

➢ any determination we make with respect to a post-service claim that results in your owing any money to your provider other than co-payments you make, or are required to make, to your provider.

- our denial of any urgent or non-urgent pre-service claim; or,

- any adverse concurrent care determination (for example, we deny your request to extend previously approved care.)

Appealing a Claim Denial

If you disagree with a claim determination, you or your authorized representative can contact the Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include the following: 1) your name and address; (2) the fact that you are appealing the initial decision (giving the date of the decision appealed from); (3) the basis of your appeal and (4) any documentation or other written information to support your request for claim payment.

Your appeal must be submitted to the Administrator within 180 days after you receive the claim denial. (Note that although the request for review will be made to the Administrator, the denial will be reviewed by a committee of reviewers that is independent of the Administrator). You have the right to:

Submit for review written comments, documents, records and other information relating to the claim;

Request, and be provided, free of charge, reasonable access to, and copies of, all documents, records and other information (1) that the reviewer relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination or (4) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment of benefit without regard to whether the statement was relied on;

A review that takes into account all comments, documents, records, and other information submitted or considered in the initial claim decision;

A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor that person's subordinate;

If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and

The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

Timing of Notification of Determination on Appeal

You will be provided written or electronic notification (or notification by some other expeditious method with respect to certain urgent care claims) of decision on your appeal as follows:

For appeals of urgent care claims, as soon as possible taking into account the medical exigencies. You will be notified by the Plan of the reviewer's decision within 72 hours from receipt of a request for appeal of a claim denial.

For appeals of pre-service claims, within a reasonable period of time appropriate to the medical circumstances, but not more than 30 days after the Administrator has received the request for the review on appeal.

For appeals of post-service and disability claims, no later than the date of the meeting of the reviewers that immediately follows the Administrator's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Administrator's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the reviewers following the Administrator's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the reviewers will notify you in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The reviewers will notify you of the benefit determination as soon as possible, but no later than 5 days after the benefit determination is made.

For appeals of health care concurrent care claims, in accordance with the time periods applicable to the type of underlying care for which the concurrent care claim is being submitted (e.g., post-service, pre-service or urgent health care).

Note: You must fully exhaust the administrative remedies under the Plan's claim procedures outlined in this booklet prior to filing a suit.

Content of Notification of Determination on Appeal

Any notice of denial of your appeal shall include:

The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (1) that the reviewer relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrate compliance with the administrative processes and safeguards required in making the determination or (4) that constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment or benefit without regard to whether the statement was relied on;

A statement describing any voluntary appeal procedure offered by the Plan and your right to obtain the information about such procedures, and a statement of your rights to bring an action under section 502(a) of ERISA;

If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

Civil Actions

No person whose application for benefits under the Plan has been denied, in whole or in part, may bring any action in any court or file any charge, complaint or action with any state, federal or local government agency prior to exhausting his available appeals within the time limits as provided in this Article. A claimant whose claim for benefits and appeal has been denied who wishes to bring suit must do so within three (3) years from the date on which the Board makes its final decision on the claimant's appeal. For all other actions, the claimant must commence that litigation within three (3) years of the date on which the violation of Plan terms is alleged to have occurred. For any action to enforce the terms of the Plan, including but not limited to benefit claims denied on appeal, if a claimant wishes to file suit, the claimant must bring that litigation in the United States District Court for the District of Maryland. A claimant includes, but is not limited to, a Participant and his or her Spouse, Dependent, or Beneficiary, and any provider suing with respect to payment alleged to be owed by the Plan for services rendered to a Participant, Spouse, or other Dependent. This Section applies to all litigation against the Plan, including litigation in which the Plan is named as a third party defendant.

You must send your appeals to the following address:

M.M.&P. Health and Benefits Plan
700 Maritime Boulevard, Suite A
Linthicum Heights, Maryland 21090

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal.

We will, of course, do everything we can to resolve your questions or concerns.

The following Chart outlines the time frame the Plan Office will utilize when determining your claim for payment/appeal.

Time Limits Based on Type of Claim				
	Urgent Health Care (Clinical Mgt.)	**Pre-Service Health Care (Non-Urgent) (Clinical Mgt. & Claims for Pre-Authorization)**	**Post-Service Health Care (Claim)**	**Disability (Claim)**
To Make Initial Claim Determination	72 hours (depending on medical circumstances)	15 days	30 days	45 days
To Notify of Failure to Follow Procedures	24 hours	5 days	n/a	n/a
Extension (if proper notice and delay is beyond plan control)	None	15 days	15 days	30 days plus another 30 days
To Request Missing Information from Claimant	24 hours	15 days	30 days	45 days
For Claimant to Provide Missing Information	48 hours	45 days	45 days	45 days
For Claimant to Request Appeal	180 days	180 days	180 days	180 days

To Make Determination on Appeal	72 hours (depending on medical circumstances)	30 days	Next meeting unless filed 30 days prior. In that case, by second meeting. May extend to third.	Next meeting unless filed 30 days prior. In that case, by second meeting. May extend to third.

GLOSSARY

Active Employee
A member of I.O.M.M.&P. who works for an employer that:
has a collective bargaining agreement with the Organization, or
has executed a participation agreement and contributes to the Plan on the Participant's behalf.

Allowable Expense
A charge for medical services that:
is necessary for the care and treatment of an injury or illness that is not job related,
is for treatment received by a person eligible for Plan benefits at the time of treatment,
is recommended and approved by a physician for a valid course of medical treatment, which is not considered experimental by Medicare, is for treatment of an illness or injury that is *responsive* to treatment, and expected to lead to the cure or rehabilitation of the patient, and
is for a Covered Charge and Reasonable Charge as defined in the Plan Rules and Regulations.

Annual Physical
A comprehensive examination given once a year by a physician for a covered individual for whom no specific diagnosis or symptoms led to the examination.

Appeal
The steps you may follow when you disagree with an administrative decision regarding a claim. The appeals process can result in your claim being reconsidered.

Beneficiary
The person or persons you name to receive death benefits and accidental death benefits when you die.

Board of Trustees
The group of Organization and Employer Representatives who jointly administer the Plan and are the Plan's fiduciaries. The Trust calls for seven Organization Trustees and seven Employer Trustees and Alternate Trustees.

COBRA
The Consolidated Omnibus Budget Reconciliation Act. This law allows you and your eligible dependents to continue health coverage for medical benefits you have under the Plan when circumstances would otherwise cause this coverage to end. You have to pay to continue your health related benefits under COBRA.

Comprehensive Major Medical Plan
Your medical plan which pays a percentage of covered hospital and medical services and supplies after you pay an annual deductible.

Concurrent Review
A review of the length of your hospital stay while you are in the hospital. The review is conducted by the Plan's utilization review organization to make certain that all of the days you are in the hospital are medically necessary.

Continuation of Coverage Program
A limited plan of benefits that may be available to pensioners who do not participate in the Co-Pay Program and to certain surviving spouses. Under this Program, you may continue comprehensive major medical, prescription drugs, comprehensive annual physical examination and hearing aid benefits for yourself and your eligible dependents by paying a monthly premium.

Co-Pay Program
A plan of benefits available to pensioners who authorize the MM&P Pension Plan to deduct a Co-Pay contribution from the MM&P Pension Benefit or, for those who elect a lump sum buyout from the MM&P Pension Plan, who pay required quarterly Co-Pay Contributions in advance. This Program provides comprehensive major medical, prescription drugs, comprehensive annual physical examination, vision care and other benefits to pensioners and their dependents in accordance with the Plan's Rules and Regulations.

Covered Charge
Charges you incur for hospital and medical services covered by the Plan that are within the amounts allowed in the geographical Medical, Surgical and Dental Schedules adopted by the Trustees.

Covered Employment
Shipboard employment and earned days of vacation.

Covered Individual
All Eligible Employees and their Dependents, all Eligible Pensioners and their Dependents.

Deductible
The dollar amount of Covered Charges that you must incur during a calendar year before the Plan will pay benefits, currently these are $250/individual and $500/family.

Dependents
Your spouse shall mean the person to whom an Eligible Employee or Pensioner is legally married under applicable law. Each natural child, adopted child, child placed for adoption, or step-child of an Eligible Employee or Pensioner, or a child for whom the Participant has been named legal guardian by court order who is under age 26. Your parents, if you are an active employee who does not have a

spouse or children and you claim your parents as dependents for tax purposes. Also a person who meets the requirements of Alaska Administrative Code, Title 2, Section 38.010(2006) and only as long as the person meets those requirements.

Disability Period
A period during which disability leaves you unable to work. A disability period begins after you have been disabled for seven days or on the first day you are admitted to a hospital, as certified in a "not fit-for-duty" certificate.

Earnings Limitations for Pensioners Under Age 65
Earnings, for purposes of determining earnings limitations for Pensioners under age 65 means wages, earned income or remuneration or compensation for services, whether reported on a Form W-2 or Form 1099, and includes vacation or severance pay, payment for unused sick leave, fees and commissions but does not include passive investment income such as dividends, interest, capital gains, rent or royalties. Such earnings limitations are governed by the limits used for purposes of determining cost of living adjustments under the MM&P Pension Plan and for retiree health care under the Plan.

ERISA
The Employee Retirement Income Security Act of 1974, as amended. This law gives you certain rights to information about your benefits, imposes certain duties on the Plan's fiduciaries, and provides you with a way to pursue disagreements with the Plan.

Family and Medical Leave Act ("FMLA")
If you take a leave of absence from your job to care for a newborn or newly adopted child (or a child placed with you for foster care), to care for your spouse, child or parent who has a serious health condition, or because you are unable to work due to your own serious health condition, your leave may be covered by the Family and Medical Leave Act ("FMLA"). FMLA applies to covered leaves for up to 12 weeks. While on an FMLA covered leave, your employer may be required to make contributions to the Plan on your behalf as though you were still employed. (You may be required to repay your employer for those contributions if you don't return to work following your FMLA leave, unless you don't return because of a serious health condition or due to certain other circumstances beyond your control.) Any days for which your employer makes contributions while you are on FMLA leave will be considered as days worked in Covered Employment for purposes of determining your eligibility for Plan coverage. You should contact your employer about your rights under the FMLA.

Health Insurance Portability and Accountability Act ("HIPAA")
If your regular or COBRA coverage under the Plan terminates, the Plan Office will provide you with a HIPAA certificate that shows the Plan coverage you had. You may need to use your HIPAA certificate to buy an individual insurance policy that does not have pre-existing condition exclusion. You may also request a HIPAA certificate at any time up to 24 months after your Plan coverage ends by contacting the Plan Office in writing.

Hospital
An institution which maintains permanent, full-time facilities for five or more resident patients, has a physician in regular attendance; continuously provides 24-hour day nursing by a registered nurse; and is primarily engaged in providing diagnostic and therapeutic services on a basis other than as a

rest home, nursing home, convalescent home, as a place for the aged, or alcohol or chemically-dependent patients.

In-patient
A person who has been admitted to a hospital as a patient.

Medicare
A program of the U.S. Government that provides hospital and medical benefits. You become eligible for Medicare when you reach age 65, or earlier, if you are disabled.

Medically Necessary Care and Treatment
Treatment appropriate for injury and sickness and consistent with the admission's recorded diagnosis. Medically necessary treatment does not include heroic medical services as determined by the Plan's Consultants.

Orthodontia
The prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids.

Out-of-Pocket Expense
The amount of Covered Medical Expenses that each Individual Participant incurs which are not reimbursed by the Plan's health care coverage.

Out-patient
A person who is not admitted to a hospital as a patient but who receives treatment in a hospital's emergency room or out-patient department and is released.

Pensioner
A retiree who is receiving a benefit from the MM&P Pension Plan.

Plan
The MM&P Health & Benefit Plan.

Plan Office
The location where the Plan is administered. You may contact the Plan Office for information, claim forms and beneficiary forms.

The Plan Office is located at:
700 Maritime Boulevard, Suite A
Linthicum Heights, MD 21090-1996

Pre-Admission Certification
The approval given by the Plan's utilization review organization for a medically necessary hospital admission recommended by your doctor. With the exception of childbirth, the Plan requires pre-admission certification before hospital admissions or benefit will be reduced.

Prescription Drugs
Drugs that can legally be dispensed only upon the oral or written prescription of a physician licensed by the law to administer it, as provided under the Federal Food, Drug and Cosmetic Act.

Primary Provider of Health Coverage
The health plan that pays benefits first when a person has health coverage under two or more group plans.

QMCSO or NMSN (Qualified Medical Child Support Order or National Medical Support Notice)
The Plan will make a determination and provide coverage if Order is within the meaning of Section 609(a)(2)(B) of ERISA.

Reasonable Charge
The lesser of:

- the Usual, Customary and Reasonable charges in the geographical area where service is provided;
- the actual charge for a service or supply;
- for assigned Pensioners claims, the Medicare Allowable Expense; or
- contracted rate of a PPO provider

Second Surgical Opinion
An opinion about whether surgery is medically necessary and the best treatment for a condition that is provided by a physician other than the physician who originally recommends surgery.

Secondary Provider of Health Coverage
The health plan that pays benefits second when a person has health coverage under two or more group plans.

Shipboard Covered Employment
Shipboard employment only, excluding days of vacation and disability.

Significant Break in Coverage
This term “Significant Break in Coverage” shall mean a period of 63 consecutive days during all of which an individual did not have any creditable coverage, as defined in section 701 (C)(1) of ERISA, but does not include waiting periods and affiliation periods.

Utilization Review Organization
A company made up of physicians and other health care professionals that is responsible for approving hospital stays and reviewing the length of hospital stays. CIGNA is the Plan’s utilization review organization.

Women’s Health and Cancer Rights Act of 1998 – Coverage for Reconstructive Surgery after Mastectomies (WHCRA)
The Act requires Plans that provide medical and surgical benefits with respect to mastectomies to provide coverage for reconstructive surgery.

ADMINISTRATIVE INFORMATION

Official Name of the Plan:	MM&P Health & Benefit Plan
Administrator's Identification Number Assigned by the Internal Revenue Service:	13-6696938
Plan Number:	501
Type of Plan:	Group Health & Benefit Plan
Source of Contributions to Plan	Employer and Employee
End of the Plan's Fiscal Year	December 31
Plan Administrator: Board of Trustees, MM&P Health and Benefit Plan 700 Maritime Boulevard Suite A Linthicum Heights, MD 21090-1996	Telephone: (410) 850-8500 Fax: (410) 850-8655 and (410) 859-0399
Agent for Service of Legal Process:	Patrick McCullough, Administrator or the Board of Trustees
Fund Co-Counsel	Steptoe & Johnson, LLP and Slevin & Hart, PC
Consultant and Actuary	The Segal Company
Auditors	Gorfine, Schiller & Gardyn, P.A.

BOARD OF TRUSTEES

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Alternate Union Trustee

Capt. George Quick
I.O.M.M.&P.
700 Maritime Boulevard, Suite B
Linthicum Heights, MD 21090-1953

Mr. John Schaeffner
I.O.M.M.&P.
2225 N. Lombard St. No 206
Portland, Oregon 97217

Alternate Employer Trustees

Mr. Pete Strohla
Horizon Lines, LLC
Ocean Transportation Services
600 E. Las Colinas Blvd., Suite 550
Irving, TX 75039

Mr. Gerald Carbiener
c/o APL Marine Services, Ltd.
1111 Broadway
Oakland, CA 94607

Employer Trustees

Mr. Edward Morgan
c/o M.M.&P. Plans
700 Maritime Blvd, Suite A
Linthicum Heights, MD 21090-1996

Mr. Mark Blankenship
Horizon Lines, LLC
4064 Colony Road, Suite 200
Charlotte NC 28211

Mr. Robert Stephens
APL Marine Services, Ltd.
1111 Broadway
Oakland, CA 94607

Capt. John Sullivan
Matson Navigation Company
555 12th Street
Oakland, CA 94607

Mr. William M. Cameron
Waterman Steamship Corporation
Lash Marine Services
11 North Water Street, Suite 18290
Mobile, AL 36602

Ms. Jean Harrington
Maersk Lines, Ltd.
One Commercial Place, 20th Floor
Norfolk, VA 23510

Mr. Timothy Gill
Patriot Contract Services
1320 Willow Pass Road
Suite 485
Concord, CA 94520

A complete list of the employer and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Administrator and is available for examination at normal business hours.

You may receive from the Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, their address.

International Headquarters	700 Maritime Boulevard	Telephone:	(410) 850-8700
	Linthicum Heights, MD 21090	Fax:	(410) 850-0973
		Cables:	Bridgedeck, Washington D.C.

International President	Captain Donald Marcus
International Secretary-Treasurer	Mr. Steven Werse

Directory of Port Offices

Boston, Massachusetts
Marine Industrial Park
12 Channel Street, Suite 606-A
Boston, Massachusetts 02210-2333
(617) 671-0769 Fax (617) 261-2334

Charleston, South Carolina
1529 Sam Rittenberg Boulevard, 1B
Charleston, South Carolina 29407
(843) 766-3565 Fax (843) 766-6352

Honolulu, Hawaii
521 Ala Moana Blvd., Ste. 254
Honolulu, Hawaii 96813
(808) 523-8183 Fax (808) 538-3672

Houston, Texas
13850 Gulf Freeway, Suite 250
Houston, Texas 77034
(281) 464-9650 Fax (281) 464-9652

Jacksonville, Florida
349 East 20th Street
Jacksonville, Florida 32206
(904) 356-0041 Fax (904) 353-7413

New Orleans, Louisiana
347 Girod Street, Suite B
Mandeville, Louisiana 70448-5891
(985) 626-7133 Fax (985) 626-7199

New York/New Jersey
35 Journal Square, Suite 912
Jersey City, New Jersey 07306-4103
(201) 963-1900 Fax (201) 963-5403

Norfolk, Virginia
Interstate Corporate Center
6325 North Center Drive, Suite 100
Norfolk, Virginia 23502
(757) 489-7406 Fax (757) 489-1715

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540 East McNab Road, Suite B
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548 Thomas L. Berkley Way
20th Street
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San Juan, Puerto Rico 00920
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15208 52nd Avenue, South - Suite 100
Seattle, Washington 98188
(206) 441-8700 Fax (206) 448-8829

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202 S. 22nd St. – Suite 205
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(813) 247-2164 Fax (813) 248-1592

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533 North Marine Avenue, Suite A
Wilmington, California 90744-5527
(310) 834-7201 Fax (310) 834-6667

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1250 Old River Rd., 3rd Floor
Cleveland, Ohio 44113
(216) 776-1667 Fax (216) 776-1668

Juneau, Alaska
229 Fourth St.
Juneau, Alaska 99801
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2225 N. Lombard St. No 206
Portland, Oregon 97217
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