

M.M.& P. HEALTH & BENEFIT PLAN

RULES AND REGULATIONS

The Rules and Regulations of the Masters, Mates & Pilots Health & Benefit Plan are hereby amended to read in the form annexed hereto.

Revised: June 2, 2022
(Through Amendment #156)

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M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I **DEFINITIONS**

Section 1. Rules and Regulations

The term "Rules and Regulations", or "Regulations", as used herein, shall mean the Amended Masters, Mates and Pilots Health and Benefit Plan Rules and Regulations set forth herein, adopted 1987 and any modification, amendment, extension or renewal thereof as created pursuant to a Collective Bargaining Agreement, Trust Agreement or Trustee action.

Section 2. Organization

The term "Organization" as used herein, shall mean the International Organization of Masters, Mates and Pilots, AFL/CIO.

Section 3. Employer

The term "Employer" shall mean various Employers of Employees working under the provisions of a Collective Bargaining Agreement with the Organization which requires contributions be made to this Plan, and Employers who have executed a Participation Agreement with the Organization requiring that contributions be made on behalf of Employees. The term "Employer" shall also be deemed to be an M.M.& P. Fund, Plan or Committee, or the Organization, and any other Employer from whom the Trustees mutually agree that contributions may be accepted, who is not covered by a Collective Bargaining Agreement or Participation Agreement. The term "Employer" shall also mean any Employer that has entered into a Participation Agreement with the Trustees.

Section 4. Plan

The term "Plan", "Health and Benefit Plan" or "M.M.& P. Health & Benefit Plan", as used herein, shall mean the Masters, Mates and Pilots Health and Benefit Plan.

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 5. Employee

The term "Employee" shall mean an individual who is employed in Covered Employment and shall include: Offshore Employees, Officers and Employees of the Organization, Pilots, Regular Office Employees of the Organization, Administrative Employees, Shoreside Employees, Pacific Maritime Region Employees, Alaska Marine Highway System Group Employees and Non-Bargaining Unit Employees as described below.

- A. The term "Offshore Employee" shall mean an Employee who works offshore for an Employer under the provisions of a Collective Bargaining Agreement or Participation Agreements with the Organization and for whom his Employer is obligated to contribute to the M.M.& P. Health and Benefit Plan.
- B. The term "Officers and Employees of the Organization" shall mean officers and employees of the Organization, as a party to the Agreement and Declaration of Trust, for whom the Organization has agreed to make contributions to the M.M.& P. Health and Benefit Plan in such amounts as are reasonably necessary to insure the economic feasibility of the Health and Benefit Plan as determined by the Trustees.
- C. The term "Pilot" shall mean the officers and representatives and all members and employees of a Branch of the Pilot Membership Group of the Organization, when such Branch enters coverage under the Agreement and Declaration of Trust, and on whose behalf contributions are required to be made thereto, as determined by the Trustees; provided, however, that such officers, employees and members of such a Branch and their Dependents shall only be entitled to benefits hereunder to the extent specifically agreed upon in determining participation and contributions.

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 5. Employee (Continued)

- D.** The term "Regular Office Employees of the Organization" shall mean each of the regular employees of the Organization for whom the Organization has agreed to make contributions to the M.M.& P. Health & Benefit Plan in such amounts reasonably necessary to insure the economic feasibility of the Plan as determined by the Trustees.
- E.** The term "Administrative Employees" shall mean the regular employees of the M.M.& P. Plan Office for whom contributions, as determined by the Trustees, are made.
- F.** The term "Shoreside Employee" shall mean each Employee who works ashore for an Employer under the provisions of a Collective Bargaining Agreement or Participation Agreement with the Organization and for whom his Employer is obligated to contribute to the M.M.& P. Health & Benefit Plan. Included in this group are employees of the United Inland Group Atlantic and Gulf Companies and the Great Lakes Groups and the Atlantic Maritime Group.
- G.** The term "United Inland Group Pacific Maritime Region Employee" shall mean an Employee who works ashore or afloat in the maritime industry in the United Inland Group Pacific Maritime Region for an Employer under the provisions of a Collective Bargaining Agreement or a Participation Agreement with the Organization and for whom his Employer is obligated to contribute to the M.M.& P. Health and Benefit Plan. The term "United Inland Group Pacific Maritime Region

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 5. Employee (Continued)

G. (Continued)

Employee" shall also mean a Retiree of such an Employer which Retiree is required to make contributions to the M.M.& P. Health and Benefit Plan in such amounts as are reasonably necessary to ensure the economic feasibility of the Plan as determined by the Trustees.

H. The term "United Inland Group Alaska Marine Highway System Group Employee" shall mean an Employee who works in the maritime industry with the United Inland Group Alaska Marine Highway System Group for an Employer under the provisions of a Collective Bargaining Agreement or a Participation Agreement with the Organization and for whom the Employer is obligated to contribute to the M.M.&P. Health and Benefit Plan.

I. The term "Non-Bargaining Unit Employee" shall mean an individual who is not a member of a collective bargaining unit and whose Employer has entered into a Participation Agreement with the Organization or with the Plan's Trustees that requires contributions to be made to the M.M.&P. Health & Benefit Plan on behalf of Non-Bargaining Unit Employees of the Employer.

Section 6. Eligible Employee

The term "Eligible Employee" shall mean an Employee who meets the conditions of eligibility set forth in Article III, Sections 1, 3, 4, 5, 6, 7 and 15 herein, or who is otherwise approved for participation in the Plan by the Trustees.

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ARTICLE I
DEFINITIONS

Section 7. Pensioner

The term "Pensioner" shall mean an individual who is receiving a pension, other than a Deferred Vesting Pension, or has opted for and received his Pension benefit in the form of a Lump Sum Payment from the M.M.& P. Pension Plan and who meets the conditions of eligibility set forth in Article III, Section 2 herein. To be considered a Pensioner under this Section 7, an individual must meet the eligibility requirements of his Pension benefit based solely on Pension Credits and employment for which contributions were made by a contributing employer to the M.M.& P. Pension Plan. The term "Pensioner" shall not include any individual whose eligibility for a pension, making him thereby eligible for health benefits hereunder, was based on "purchased" Pension Credits pursuant to Article IV-B of the M.M.& P. Pension Plan Restated Regulations.

Notwithstanding anything herein to the contrary, the term "Pensioner" shall also mean an individual who meets the conditions of eligibility set forth in Article III, Section 2.A.8 herein or who is a retired Organization official of the United Inland Group but not eligible for retiree health coverage under Article III, Section 6.B hereunder or who is a retired Savannah docking pilot or who received health coverage hereunder as an Eligible Employee immediately prior to his retirement and is otherwise not eligible for health coverage hereunder.

Section 8. Trustees

The term "Trustees" shall mean the Employer Trustees and Organization Trustees, collectively, and shall include their Alternates when acting as Trustees.

Section 9. Disability

The term "Disability" shall mean such physical condition as to make an Employee unable to perform his regular job function for which he is receiving coverage under this Plan.

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 10. Dependent

A. Child or Children

1. Each natural child, adopted child, child placed for adoption or step-child of an Eligible Employee or Pensioner or each child for whom the Participant has been named the legal guardian by court order who is under 26 years of age, provided that any such child over the age of 19 does not have health coverage available to him by his or his spouse's employer; provided further, however, that any such child over the age of 19 and under age 23 who may have health coverage available to him by his employer would still be eligible for coverage under this Plan if he is a full-time student and dependent on the Eligible Employee or Pensioner for support. A full-time student shall mean a student taking at least twelve (12) course credits at an accredited educational institution or licensed vocational school. Notwithstanding anything herein to the contrary, effective January 1, 2010, if a Dependent child is on a medically necessary leave of absence from post-secondary school because of a serious injury or illness, coverage under this Plan will be extended to the Dependent during his or her leave of absence until the earlier of: (i) the one-year anniversary of the date on which the Dependent child's leave of absence began, or (ii) the date on which the Dependent child's coverage under the Plan would otherwise terminate (other than because the Dependent child is no longer a full-time student due to the medically necessary leave of absence). To be eligible for this extended coverage, the

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 10. Dependent (Continued)

A. Child or Children (Continued)

1. (Continued)

Plan Office must be provided with written certification from the Dependent child's treating physician that his or her leave of absence from school is medically necessary and is a result of a serious illness or injury. The extended coverage will not be provided until the date such certification is received by the Plan Office, but will be retroactive to the date on which his or her leave of absence began. The extended coverage under this paragraph is concurrent with, and not in addition to, COBRA continuation coverage under Article III, Section 11 hereunder, such that if the Dependent child receives one year of extended coverage under this paragraph and, after the expiration of this one-year period, he or she is not eligible for Plan coverage (either because he or she did not return to school or otherwise no longer meets the definition of Dependent), the child can elect to continue coverage under COBRA, but only for a maximum of 24 months.

Notwithstanding anything herein to the contrary, effective January 1, 2014, each natural child, adopted child, child placed for adoption or step-child of an Eligible Employee or Pensioner or each child for whom the Participant has been named the legal guardian by court order who is under 26 years of age.

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 10. Dependent (Continued)

A. Child or Children (Continued)

2. The term "Child" shall include any person who is over age 26 and unmarried and who, while covered as a Child as defined above and while under the age of 19, became and continues to be Totally and Permanently Disabled, provided that if the Eligible Employee's or Pensioner's eligibility herein terminates, the Totally and Permanently Disabled Child's eligibility shall not terminate if such Child is eligible for coverage under Article III, Section 9.A.4 herein. For purposes of this subsection, Totally and Permanently Disabled shall mean a disabling condition resulting from non-occupational injury or non-occupational disease which (1) prevents the individual from engaging in substantially all of the normal activities of a person of like age and sex in good health, and (2) renders the individual incapable of self-support. In no event, shall coverage under this section continue beyond the earlier of (1) termination of the Eligible Employee's or Pensioner's eligibility under this Plan, (2) the individual becoming covered by any other group health benefit plan or policy or (3) the individual no longer being wholly dependent upon the Eligible Employee or Pensioner for financial support.
3. Payment of benefits hereunder to a Child in the event the parents are divorced or separated, shall be governed by the provisions of Article V, Section 3(C)(2) herein.

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 10. Dependent (Continued)

B. Spouse

The term "Spouse" means a person who is wedded to an Eligible Employee or Pensioner pursuant to a marriage that is accepted as legal in the State of the Eligible Employee or Pensioner's domicile, provided, however, such marriage must be between a man and a woman." Effective January 1, 2014, the term "Spouse" shall mean the person to whom an Eligible Employee or Pensioner is legally married under applicable law. The status of "Spouse" shall cease at the date of a legal separation or of any interlocutory or final decree in a proceeding to dissolve or terminate the marriage and any benefit otherwise payable with respect to a spouse shall also thereupon cease.

C. Parent(s)

An Eligible Employee may designate his parent or parents as his Dependents by filing a beneficiary designation form with the Plan Office, provided however, that at the time of occurrence of a claim involving such parent:

1. The Eligible Employee does not have a Spouse or Child who falls within the definition of the term "Dependent" as defined in these Rules and Regulations.
2. The parent or parents designated by the Eligible Employee as his Dependent or Dependents have been claimed as dependent(s) for tax exemption purposes in the Employee's Federal Income Tax Return for the calendar year preceding the date on which a claim is incurred.

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ARTICLE I
DEFINITIONS

Section 10. Dependent (Continued)

D. Documentation

The Plan Office, at its discretion, may require documents to establish responsibility for coverage of these dependents including, but not limited to IRS Form 1040, Adoption Papers, Divorce Decree, School Registration, Marriage Certificate or Birth Certificate.

E. Notification Requirements

Participants must request an enrollment form from the Plan Office in writing within 60 days of an event calling for the addition of a Dependent as defined in this Section 10. Such an event shall include but not be limited to: initial enrollment; the addition of a Dependent, after a Participant first becomes eligible for coverage, as a result of marriage, the birth of a child, adoption of a child, or placement of a child for adoption or under legal guardianship; or loss of other group health plan coverage or health insurance policy coverage under which a Dependent was covered when initially offered the opportunity to enroll in the Plan. The Plan Office shall provide the appropriate forms after notification is received. No coverage under this Plan will be made available to Dependents pursuant to this paragraph unless the Plan Office received the necessary enrollment forms and supporting documentation and is otherwise properly notified in writing of such an event within the 60 day notification period until January 1 following the next annual open enrollment period during November and December each year thereafter during which such Dependent shall be given the opportunity to enroll in the Plan.

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 10. Dependent (Continued)

F. Special Rule for Participants Eligible For Benefits Under Article III, Section 7

Effective January 1, 2007, Eligible Dependent shall include a person who meets the requirements of Alaska Administrative Code, Title 2, Section 38.010 (2006), and only so long as the person meets those requirements. No coverage will be made available to such person unless the Plan Office receives such information as requested, including, but not limited to, an original affidavit in conformity with the requirements of the above-cited state regulatory provision, as well as documentation establishing at least five of the criteria set forth in Alaska Administrative Code, Title 2, Section 38.010 (c)(2006).

G. Special Rule Regarding the Children's Health Insurance Program ("CHIP")

In order to enroll a Dependent for coverage under the Plan pursuant to this subsection, Eligible Employees eligible for benefits hereunder must notify the Plan Office in writing within 60 days of: (1) the date that coverage of a Spouse, Child or Parent, who would otherwise be eligible for coverage under the Plan as a Dependent, has been terminated under CHIP or Medicaid; or (2) the date that the individuals described in paragraph 1 hereinabove are eligible for a premium assistance subsidy according to state-specific guidelines under CHIP or Medicaid. The Plan Office shall provide the appropriate forms after notification is received. No coverage will be made available to Dependents pursuant to this subsection unless the Plan Office is properly notified in writing of such an event within the 60 day notification period.

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ARTICLE I
DEFINITIONS

Section 10. Dependent (Continued)

H. Special Rule Regarding Eligible Dependents of a Retired Pilot in a Pilot Membership Group

Notwithstanding anything herein to the contrary, a Dependent of a retired Pilot in a Pilot Membership Group, who is eligible for coverage under the Plan, shall also be an Eligible Dependent under this Plan if approved by the Pilot Membership Group.

Section 11. Covered Individual

The term "Covered Individual" shall mean all Eligible Employees, their Dependents and Pensioners and their Dependents.

Section 12. Covered Employment

The term "Covered Employment" shall mean employment or membership for which an Employer is obligated to or does contribute to the M.M.& P. Health & Benefit Plan. Employment by an Employer, after notice has been sent advising him that such Employer is delinquent in its contributions to the Plan, shall not be considered Covered Employment or shipboard employment for the purpose of determining initial or continuing eligibility.

Section 13. Allowable Charge

The term Allowable Charge for necessary services and supplies shall mean the lowest of:

- A. The charges usually made for such service or supply by the provider who furnishes it, or
- B. The maximum amount that the Plan has determined that it will pay for such service or supply, or
- C. The actual charge for such service or supply, or

M.M.& P. HEALTH & BENEFIT PLAN RULES & REGULATIONS

ARTICLE I
DEFINITIONS

Section 13. Allowable Charge (Continued)

- D. The contractual rate for an expense with a Contracted Hospital or Contracted Provider, or between a provider and the plan with which it is coordinating, or
- E. For Medicare assigned claims, the amount of the Medicare Allowable Expense which is the amount the provider has agreed to accept.
- F. For all other Medicare claims, the amount(s) not covered by Medicare provided, however, that the amount payable does not exceed the amount which would have been payable by the Plan if there were no other health coverage involved, except that claims for No Surprises Services will be payable in accordance with the No Surprises Act and subject to the Plan's applicable Cost Sharing.

Section 14. Surgery

A surgical procedure consists of a systematic protocol usually involving an instrument for cutting, manipulation of treatment or a condition to repair damage or restore health. The Trustees in their sole discretion shall determine what constitutes a surgical procedure and whether or not a surgical procedure is covered by the Plan.

Section 15. Medicare

The term "Medicare" shall mean the insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted or as subsequently amended.

Section 16. Physician

The term "Physician" shall be defined as a person licensed to practice medicine and surgery as a Doctor of Medicine (M.D.); Psychiatrist (M.D., PhD); Osteopath (D.O.); Chiropractor (D.C.);

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ARTICLE I
DEFINITIONS

Section 16. Physician (Continued)

or Dentist (D.D.S.). The definition of a Physician shall not include the Covered Individual or his dependents or any person who is the spouse, parent, child, brother or sister of such Covered Individual or his dependents. In any state or other jurisdiction which has a board of examiners for the certification of psychologists, the definition of Physician shall also include a psychologist who is duly licensed and certified by such a board.

Effective January 1, 1991, a Master of Social Work or a Certified Social Worker who is licensed and acting within the lawful scope of his license and performing a service which would be payable by the Plan if the services were performed by a Physician, within the meaning of the above paragraph, shall also be considered a Physician for the purpose of benefit coverage.

Effective March 1, 1993, a Certified Registered Nurse Anesthetist who is licensed and acting within the lawful scope of his license and performing a service which would be payable by the Plan if the services were performed by a Physician, within the meaning of the above paragraph, shall also be considered a Physician for the purpose of benefit coverage. It is not the intention of this paragraph to provide coverage for both a Certified Registered Nurse Anesthetist and a Physician during a single procedure, in which case only the services of the Physician will be covered; provided, however, effective November 1, 2000, coverage is provided for both a Certified Registered Nurse Anesthetist and a Physician during a single procedure if the state medical society or standard medical practice in the state requires the services of both during the procedure, but such coverage is limited to the Allowable Charge for the services of the Physician.

Effective September 1, 1993, services performed by other non-physician practitioners, whose services would otherwise be covered by this Plan if performed by a Physician, shall be

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ARTICLE I
DEFINITIONS

Section 16. Physician (Continued)

covered, provided the practitioner is licensed to perform these services in the State in which he is practicing and only to the extent such non-physician services are considered covered by Medicare; provided further, however, that effective April 1, 2007, acupuncture services shall be covered to the extent provided under Article IV, Section 5. L and not excluded under Article IV, Section 6. Q, provided that: (i) if the acupuncture services are performed by a medical physician, such physician must meet the acupuncture training requirements approved by the American Board of Medical Acupuncture (ABMA); and (ii) if the acupuncture services are performed by an acupuncturist who is not a medical physician, such acupuncturist must have completed training in a masters degree program accredited by the Accreditation Commission for Acupuncture and Oriental Medicine and must be certified by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM); provided further, however, that effective January 1, 2008, services for 'movement therapy' treatment for degenerated joints shall be covered if recommended and prescribed by a treating Physician and if the treating Physician has concluded that such treatment will avoid the medical necessity of an arthroplasty.

Section 17. Hospital

The term "Hospital" shall mean an institution operated pursuant to law which meets all of the following requirements:

- A. Maintains permanent and full-time facilities for bed care of five or more resident patients;
- B. Has a Physician in regular attendance;

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ARTICLE I
DEFINITIONS

Section 17. Hospital (Continued)

- C. Continuously provides twenty-four hour a day nursing service by a Registered Nurse;
- D. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics or a place for drug addicts.

Section 18. Skilled Nursing Facility

The term "Skilled Nursing Facility" shall mean an institution operated pursuant to law which meets all of the following requirements:

- A. It is regularly engaged in providing skilled nursing care for sick and injured persons under twenty-four hours a day supervision of a Physician or a Registered Nurse;
- B. The services of a Physician who is a staff member of a general hospital is available at all times;
- C. It has either a Registered Nurse, Licensed Practical Nurse, Licensed Vocational Nurse on duty twenty-four hours a day and has a Registered Nurse on duty at least eight hours per day;
- D. It maintains a daily medical record for each patient;
- E. It complies with all licensing and other legal requirements;
- F. It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for alcoholics or drug addicts, a hotel or a similar institution.

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ARTICLE I
DEFINITIONS

Section 19. Gender

Except as the context may specifically require otherwise, use of the masculine gender shall be understood to include both masculine and feminine genders.

Section 20. Vacation

The term "Vacation" shall mean a vacation day taken by the Employee and paid by the industry-wide program known as the M.M.&P. Vacation Plan which provides Vacation benefits to Eligible Employees.

Section 21. Beneficiary

The term "Beneficiary" shall mean the person or persons designated by an Employee or Pensioner in accordance with the provisions of Article IV Part D.

Section 22. Plan Office

The "Plan Office" shall mean the administrative office of the M.M.& P. Plans at Linthicum Heights, Maryland.

Section 23. Certificate of Coverage

The term "Certificate of Coverage" shall mean a written certification provided by any source that offers medical care coverage, including this Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Section 24. Significant Break in Coverage

The 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.

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Section 25. Concurrent Care Claim

The term “Concurrent Care Claim” shall mean a claim for extension of the duration or number of treatments provided pursuant to a previously-approved benefit claim.

Section 26. Post-Service Claim

The term “Post-Service Claim” shall mean any claim for a benefit under the Plan that is not a Pre-Service Claim.

Section 27. Pre-Service Claim

The term “Pre-Service Claim” shall mean any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Section 28. Urgent Care Claim

The term “Urgent Care Claim” shall mean any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations specified in Section 4 of Article VII: (a) could seriously jeopardize the life or health of the Claimant (defined in Section 4 of Article VII) or the ability of the Claimant to regain maximum function; or (b) in the opinion of a physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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Section 29. Ancillary Services

Effective January 1, 2022, the term Ancillary Services shall mean, with respect to a Contracted Hospital or Contracted Provider:

- A. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-physician practitioner,
- B. Items and services provided by assistant surgeons, hospitalists, and intensivists;
- C. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by federal regulation; and
- D. Items and services provided by a Non-contracted provider if there is no Contracted Provider who can furnish such item or service at such Contracted Health Care Facility.

Section 30. Cost Sharing or Cost Share

Effective January 1, 2022, the term Cost Sharing Shall mean the amount a Covered Individual is responsible for paying for a covered item or service under the terms of the Plan. Cost Sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-contracted providers, or the cost of items or services that are not covered under the Plan. Effective January 1, 2022, a Covered Individual's Cost Share applicable

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DEFINITIONS

Section 30. Cost Sharing or Cost Share (Continued)

to No Surprises Services is based on the lesser of the Qualifying Payment Amount payable for such Services or the amount billed by the Non-contracted provider. Co-Insurance amounts paid for No Surprises Services will count towards a Covered Individual's Deductible Amount, as detailed in Article IV, Section 3, and any applicable Contracted out-of-pocket Allowable Expenses but not Non-contracted out-of-pocket Allowable Expenses, as may apply under Article IV.

Section 31. Emergency Medical Condition

Effective January 1, 2022, the term Emergency Medical Condition shall mean a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Section 32. Emergency Services

Effective January 1, 2022, the term Emergency Services shall mean, with respect to an Emergency Medical Condition:

- A. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent

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DEFINITIONS

Section 32. Emergency Services (Continued)

A. (Continued)

Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the Covered Individual (regardless of the department of the Hospital in which such further examination or treatment is furnished).

C. Services provided by a Non-contracted provider or facility after the Covered Individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

1. The provider or facility determines the Covered Individual is able to travel using nonmedical transportation or nonemergency medical transportation;
2. The Covered Individual is supplied with a written Notice, as required by federal law, that the provider is a Non-contracted Provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any Contracted Providers at the facility who are able to treat

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Section 32. Emergency Services (Continued)

C. (Continued)

2. (Continued)

the Covered Individual, and that the patient may elect to be referred to one of the Contracted Providers listed; and

- 3.** The Covered Individual gives informed Consent to continued treatment by the Non-contracted Provider, acknowledging that she or he understands that continued treatment by the Non-contracted Provider may result in greater costs to the Covered Individual.

Section 33. Health Care Facility (for non-emergency services)

Effective January 1, 2022, the term Health Care Facility (with respect to non-Emergency Services) shall mean:

- A.** A hospital (as defined in section 1861(e) of the Social Security Act);
- B.** A hospital outpatient department;
- C.** A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- D.** An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Section 34. Independent Freestanding Emergency Department

Effective January 1, 2022, the term Independent Freestanding Emergency Department shall mean a health-care facility that is geographically separate and distinct

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Section 34. Independent Freestanding Emergency Department (Continued)

from a Hospital under applicable State law and is licensed under state law to provide Emergency Services.

Section 35. No Surprises Act

The term No Surprises Act means Title I of Division BB of the Consolidated Appropriations Act, 2021, P.L. 116-260.

Section 36. Non-contracted

Effective January 1, 2022, the term Non-contracted means a provider, facility, or rate that is not designated as in-network by the Plan's preferred provider organization(s).

Section 37. Contracted

The term Contracted means a provider, facility, or rate that is designated as in-network by the Plan's preferred provider organization(s).

Section 38. Qualifying Payment Amount

Effective January 1, 2022, the term Qualifying Payment Amount means generally the median contracted rate for the Plan for the item or service in the geographic region, or such other rate as determined by the Plan in accordance with Federal law. This amount is subject to change.

Section 39. Continuing Care Patient

Effective January 1, 2022, the term Continuing Care Patient means a Covered Individual who is: (1) undergoing a course of treatment for a Serious and Complex condition, (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4)

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DEFINITIONS

Section 39. Continuing Care Patient (Continued)

determined to be terminally ill and receiving treatment for the illness; or (5) undergoing a course of institutional or inpatient care from the provider or facility.

Section 40. Serious and Complex Condition

Effective January 1, 2022, the term Serious and Complex Condition shall mean one of the following:

- A. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- B. In the case of a chronic illness or condition, a condition that is the following:
 - 1. Life-threatening, degenerative, potentially disabling, or congenital; and
 - 2. Requires specialized medical care over a prolonged period of time.

Section 41. No Surprises Services

Effective January 1, 2022, No Surprises Services means the following, to the extent covered under the Plan: (1) Non-contracted Emergency Services, (2) Non-contracted air ambulance services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology, neonatology and diagnostics, when performed by a Non-contracted provider at a Contracted Health Care Facility; and (4) other Non-contracted non-emergency services performed by a Non-contracted provider at a

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DEFINITIONS

Section 41. No Surprises Services (Continued)

Contracted Health Care Facility with respect to which such provider does not comply with federal Notice and Consent requirements, as defined in Article I, Section 42.

Section 42. Notice and Consent or Consent

Effective January 1, 2022, Notice and Consent with respect to Non-contracted services provided at a Contracted Health Care Facility, means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), a Covered Individual is provided with a written notice, as required by federal law, that the provider is a Non-contracted provider with respect to the Plan, the estimated charges for the Covered Individual's treatment and any advance limitations that the Plan may put on the Covered Individual's treatment, the names of any Contracted providers at the facility who are able to treat the Covered Individual and that the Covered Individual may elect to be referred to one of the Contracted providers listed; and (2) the Covered Individual gives informed Consent to continued treatment by the Non-contracted provider, acknowledging that he or she understands that continued treatment by the Non-contracted provider may result in greater cost to the Covered Individual. The Notice and Consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-contracted provider satisfied the Notice and Consent criteria.

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Section 1. Proof of Claim

All benefits hereunder shall be payable only upon receipt by the Plan Office of written proof, satisfactory to the Trustees, covering the occurrence, character and extent of the event for which claim is made. Claims for benefits must be made within two (2) years after the date the covered expense is incurred, except that claims for Prescription Drugs under Article IV, Part B may be made up to three (3) years after the date the covered expense is incurred.

Section 2. Examination

The Trustees or their duly-appointed representatives shall have the right and opportunity to examine the person of a Covered Individual during the pendency of a claim hereunder and the right to an autopsy in case of death where it is not forbidden by law.

Section 3. Payment of Claims

Benefits hereunder shall be payable to the Eligible Employee or Pensioner or Dependent, or in the case of death benefits, the designated Beneficiary, provided, however, that the Trustees, in their discretion, may pay such benefits (less any overpayments previously paid by the Plan):

- A. to a Hospital, Physician or provider furnishing services, supplies, care or treatment for benefits;
- B. or to any person, including a Dependent, who has paid the Hospital, Physician or provider for such services, supplies, care or treatment. Such payments shall constitute a full discharge of the liability of the Trustees and Plan to the extent of the benefits so paid.

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Section 3. Payment of Claims (Continued)

Notwithstanding the foregoing, effective January 1, 2022, a Non-contracted provider of No Surprises Services will receive an initial payment or notice of denial of payment for a No Surprises Services claim within 30 calendar days of the Plan's receipt of the billed charges and all information necessary to adjudicate the claim.

Section 4. Limitation of Action

No action at law or in equity shall be brought to recover under these Rules and Regulations prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements established by the Trustees, nor shall such action be brought at all unless brought within two years and ninety days after the date of loss upon which the cause of action is based.

Section 5. Non-Assignment of Benefits

Except as provided above, no Eligible Employee, Pensioner, Dependent or Beneficiary shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute or anticipate any benefit payment hereunder, and any such payment shall not be subject to any legal process to levy, execution upon or attachment or garnishment proceeding against for the payment of any claims.

Section 6. Pre-existing Conditions

No benefits shall be payable for any claim based on any illness, disease or injury for which treatment was received or expense incurred for services or supplies of the type covered under this

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GENERAL PROVISIONS

Section 6. Pre-existing Conditions (Continued)

Plan during the six-month period immediately preceding a new Covered Individual's effective date of coverage. However, the Plan will pay for covered services and supplies for such illness, disease or injury after such Covered Individual has been covered under the Plan for a period of at least twelve (12) consecutive calendar months. For the purpose of pre-existing conditions, a new Covered Individual shall be defined as an individual who first participates in the Plan on or after January 1, 1989, or an existing participant who has lost coverage for one year or more.

The Plan will also pay for covered services and supplies for such pre-existing illness, disease or injury of a Covered Individual if the Plan is providing replacement coverage for prior group coverage of an Employer becoming a participating Employer in this Plan if all the following conditions are met:

- A. He or she was eligible under the prior plan at discontinuance of the prior plan;
- B. This Plan replaces the prior plan within a period of sixty (60) days from discontinuance of the prior group coverage;
- C. The individual is eligible for coverage under this Plan;
- D. The Covered Individual is not Disabled, as defined in Article I, Section 9, at the effective date of coverage under the Plan; and
- E. Such pre-existing illness, disease or injury is not covered by the prior group coverage.

Notwithstanding anything herein to the contrary, effective January 1, 2001, the Plan will pay for Allowable Expenses for such illness, disease or injury for such Covered Individual where such Allowable Expenses were incurred by such Covered Individual on or after January 1, 2001.

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Section 7. Recovery of Overpayments

In the event of any overpayments made by the Plan, the Plan shall have the right, exercisable alone and at its sole discretion, to recover such overpayments to the extent of such overpayment from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to, whom Plan payments were made; any insurance companies, providers of services, hospitals, institutions and/or organizations. The Plan shall furthermore have a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any overpaid benefits received by a Covered Individual or a representative of a Covered Individual (including an attorney) that is due to the Plan under this Section, and any such amount is deemed to be held in trust by a Covered Individual for the benefit of the Plan until paid to the Plan. By accepting benefits from the Plan, a Covered Individual consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien and/or equitable lien by agreement, agrees to cooperate with the Plan in reimbursing it for all its costs and expenses related to the collection of those benefits.

Any refusal by a Covered Individual to reimburse the Plan for an overpaid amount will be considered a breach of the agreement with the Plan that the Plan will provide the benefits available under the Plan and a Covered Individual will comply with the rules of the Plan. Further, by accepting benefits from the Plan, a Covered Individual affirmatively waives any defenses he may have in any action by the Plan to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

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Section 7. Recovery of Overpayments (Continued)

If a Covered Individual refuses to reimburse the Plan for any overpaid amount, the Plan has the right to recover the full amount by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against a Covered Individual's future benefit payments under the Plan. For example, if the overpayment or advancement was made to a Covered Individual, the Plan may offset the future benefits payable by the Plan to a Covered Individual. If the overpayment or advancement was made to or on behalf of a Covered Individual, the Plan may offset the future benefits payable by the Plan to a Covered Individual.

The Plan also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Plan is required to pursue legal action against a Covered Individual to obtain repayment of the benefits advanced by the Plan, a Covered Individual shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Plan in connection with the collection of any amounts owed the Plan or the enforcement of any of the Plan's rights to reimbursement. In the event of legal action, a Covered Individual shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Covered Individual becomes obligated to repay the Plan through the date that the Plan is paid the full amount owed. The Plan has the right to file suit against a Covered Individual in any state or federal court that has jurisdiction over the Plan's claim.

Finally, failure to reimburse the Plan for such overpayment within four weeks from the date of the demand by the Plan for repayment of the overpayment may in the Trustees' discretion disqualify the Covered Individual from receiving any future benefits under the Plan, and could result in the pursuit of legal action.

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Section 8. HIPAA Privacy Provisions

A. Applicability

This Section 8 of Article II (General Provisions) shall apply only to the extent that (1) the Plan is treated as a covered entity subject to the HIPAA standards for privacy and security, as set forth at 45 C.F.R. Parts 160 & 164, Subparts A and E (“Privacy Rule”), 45 C.F.R. Parts 160 & 164, Subparts A and C (“Security Rule”), and as modified by the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”) and regulations thereunder (collectively, “HIPAA Privacy Rules”), and (2) any protected health information received from the Plan is used or disclosed by the Trustees or by Employees of the Plan Office, subject to the HIPAA Privacy Rules.

B. Uses and Disclosures of Protected Health Information

Any use or disclosure of protected health information (“PHI”) by the Trustees or by Employees of the Plan Office shall be made in accordance with the HIPAA Privacy Rules. The Plan may disclose to the Trustees or to Employees of the Plan Office information on whether an individual is participating in the Plan. In addition, unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph (C) below, the Plan may disclose PHI to the Trustees or to Employees of the Plan Office, provided that the Trustees or Employees of the Plan Office use or disclose such PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Trustees or by

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GENERAL PROVISIONS

Section 8. HIPAA Privacy Provisions (Continued)

B. Uses and Disclosures of Protected Health Information (Continued)

Employees of the Plan Office on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. Except as provided in an individual authorization or as otherwise permitted under the HIPAA Privacy Rules, Plan administration functions do not include functions performed by the Trustees or by Employees of the Plan Office in connection with any other benefit or benefit plan, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Trustees or Employees of the Plan Office be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

C. Uses and Disclosures of PHI

The following subsections contain warranties that are required under the HIPAA Privacy Rules when the Trustees or Employees of the Plan Office receive PHI from the Plan for Plan administration purposes. Prior to any disclosure of PHI to the Trustees or to Employees of the Plan Office, the Trustees shall ensure that the following protections accorded to PHI have been adopted by the Plan and that the Trustees and Employees of the Plan Office agree to:

1. not use or further disclose PHI other than as permitted or required by the Plan or by law;

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GENERAL PROVISIONS

Section 8. HIPAA Privacy Provisions (Continued)

C. Uses and Disclosures of PHI (Continued)

2. ensure that any Business Associates to whom they provide PHI received by the Plan agrees to enter into a business associate agreement that provides for the same restrictions and conditions that apply to the Trustees and Employees of the Plan Office with respect to PHI. The Plan will require each Business Associate to require that any agent or subcontractor to whom the Business Associate provides PHI agrees to the same restrictions that apply to the Business Associate with respect to such information. After the Plan obtains satisfactory, contractual assurances that the Business Associates will protect PHI and limit their use and disclosure of PHI, the Plan will disclose PHI to its Business Associates only to the extent necessary for the Business Associates to carry out their contractual duties;
3. except as provided in an individual authorization or as otherwise permitted under the HIPAA Privacy Rules, not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
4. report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which they become aware;
5. make available PHI in accordance with HIPAA Privacy Regulation section 164.524, and if a covered individual's PHI is maintained as an electronic health record, as defined in regulations under HIPAA, the Plan will provide

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Section 8. HIPAA Privacy Provisions (Continued)

C. Uses and Disclosures of PHI (Continued)

5. (Continued)

the participant with a copy of the PHI in an electronic format, upon request;

6. make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA Privacy Regulation section 164.526;

7. make available the information required to provide an accounting of disclosures in accordance with HIPAA Privacy Regulation section 164.528, and in the case of disclosures made through an electronic health record, the accounting of disclosures shall include disclosures of PHI for treatment, payment, or health care operations;

8. make their internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to Secretary of Health and Human Services for purposes of determining compliance by the Plan;

9. if feasible, return or destroy all PHI received from the Plan that the Trustees or the Employees of the Plan Office still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

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Section 8. HIPAA Privacy Provisions (Continued)

C. Uses and Disclosures of PHI (Continued)

10. ensure that an individual is permitted to request that the Plan restrict the uses or disclosures of PHI about the individual as contemplated in Section 164.522 of the HIPAA Privacy Regulation. The Plan if not required to agree to a request, unless the disclosure in question is for payment purposes and the participant has paid the health care provider in full, out of pocket; and
11. ensure that the adequate separation is established, as contemplated in Section 164.504(f)(2)(iii) of the HIPAA Privacy Regulation. Generally, those employees or classes of employees under the control of the Trustees to be given access to any protected health information include authorized human resource personnel and their agents and Employees of the Plan Office. It also includes the Administrator. Access to and by such personnel, the Administrator or Employees of the Plan Office shall be restricted to the plan administration functions that the Trustees and Employees of the Plan Office perform for the Plan. Any issues of noncompliance shall be resolved in accordance with the requirements of the HIPAA Privacy Regulation.

D. Breach Notification

The Plan, to the extent practicable, will implement reasonable and appropriate technologies and methodologies designed to secure PHI from unauthorized disclosure. In the event of a breach of unsecured protected health information as

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GENERAL PROVISIONS

Section 8. HIPAA Privacy Provisions (Continued)

D. Breach Notification (Continued)

described in 45 C.F.R. Section 164.402, the Plan will comply with the requirements of the Breach Notification Rule at 45 C.F.R. Sections 164.400-14.

1. Methods of Protection

To the extent possible, PHI relating to the Plan will be secured, so as to make it unusable, unreadable, or indecipherable to unauthorized individuals, in accordance with the methodologies and technologies specified in 42 U.S.C. Section 17932(h) and regulations thereunder, including encrypting, shredding or destroying records such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is not sufficient to render PHI unreadable.

2. Risk Assessment

In the event of the unauthorized acquisition, access, use, or disclosure of unsecured protected health information (i.e., that has not been secured in accordance with paragraph (D)(1) above), by a Business Associate of the Plan, the Privacy Officer will work with the Business Associate to determine whether a Breach has occurred based on a risk assessment, pursuant to the terms of the business associate agreement between the parties. In appropriate circumstances, including an unauthorized disclosure of unsecured PHI by the Plan, the Privacy Officer shall conduct the risk assessment. A risk

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Section 8. HIPAA Privacy Provisions (Continued)

D. Breach Notification (Continued)

2. Risk Assessment (Continued)

assessment will include at least the following factors: (i) the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made, (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.

3. Notification of Breach

- a.** If it is determined that a Breach of Unsecured Protected Health Information has occurred, the individual will be notified as may be required by the Breach Notification Rule at 45 C.F.R. Sections 164.400-14, including the following:
- (i)** Written notice to the individual (or next of kin or personal representative if the individual is deceased) at the last known address of the individual (or next of kin) by first class mail (or by electronic mail if agreed to by the individual);
 - (ii)** In the case in which there is insufficient or out-of-date contact information (excluding for next-of-kin or personal representative), substitute notice shall be provided. In cases of fewer than 10 individuals for whom there is insufficient or

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Section 8. HIPAA Privacy Provisions (Continued)

D. Breach Notification (Continued)

3. Notification of Breach (Continued)

a. (Continued)

(ii) (Continued)

out-of-date contact information, substitute notice may be by an alternative form of written notice, telephone, or other means.

(iii) In the case of 10 or more individuals for whom there is insufficient contact information, conspicuous posting for 90 days consecutive days on the Plan's website and/or notice in major print or broadcast media, each including a toll-free number, will occur, as determined by the Privacy Officer.

(iv) In cases that the Privacy Officer deem urgent based on the possibility of imminent misuse of the unsecured PHI, notice by telephone or other method is permitted in addition to the above methods.

b. Details of the notice shall include the following:

i. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

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GENERAL PROVISIONS

Section 8. HIPAA Privacy Provisions (Continued)

D. Breach Notification (Continued)

3. Notification of Breach (Continued)

b. (Continued)

- ii. A description of the types of unsecured PHI that were involved in the breach (such as full name, SSN, DOB, home address, account number, or disability code);
- iii. The steps individuals should take to protect themselves from potential harm resulting from the breach;
- iv. A brief description of what the Plan is doing to investigate the breach, mitigate losses, and protect against any further breaches;
- v. Contact procedures for individuals to ask questions or learn additional information, which shall generally include a toll free telephone number, an e-mail address, web site, or postal address.

- c. If a breach is caused or discovered by a Business Associate of the Plan, the Privacy Officer shall work with the Business Associate to address the notice requirements, in accordance with the terms of the business associate agreement in place between the parties. The timing and content of any required notice shall be in accordance with applicable law.

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ARTICLE III
ELIGIBILITY

Section 1. Offshore Employees

A. Initial Eligibility - For New Employees Never Before Eligible Under this Plan

An Offshore Employee who first worked in Covered Employment on or after July 21, 1988, shall become an Eligible Employee, eligible for benefits hereunder, on the date such Employee has accrued 30 days of shipboard Covered Employment (excluding Port Relief, Disability and Vacation days) in any six (6) consecutive calendar month period.

B. Reinstatement of Eligibility - For Employees Who Once Were Eligible Employees Under This Plan

An Offshore Employee who was previously an Eligible Employee hereunder will again become an Eligible Employee on the date such Employee completes thirty (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. However, such an Employee shall become an Eligible Employee commencing on the date he proceeds to sea on a foreign voyage contemplated to exceed thirty (30) days.

C. Port Relief Officer Employment

Effective on or after July 21, 1988, a Port Relief Officer who has accrued thirty (30) days of shipboard Covered Employment (excluding Port Relief, Disability and Vacation) in any period of six (6) consecutive calendar months, may extend coverage by one (1) calendar month for each forty (40) hours of employment as a Port Relief Officer while eligible hereunder. Such extended eligibility shall be limited to a maximum of six (6) calendar months.

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Section 1. Offshore Employees (Continued)

C. Port Relief Officer Employment (Continued)

Effective on or after February 1, 1995, Port Relief Officer employment performed during a period not to exceed sixty (60) days immediately following the last day of Shipboard Covered Employment may also be used to extend eligibility as described above, provided, however, that extended eligibility due to all Port Relief Officer employment does not exceed a maximum of six (6) calendar months.

D. Co-Pay Requirements (Actives)

Effective May 1, 1987, an Employee shall not become an Eligible Employee, nor shall he continue to remain an Eligible Employee, unless he contributes, under procedures established by the Administrator, the sum of one and one-half percent (1-1/2%), if required by the Collective Bargaining Agreement or participation agreement, of all earnings from employment and vacation with an Employer on a maximum earnings base equal to that used by Social Security for calculating F.I.C.A. taxes; provided, however, effective January 1, 2007, the one and one-half percent (1-1/2%) co-pay contribution shall be deducted on a pre-tax basis from all earnings from employment and vacation with an Employer without any maximum earnings limit.

E. Termination of Eligibility

The eligibility of an Offshore Employee and his Dependents shall terminate on the earliest of the following dates:

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Section 1. Offshore Employees (Continued)

E. Termination of Eligibility (Continued)

1. With the exception of Unlicensed Offshore Employees, the end of the sixth calendar month following the month in which he last worked in Covered Employment or otherwise provided for in the Collective Bargaining Agreement.

For Unlicensed Offshore Employees, the end of the calendar month following the month in which he last worked in Covered Employment or otherwise provided for in the Collective Bargaining Agreement. For this purpose, Covered Employment will include actual shipboard employment followed immediately by days of vacation earned and payable for such employment, regardless of whether the vacation time was actually taken or paid at that time, provided, however, that the actual shipboard employment was for a minimum of thirty (30) days. Notwithstanding anything herein to the contrary, effective June 1, 2004, for this purpose, for Licensed Offshore Employees electing a Voluntary Leave of Absence ("VLOA"), Covered Employment will also include actual shipboard employment followed immediately by the paid vacation days, and the banked vacation days will be included with the days of vacation earned after his return to actual shipboard employment from the VLOA. Notwithstanding anything herein to the contrary, effective April 1, 2016, for this purpose, for Licensed Offshore Employees experiencing an Involuntary Leave of Absence ("ILOA"),

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Section 1. Offshore Employees (Continued)

E. Termination of Eligibility (Continued)

1. (Continued)

Covered Employment will also include actual shipboard employment followed immediately by the paid vacation days, and the banked vacation days will be included with the days of vacation earned after his return to actual shipboard employment from the ILOA. Neither lag time or banked days or disability days or Port Relief days or Vacation days shall otherwise be considered Covered Employment for this purpose.

2. The date he is granted a withdrawal card from the Organization, or, if earlier, the date the Plan receives notice from the Organization that the Employee is six (6) months delinquent in his Union dues.
3. The date he ceases to be a member of the Organization.
4. The date he becomes eligible for benefits under any Health & Benefit Plan established by the Organization.
5. The date he enters the military or naval or air forces of any country, state or union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act.

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Section 1. Offshore Employees (Continued)

E. Termination of Eligibility (Continued)

6. The date he becomes a Pensioner, except as provided in Article IV, Part M for a Pensioner and his Dependents.
7. The date he accepts employment with an employer operating vessels who is not a party to this Health & Benefit Plan or to any affiliated Plans, except upon the approval of the Trustees after application has been submitted through the Organization, or such employment has been obtained through the offices of the Organization and benefit plan contributions attributable to such employment are received by the Plan either directly from the Employer or passed through to the Plan by virtue of an agreement acceptable to the Organization.
8. The day he commences employment as a Pilot; unless he is a member of a Pilot's Branch that is participating in the Plan.

Section 2. Pensioners

A. Initial Eligibility

A Pensioner (as defined in Article I, Section 7) shall become eligible for benefits as provided for in Article IV, Part M commencing with the first day of the month in which his pension from the M.M.&P. Pension Plan (or such other pension plan as provided in Paragraph 8 herein) becomes effective, or recommences, provided he meets the following conditions as provided in Paragraphs 1 through 6 or as provided in Paragraph 7 or 8:

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Section 2. **Pensioners (Continued)**

A. **Initial Eligibility (Continued)**

1. For pensions with an effective date on and after May 1, 1985, the Employee had at least 400 days of Covered Employment, including Vacation or Disability days in the three (3) year period prior to his pension effective date, or re-retirement date, and
2. The Employee had not been employed after December 1, 1984, prior to becoming a Pensioner, for thirty (30) or more days, in the aggregate, in any capacity relating to the operation or maintenance of any U.S. flag oceangoing vessels operated by a company that does not participate in this Plan at the time of such employment, unless;
 - a. Such Employee subsequently resumed Covered Employment with an Employer that contributed to this Plan at a rate calculated to include Pensioner's health benefits for 400 or more days, including Vacation and Disability days, during the three (3) year period prior to the employee's retirement, or
 - b. The Trustees waive this provision due to the company, who employed such individual in non-Covered Employment, becoming or regaining its status as an Employer under this Plan, and
3. Effective August 1, 1987, the Pensioner must:
 - a. be eligible to vote on contracts covering wages, hours and working conditions applicable to the Offshore Membership Group's

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ELIGIBILITY

Section 2. Pensioners (Continued)

A. Initial Eligibility (Continued)

3. a. (Continued)

membership or be eligible for coverage under the Plan by virtue of any other M.M.& P. Membership Group contract or participation agreement, and

b. make or authorize the M.M.& P. Pension Plan to make the necessary deductions to satisfy the "Co-pay" requirements set forth in paragraphs 5 and 6 of Subsection A of this Article, and

4. Effective September 1, 1989, the Pensioner must have been employed in Covered Employment with an Employer that contributed to this Plan at a rate calculated to include Pensioner's health benefits for 400 or more days, including Vacation and Disability days, during the three (3) year period prior to the employee's retirement.

5. Co-Pay Requirements (Pensioners)

Effective August 1, 1987 a Pensioner and his dependents shall not be eligible for continued benefits under this Plan unless he shall pay or authorize the deductions from his pension benefits under the M.M.& P. Pension Plan, in accordance with procedures established by the Administrator, a monthly contribution in the amount of two percent (2%) of the pension benefit, with a minimum contribution per month in the amount of twenty-five (\$25.00)

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Section 2. Pensioners (Continued)

A. Initial Eligibility (Continued)

5. Co-Pay Requirements (Pensioners) (Continued)

dollars and a maximum contribution per month in the amount of one hundred (\$100.00) dollars.

Effective April 1, 2002, and until March 31, 2024 (unless further extended by the Trustees), a Pensioner and his Dependents shall not be eligible for continued benefits under this Plan unless he shall pay or authorize the deductions from his pension benefits under the M.M.&P. Pension Plan, in accordance with procedures established by the Administrator, a monthly contribution in the amount of three percent (3%) of the pension benefit, with a minimum contribution per month in the amount of thirty-five dollars (\$35.00) and a maximum contribution per month in the amount of one hundred and seventy-five dollars (\$175.00).

6. Pensioners Receiving a Lump-Sum Payout

Effective March 1, 1991, in the case of a Pensioner who has opted for and receives his pension benefit in the form of a Lump-Sum Payment, pursuant to the M.M.& P. Pension Plan Restated Regulations, such Pensioner shall not be eligible for continued benefits under this Plan unless he shall pay, in accordance with procedures established by the Administrator, an amount equal to two percent (2%) of the gross monthly pension benefit payable had the Lump-Sum Payment not been elected, with a minimum contribution per

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Section 2. Pensioners (Continued)

A. Initial Eligibility (Continued)

6. Pensioners Receiving a Lump-Sum Payout (Continued)

month in the amount of twenty-five (\$25.00) dollars and a maximum contribution per month in the amount of one hundred (\$100.00) dollars.

Effective April 1, 2002, and until March 31, 2024 (unless further extended by the Trustees), in the case of a Pensioner who has opted for and receives his pension benefit in the form of a Lump-Sum Payment pursuant to the M.M.&P. Pension Plan Second Restated Regulations, such Pensioner shall not be eligible for continued benefits under this Plan unless he shall pay, in accordance with procedures established by the Administrator, an amount equal to three percent (3%) of the gross monthly pension benefit payable had the Lump-Sum Payment not been elected, with a minimum contribution per month in the amount of thirty-five dollars (\$35.00) and a maximum contribution per month in the amount of one hundred and seventy-five dollars (\$175.00).

7. A member of a Branch of the Pilots Membership Group of the Organization participating in the Plan, who meets the definition of a "Pensioner" set forth in Article I, Section 7 herein and the definition of an "Eligible Employee" set forth in Article I, Section 6 herein the day before his pension effective date under the M.M.&P. Pension Plan, shall become eligible for benefits as provided for in Article IV, Part M commencing with the first day of the

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ELIGIBILITY

Section 2. Pensioners (Continued)

A. Initial Eligibility (Continued)

7. (Continued)

month in which his pension from the M.M.&P. Pension Plan becomes effective, or recommences, provided he meets all of the conditions set forth in this Subsection A, other than the condition set forth in Paragraph 4 herein.

8. A supervisory employee of the M.A.T.E.S. Program, who meets the definition of an “Eligible Employee” set forth in Article I, Section 6 herein the day before his pension effective date under a pension plan, shall become eligible for benefits as provided for in Article IV, Part M commencing with the first day of the month in which his pension becomes effective, or recommences, provided he meets all of the conditions set forth in the Subsection A, other than the condition that his pension be from the M.M.&P. Pension Plan and the conditions set forth in Paragraph 6 herein.

Furthermore, effective March 1, 2008, an Office Employee of the Organization, the Plan Office, the M.A.T.E.S. Program, MIRAID or the M.M.&P. Federal Credit Union who meets the definition of an “Eligible Employee” set forth in Article I, Section 6 herein the day before the earlier of his retirement or his pension effective date under a pension plan, other than the M.M.&P. Pension Plan, shall become eligible for benefits under the “Continuation of Coverage” provisions under Section 8 here commencing

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Section 2. Pensioners (Continued)

A. Initial Eligibility (Continued)

8. (Continued)

with the first day of the month in which he retires or in which his pension becomes effective, provided he meets all of the following conditions:

- a. before he retires, he must have been an Office Employee of the Organization, the Plan Office, the M.A.T.E.S. Program, MIRAID and/or the M.M.&P. Federal Credit Union for a total of at least seventeen (17) years, and effective January 1, 2017, for a total of at least twelve (12) years;
- b. the sum of his age and his years as an Office Employee of the Organization, the Plan Office, the M.A.T.E.S. Program, MIRAID and/or the M.M.&P. Federal Credit Union must equal 75 or more, and effective January 1, 2017, must equal 70 or more;
- c. he must elect coverage under the "Continuation of Coverage" provisions under Section 8 herein just prior to the earlier of his retirement date or his pension effective date and may not elect such coverage after such date.

B. Termination of Eligibility

- 1. The eligibility of a Pensioner and his Dependents (unless otherwise provided) shall terminate upon the earlier of:
 - a. his death, or

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ELIGIBILITY

Section 2. Pensioners (Continued)

B. Termination of Eligibility (Continued)

- b. the suspension of his pension from the M.M.&P. Pension Plan, or
 - c. discontinuance of Health Benefits for a class of Pensioners to which the Pensioner belongs; or
 - d. the failure of a Pensioner (other than a Pensioner described in the second sentence of Subsection A(8) of this Section) to continue to comply with the requirements of Subsection A(3) of this Section provided, however, that the Pensioner shall continue to be eligible for any Death Benefits that were fully funded prior to the Pensioner's loss of his eligibility status, or
 - e. the Pensioner is granted a withdrawal card from the Organization or, if earlier, the date the Plan receives notice from the Organization that the Pensioner is six (6) months delinquent in his Union dues, or
 - f. the failure of a Pensioner described in the second sentence of Subsection A(8) of this Section to pay the monthly premium approved by the Trustees for the "Continuation of Coverage" provisions under Section 8 herein.
- 2. A Pensioner and his Dependents shall permanently lose eligibility under this Plan if after December 1, 1984, he is employed thirty (30) or more days, in the aggregate, in any capacity relating to the operation or maintenance of any

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ELIGIBILITY

Section 2. Pensioners (Continued)

B. Termination of Eligibility (Continued)

2. (Continued)

vessel operated by a company that does not participate in this plan at the time of such employment, provided:

- a. the word "vessel" shall not include fishing vessels, yachts, dredges, oceanographic or research vessels of 300 feet or less in length;
- b. such employment shall not include employment as a civilian employee of the Military Sealift Command or other governmental entity;
- c. such employment shall not include employment on any vessels engaged in offshore oil drilling, exploration or research, or on vessels whose operations are ancillary to such offshore oil operation, including but not limited to supply boats, oil drilling vessels and oil drilling rigs, provided that such Pensioner must obtain written authorization for each job assignment through the Offices of the Organization, with written notice of such employment being furnished to the Board of Trustees; such employment shall also not include employment by Pensioners who worked as licensed engineers before they retired and who retired because they were unable to work in Covered Employment due to the limited number of

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Section 2. Pensioners (Continued)

B. Termination of Eligibility (Continued)

2. (Continued)

c. (Continued)

billets available for such rating, and employment aboard any maritime academy education or training vessel, but only when sailing as Masters aboard such vessels, provided that such Pensioner must obtain prior written authorization for each job assignment through the Offices of the Organization, with written notice of such employment being furnished to the Board of Trustees; such employment shall also not include employment, including Covered Employment, aboard any military vessels manned pursuant to a federal government contract and covered by collective bargaining agreements with or manned by personnel represented by Membership Groups affiliated with the Organization, provided that such Pensioner must obtain prior written authorization for each job assignment through the Offices of the Organization, with written notice of such employment being furnished to the Board of Trustees.

- d.** the Trustees at their discretion may approve other employment if written permission is granted in advance.

In the event a company becomes an Employer or regains the status of Employer under this Plan, the Trustees may restore eligibility to a

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Section 2. Pensioners (Continued)

B. Termination of Eligibility (Continued)

2. (Continued)

d. (Continued)

former Pensioner who lost eligibility under this Plan by virtue of employment with such company.

- e.** Notwithstanding anything herein to the contrary, effective February 9, 2018 if a Pensioner returns to Covered Employment that is unauthorized by the Trustees and/or the Organization, such Pensioner shall be permanently ineligible for the benefits provided under Article IV, Part M in the future. Such Pensioner shall also be ineligible for coverage under this Plan as an active Participant.

Section 3. Officers of the Organization and Office Employees of the Organization and Plan Office

A. Initial Eligibility

Each Officer of the Organization and Office Employee of the Organization and Plan Office shall become eligible for benefits hereunder on the date he completes one month of continuous service; provided, however, that the eligibility of such an individual who at the initiation of such service was an Eligible Employee, shall commence on the date he commences employment or service.

B. Termination of Eligibility

Eligibility of an Employee under this Section shall terminate in accordance with the terms of the Collective Bargaining Agreement, or the earliest of:

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**Section 3. Officers of the Organization and Office Employees
of the Organization and Plan Office (Continued)**

B. Termination of Eligibility (Continued)

1. the end of the sixth calendar month following the month in which he last worked in Covered Employment, provided, however, that, effective June 1, 2018, the Employee and the Organization or Plan Office may agree to a different period of extended coverage through collective bargaining or otherwise, with premium rates and coverage as provided through collective bargaining or as otherwise agreed to, or
2. the date on which the Employee commences employment elsewhere, or
3. his death, or
4. the date he ceases to be a member of the Organization, or
5. the date he enters the military or naval or air forces of any country, state or union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act, or
6. the date he becomes a Pensioner, except as provided in Article IV, Part M for a Pensioner and his Dependents.

Termination of employment or service shall mean the date when active work for the Organization, Plan Office or its subordinate bodies as the case may be, ceases; except that in the case of continuous sickness, injury or official leave of absence, employment or service

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**Section 3. Officers of the Organization and Office Employees
of the Organization and Plan Office (Continued)**

B. Termination of Eligibility (Continued)

shall be deemed to continue until the last day of the third calendar month following the month in which active work ceased. The period of eligibility in the case of sickness, injury or leave of absence may be extended by the Trustees, in their discretion, after consideration of all the facts.

C. Co-Pay Requirements (Actives)

An Officer of the Organization and Office Employee of the Plan Office shall not become an Eligible Employee, nor shall he continue to remain an Eligible Employee, unless he contributes, under procedures established by the Administrator, the sum of one and one-half percent (1-1/2%), if required by the Collective Bargaining Agreement or participation agreement, of all earnings from employment and vacation with an Employer on a maximum earnings base equal to that used by Social Security for calculating F.I.C.A. taxes; provided, however, effective January 1, 2007, the one and one-half percent (1-1/2%) co-pay contribution shall be deducted on a pre-tax basis from all earnings from employment and vacation with an Employer without any maximum earnings limit.

**Section 4. Shoreside Employees and Employees of the United Inland Group
Atlantic and Gulf Membership and Great Lakes Groups and
the Atlantic Maritime Group**

A. Initial Eligibility

A Shoreside Employee shall become an Eligible Employee for benefits hereunder on the date he completes thirty (30) days in Covered Employment with one or more

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**Section 4. Shoreside Employees and Employees of the United Inland Group
Atlantic and Gulf Membership and Great Lakes Groups and
the Atlantic Maritime Group (Continued)**

A. Initial Eligibility (Continued)

Employers within any period of six (6) consecutive calendar months. Notwithstanding anything herein to the contrary, if a group commences participation in the Plan at the beginning of a month after January 1, the Deductible Amount and out-of-pocket amounts required under the Plan's provisions hereinafter will be pro-rated in that first year of participation to reflect participation on a partial year basis.

B. Termination of Eligibility

Eligibility of an Employee under this Section shall terminate in accordance with the terms of the Employee Collective Bargaining Agreement or the earliest of:

1. the date he commences employment outside of Covered Employment, or
2. the date he enters the military or naval or air forces of any country, state or union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act, or
3. the date the Employer ceases contributions on the Employee's behalf, or
4. the date he ceases to be a member of the Organization, or
5. the date he becomes eligible for benefits under any Health & Benefit Plan established by the Organization, or
6. the date he dies.

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Section 5. Pilots Membership Group

A. Initial Eligibility

A member, Employee, retiree or surviving spouse of a retiree of a Branch of the Pilots Membership Group of the Organization, when such Branch signs an M.M.& P. Health & Benefit Plan Agreement and Declaration of Trust, and by signing such Agreement and Declaration of Trust agrees to maintain the minimum participation requirements and to pay the monthly contribution amounts as may be established by the Trustees from time to time, shall become eligible for certain specified benefits as provided in Article IV on the day he completes one month of such employment, for which his Branch has made contributions on his behalf, as required by the Trustees. A new member or Employee of a Branch already participating in the Plan, must, within thirty (30) days of the commencement of membership or employment (whichever occurs first), elect or reject participation in the Plan.

If the member or Employee initially rejects participation, he shall be given further opportunities to participate in the Plan on an annual basis as described below.

Effective January 1, 2001, there shall be an annual open enrollment period during November and December each year thereafter during which a member or Employee of a participating Pilot Branch, as well as their Eligible Dependents, shall be given the opportunity to participate in the Plan commencing on the subsequent January 1. Notwithstanding anything herein to the contrary, if a Pilot Branch commences participation in the Plan at the beginning of a month after January 1, the Deductible Amount and out-of-pockets required under the Plan's provisions hereinafter will be

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Section 5. Pilots Membership Group (Continued)

A. Initial Eligibility (Continued)

prorated in that first year of participation to reflect participation on a partial year basis.

B. Termination of Eligibility

Eligibility under this Section shall terminate the earliest of...

1. the date the Branch ceases contributions on a Pilot's behalf, or
2. the date the Pilot ceases active employment with a participating Branch due to illness or injury and is not retired, or,
3. the date he is granted a withdrawal card from the Organization, or, if earlier, the date the Plan received notice from the Organization that the Employee is six (6) months delinquent in his Union Dues, or
4. the date of the Branch's withdrawal from the Plan unless the Branch has deposited with the Plan contributions to provide for one or two additional months of eligibility under the Plan, or
5. the date he becomes eligible for benefits under any Health and Benefit Plan established by the Organization, or
6. the date he enters the military or naval or air forces of any country, state of union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to

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Section 5. Pilots Membership Group (Continued)

B. Termination of Eligibility (Continued)

6. (Continued)

military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act, or

7. the date he dies, or
8. the date the Branch ceases to maintain the minimum participation requirements and/or to pay the monthly contribution amounts as may be established by the Trustees from time to time.

Section 6. United Inland Group Pacific Maritime Region Employees

Eligible Employees of the United Inland Group Pacific Maritime Region shall become eligible for certain benefits specified under Subsection E below as follows:

A. Active Employee

1. Regular Employees

a. Monthly Reporting Employer

<u>Contributions For the Month of</u>	<u>Provide Eligibility for the Month of</u>
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October

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Section 6. United Inland Group Pacific Maritime Region Employees (Continued)

A. Active Employee (Continued)

1. Regular Employees (Continued)

a. Monthly Reporting Employer (Continued)

September	November
October	December
November	January
December	February

b. Bi-Monthly Reporting Employer

<u>Contributions</u> <u>For the Month of</u>	<u>Provide Eligibility</u> <u>For the Month of</u>
January/February	April/May
March/April	June/July
May/June	August/September
July/August	October/November
September/October	December/January
November/December	February/March

- 2. Casual Employees** - A Casual Employee who works in Covered Employment for one or more contributing Employers shall become eligible for benefits as provided under Section 6(A)(1) and (E) on the earlier of:
- a.** the first of a month after required contributions are made by his Employer on his behalf sufficient to pay for a month's coverage, or
 - b.** the first of a month after the required deduction from his Individual Reserve Account is made to the Plan sufficient to pay for a month's coverage, unless otherwise provided in their Collective Bargaining

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Section 6. United Inland Group Pacific Maritime Region Employees (Continued)

A. Active Employee (Continued)

2. Casual Employees (Continued)

b. (Continued)

Agreement. Casual Employees may maintain their coverage by making timely self-payments and/or deductions from the existing dollar credit in their reserve account in the amount of the required monthly contribution, provided there is no lapse in coverage and provided the payment for the prior month's coverage has not been a COBRA self-payment.

If the Employee's Reserve Account is not sufficient to pay one month's coverage, and the Casual Employee does not make a partial self-payment to continue his coverage, he will not be eligible to make future self-payments until his reserve account has sufficient Employer contributions to pay for a month's coverage, provided, however, he may be offered COBRA Continuation of Coverage as set forth hereunder. The required self-payment must be received by the 10th day of the month for which coverage is requested.

B. Inactive Employees

An Employee whose individual reserve account has been depleted below the minimum necessary to pay for one month's coverage, and whose account shows no activity for a period of twelve (12) consecutive months because of his failure to

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Section 6. United Inland Group Pacific Maritime Region Employees (Continued)

B. Inactive Employees (Continued)

work in Covered Employment or make self-payments, shall have his entire remaining reserve account revert to the general surplus of the Plan. In order to be subsequently eligible for coverage, the Employee must re-establish eligibility in accordance with Section 6 A above.

C. Retirees

United Inland Group Pacific Maritime Region Retirees and/or Surviving Spouses who were covered for benefits as of May 1, 2000 may continue coverage for benefits for themselves and their Eligible Dependents by paying to the Plan the amount of contributions required for such coverage as determined by the Trustees.

Notwithstanding anything herein to the contrary, the Surviving Spouses of United Inland Group Pacific Maritime Region Retirees, who die after June 1, 2008, may continue coverage for benefits for themselves and their Eligible Dependents by paying to the Plan the amount of contributions required for such coverage as determined by the Trustees. In order to be eligible to health benefits as a Retiree, the Active Employee must meet the following requirements:

1. He must have been covered for health benefits as a result of Covered Employment for twenty-four (24) calendar months in the last thirty-six (36) calendar months prior to his effective date of retirement, and

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Section 6. United Inland Group Pacific Maritime Region Employees (Continued)

C. Retirees (Continued)

2. He must have been in Covered Employment and eligible to health benefits under this Plan or the Columbia Northwest Marine Benefit Trust Plan for three (3) calendar months preceding his effective retirement date.

D. Termination of Eligibility

1. Active United Inland Group Pacific Maritime Region Employee

Eligibility of an Employee under this Section shall terminate on the earliest of the following dates:

- a. At the end of the second calendar month following the month in which he last worked in Covered Employment or as otherwise provided in this Section 6, or
- b. the date he commences employment outside of Covered Employment, or
- c. the date he enters the military or naval or air forces of any country, state or union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act, or

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Section 6. United Inland Group Pacific Maritime Region Employees (Continued)

D. Termination of Eligibility (Continued)

1. Active United Inland Group Pacific Maritime Region Employee

(Continued)

- d.** the date he ceases to be a member of the Union, or
- e.** the date he becomes a Retiree, except as provided in Article III, Subsection C, or
- f.** the date he dies.

2. United Inland Group Pacific Maritime Region Retiree

Eligibility of a United Inland Group Pacific Maritime Region Retiree and his Dependents shall terminate upon the earlier of:

- a.** His Death, or
- b.** non-payment of contributions, or
- c.** the date the Retiree ceases to be a member of the Union, or,
- d.** discontinuance of health benefits for a class of Retirees to which the Retiree belongs.

- E.** The following applicable benefits shall be available to the United Inland Group Pacific Maritime Region Eligible Employees and/or Retirees and their Eligible Dependents: Death and/or AD&D, Comprehensive Major Medical, Prescription Drugs, Dental, Vision, Annual Physical Examination and Hearing Aid. Notwithstanding anything herein to the contrary, effective January 1, 2006, the maximum reimbursement or payment for Prescription Drug Benefits under Article IV, Part B herein shall not exceed

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Section 6. United Inland Group Pacific Maritime Region Employees (Continued)

E. (Continued)

\$1,000 in any calendar year for any United Inland Group Pacific Maritime Region Retiree or their Surviving Spouse who is eligible for coverage hereunder. Notwithstanding anything herein to the contrary, effective January 1, 2014, the maximum reimbursement or payment amount for Prescription Drug Benefits described in the previous sentence shall not apply.

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Section 7. United Inland Group Alaska Marine Highway System Group Employees

A. Initial Eligibility

An Eligible Employee with the United Inland Group Alaska Marine Highway System Deck Officers Group ("AMHS Group") and his Eligible Dependents shall become eligible for certain benefits specified in Subsection C below as follows: (1) for employees with the United Inland Group AMHS Group as of July 1, 2001 who were eligible for health coverage provided by the Employer immediately prior to that date, and (2) for a new employee with the United Inland Group AMHS Group after July 1, 2001, on the first day of the month after the employee completes one month of employment for the Employer and for which his Employer has made contributions on the employee's behalf, as required by the Trustees.

B. Termination of Eligibility

Eligibility under this Section shall terminate the earliest of...

1. the date the Employer ceases contributions on an Employee's behalf, or
2. the date the Employee ceases active employment with the Employer due to illness or injury or retirement, or
3. the date the Employee withdraws from the Organization, or, if earlier, the date the Plan received notice from the Organization that the Employee is six (6) months delinquent in his Union Dues, or
4. the date of the Employer's withdrawal from the Plan, or

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Section 7. United Inland Group Alaska Marine Highway System Group Employees
(Continued)

B. Termination of Eligibility (Continued)

5. the date the Employee becomes eligible for benefits under any Health and Benefit Plan established by the Organization, or
6. the date the Employee enters the military or naval or air forces of any country, state of union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act, or
7. the date the Employee dies.

- C. The following benefits shall be available to United Inland Group AMHS Group Eligible Employees and their Eligible Dependents: Comprehensive Major Medical, Prescription Drugs, Dental, Vision, Annual Physical Examination, Hearing Aid and Death and AD&D.

Section 8. Continuation of Coverage for Pensioners

Pensioners who lose eligibility for benefits under this Plan on or after August 1, 1987, due to the operation of Section 2(A) (3) of this Article, shall be afforded the opportunity to continue coverage for the benefits described in Article IV, Parts A, B, C and H for themselves and their eligible Dependents until June 30, 2023 by paying to the Plan the appropriate costs for such coverage, as determined by the Plan's actuary, in accordance with rules established by the Trustees. Furthermore, effective March 1, 2008, a Pensioner described in, and who meets all the eligibility

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Section 8. Continuation of Coverage for Pensioners (Continued)

requirements of the second sentence of Article III, Section 2.A.8 herein shall be afforded the opportunity to continue coverage for the benefits described in Article IV, Parts A, B C and H for themselves and their eligible Dependents until June 30, 2023 by paying to the Plan the appropriate costs for such coverage, as determined by the Plan's actuary, in accordance with rules established by the Trustees. Furthermore, effective October 1, 2011, a Pensioner who is a retired Organization official of the United Inland Group but not eligible for retiree health coverage under Article III, Section 6.B hereunder, or who is a retired Savannah docking pilot, shall be afforded the opportunity to be eligible for coverage for the benefits described in Article IV, Parts A, B, C and H for themselves and their eligible Dependents until June 30, 2023 by paying to the Plan the appropriate costs for such coverage, as determined by the Plan's actuary, in accordance with rules established by the Trustees.

Furthermore, effective February 1, 2012, a Pensioner who received health coverage under the Plan as an Eligible Employee immediately prior to his retirement and is otherwise not eligible for health coverage as a Pensioner hereunder shall be afforded the opportunity to be eligible for coverage for the benefits described in Article IV, Parts A, B, C and H for themselves and their eligible Dependents until June 30, 2023, if at the time of his retirement he elects coverage under this Section and if he pays to the Plan the appropriate costs for such coverage as determined by the Plan's actuary in accordance with rules established by the Trustees.

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Section 9. Extended Coverage for Dependents

With the exception of Eligible Employees in Sections 5 and 6 and groups participating under Cafeteria Rates, eligible Dependents of deceased Employees and Pensioners shall continue to be Covered Individuals as follows:

A. Active Participants/Eligible Dependents

1. **Eligible Dependents of Deceased Eligible Employees** not eligible to a pension under the M.M.& P. Pension Plan shall be deemed to be Covered Individuals for five (5) calendar months following the month in which the Eligible Employee's death occurred, unless such eligible dependent(s) chooses to be covered under COBRA Continuation of Coverage.
2. **The Eligible Dependent Spouse of an Eligible** Employee entitled to pension benefits under the M.M.& P. Pension Plan on a deferred basis shall be offered COBRA Continuation Coverage.
3. **Dependent Spouse of an Eligible Employee entitled** to pension benefits under the M.M.& P. Pension Plan, and who meets the Initial Eligibility requirements of Section 2(A) of this Article III, shall be offered coverage pursuant to Subsection (B) of this Section 9.

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Section 9. Extended Coverage for Dependents (Continued)

A. Active Participants/Eligible Dependents (Continued)

4. **A Dependent Child of a deceased Eligible Employee** who was entitled to a pension from the M.M.& P. Pension Plan and/or a Dependent Child of a deceased Pensioner shall continue to be a Covered Individual until his status as Dependent ceases under Article I, Section 10 of these Rules and Regulations, or until the Trustees otherwise modify, limit or discontinue this provision.

For the purpose of this Section, the Dependent Spouse of an Eligible Employee or Pensioner shall not remain a Covered Individual unless married to the Employee or Pensioner throughout the one year period prior to his death, provided however that this Spouse shall be offered COBRA coverage. Effective July 1, 2004, the 'Totally and Permanently Disabled Child,' as defined in Article I, Section 10.A.5 herein, of a deceased Eligible Employee who was entitled to a pension from the M.M.&P. Pension Plan or of a deceased Co-Pay Pensioner eligible to health benefits under this Plan shall be provided the opportunity to:

- a. purchase coverage under COBRA Continuation of Coverage Program for up to the maximum period permitted under Article III, Section 11 herein, or

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ARTICLE III
ELIGIBILITY

Section 9. Extended Coverage for Dependents (Continued)

A. Active Participants/Eligible Dependents (Continued)

4. A Dependent Child of a deceased Eligible Employee (Continued)

- b. waive coverage, to the extent permitted by law, under COBRA Continuation of Coverage, and purchase health coverage under the Continuation of Coverage Program, under Article III, Section 8 herein, which Program is subject to renewal and extension by the Trustees each year.

B. Surviving Spouses of Co-pay Pensioners

1. Age 65 and Over

Effective February 6, 1992, the Surviving Spouse of a deceased Co-pay Pensioner not eligible to purchase COBRA coverage because he/she has become eligible for Medicare benefits, shall be provided the opportunity to purchase health coverage under the Continuation of Coverage Program for up to twelve (12) calendar months, following the month of the Spouse's death, or, if earlier, termination of the Continuation of Coverage Program by the Trustees.

2. Under Age 65

Effective August 17, 1994, the Surviving Spouse of a Co-pay Pensioner eligible to health benefits under this Plan shall be provided the opportunity to:

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Section 9. Extended Coverage for Dependents (Continued)

B. Surviving Spouses of Co-pay Pensioners (Continued)

- a. purchase coverage under COBRA Continuation of Coverage Program for up to the maximum permitted under Article III Section 11 of these Rules and Regulations, or
- b. waive coverage, to the extent permitted by law, under COBRA Continuation of Coverage, and purchase health coverage under the Continuation of Coverage Program, which Program is subject to renewal and extension by the Trustees each year.

Effective June 1, 1998, Surviving Spouses of Co-pay Pensioners eligible to health benefits under this Plan at the time of death shall be provided the opportunity to:

- a. purchase coverage under COBRA Continuation of Coverage Program for up to the maximum permitted under Article III, Section 11 of these Rules and Regulations, or
- b. waive coverage, to the extent permitted by law, under COBRA Continuation of Coverage and purchase health coverage under the Continuation of Coverage Program, which Program is subject to renewal and extension by the Trustees each year.

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Section 9. Extended Coverage for Dependents (Continued)

C. Surviving Spouses of Continuation of Coverage Pensioners

1. Under Age 65

Shall be offered COBRA Continuation of Coverage for up to the earlier of thirty-six (36) months or entitlement to Medicare.

2. Over Age 65

Coverage terminates the end of the month in which the Continuation of Coverage Pensioner dies.

3. Effective June 1, 1998, eligible Surviving Spouses of Continuation of Coverage Pensioners will be offered COBRA Continuation of Coverage until the earlier of

- a. entitlement to Medicare, or**
- b. thirty-six (36) calendar months.**

Section 10. Right to COBRA Continuation Coverage

Notwithstanding the above, effective January 1, 1990, Eligible Dependents of deceased Eligible Employees not eligible for pension benefits from the M.M.& P. Pension Plan may continue coverage under the Plan under one of two options: Extended Coverage under Section 9 (A)(1) of this Article III or COBRA Continuation Coverage in accordance with Section 11 below.

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Section 11. COBRA Continuation Coverage

Effective January 1, 1990, a Qualified Beneficiary shall have the right and option to continue only their Standard Medical Benefits, as defined under Subsection (A) of this Section, or both their Standard Medical Benefits and their Supplemental Medical Benefits, as defined under Subsection (B) of this Section, if such benefits would otherwise terminate because of a Qualifying Event as defined under Subsection (E) of this Section.

Effective April 1, 1999, a Qualified Beneficiary shall have the right and option to continue only a combination of both their Standard Medical Benefits, as defined under subsection (A) of this Section, and their Supplemental Medical Benefits, as defined under Subsection (B) of this Section, if such benefits would otherwise terminate because of a Qualifying Event as defined under Subsection (E) of this Section; provided, however, if the benefits that would otherwise terminate because of such Qualifying Event were only the Standard Medical Benefits, then the Qualified Beneficiary shall have the right and option to continue only such benefits pursuant to this Section 10.

A. Standard Medical Benefits

The term "Standard Medical Benefits" as used herein shall mean the benefits described in Article IV, Parts A, B, and C.

B. Supplemental Medical Benefits

The term "Supplemental Medical Benefits" as used herein shall mean the benefits described in Article IV, Parts F, G and H.

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Section 11. COBRA Continuation Coverage (Continued)

C. Non-medical Benefit

The term "Nonmedical Benefits" as used herein shall mean the benefits described in Article IV, Parts D, E, I, J, K, L and M.

D. Qualified Beneficiary

The term "Qualified Beneficiary" as used herein shall mean a Covered Individual under the Plan on the day before a Qualifying Event.

Effective January 1, 1997, the term "Qualified Beneficiary" shall also include a newborn/adopted child of a "Qualified Beneficiary" provided the Plan Administrator is notified within sixty (60) days of the birth or adoption and provided further that the newborn/ adopted child of a Dependent is not a "Qualified Beneficiary" unless the Dependent has COBRA coverage because of the Dependent's Qualifying Event.

Effective June 1, 1998, the term Qualified Beneficiary as used herein shall also include a Surviving Spouse age 65 or over who was an Eligible Dependent of the Pensioner at the time of his death.

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Section 11. COBRA Continuation Coverage (Continued)

E. Qualifying Event

The term "Qualifying Event", as used herein, shall mean any of the following, the occurrence of which would result in the loss of coverage under the Plan were it not for the right to continue coverage pursuant to this Section:

1. termination of eligibility as defined under Article III, Section 1(E), Section 2(B) (1)(b), (c), (d), and (e), Section 3(B), (1), (2), (3), and (4), Section 4(B), (3), (4), (5) and (6), Section 5(B), (a), (b), (c) and (d), Section 6(D) (1 a, c and d) and (2 b, c and d), Section 7(B)(1), (2) and (3), and Article IV Part M Section 4(A), except if such termination is due to the Eligible Employee's gross misconduct;
2. death of an Eligible Employee or a Pensioner;
3. divorce or legal separation of an Eligible Employee or Eligible Pensioner and spouse; and
4. an Eligible Dependent ceasing to be an Eligible Dependent under this Plan; However, the term "Qualifying Event" shall not include the complete withdrawal of a contributing Employer and the subsequent loss of coverage to a Covered Individual.

F. Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is as follows:

1. for reasons defined under Subsection E(1), 24 months from the date of the Qualifying Event, unless such Eligible Employee is determined by Social

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Section 11. COBRA Continuation Coverage (Continued)

F. Maximum Period of COBRA Continuation Coverage (Continued)

1. (Continued)

Security to have been totally and permanently disabled at the time of his Qualifying Event or within 60 days of his Qualifying Event, in which case the maximum period for him and any other covered family members, who may opt for such additional coverage, shall be 29 months, and

2. for all other Qualifying Events, 36 months from the date of the initial Qualifying Event, even if multiple Qualifying Events occur during the period of COBRA Continuation Coverage.

G. Termination of COBRA Continuation Coverage

COBRA Continuation Coverage shall terminate on the earliest to occur of the following:

1. the last day of the month preceding the month for which the required Applicable Premium, defined under Subsection H of this Section, is not paid on time;
2. the date the covered Qualified Beneficiary becomes covered under another employer sponsored group health plan, unless such other health plan limits coverage for pre-existing conditions, in which case coverage can be continued pursuant to this Section until expiration of such pre-existing condition limitation or, if earlier, the maximum period of COBRA Continuation Coverage has been reached;

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Section 11. COBRA Continuation Coverage (Continued)

G. Termination of COBRA Continuation Coverage (Continued)

3. the date the covered Qualified Beneficiary becomes entitled to Medicare;
4. the date the Plan terminates all coverages under Article IV; or
5. the last day of the maximum period of COBRA Continuation Coverage.

H. Applicable Premium

The term "Applicable Premium" as used herein shall mean the amount determined by the Plan's Actuary and shall not exceed the maximum amount permitted by law or be changed more frequently than permitted by law.

I. Notification and Administrative Procedures

The Board of Trustees shall establish as required by law, notification and administrative procedures for the election and implementation of COBRA Continuation Coverage and payment of premiums.

J. Certificates of Creditable Coverage

With respect to Eligible Employees who are Qualified Beneficiaries, effective January 1, 2001, the Plan will provide individuals with an automatic Certificate of Coverage in cases where they lose coverage under this Plan and are entitled to elect continuation coverage under this Section 11. Such Certificates of Coverage will contain the information described in Section 6 of Article II and will be provided within the following timeframes:

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Section 11. COBRA Continuation Coverage (Continued)

J. Certificates of Creditable Coverage (Continued)

1. For an individual who is a Qualified Beneficiary entitled to elect continuation coverage under this Section 11, no later than when a notice is required to be provided for a Qualifying Event, as set forth in this Section 11.
2. For an individual who is not a Qualified Beneficiary entitled to elect continuation coverage under this Section 11, within a reasonable time after coverage ceases.
3. For an individual who is a Qualified Beneficiary and who has elected continuation coverage under this Section 11, within a reasonable time after cessation of continuation coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

In addition to the foregoing, a Certificate of Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it. In either case, the certificate will contain the information described in Labor Regulation Section 2590.701-5(a)(3).

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Section 12. Coverage Under a Qualified Medical Child Support Order or National Medical Support Notice

In the event the Plan receives a medical child support order (within the meaning of Section 609(a)(2)(B) of ERISA) or a National Medical Support Notice (“NMSN”) (as described under Section 609(a)(5)(C) of ERISA and as promulgated under section 401(b) of the Child Support Performance and Incentive Act of 1998), the Administrator shall notify the affected Covered Individual, and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a Qualified Medical Child Support Order (within the meaning of Section 609(a)(2)(A) of ERISA). Within a reasonable period, the Administrator shall determine whether the order is a Qualified Medical Child Support Order and shall notify the Covered Individual and alternate recipient of such determination. To give effect to this requirement, the Administrator shall (1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order and (2) permit any alternate recipient to designate a representative for receipt of copies of notices.

Within twenty (20) business days after the date of the NMSN, the applicable Employer will provide the Administrator with the notice. Within forty (40) business days of the date of the notice, the Administrator shall: (1) notify the state or local agency issuing the NMSN whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the Plan, and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to effectuate coverage, and (2) provide to the custodial

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Section 12. Coverage Under a Qualified Medical Child Support Order or National Medical Support Notice (Continued)

parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

Section 13. Family and Medical Leave

Notwithstanding any other provision hereof to the contrary, an Employee's eligibility for benefits shall continue during any leave of absence approved by his Employer pursuant to the Family and Medical Leave Act.

Section 14. Special Rule Regarding Enrollment of Former Medicaid Participants

In order to enroll for coverage under the Plan pursuant to this Section, Employees who would otherwise be eligible for coverage under the Plan must notify the Plan Office in writing within 60 days of the date that their coverage under Medicaid has been terminated. The Plan Office shall provide the appropriate forms after notification is received. No coverage will be made available pursuant to this Section unless the Plan Office is properly notified in writing of such an event within the 60 day notification period until January 1 following the next annual open enrollment period during November and December each year thereafter during which such Employee shall be given the opportunity to enroll in the Plan.

Section 15. Non-Bargaining Unit Employees

A. Initial Eligibility

Each Non-Bargaining Unit Employee shall become eligible for benefits hereunder on the date he completes one month of continuous service; provided, however, that

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ELIGIBILITY

Section 15. Non-Bargaining Unit Employees (Continued)

A. Initial Eligibility (Continued)

the eligibility of such an individual, who at the initiation of such service was an Eligible Employee, shall commence on the date he commences employment or service.

B. Termination of Eligibility

Eligibility of an Employee under this Section shall terminate in accordance with the terms of the Participation Agreement, or the earliest of:

1. the end of the sixth calendar month following the month in which he last worked in employment or service with the Employer, or
2. the date on which the Employee commences employment elsewhere, or
3. his death, or
4. the date he ceases to be a member of the Organization, or
5. the date he enters the military or naval or air forces of any country, state or union or association thereof; provided, however, that if the Employee had any extended coverage under the Plan remaining as of his being recalled to military service, then the remaining extended coverage will be reinstated if he returns to Covered Employment in accordance with the Uniformed Services Employment and Reemployment Rights Act.

Termination of employment or service shall mean the date when active work for his Employer ceases; except that in the case of continuous sickness, injury or official leave of absence, employment or service shall be deemed to continue until the last day of the third

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ELIGIBILITY

Section 15. Non-Bargaining Unit Employees (Continued)

B. Termination of Eligibility (Continued)

calendar month following the month in which active work ceased. The period of eligibility in the case of sickness, injury or leave of absence may be extended by the Trustees, in their discretion, after consideration of all the facts.

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ARTICLE IV
BENEFIT PROVISIONS
PART A - COMPREHENSIVE MAJOR MEDICAL BENEFITS

COMPREHENSIVE MAJOR MEDICAL BENEFITS

The benefits listed in this Article IV are available to all Covered Individuals except where Provided otherwise in Collective Bargaining or Participating Agreements approved by the Trustees.

Section 1. Allowable Expense

For the purposes of this Part A, an expense or charge shall be an Allowable Expense only if the Trustees in their sole discretion determine that:

- A. It is necessary for the care and treatment of a non-occupational accidental bodily injury or sickness of a person who is a Covered Individual at the time the expense is incurred; and,
- B. It is recommended and approved by a Physician and is for a valid course of medical treatment, which is not experimental as determined by Medicare, and which is expected to lead to the cure and/or rehabilitation of the patient, provided that the Plan may obtain and rely upon independent medical advice to determine whether services or supplies are necessary for such medical treatment, are consistent with professionally recognized standards of care with regard to quality, frequency and duration and are provided in the most economical and medically appropriate site for treatment; and,
- C. It is a Covered Charge as described in Section 2 below; and,
- D. It is an Allowable Charge as defined in Article I, Section 13; and,
- E. It is not otherwise excluded or limited by provisions under this Part A.

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ARTICLE IV
BENEFIT PROVISIONS
PART A - COMPREHENSIVE MAJOR MEDICAL BENEFITS

Section 2. Covered Charges

Covered Charges are as follows:

- A. Charges made by a Hospital on its own behalf for room, board and other necessary services, and supplies provided during hospital confinement; except that any charges for room and board for any day of Hospital confinement in excess of the number of days certified by pre-admission and concurrent review shall not qualify as Allowable Charges; or
- B. Charges made by a Physician for professional services; or
- C. Charges for surgical procedures and post operational treatment; or
- D. Charges for private duty nursing service furnished in a hospital or elsewhere by a registered graduate nurse (one entitled to use the designation "R.N.") or licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) or for services provided in a hospital only, a Nursing Assistant, provided in any case that such nurse is one who does not ordinarily reside in the home of the Employee and is not a member of the Employee's immediate family (for purposes of this coverage "immediate family" consists of the Employee, the Employee's spouse, children, brothers, sisters and parents); or
- E. Charges for the rental of necessary durable medical and surgical equipment or purchase of same if;
 - 1. long range use is planned, and
 - 2. the equipment cannot be rented, or

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ARTICLE IV
BENEFIT PROVISIONS
PART A - COMPREHENSIVE MAJOR MEDICAL BENEFITS

Section 2. Covered Charges (Continued)

E. (Continued)

3. it is likely to cost less to buy the equipment than to rent it; or

- F.** Charges for anesthesia and its administration, subject to the limitations under Section 16 of Article I; diagnostic x-rays and laboratory examinations; x-ray, radium and isotope treatment; unreplaced blood and blood plasma and the administration thereof; prosthetic appliances; braces or crutches; dressings; or
- G.** Charges for professional ground ambulance service to or from the nearest facility capable of rendering appropriate emergency care for the patient's conditions, or air transportation only as medically necessary due to inaccessibility by ground transportation and/or if the use of ground transportation would be detrimental to the health status of the patient, up to the maximum allowed under Section 5, Paragraph K of this Article IV, Part A.
- H.** Charges for banking of blood under an autologous blood bank program with the specific intention of having this blood administered to the Covered Individual during a scheduled or pending surgical operation.
- I.** For charges incurred on or after January 1, 1999 for in-patient and out-patient benefits relating to Physical Therapy/Physical Medicine and/or Rehabilitation at an approved treatment facility or hospital up to the maximum allowed under Section 5 Subsection H.

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ARTICLE IV
BENEFIT PROVISIONS
PART A - COMPREHENSIVE MAJOR MEDICAL BENEFITS

Section 2. Covered Charges (Continued)

J. Transplant Surgery

1. Other Than Under National Organ Transplant Program

Charges for expenses related to transplant surgery for the following body organs up to \$250,000 per transplant and subject to current Plan maximums:

- | | |
|--------------|---------------|
| ➤ Kidney | ➤ Liver |
| ➤ Heart | ➤ Pancreas |
| ➤ Heart/Lung | ➤ Bone Marrow |
| ➤ Lung | ➤ Cornea |

Benefits for Pensioners and other Covered Individuals for whom Medicare is primary shall be coordinated with Medicare, and benefits payable only to the extent such transplant surgery Covered Charges are covered by Medicare.

2. National Organ Transplant Program

Effective April 1, 1995, charges for expenses related to transplant surgery for the following body organs coordinated through and approved by the Plan Review Organization's National Organ Transplant Program up to \$400,000 per transplant, unless otherwise noted, and subject to current Plan maximums:

- | | |
|----------------------------|-------------------|
| ➤ Kidney (up to \$300,000) | ➤ Pancreas/Kidney |
| ➤ Heart | ➤ Bone Marrow |
| ➤ Heart/Lung | -Allogenic |
| ➤ Lung | -Autologous |
| ➤ Liver | |

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BENEFIT PROVISIONS
PART A - COMPREHENSIVE MAJOR MEDICAL BENEFITS

Section 2. Covered Charges (Continued)

J. Transplant Surgery (Continued)

2. National Organ Transplant Program (Continued)

Travel expenses associated with such transplant under the Plan's Review Organization National Organ Transplant Program up to \$10,000 subject to the following conditions:

- No travel and lodging benefits will be payable unless the patient lives at least 100 miles from the designated facility.
- Co-payment, deductibles and Plan maximums do not apply to the travel and lodging coverage.
- This benefit covers the patient only.
- The Plan will pay for pre-approved travel and lodging to a designated transplant facility for the pre-transplant evaluation even if the transplant is not eventually certified as medically appropriate.

Donor medical expenses, without application of co-payment or deductibles, up to \$10,000 provided the transplant surgery is coordinated and approved by the Plan's Review Organization's National Organ Transplant Program.

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Section 2. **Covered Charges** (Continued)

J. **Transplant Surgery** (Continued)

2. **National Organ Transplant Program** (Continued)

Covered Charges payable under this paragraph J. 2. And coordinated through the Plan's Review Organization's National Organ Transplant Program shall be considered payable at 95% of Covered Charges, or at 100% of Covered Charges if the Covered Individual has incurred a total of \$2,000 of out-of-pocket Allowable Expenses in a calendar year, and effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, if the Covered Individual has incurred a total of \$3,000 of out-of-pocket Allowable Expenses in a calendar year.

Effective April 1, 1995, charges for expenses related to transplant surgery for the following body organs coordinated through and approved by the Plan Review Organization's National Organ Transplant Program up to \$400,000 per transplant, unless otherwise noted, and subject to current Plan maximums:

- | | |
|----------------------------|---------------------------------------|
| ➤ Kidney (up to \$300,000) | ➤ Pancreas/Kidney |
| ➤ Heart | ➤ Bone Marrow |
| ➤ Heart/Lung | -Allogenic (<u>up to \$870,000</u>) |
| ➤ Lung | -Autologus |
| ➤ Liver | |

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Section 2. Covered Charges (Continued)

- K.** Charges for reconstruction of the breast on which the mastectomy was performed and charges for surgery and reconstruction of the other breast to produce a symmetrical appearance.
- L.** Charges for educational services or self-care training up to the lesser of \$300 or three (3) sessions, provided that such services or training are recommended by the Covered Individual's Physician; provided further that such services or training are provided by a Physician, registered graduate nurse, registered pharmacist, registered dietician under the auspices of a covered facility or licensed social worker; and provided further that such services or training are not otherwise excluded under Section 6 hereinafter.
- M.** Effective January 1, 2012, charges for the pregnancy and delivery of a newborn child of an Eligible Employee's Dependent Child.
- N.** Effective March 18, 2020 through the end of the federally-declared public health emergency related to COVID-19, the following services will be covered with no cost sharing (including deductibles, co-payments and co-premiums) and no requirement of prior authorization:

 - 1.** Diagnosis products for the detection of SARS-CoV-2 or the diagnosis of COVID-19 and the administration of such diagnostic products. The types of tests that will be covered include:

 - a)** Diagnostic testing authorized by the FDA or the Secretary of HHS;

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Section 2. **Covered Charges (Continued)**

N. (Continued)

- b) Diagnostic testing that is under review, or will be submitted for review, by the FDA for emergency use; and
 - c) Diagnostic testing authorized by a State, if that State has notified the Secretary of HHS.
- 2. Items and services furnished to a Participant or Dependent during health care provider office visits, urgent care visits, and emergency room visits that result in an order for, or administration of, a diagnosis product, but only to the extent that the item or service relates to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test.

For these services, the Fund will cover 100% of the charges of the cost of COVID-19 diagnostic testing billed by an in-network provider, with no co-payment, co-insurance or deductible. For out-of-network claims for these services, the Fund will pay 100% of the lesser of (i) the provider's billed charges, (ii) or the in-network rate. If the out-of-network provider's billed rate is higher than the in-network rate, the Plan will pay the rate negotiated by the Plan with such provider for such service.

- 3. In addition, to the extent required by federal law, the Fund will cover items, services, or immunizations intended to prevent or mitigate COVID-19, provided the item, service or immunization must be intended to prevent or mitigate COVID-19 and meet certain criteria and ratings of the U.S.

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Section 2. Covered Charges (Continued)

N. (Continued)

3. (Continued)

Preventative Services Task Force or recommended by the Centers for Disease Control and Prevention for the individual involved. To the extent permitted by law, cost-sharing will be applied to any such covered services.

- O.** Effective January 1, 2022, charges for No Surprises Services are covered as required by the No Surprises Act, and subject to applicable Cost Sharing. In addition, if a Covered Individual receives No Surprises Services from a Non-contracted provider that the Covered Individual thought was a Contracted provider, based on inaccurate information in a current provider directory, then the No Surprises Services provided by that Non-contracted provider will be covered as if the provider was Contracted.
- P.** Effective January 1, 2022, Emergency Services are covered without the need for prior authorization.

Section 3. Deductible Amount

The Deductible Amount of the Plan is \$150 per year for each Covered Individual; provided, however, effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, the Deductible Amount of the Plan is \$250 per year for each Covered Individual. However,

- A.** any Allowable Expenses incurred during the last three (3) months of a calendar year which are applied against a Covered Individual's Deductible Amount will also reduce his or her Deductible Amount for the next calendar year; and

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Section 3. Deductible Amount (Continued)

- B. after Deductible Amounts totaling \$300 and, effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, \$500 have been applied during any calendar year to any combination of Covered Individuals within a family, no further Deductible Amounts will be applicable to the Eligible Employee or any of his Dependents for the remainder of the calendar year, unless otherwise provided hereinafter. Such \$300 or, if applicable, \$500 for any calendar year will be reduced by an amount equal to the amount applied to satisfy the Deductible during the last three (3) months of the preceding calendar year.

Notwithstanding anything herein to the contrary, such Deductible Amounts for a group referenced in Article III, Sections 4, 5, 6 and 7 hereinabove that become eligible for benefits at the beginning of a month after January 1, shall be pro-rated in that first year of participation to reflect participation on a partial year basis.

Section 4. Benefits

After a Covered Individual has satisfied the Deductible Amount, and subject to the limitations in Section 5 of this Part, the Plan will pay benefits as follows: 80% of the Allowable Expense, except that if a Covered Individual has incurred a total of \$2,000 of out-of-pocket Allowable Expenses in a calendar year, such individual shall receive 100% of the balance of such Allowable Expenses.

Notwithstanding anything herein to the contrary, effective April 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, after a Covered Individual has satisfied the Deductible Amount, as well as a \$150 per inpatient hospital admission deductible and/or a \$150

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Section 4. Benefits (Continued)

annual physician expense deductible, the Plan will pay as follows: 70% of the Allowable Expense for an inpatient hospital expense, 90% of the Allowable Expense for a primary care physician expense and 70% of the Allowable Expense for a specialist physician expense, provided, however, that effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, if a Covered Individual has incurred a total of \$3,000 of out-of-pocket Allowable Expenses in a calendar year, such individual shall receive 100% of the balance of such Allowable Expenses; provided further, however, that effective January 1, 2012, if an Eligible Employee's family has incurred a total of \$10,000 of out-of-pocket Allowable Expenses in a calendar year, such family shall receive 100% of the balance of such Allowable Expenses.

Notwithstanding anything herein to the contrary, effective May 1, 2003, the \$150 annual physician expense deductible referenced herein shall not apply to an Allowable Expense of an emergency room Physician incurred in a "Contracted Hospital," even if the Physician is not a "Contracted Provider," as those terms are defined in Section 5 of this Part.

Effective January 1, 2022, the \$150 annual physician expense deductible referenced herein shall not apply to an Allowable Expense of an emergency room Physician whether incurred in a Contracted Hospital or a Non-contracted Hospital.

Notwithstanding anything herein to the contrary, such Deductible Amounts and such amount of out-of-pocket Allowable Expenses required herein for a group referenced in Article III, Sections 4, 5, 6 and 7 hereinabove that become eligible for benefits at the beginning of a month after January 1, shall be pro-rated in that first year of participation to reflect participation on a partial year basis.

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Section 5. Limitations

Notwithstanding anything herein to the contrary, effective January 1, 2022, a Covered Individual's claim for a No Surprises Service will be calculated subject to the Plan's applicable Cost Sharing.

A. Hospital room and board expenses will be paid at the average semi-private room rate; except room and board expenses in special-care units will be paid at the rate for such units.

B. If a Covered Individual is confined in a hospital designated as a "Contracted Hospital" by CIGNA, the Plan will pay 90% of such contracted hospital's Covered Charges. For services on and after January 1, 1997, if a Covered Individual utilizes the services of a hospital designated as a "Contracted Hospital" by CIGNA, the Plan will pay 100% for such contracted hospital's Covered Charges. If a Covered Individual utilizes the services of a hospital designated as a "Contracted Hospital" by MultiPlan, the Plan will pay 90% of such contracted hospital's Covered Charges. Periodically the Plan will make available lists of Hospitals which are Contracted Hospitals.

If a Covered Individual receives treatment or services from a CIGNA "Contracted Provider" of medical services, the Plan will pay 95% of the lesser of such Contracted Provider's Covered Charges or the Allowable Expense.

If a Covered Individual receives treatment or services from a MultiPlan "Contracted Provider" of medical services, the Plan will pay 90% of the lesser of such Contracted Provider's Covered Charges or the Allowable Expense.

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Section 5. Limitations (Continued)

B. (Continued)

If a Covered Individual utilizes the services of a "Contracted Hospital" or receives treatment or services from a "Contracted Provider" which is designated as such by both CIGNA and MultiPlan, the Plan will pay 100% of the CIGNA contracted hospital's Covered Charges and 95% of the lesser of CIGNA Contracted Providers Covered Charges or the Allowable Expense.

Notwithstanding anything herein to the contrary, effective April 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees:

- (1) if a Covered Individual is confined in a hospital designated as a "Contracted Hospital" by CIGNA or by MultiPlan, the Plan will pay 90% of such Contracted Hospital's Covered Charges after a Covered Individual has satisfied the Deductible Amount, as well as a \$150 per inpatient hospital admission deductible;
- (2) if a Covered Individual utilizes the services of a hospital designated as a "Contracted Hospital" by CIGNA or by MultiPlan, the Plan will pay 90% of such Contracted Provider's Covered Charges after a Covered Individual has satisfied the Deductible Amount; and
- (3) if a Covered Individual receives treatment or services at the offices of a CIGNA or MultiPlan "Contracted Provider", the Plan will pay the following percentage of such Contracted Provider's Covered Charges, provided that such Covered Individual has satisfied the Deductible Amount:

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Section 5. Limitations (Continued)

B. (Continued)

(3) (Continued)

- (i) With respect to the treatment or services of a Physician who is a “primary care physician”, 100% of such Covered Charges, provided that the Covered Individual pays a co-payment of \$15 per office visit;
 - (ii) With respect to the treatment or services of a Physician who is a “specialist”, 100% of such Covered Charges, provided that the Covered Individual pays a co-payment of \$25 per office visit; or
 - (iii) With respect to the treatment or services of a Physician who provides mental health or substance abuse services, 90% of such Covered Charges that are a Covered Individual’s out-of-pocket cost for office visits, up to a maximum of \$15 per office visit, and 100% of the Covered Charges thereafter.
- C.** If a Covered Individual is confined in a hospital that is state mandated as Diagnostic Related Group (DRG) Hospital, the Allowable Expense shall not exceed that DRG allowance.
- D.** Effective January 1, 1995, charges incurred for in-patient or out-patient care associated with mental and nervous conditions are limited to \$30,000 per Covered Individual during a two (2) consecutive calendar year period. All in-patient care must be received at a facility licensed by the State in which it is located and approved by the Plan’s review organization.

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Section 5. Limitations (Continued)

D. (Continued)

Effective January 1, 1998, charges incurred for in-patient or out-patient care associated with mental and nervous conditions are limited to 30 days in-patient care, or 50 days in-patient care in a facility designated as a “Contracted Hospital” and 200 visits of out-patient care during a two (2) consecutive calendar year period. All in-patient care must be received at a facility licensed by the State in which it is located and approved by the Plan’s Review Organization.

Effective January 1, 2016, notwithstanding anything herein to the contrary, the above maximum limits on the number of days of in-patient or out-patient care associated with mental and nervous conditions or with substance abuse services shall not apply. All in-patient care must be received at a facility licensed by the State in which it is located and approved by the Plan's review organization.

- E.** Effective January 1, 2011, charges incurred in connection with treatment of alcoholism or substance abuse shall be limited to a maximum annual benefit of \$750,000 per Covered Individual. Effective January 1, 2012, charges incurred in connection with treatment of alcoholism or substance abuse shall be limited to a maximum annual benefit of \$1,250,000 per Covered Individual. Effective January 1, 2013, charges incurred in connection with treatment of alcoholism or substance abuse shall be limited to a maximum annual benefit of \$2,000,000 per Covered Individual. Effective January 1, 2014, the above maximum annual benefit limits

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Section 5. Limitations (Continued)

E. (Continued)

shall not apply to any charges incurred in connection with treatment of alcoholism or substance abuse for a Covered Individual. 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 to do so, and which is approved by the Plan's Review Organization.

Charges incurred in connection with treatment of alcoholism on an out-patient basis shall be payable subject to the maximum annual benefit set forth above, if such treatment is approved by the Plan's Review Organization, 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, and
2. such treatment is required by the State Division of Motor Vehicles in connection with the resolution of a DUI or DWI charge.

F. Home nursing services are limited to thirty (30) calendar days following a Hospital confinement or, effective January 1, 2002, an out-patient procedure.

G. The maximum reimbursement or payment for Allowable Expenses shall not exceed \$1 million dollars per lifetime per Eligible Employee and each of their eligible Dependents. For Pensioners, retired Pilots, and each of their eligible Dependents,

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Section 5. Limitations (Continued)

G. (Continued)

this lifetime maximum is also \$1 million dollars with the exception that the maximum reimbursement in any single calendar year may not exceed \$250,000.

However, nothing in this paragraph is meant to extend reimbursement or payment to any Covered Individual in excess of \$1 million dollars over his or her lifetime.

Notwithstanding anything herein to the contrary, effective October 1, 2006, the lifetime maximum reimbursement or payment for Allowable Expenses for a member, Employee, retiree, surviving spouse of a retiree or each of their eligible Dependents, of a Branch of the Pilot Membership Group of the Organization participating in the Plan shall be \$1.5 million with the exception that the maximum reimbursement for retired Pilots and each of their eligible Dependents may not exceed \$250,000 in any calendar year.

Notwithstanding anything herein to the contrary, effective January 1, 2008, the lifetime maximum reimbursement or payment for Allowable Expenses for an Offshore Employee, a Pensioner who retired as an Offshore Employee, his surviving spouse or his eligible Dependents shall be \$1.5 million with the exception that the maximum reimbursement for a Pensioner, his surviving spouse and each of his eligible Dependents may not exceed \$250,000 in any calendar year.

Notwithstanding anything herein to the contrary, effective September 23, 2010, the lifetime maximums herein above are rescinded, but, effective January 1, 2011, the maximum reimbursement for Pensioners, retired Pilots and each of their eligible

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Section 5. Limitations (Continued)

G. (Continued)

Dependents may not exceed \$750,000 in any calendar year, which includes the treatment of alcoholism or substance abuse, unless the Plan receives a waiver from the Department of Health & Human Services ("HHS") in which case the maximum annual limit for such individuals shall remain at \$250,000 for each year for which a waiver is granted. Notwithstanding anything herein to the contrary, effective January 1, 2012, the maximum reimbursement for Pensioners, retired Pilots and each of their eligible Dependents may not exceed \$1,250,000 in any calendar year, which includes the treatment of alcoholism or substance abuse. Notwithstanding anything herein to the contrary, effective January 1, 2013, the maximum reimbursement for Pensioners, retired Pilots and each of their eligible Dependents may not exceed \$2,000,000 in any calendar year, which includes the treatment of alcoholism or substance abuse.

Notwithstanding anything herein to the contrary, effective January 1, 2014, the above maximum reimbursement or payments amounts will not apply to any Allowable Expenses on an annual or lifetime basis including for treatment of alcoholism or substance abuse.

- H.** Benefits relating to Physical Therapy/Physical Medicine/ Rehabilitation within six (6) months of either a hospital confinement or, effective January 1, 2001, an out-patient procedure for heart disease or stroke are limited to an aggregate of sixty (60) days of in-patient hospital and/or out-patient care per calendar year.

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Section 5. Limitations (Continued)

H. (Continued)

Effective for services on or after January 1, 1999, benefits relating to Physical Therapy/Physical Medicine/Rehabilitation in the aggregate are limited to ninety (90) days in a calendar year for in-patient hospital and out-patient care, or a combination of both, unless additional treatments are determined to be medically necessary by the treating Physician and approved by the Plan's medical consultant.

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

For the purposes of this section, the facility will be deemed appropriate if its treatment program has been approved by the State in which it is located or certified by any other state agency that has legal authority to do so.

- I.** Chiropractor's services shall be limited to a maximum of thirty (30) visits per calendar year. Effective January 1, 1994, the maximum amount to be reimbursed under this paragraph I shall be \$2,100 per Covered Individual per calendar year.

Effective June 1, 2014, acupuncture treatments shall be payable, as an alternative treatment option to chiropractor services, subject, on a combined basis, to the same number of maximum visits and the same maximum amount provided under this paragraph I.

- J.** Multiple surgical procedures shall be payable as follows:

- 80% of the Allowable Charge for the first or highest cost procedure.

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Section 5. Limitations (Continued)

J. (Continued)

- 50% of the Allowable Charge for the second highest cost procedure.
- 25% of the Allowable Charge for all other procedures.

The above is subject to the reimbursement provisions of paragraph B of this Section 5, in which case the above reimbursement levels shall be 95%, 50% and 25% of the Allowable Expense, respectively, for CIGNA Contracted Providers, and, effective November 1, 1996, 95% of the Allowable Expense for all such procedures if performed by CIGNA Contracted Providers.

Effective July 1, 1999, if services for Covered Charges are rendered by MultiPlan "Contracted Providers of Medical Services" the Plan will pay 90% of the Allowable Expense.

If the Contracted Provider is designated as such by both CIGNA and MultiPlan, the Plan will pay 95% of the CIGNA Allowable Expense.

Notwithstanding anything herein to the contrary, effective April 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, if the surgical procedures are not performed by a Contracted Provider, the first or highest cost procedure shall be payable at 70% of the Allowable Charge, and if such surgical procedures are performed by a Contracted Provider who is designated as such by both CIGNA and MultiPlan, the Plan will pay 90% of the CIGNA Covered Charges.

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Section 5. Limitations (Continued)

- K. Air ambulance services shall be payable but limited to \$6,000 per instance.
Effective January 1, 2017, air ambulance services shall be payable but limited to \$10,000 per instance.
Effective January 1, 2022, medically necessary use of Non-contracted air ambulance services are a No Surprises Service subject to the Plan's applicable Cost Sharing.
- L. Effective April 1, 2007, if a Physician, other than an acupuncturist, recommends that a Covered Individual receive acupuncture treatment to help relieve nausea and vomiting secondary to chemotherapy treatment for the Covered Individual who has not been able to find such relief using other agents, up to ten (10) such acupuncture treatments shall be payable if provided by a medical physician or acupuncturist who meets the requirements described in Article I, Section 16 hereinabove.
- M. If a Covered Individual is a Continuing Care Patient, and the contract with the Covered Individual's treating Contracted provider or Contracted Health Care Facility terminates, the Plan will do the following:
- (1) Notify the Covered Individual in a timely manner of the termination of his or her provider's or facility's contract and inform the Covered Individual of their right to elect continued transitional care from that provider or facility; and
 - (2) If the Covered Individual elects, allow ninety (90) days of continued coverage at the Plan's Contracted rate as if that provider or facility continued to be Contracted, to allow for a transition of care to a Contracted provider.

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Section 6. Exclusions

Except to the extent otherwise required by applicable law, no Comprehensive Major Medical benefits shall be payable with respect to expenses (any and all of which shall not be considered as Allowable Expenses) incurred:

- A. for services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified by a Physician as necessary for the therapeutic treatment of the Covered Individual's disablement;
- B. for all days of hospital confinement that are not approved by the Plan's Review Organization, except in cases of hospital confinements due to the birth of a child which will allow coverage for a minimum confinement of forty-eight (48) hours for a natural birth or ninety-six (96) hours for a Caesarean birth;
- C. in connection with dental care, treatment or surgery unless necessitated by non-occupational accidental bodily injury to sound natural teeth;
- D. for eye examinations, eye glasses, hearing aids, or for the fitting thereof;
- E. in connection with cosmetic surgery and/or treatment unless caused by non-occupational accidental bodily injury;
- F. for confinement in nursing homes, institutions, hospitals or other qualified health care facilities after the Covered Individual has been cured or where the illness has been determined to be permanent and not responsive to further treatment;
- G. for treatment for service related illness or injury in a United States Government hospital, or elsewhere at federal government expense;

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Section 6. Exclusions (Continued)

- H. in the case of a Dependent, benefits shall not be payable for expenses for injury or illness during or arising out of a period of employment for which Worker's Compensation benefits are payable;
- I. in the case of an Eligible Employee, other than a Pilot, benefits shall not be payable for expenses assumed or paid by an Employer. Injuries incurred in the service of the vessel are the responsibility of the Employer. Medical expenses incurred overseas and transportation back to the U. S. shall be the responsibility of the Employer. Coverage will no longer be provided for ship related injuries incurred in the service of the vessel;
- J. for investigational or experimental surgery or procedures as determined by Medicare;
- K. for a Physician's visit to the hospital on the same day that surgery is performed by that physician;
- L. for custodial care;
- M. for nursery, medical and related expenses of a newborn child of an Eligible Employee's Dependent Child;
- N. as a result of any injury or disease resulting from war or any act of war; whether declared or undeclared;
- O. for preventive care and physical exercise programs, except as otherwise allowed under Part C of this Article, regardless of the fact that they may be supervised by a physician;

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Section 6. Exclusions (Continued)

- P. for expenses for acupuncture and/or acupressure; provided, however, that effective April 1, 2007, expenses for acupuncture treatments that meet the requirements of Article IV, Section 5. L and that are performed by a medical physician or acupuncturist who meets the requirements described in Article I, Section 16 hereinabove are not excluded;
- Q. for expenses related to the treatment of infertility, smoking cessation and/or weight control;
- R. for naturopathic or homeopathic treatment or procedures and/or any other treatment for a condition other than an illness or accident;
- S. for expenses resulting from or occurring (1) during the commission of a crime (whether or not convicted); or (2) during engagement in an illegal act, illegal occupation or felonious act, aggravated assault, or intentional tort; provided, however, that this exclusion does not preclude the payment of charges incurred in connection with the treatment of alcoholism or substance abuse in accordance with Section 5 (E) hereinabove;
- T. for corrective vision eye surgery, which includes, but is not limited to, laser and LASIK eye surgery.
- U. For any and all telephone calls or video conferences between a Physician and any patient for any purpose whatsoever, including, without limitation: communication with any representative of the Plan for any purpose related to the care or treatment of

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Section 6. Exclusions (Continued)

U. (Continued)

a Covered Individual, consultation with any Physician regarding medical management or care of a patient; coordinating medical management of a new or established patient; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; or providing counseling to anxious or distraught patients or family members.

V. charges related to Gene Therapy, including but not limited to Zolgensma. For purposes of this exclusion, Gene Therapy shall mean therapy that involves introducing or inserting human DNA into an individual to replace or compensate for an abnormal or disease-causing mutated gene with a functioning gene that does not contain the abnormality or mutation for purposes of treating or curing a genetic disease. The Plan does not cover any type of Gene Therapy, even if such therapies have received approval from the Food and Drug Administration.

**Section 7. Pre-Admission Certification for Non-emergency
Hospital Admissions**

If a Physician recommends that a Covered Individual be admitted into a hospital as an in-patient for non-emergency medical treatment, pre-admission approval must be obtained. Pre-admission approval must be initiated either by the Covered Individual or the attending Physician telephoning the Plan's Review Organization or submitting the appropriate form. If a Covered Individual does not follow this procedure, any benefits otherwise payable under this Part shall be subject to the non-compliance penalty provisions of Section 11 of this Part.

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**Section 7. Pre-Admission Certification for Non-emergency
Hospital Admissions (Continued)**

This provision will not apply to Medicare eligible Pensioners, Medicare eligible Dependents or in other cases where this Plan provides only secondary coverage to another group health plan.

**Section 8. Concurrent Review for Emergency and Non-emergency
Hospital Confinements**

Once a Covered Individual is confined in a Hospital, regardless of whether it is an emergency or non-emergency confinement, the Plan's Review Organization must be advised by the Covered Individual, his family, the physician or the Hospital. Only those days determined by the Plan's Review Organization to be medically necessary will be considered Allowable Expenses.

If the Covered Individual does not follow this procedure, any benefits otherwise payable under this Part shall be subject to the non-compliance penalty provisions of Section 11 of this Part, except in the case of No Surprises Services.

This provision will not apply to Medicare eligible Pensioners, Medicare eligible Dependents, or in other cases where this Plan provides only secondary coverage to another group health plan.

Section 9. Second Surgical Opinion Program

Effective August 1, 1991, a Covered Individual shall be eligible to receive a second opinion at the Plan's expense for any elective surgical procedure.

The second opinion must be obtained within the six (6) month period immediately preceding the performance of the recommended surgical procedure, and must be performed by a Physician no later than 6 months following the initial recommendation of such surgery.

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Section 9. Second Surgical Opinion Program (Continued)

One hundred percent (100%) of the cost of the second opinion and ancillary tests will be covered by the Plan. A Covered Individual may proceed with the surgery regardless of the outcome of the second opinion; however, if the surgeon who rendered the second opinion performs the surgery, his charges will not be considered an Allowable Expense.

A third opinion may also be obtained at the Covered Individual's option, and will be paid in full by the Plan.

This provision will not apply to Medicare eligible Pensioners, Medicare eligible Dependents or in other cases where this Plan provides only secondary coverage to another group health plan.

Section 10. Hospital Audit Reward Program

Covered Individuals who discover and correct in-patient hospital billing errors will receive a reward equal to 50% of the documented error, up to a maximum reward of \$1,000.

Section 11. Non-Compliance Penalties

Covered Individuals not complying with the procedures described in Sections 7 and 8 of this Part will have non-compliance penalties applied to any benefits otherwise payable under this Part in connection with such non-compliant claim. Non-compliance penalties are not applicable toward satisfaction of the Deductible Amount as described in Section 3 of this Part.

The non-compliance penalty will be \$250 reduction in otherwise payable benefits for the first such occurrence by any Covered Individual or any member of the Covered Individual's immediate family. For second and subsequent occurrences of non-compliance by the Covered Individual or any member of the Covered Individual's immediate family, the non-compliance penalty will be a 50% reduction in any benefits otherwise payable under this Part. The 50% non-compliance penalty

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Section 11. Non-Compliance Penalties (Continued)

will be applied if the Eligible Employee, Pensioner or one of his or her Dependents had previously incurred a claim without complying with the procedures described in Sections 7 or 8 of this Part, regardless of whether the \$250 penalty was applied.

Notwithstanding the above, the Trustees may waive a non-compliance penalty if the Trustees determine, in their sole and absolute discretion, that a Covered Individual's failure to comply with the provisions of Sections 7 or 8 of this Part was due to extenuating circumstances.

Section 12. Out-Patient Surgical Benefit

If one of the following surgical procedures is performed on an out-patient basis (without overnight hospital stay) the Allowable Expense in connection with the hospital expense and such surgical procedure will be reimbursed at 90% subject to application of any necessary Deductible Amount, provided, however, that if the services are rendered at a "Contracted Hospital" and the surgery performed by a "Contracted Provider", charges will be reimbursed in accordance with Section 5 B.

- A. Adult Inguinal Hernia Repair
- B. Vein Ligation and Stripping
- C. Tonsillectomy/Adenoidectomy
- D. Bunionectomy
- E. Submucous Resection
- F. Hemorrhoidectomy

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Section 12. Out-Patient Surgical Benefit (Continued)

Notwithstanding anything herein to the contrary, effective April 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, such surgical procedures will be reimbursed at 70% of the Allowable Expense; provided, however, that if the services are rendered at a “Contracted Hospital” and the surgery performed by a “Contracted Provider,” charges will be reimbursed in accordance with Section 5B. Notwithstanding anything herein to the contrary, any out-patient surgical procedure that has a procedure code of “experimental/investigational” or “gastric bypass” must be approved by the Plan’s Review Organization.

Notwithstanding the foregoing, any non-Emergency Services by a Non-contracted provider at a Contracted Health Care Facility with respect to which such provider does not comply with federal Notice and Consent requirements, is a No Surprises Service subject to applicable Cost Sharing.

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PART B - PRESCRIPTION DRUG BENEFIT

Section 1. Prescription Drugs Defined

Prescription Drugs shall mean any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendment thereto, only upon a written or oral prescription of a Physician licensed by law to administer it. Covered drugs shall also include insulin and diabetic supplies including syringes, needles and test material.

Section 2. Reimbursement Program

The Plan will pay 80% of the Allowable Charges incurred by a Covered Individual in connection with the purchase of Prescription Drugs. No Deductible Amount will apply. Actual reimbursement will not be payable until there is an accumulation of a least \$50 out-of-pocket prescription drug expenses.

Section 3. Retail Program for Short Term Medication

Effective October 1, 1999, the following will apply:

- A. Covered Individuals may obtain one prescription and up to a maximum of 2 refills at participating pharmacies by payment of 20% of the network pharmacy discounted price. Subsequent refills may be obtained through the Mail Order Program described under Section 4 of this Part B of Article IV. Notwithstanding anything herein to the contrary, effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, Covered Individuals may obtain prescriptions at participating pharmacies by payment of 20% of the network pharmacy discounted price.

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Section 3. Retail Program for Short Term Medication (Continued)

A. (Continued)

Notwithstanding anything herein to the contrary, effective January 1, 2006, Covered Individuals will be required to pay a minimum co-payment of \$15.00 for brand name drugs and \$7.50 for a generic equivalent, provided further, however, that if there is a therapeutic generic equivalent of the brand name Prescribed Drug and the Covered Individual directs the brand name version be dispensed, the Covered Individual shall be responsible for a co-payment equal to the difference in costs between such brand name and the therapeutic generic equivalent in addition to the above minimum dollar co-payments.

B. For Covered Individuals residing in the United States who purchase prescription drugs from non-participating pharmacies, the maximum reimbursement will be 80% of the network pharmacy discounted price (Allowable Charge). Charges in excess of that price are not payable by the Plan.

C. Out of network claims will be processed and paid by the Contracted Provider after appropriate claim forms and receipts are submitted by the Covered Individual. A minimum accumulation of \$50 (in out-of-network prescription drugs) per Covered Individual is required before reimbursement can be made.

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Section 4. Mail Order Drug Program

Chronic or maintenance type Prescription Drugs prescribed by a Physician must be ordered through the Mail Order Drug Program. A Covered Individual can order up to a maximum 90 days supply of the Prescribed Drug. Effective September 1, 1988 all Prescribed Drugs dispensed through the Mail Order Drug Program shall be dispensed generically unless the prescribing Physician or Covered Individual directs a brand name drug be dispensed or there is no therapeutic generic equivalent of the Prescribed Drug. If there is a therapeutic generic equivalent of the brand name Prescribed Drug and the prescribing Physician or Covered Individual directs the brand name version be dispensed, the Covered Individual shall be responsible for a co-payment equal to the difference in costs between such brand name and the therapeutic generic equivalent. Otherwise, there is no Deductible Amount or co-payment for Prescription Drugs obtained through the Mail Order Drug Program.

Notwithstanding anything herein to the contrary, effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, the Plan will pay 80% of the expense for Prescription Drugs ordered through the Mail Order Program and the Covered Individual shall be responsible for 20% of the expense as a co-payment but limited to a maximum co-payment of \$75 per prescription, provided, however, that if there is a therapeutic generic equivalent of the brand name Prescribed Drug and the prescribing Physician or Covered Individual directs the brand name version be dispensed, the Plan will pay 80% of the cost of the therapeutic generic equivalent and the Covered Individual shall be responsible as a co-payment for 20% of that cost plus the difference in cost between such brand name and the therapeutic generic equivalent.

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Section 5. Exclusions

No Prescription Drug Benefits shall be payable for:

- A. pharmaceuticals requiring a prescription that have not been approved by the U. S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed; or are experimental and/or investigational;
- B. non-prescription (over-the-counter) drugs or medicines or drugs dispensed without prescription drug order;
- C. drugs furnished without charge;
- D. foods and diet and nutritional supplement including, but not limited to, home meals, formulas, foods, diets, vitamins (excluding pre-natal vitamins), minerals, amino acid supplements, except when provided during hospitalization;
- E. naturopathic or homeopathic services, substances and supplies;
- F. drugs, medicines or devices, even though such devices may require a prescription, for cosmetic purposes, hair growth, infertility, smoking cessation and/or weight control and, for Dependent Children, drugs, medicines or devices for contraception; provided, however, effective June 1, 2015, drugs, medicines or devices for contraception shall be payable for female Dependent Children of Eligible Employees of a Pilot Membership Group; provided, however, effective February 1, 2016, drugs, medicines or devices for contraception shall be payable for female Dependent Children of Eligible Employees;

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Section 5. Exclusions (Continued)

- G. compounded prescriptions that are not comprised entirely of FDA approved drugs that require a prescription as defined by Federal or State law are not covered by the Plan. Any compounded prescriptions that are covered by the Plan and cost more than \$300 require prior authorization or they will not be covered;
- H. any prescription drug or medicine for which there is a generic equivalent available in non-prescription form;
- I. take home drugs or medicines provided by a hospital, emergency, ambulatory center or other health care facility free of charge;
- J. drugs for which the Covered Individual would have no obligation to pay in the absence of this or similar coverage;
- K. drugs or supplies that are required because of an injury or sickness resulting from an act of war or a warlike action during peacetime;
- L. drugs or supplies for which the Covered Individual is entitled to reimbursement under Worker's Compensation laws or any municipal, state or federal program.
- M. any prescription or medication that constitutes Gene Therapy, as defined under Article IV, Part A, Section 6.V.

Section 6. Coronavirus Vaccine Coverage

Effective January 18, 2021, the Plan will cover the costs of an immunization intended to prevent or mitigate the coronavirus (COVID-19) disease ("Coronavirus Vaccine") and the cost of its administration, provided the immunization has received either (i) a recommendation from the U.S. Preventive Services Task Force or (ii) a recommendation from the Advisory Committee on

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Section 6. **Coronavirus Vaccine Coverage (Continued)**

Immunization Practice, which has been approved by the CDC. The costs of a Coronavirus Vaccine and its administration will be covered at 100% of the Allowable Charge and shall not be subject to the Deductible Amount, Co-payment provisions of this Part, or the above minimum out-of-pocket accumulation per Covered Individual requirement. The Plan will determine the Allowable Charge for a nonparticipating pharmacy for the Coronavirus Vaccine and its administration based on the amount the Plan determines is reasonable. In no event will the Allowable Charge exceed the amount that would be paid under Medicare for the Coronavirus Vaccine and its administration. This provision will remain in effect for as long as the ingredient costs of the Coronavirus Vaccine continue to be fully subsidized by the Federal Government.

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PART C - COMPREHENSIVE ANNUAL PHYSICAL EXAMINATION IMMUNIZATION,
and MSC PRE-EMPLOYMENT PHYSICAL EXAMINATION

Effective for charges incurred on and after July 1, 2000, Covered Individuals who receive an Annual Physical Examination shall be eligible to receive a reimbursement of up to \$1,000 per family per year. Effective for charges incurred on and after January 1, 2007, Covered Individuals who receive an Annual Physical Examination shall be eligible to receive a reimbursement of up to \$1,250 per family per year. Such reimbursement shall not be subject to the Deductible Amount or Co-payment provisions of Part A of this Article. An Annual Physical Examination is defined as a comprehensive examination by a Physician for a Covered Individual for whom no specific diagnosis or symptoms precipitated the examination and includes all diagnostic, x-ray and laboratory services ordered by a Physician related to this Annual Physical Examination, and all immunizations recommended or ordered by the Physician, but excludes other expenses or x-rays, examinations and laboratory work related to an illness or injury. Effective January 1, 2011, each Covered Individual may receive an Annual Physical Examination. Reimbursement for Annual Physical Examinations shall be payable on a family basis as follows: (1) the first \$1,250 per family per year shall not be subject to the Deductible Amount or Co-payment provisions of Part A of this Article, and (2) any charges above that amount shall be limited to the Allowable Charge and be subject to the Deductible Amount and Co-payment provisions of Part A of this Article; provided, however, the reimbursement for “well baby, well child visits” for a Child under the age of 19, including immunizations administered to such Child, shall not be subject to the Deductible Amount or Co-payment provisions of Part A of this Article; provided further, however, effective January 1, 2012, the following medical procedures shall be payable at 100% of the Allowable Charge and shall not be subject to the Deductible Amount, Co-payment provisions of Part A of this Article or

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the above limit of \$1,250 per family per year: (1) colorectal cancer screening using sigmoidoscopy or colonoscopy starting at age 50 until age 75 once every five years, and (2) a mammogram for women over age 40 every year and cervical cancer screening every three years.

Effective July 1, 2000, a Covered Individual, who is a Military Sealift Command (MSC) job applicant, shall be eligible to receive reimbursement for a pre-employment physical examination required by the Military Sealift Command but not more than once per calendar year. An Employer shall also be eligible to receive reimbursement for such a pre-employment physical examination of an Employee, who is a Military Sealift Command job applicant, if and when such Employee meets the conditions of eligibility set forth in Article III, Section 1 herein. Such reimbursement shall not be subject to the Deductible Amount or Co-payment provisions of Part A of this Article.

Effective January 18, 2021, the Plan will cover the costs of an immunization intended to prevent or mitigate the coronavirus (COVID-19) disease ("Coronavirus Vaccine") and the cost of its administration, provided the immunization has received either (i) a recommendation from the U.S. Preventive Services Task Force or (ii) a recommendation from the Advisory Committee on Immunization Practice, which has been approved by the CDC. Notwithstanding the above, such Coronavirus Vaccine and its administration will be covered regardless of whether a Covered Individual received the immunization in connection with an Annual Physical Examination or whether a Covered Individual received the immunization upon a recommendation or order from a Physician. The costs of a Coronavirus Vaccine and its administration will be covered at 100% of the Allowable Charge and shall not be subject to the Deductible Amount, Co-payment provisions of Part A of this Article, or the above limit of \$1,250 per family per year. The Plan will determine the

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Allowable Charge for an out-of-network provider for the Coronavirus Vaccine and its administration based on the amount the Plan determines is reasonable. In no event will the Allowable Charge exceed the amount that would be paid under Medicare for the Coronavirus Vaccine and its administration. This provision will remain in effect for as long as the ingredient costs of the Coronavirus Vaccine continue to be fully subsidized by the Federal Government.

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Section 1. **Death Benefit (Non-Accidental) for all Eligible**
Employees Except Pilots

Subject to the terms and conditions of an insurance policy purchased by the Plan applicable to this coverage, upon receipt of the due proof at the Plan Office of the death of an Eligible Employee, other than a Pilot, by other than a risk or peril which is excluded hereunder, the Beneficiary shall be paid whichever of the following death benefits is appropriate:

Class	Coverage Amount
Eligible Employees with 400 days of Covered Employment, Vacation or Disability within the 36 months prior to death and are not eligible for a benefit from the M.M.& P. Pension Plan and/or M.M.& P. Adjustable Pension Plan.	\$20,000
Eligible Employees who do not have 400 days of Covered Employment, Vacation or Disability within the 36 months prior to death and are not eligible for a benefit from the M.M.& P. Pension Plan and/or M.M.& P. Adjustable Pension Plan.	\$ 7,500
Eligible Employees who are eligible for but not receiving a benefit from either of the above-referenced pension plans.	\$10,000

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Section 2. Accidental Death and Dismemberment Benefits

A. Accidental Death Benefits

Upon receipt of the due proof at the Plan Office of the death of an Eligible Employee by accidental means, other than a risk or peril excluded hereunder, subject to the terms and conditions of an insurance policy purchased by the Plan applicable to this coverage, the Beneficiary shall be paid whichever of the following accidental death benefits is appropriate, in addition to the death benefits under Section 1 hereinabove:

Division 1 – Masters/Mates	
Class	Coverage Amount
Eligible Employees with 400 days of Covered Employment, Vacation or Disability within the 36 months prior to death and are not eligible for a benefit from the M.M.& P. Pension Plan and/or M.M.& P. Adjustable Pension Plan.	\$20,000
Eligible Employees who do not have 400 days of Covered Employment, Vacation or Disability within the 36 months prior to death and are not eligible for a benefit from the M.M.& P. Pension Plan and/or M.M.& P. Adjustable Pension Plan.	\$ 7,500
Eligible Employees who are eligible for but not receiving a benefit from either or both of the above-referenced pension plans.	\$10,000
Division 2 - Pilots	
Class	Coverage Amount
Active Pilots	\$25,000

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Section 3. Exclusion of Liability

No death benefit shall be payable under this Article IV Part D in the event of death resulting from a risk or peril for which benefits are payable under a policy provided for seamen by the United States Government or by a policy carried, or an insurance program maintained by an Employer in compliance with a Collective Bargaining Agreement with the Organization; provided such benefits under Article IV Part D are payable by reason of shipping operations in an area of war, or under wartime conditions, or as a result of an act of war. This provisions shall be deemed to include a policy or program providing benefits substantially the same as those commonly known as War Risk Policy Insurance Coverage.

Section 4. Continuation of Death Benefit Coverage in the
Event of Permanent and Total Disability for
all Eligible Employees Except Pilots

- A. An Eligible Employee who becomes totally and permanently disabled shall continue to retain eligibility with respect to the \$7,500 Death Benefit provided in Section 1 above until he becomes a Pensioner under the M.M.& P. Pension Plan, even though his eligibility for any other benefits hereunder is terminated under other provisions of these Rules and Regulations, provided:
1. He becomes "Totally and Permanently Disabled" before attaining age 60.
For purposes of this Section A, Total and Permanent Disability shall mean a disabling condition as a result of bodily injury or disease, which prevents

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Section 4. Continuation of Death Benefit Coverage in the
Event of Permanent and Total Disability for
all Eligible Employees Except Pilots (Continued)

A. (Continued)

1. (Continued)

him from engaging in any business or occupation and from performing any work for compensation or profit, provided the bodily injury or disease did not result from a risk or peril for which benefits are payable under War Risk Insurance Coverage;

2. Such Total and Permanent Disability is continuous until his death;

3. He furnishes the Plan Office, after nine months following the date he becomes Totally and Permanently Disabled, but within twelve months following the date of termination of his eligibility, written proof satisfactory to the Trustees that he is Permanently and Totally Disabled and has been so continuously since the date he incurred such Disability. At the time he furnishes such proof of Disability, the Trustees shall certify acknowledgement of receipt of said proof and the date upon which it was received, such date to be referred to as the Original Date of Certification;

4. He furnishes the Plan Office written proof of continued Permanent and Total Disability within the three months immediately prior to each anniversary of the Original Date of Certification during his life. The Trustees will certify to

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Section 4. Continuation of Death Benefit Coverage in the
Event of Permanent and Total Disability for
all Eligible Employees Except Pilots (Continued)

A. (Continued)

4. (Continued)

him each year when such proof of continued Total and Permanent Disability is furnished;

5. Written notice of the Eligible Employee's death is furnished to the Plan Office within one year of the death of such person. In the event his death is within one year from the date of termination of his eligibility, and before any such proof of Total and Permanent Disability has been submitted, written proof that he was continuously Disabled from the date to the date of death shall be furnished to the Plan Office within one year after his death.

- B.** The Trustees shall have the right to have any such person who submits proof of Disability, in accordance with this Section, examined at any time by Physicians designated by them; provided that, after such Disability shall have continued for two full years, such examination shall not be required more often than once in each subsequent year.

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**Section 4. Continuation of Death Benefit Coverage in the
Event of Permanent and Total Disability for
all Eligible Employees Except Pilots (Continued)**

- C. All rights of such person under this Section 4 shall cease on the earliest of the following dates:
1. The date of cessation of such person's Total and Permanent Disability;
 2. The date he engages in any business or occupation or performs any work for compensation or profits;
 3. The last day of any twelve-month period of continued coverage under this Section 4, if the proof of Disability required by Sub-paragraph (A)(4) above is not furnished within the three-month period specified therein;
 4. The date on which such person refuses to submit to examination, by Physicians designated by the Trustees, upon their request;
 5. Termination of the Plan or termination of the benefit through collective bargaining.
- D. No judicial proceedings shall be brought to enforce the rights of any person to coverage under this Section 4 unless brought within two years after the Trustees refuse in writing to determine or to certify that such person is entitled to rights on account of permanent or total disability.

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Section 5. Transportation Expenses

In the event an Eligible Offshore Employee dies while outside the continental United States, the Trustees, in their discretion, may authorize reimbursement in an amount not exceeding \$1,000 for transportation and other incidental expenses necessarily incurred by the Beneficiary or other member of the family in returning the body of the decedent to the United States.

Section 6. Beneficiaries

Each Employee shall have the right to designate a Beneficiary or Beneficiaries to receive benefits hereunder payable by reason of his death and any benefits payable to such Employee accrued prior to his death, but such designation shall not be valid unless it is in writing, on forms supplied for that purpose by the Trustees or satisfactory to the Trustees, and is on file at the Plan Office. The Beneficiary or Beneficiaries so designated shall be known as the Beneficiary or Beneficiaries of record and shall remain in effect unless and until such designation is effectively revoked or changed.

- A. In the event of an effective revocation which is not accompanied or followed by a new valid designation of Beneficiary, such benefits shall be payable, as set forth below, as though no Beneficiary had been designated.
- B. In the event of a valid change of Beneficiary or Beneficiaries of record, the new Beneficiary or Beneficiaries shall be considered the Beneficiary or Beneficiaries of record as though initially designated, and such designation shall continue until validly revoked or changed.

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Section 6. Beneficiaries (Continued)

- C. Such written notice of revocation or change or by designation of a new Beneficiary shall not be deemed valid or operative unless it is received at the Plan Office prior to the earliest date that any payment is made by the Trustees of all or any portion of the benefits payable with respect to said Employee. Upon the receipt of such valid and operative written notice at the Plan Office, the revocation or change shall relate back to take effect as of the date the Employee signed said written notice of revocation or change, whether or not the Employee be living at the time of receipt of said notice.
- D. If more than one Beneficiary is validly designated and in such designation the Employee has failed to specify their respective interests, the Beneficiaries shall share equally. In the event that any Beneficiary of record does not survive the Employee, the interest of such Beneficiary shall terminate and his share shall be payable equally to such of the Beneficiaries as survive the Employee unless the Employee has made written request to the contrary.
- E. The amount of any benefit for which there is no Beneficiary at the death of the Employee because no Beneficiary of record survives or no Beneficiary shall have been designated, shall be paid to the executors or administrators of the deceased, except that the Trustees may, in their sole discretion, pay the entire amount of such benefits to the spouse if then living or, if there is no spouse then alive, to any other person who is an object of the natural bounty of the Employee.

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Section 6. Beneficiaries (Continued)

- F. If any Beneficiary of record is a minor or is otherwise incapable of giving a valid release for any payment due, the Trustees may, at their discretion, and until claim is made by the duly-appointed guardian or custodian of such Beneficiary, make payment of the amount of the benefit to such Beneficiary, at a rate not exceeding \$200.00 per month, to any relative by blood or connection by marriage of such Beneficiary, or to any other person or institution appearing to them to have assumed custody and principal support of such Beneficiary. Such payment shall constitute a full discharge of obligations of the Trustees to the extent thereof.
- G. A Beneficiary hereunder shall not include any of the Trustees of the Plan or any employee thereof, or the Organization or any of its subordinate bodies or any Officer or Employee thereof, or any Employer.

Section 7. Facility of Payment

The Trustees may, in their sole discretion, deduct from the sum payable at the time of death of an Eligible Employee, an amount not exceeding the amount of the Death Benefit payable to be paid to any person or persons, other than the Trustees of the M.M. & P. Plans, appearing to the Trustees to be equitably entitled to the payment by reason of having incurred expenses on behalf of the Employee for his burial. The liability of the Trustees shall thereby be completely discharged to the extent of the amount so paid.

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Section 8. Burial Benefit Fund (Former Local 90)

Ancillary to the benefits provided herein, the Trustees shall have the authority to administer the Burial Benefit Fund and Program previously established by former Local 90 of the Organization, and in connection therewith, shall have the authority to receive and accept the funds and other assets of such Burial Benefit Fund and to expend the same for the purposes and in the manner as previously set forth in the 1970 By-Laws of former Local 90. The funds and assets received hereunder shall be kept in a segregated account out of which the benefits provided and the expenses of administration of the Program shall be charged. Such program shall be maintained only so long as assets remain available therefore in such segregated fund and the benefits shall be available only with respect to those former members of former Local 90, who, at the time Local 90 ceased to exist, qualified for such benefits under the terms of its By-Laws.

Section 9. Voluntary Program for Death Benefits and
Accidental Death and Dismemberment Benefits

- A. Employees who are members of the Organization can purchase Voluntary Death Benefits and Accidental Death and Dismemberment Benefits. These voluntary benefits are paid for by those Employees electing this coverage at premium rates adopted by the Trustees as determined by the Plan Actuary to be self-sustaining.

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Section 9. Voluntary Program for Death Benefits and
Accidental Death and Dismemberment Benefits (Continued)

- B. **Eligibility.** This coverage is available to all Employees who are members of the Organization only during Enrollment Periods to be established by the Trustees. Dependents may also be covered. In addition, the Enrollment Period for applicants for Organization membership will be the six-month period immediately following the applicant's application to the Organization for membership and, if coverage is not elected during this period, a second Enrollment Period will apply during the six-month period immediately following the Organization's acceptance of such applicant for membership. This coverage extends to the January 1st next following the date of retirement.
- C. **Effective Date of Coverage.** Coverage will take effect on the first day of the month immediately following the month in which the Plan Office receives and accepts the Organization applicant's or Employee's application and premium payment. Effective with the June 16, 1994 renewal, coverage will continue only through December 31, 1994 and will renew thereafter each January 1 with coverage continuing through December 31 of the same year.
- D. **Types of Coverage.** The coverage will be available in two plans, Individual Plan and Family Plan, as follows:

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Section 9. Voluntary Program for Death Benefits and
Accidental Death and Dismemberment Benefits (Continued)

D. Types of Coverage. (Continued)

1. **Individual Plan.** This Plan will cover the Employee for Death and/or Accidental Death and Dismemberment Benefits in the Principal Sum amounts of \$25,000 or \$50,000 each.
2. **Family Plan.** The Family Plan will cover the Employee for Accidental Death and Dismemberment Benefits (does not cover non-accidental death) in the Principal Sum amounts of \$25,000 or \$50,000 plus Accidental Death and Dismemberment coverage for Employee's Dependents as follows:
 - a. If the Employee has no Dependent Children, his or her spouse will be covered for 50% of the Principal Sum;
 - b. If the Employee has no spouse, each Dependent child will be covered for 10% of the Principal Sum;
 - c. If the Employee has a spouse and one or more Dependent children, his or her spouse will be covered for 40% of the Principal Sum and each Dependent child will be covered for 5% of the Principal Sum;
 - d. An Employee who elects the Family Plan will be entitled to purchase only Death Benefit coverage under the Individual Plan so there is no duplication of Accidental Death and Dismemberment Benefits under both plans.

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Section 9. **Voluntary Program for Death Benefits and**
Accidental Death and Dismemberment Benefits (Continued)

E. **Benefit Payment.** The Death Benefit Principal Sum will be payable to the Employee's designated Beneficiary in the event of death during the coverage period from any cause except those excluded by the Trustees in their discretion.

In the event of death or injury as the result of an accident, Accidental Death and Dismemberment Benefits will be payable to the covered individual's designated Beneficiary, subject to Sub-Section (G). The Principal Sum Amount will be payable for accidental loss of:

- | | |
|-------------------------|---------------------------------|
| ➤ Life | ➤ Sight of both eyes |
| ➤ Both hands | ➤ One foot and sight of one eye |
| ➤ Both feet | ➤ One hand and sight of one eye |
| ➤ One hand and one foot | |

One-half of the Principal Sum amount will be payable for accidental loss of:

- Sight of one eye
- One foot
- One hand

The loss must occur within 365 days of the accident causing the injury. The loss of a hand or foot means complete severance through or above the wrist or ankle joint.

Loss of an eye refers to the irrevocable loss of sight.

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Section 9. Voluntary Program for Death Benefits and
Accidental Death and Dismemberment Benefits (Continued)

- F. Exclusions.** The Trustees may from time to time in their discretion establish exclusions from the payment of such benefits hereunder. Such applicable exclusions will be communicated to eligible Employees at the time coverage is elected or renewed.
- G. Beneficiary Designation.** Beneficiary designation for benefits payable as a result of injury or death of a covered Employee will be in accordance with Section 6 of this Part D, except that a covered Employee may designate a Beneficiary for receipt of benefits under this Section other than the Beneficiary designated for those benefits payable pursuant to Sections 1 and 2 of this Part. The covered Employee is automatically and irrevocably the designated Beneficiary for any benefits payable as a result of injury or death of a Dependent under the Family Plan coverage.
- H. Evidence of Insurability.**
- Subsequent to the initial Enrollment Period, the Trustees will require new applicants for this coverage, as a pre-requisite for coverage, to submit satisfactory evidence of insurability. Such evidence of insurability shall be in the form of a health background questionnaire. The Trustees reserve the right to refuse coverage under this program to applicants who, in the Trustees sole discretion, are not insurable under this program. The Trustees also reserve the right to deny benefit payment upon the death of a Covered Individual if it is determined that such death was due to

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Section 9. Voluntary Program for Death Benefits and
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H. Evidence of Insurability (Continued)

a medical condition that was fraudulently omitted or concealed in the evidence of insurability health questionnaire completed by the Covered Individual.

Section 10. Optional Program for Accidental Death and
Dismemberment Benefits for Pilots

In addition to the Voluntary Death Benefit and Accidental Death and Dismemberment Benefit Programs described in Section 9 of this Part, Pilots can select a benefit from one of the following choices pursuant to the same terms and conditions as contained in Section 9 above:

- A. \$25,000 for the Pilot only
- B. \$50,000 for the Pilot only
- C. \$25,000 Family Plan
- D. \$50,000 Family Plan

Participation is optional and requires the payment of premium by the Pilot.

Section 11. Voluntary Long Term Care Insurance Program

The Trustees have contracted with Aetna Life Insurance Company ("Aetna") and, effective September 1, 2009, with The Prudential Life Insurance Company of America ("Prudential") to provide Participants and their Eligible Dependents with an opportunity to purchase long term care insurance on a voluntary basis.

The terms and conditions of eligibility and the benefit levels are described in the Certificate of Coverage or Group Insurance Certificate provided by Aetna or by Prudential directly to the Participants and Eligible Dependents subscribing to this coverage.

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Section 12. Voluntary Disability Insurance Program

The Trustees have contracted with an insurance broker to provide Eligible Employees with an opportunity to purchase through Lloyd's of London disability insurance on a voluntary basis.

The terms and conditions of eligibility and the benefit levels are described in the certificate of coverage or group insurance certificate provided by the insurer directly to the Eligible Employees subscribing to this coverage.

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PART E – DISABILITY BENEFITS

Section 1. Benefit Amount

When disability, physical or mental, shall make an Eligible Offshore Employee unable to perform his duties, and requires the care and attendance of a Physician, he shall receive a Disability Benefit of \$50.00 a week up to a maximum of 13 weeks for the period during which he is so unfit for duty.

Section 2. Eligibility Requirements

- A. The Eligible Offshore Employee has been so unfit for duty for a waiting period of seven consecutive days during each Disability Period, as established by the Trustees, during which waiting period no benefits shall be payable except that Disability Benefits shall commence in any event upon the day he is confined to a Hospital;
- B. If requested by the Plan Office, the Eligible Offshore Employee has submitted to a reasonable examination to determine his disability;
- C. The maximum payment hereunder shall not exceed \$650 for any period of disability;
- D. No benefits shall be paid for any period during which the Eligible Offshore Employee was on the payroll of an Employer or for which he receives unearned wages; but if disability occurs during the time the Eligible Offshore Employee is on such payroll, including Vacation time, such days of employment shall count for the waiting period. Receipt of maintenance and cure benefits shall not disqualify an employee for Disability Benefits.

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PART E – DISABILITY BENEFITS

Section 3. Disability Periods

- A. If an Eligible Offshore Employee has not obtained a Fit for Duty Slip, any subsequent period of disability or hospitalization shall be considered to be part of the same disability or hospitalization period.
- B. If an Eligible Offshore Employee obtains a Fit for Duty Slip, any subsequent disability after fourteen (14) days and one day of actual shipboard employment shall be considered a new disability and hospitalization period, but if there has been no actual employment, it will be considered the same disability and hospitalization period. The Trustees, however, in their discretion may determine in individual cases whether or not such subsequent disability is a new disability.
- C. The Trustees reserve the right to deny any further Disability Benefits to an Eligible Offshore Employee who, without having obtained a Fit for Duty Slip, has twice applied for Disability Benefits and during such period has registered for employment at the Organization or has accepted employment.
- D. In any case where an Eligible Offshore Employee registers for employment, it shall be presumed, unless the Trustees determine otherwise, that he is fully recovered from a disability without submission of a Fit for Duty Slip.
- E. If an employee registers for employment after a period of disability and receipt of a Limited Fit for Light Duty Slip, he shall be considered an employee receiving a normal Fit for Duty Slip for the purpose of this benefit. In the absence of any such registration, he shall be considered not fit for duty.

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PART E – DISABILITY BENEFITS

Section 4. Notice of Claim for Disability or Hospitalization

No benefit for disability shall be payable by the Plan unless notice or claim on behalf of the Eligible Offshore Employee with respect to such benefit is received within 180 days from the date the disability commences or unless the Trustees otherwise determine.

Section 5. Temporary Long-Term Disability Program

- A. Eligible Offshore Employees who become totally disabled and unable to engage in any occupation shall be provided a monthly Temporary Long-Term Disability Benefit. In order to receive this benefit an Eligible Offshore Employee at the time the disabling condition commenced, must:
1. be under the age of 60,
 2. have at least 400 days of Covered Employment within the immediate preceding thirty-six (36) consecutive calendar month period, and
 3. have been eligible for benefits from this Plan for at least five (5) calendar years for a minimum of 280 days of Covered Employment, per year, in five (5) of the preceding ten (10) years.
- B. In addition, the Eligible Offshore Employees must also meet the following conditions:
1. The disabling condition must be of a temporary, non-chronic nature, as determined by the Trustees in their sole and absolute discretion.

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Section 5. Temporary Long-Term Disability Program (Continued)

B. (Continued)

2. Application must be made to Social Security for a Disability Awarded Benefit and the necessary proof of such application having been made by the Eligible Offshore Employee must be provided to the Plan at time of the Eligible Offshore Employee's application for the benefit provided herein.

C. This benefit will be paid monthly, commencing with the sixth month following the month in which the Eligible Offshore Employee's disability occurred, provided, however, that in no event shall payment be made for any month prior to the month in which the Eligible Offshore Employee's claim is received by the Plan. The benefit amount will be equal to the average monthly earnings of the Eligible Offshore Employee in Covered Employment during the 36 months prior to disability up to a maximum of \$1,500 per month. The amount payable will be offset by any Disability or Pension Benefits payable under the M.M.& P. Pension Plan, as well as any Social Security Awards payable to such Eligible Offshore Employee. The benefit will be paid during the period of disability up to a maximum of 60 monthly payments for any one disability.

This benefit is subject to all other provisions and limitations of these Regulations, such as Subrogation, Coordination of Benefits, etc.

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PART F - DENTAL BENEFITS

Section 1. Dental Benefit

The Plan will pay Covered Dental Expenses (as defined below) incurred by a Covered Individual except Pensioners excluded by Article IV, Part M Section 3. Effective for services on and after January 1, 1997, any treatment plan in excess of \$1,000 will require a second opinion upon pre-determination, except in a medical emergency. Effective for services on and after January 1, 1998, failure to obtain the pre-determination prior to the commencement of treatment will result in a non-compliance penalty of a \$50.00 reduction in otherwise payable benefits for the first such occurrence and \$100.00 for all subsequent occurrences of non-compliance by the Covered Individual. Effective January 1, 2014, a Covered Individual may opt out of coverage for benefits provided under this Part F, but if a Covered Individual opts out of such coverage, there will be no refund or reduction in costs to the Covered Individual.

Section 2. Covered Dental Expenses

Dental services or supplies for the treatment and/or cure of the Covered Individual, provided that the Plan may obtain and rely upon independent advice to determine whether such dental services or supplies shall be considered Covered Dental Expenses to the extent that such charges are determined to be Allowable Charges, as defined in Article I, Section 13, and are not otherwise excluded or limited under Section 4 below. Treatment in excess of \$500 may, at the discretion of the Plan Office, be reviewed by the Dental Consultant.

Section 3. Benefit Amount

The Plan will pay 80% of the Covered Dental Expenses incurred by a Covered Individual. No Deductible Amount will apply.

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PART F - DENTAL BENEFITS

Section 3. Benefit Amount (Continued)

Effective October 1, 1995, if any Covered Dental Expense is performed by, or received from, a "Contracted Provider" of dental services, the Plan will pay 90% of the Allowable Charges.

Notwithstanding anything herein to the contrary, effective January 1, 2003 until January 1, 2023, unless extended thereafter by the Trustees, the Plan will pay 70% of the Covered Dental Expenses incurred by a Covered Individual, provided however, that if any Covered Dental Expense is performed by, or received from, a "Contracted Provider" of dental services, the Plan will pay 80% of the Allowable Charges.

Section 4. Exclusions

The term Covered Dental Expenses shall not include any of the following charges and/or other exclusions as determined by the Trustees from time to time:

- A. for service(s) not reasonably necessary or customarily performed for the dental care as determined by this Plan.

If an alternative professionally acceptable treatment is available, the benefit shall be limited to the less costly professionally acceptable alternative as determined by this Plan;

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PART F - DENTAL BENEFITS

Section 4. Exclusions (Continued)

- B. for the replacement of an unserviceable denture or bridge, or the replacement of a crown, including core build-up, unless an abutment is necessary for a new bridge, more frequently than once every five (5) years, provided, however, that for services effective on and after January 1, 2000, such core build-up shall be treated as a separate Covered Dental Expense in connection with a crown replacement to the extent not otherwise excluded hereunder;
- C. for services or supplies that are primarily cosmetic;
- D. for treatment by someone other than a Dentist or Physician, except when performed by a duly qualified technician under the direction of a Dentist or Physician;
- E. Effective January 1, 1999, services for treatment of temporal mandibular joint dysfunction (TMJ/TMD) in excess of a lifetime maximum of \$1500 per Covered Individual except for such treatment for a Child under the age of 19;
- F. for expenses incurred for:
 - 1. precision or semi-precision attachments,
 - 2. the application of fissure sealants to permanent bicuspid and molars more frequently than once every five (5) years or for children over the age of 19,
 - 3. instruction for plaque control,
 - 4. oral hygiene,
 - 5. bite registrations;

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PART F - DENTAL BENEFITS

Section 4. Exclusions (Continued)

- G.** procedures to correct congenital or developmental malformations including, but not limited to, lack of tooth enamel or tooth discoloration, unless, effective May 1, 1997, such procedures are not performed for cosmetic purposes;
- H.** for any service or supply payable under any other coverage in the M.M.& P. Health & Benefit Plan;
- I.** for services and supplies not recognized as generally accepted dental practice;
- J.** for more than two oral examinations per calendar year;
- K.** for adjustments to full or partial dentures and fixed bridges within six months of installation;
- L.** for the performance of more than two dental prophylaxes in any one calendar year;
- M.** for more than one fluoride treatment in any one calendar year;
- N.** for elective anesthesia except when administered in connection with oral or dental surgery;
- O.** for periodontic treatment in excess of \$2,000 per Covered Individual in any twelve (12) consecutive month period except for such treatment for a Child under the age of 19;
- P.** for orthodontic treatment in excess of \$2,000 per Covered Individual over his or her lifetime except for such treatment for a Covered Individual under the age of 19 that is medically necessary;

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PART F - DENTAL BENEFITS

Section 4. Exclusions (Continued)

- Q.** for any services which are covered by any worker's compensation law or employer's liability law;
- R.** for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- S.** for duplicate prosthetic devices;
- T.** for full mouth rehabilitation, and
- U.** for Nitrous Oxide.

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PART G - VISION CARE BENEFIT

Each Covered Individual, except Pensioners including by Article IV, Part M, Section 3, who incurs expenses for eye examinations, prescription eyeglasses or contact lenses, including expenses for corrective vision eye surgery, which includes but is not limited to, laser and LASIK eye surgery, shall be eligible to benefits as follows:

A. Out of Network (Non-Preferred Provider)

1. Effective for services on and after January 1, 1999 a maximum of \$180 per Covered Individual during any calendar year.
2. Effective for services on and after January 1, 2000 a maximum of \$360 per Covered Individual during a two calendar year period.
3. Effective for services on and after January 1, 2018, a maximum of \$540 per Covered Individual during a two calendar year period.

B. In Network (Preferred Provider)

1. Effective January 1, 1999 services valued up to a maximum of \$255, which includes a \$5.00 administrative fee, during any calendar year per Covered Individual at no cost. Benefits will be provided through a negotiated agreement with Cole Vision Services under which the Plan's cost will be a maximum of \$150 per Covered Individual during a calendar year. Schedule of benefits allowable in a calendar year is as follows:

Eye Examination: A complete examination, refraction and prescription for spectacle lenses. (Contact lens examinations require additional fees which will be the responsibility of the Covered Individual(s).

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PART G - VISION CARE BENEFIT

B. In Network (Preferred Provider) (Continued)

1. (Continued)

Spectacle Lenses: Plastic lenses, regardless of size or power with ultra violet coating included.

Contact Lenses: Any pair of contact lenses in lieu of lenses and frames up to a regular retail of \$110. Contact lenses can be obtained from a Vision One Provider or through the mail order Vision One Contact Lens Replacement Program.

Additional eye care obtained during any calendar year through Cole Vision may be purchased by a Covered Individual at discounted costs.

2. Effective January 1, 2000 services up to a maximum retail value of \$485, plus administrative fee, during a two calendar year period.

Schedule of benefits allowable in a two calendar year period is as follows:

Eye Examination: Refraction and prescription for eyeglasses, lenses or contact lenses.

Lens Options: An \$80 retainer allowance towards options.

Eyeglass Lenses: Standard uncoated plastic lenses, regardless of size and power.

Frames: Any frame up to a regular retail value of \$200.

Contact Lenses: Any pair up to a \$200 retail value.

Additional eye care obtained during any two calendar year period through Cole Vision may be purchased by a Covered Individual at discounted costs.

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PART G - VISION CARE BENEFIT

B. In Network (Preferred Provider) (Continued)

3. Effective January 1, 2008, benefits will be provided through a contracted in-network preferred provider, EyeMed Vision Care, L.L.C. ("EyeMed"), and the schedule of benefits allowable in a two calendar year period is as follows:

Eye Examination: Refraction and prescription for eyeglasses, lenses or contact lenses.

Lens Options: An \$80 retainer allowance towards options.

Eyeglass Lenses: Standard uncoated plastic lenses, regardless of size and power.

Frames: Any frame up to a regular retail value of \$200.

Contact Lenses: Any pair up to a \$200 retail value.

Additional eye care obtained during any two calendar year period through EyeMed may be purchased by a Covered Individual at discounted costs.

- C. If both in and out of network services are obtained during a Covered Individual's one (1) year coverage period, expenses incurred shall be applied proportionally to A. and B. maximums such that in combination only 100% of the limits are provided.
- D. Effective January 1, 2011, notwithstanding anything in A., B. and C. hereinabove to the contrary, the Plan will reimburse for one eye examination per year for a Child under the age of 19, and up to \$280 for eyeglass frames or up to \$200 for contact lenses every two years.

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BENEFIT PROVISIONS

PART H - HEARING AID BENEFIT

PART H - HEARING AID BENEFIT

Effective for charges incurred on or after July 1, 2000, Eligible Employees, Pensioners pursuant to Part M, Sections 2B and 3, and their eligible Dependents who incur expenses for hearing examinations or hearing aid instruments shall receive reimbursement for such expenses up to the maximums herein set forth on the following conditions:

A. Examinations - Maximum - \$75

1. For adults and Dependent children 19 years of age and older, once in each 24-month period.
2. For Dependent children under 19 years of age, once in each 12-month period, except such annual maximum limitation shall not apply to such treatment for Dependent children under the age of 19 that is medically necessary.

B. Hearing Aid Instruments - Maximum

Prior to January 1, 2018 a maximum of \$1,000 per ear per Covered Individual.

Effective on and after January 1, 2018 a maximum benefit of \$3,000 per Covered Individual during a 36 month period, which maximum shall include the cost of any warranty for the instrument.

Once in each 36-month period, except such annual maximum limitation shall not apply to such treatment for Dependent children under the age of 19 that is medically necessary.

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BENEFIT PROVISIONS
PART I – INSURANCE FOR FAILURE OF WAGE PAYMENTS PROGRAM

Section 1. The Benefit

Under rules and subject to conditions established by the Trustees, in the event an Eligible Offshore Employee shall be unable to collect his wages (which shall be deemed to include all compensation due by reason of employment on a vessel, but shall not include any payment or penalty which is not provided for under the Collective Bargaining Agreement) without recourse to legal, equitable or admiralty proceedings because his Employer is insolvent, bankrupt, or otherwise unable to pay the compensation due him, or his Employer has become delinquent in its contributions to the Plan, he shall be entitled to a payment from the Plan equal to the amount of his uncollected wages, taking into account any collection expenses which might reasonably be incurred.

The benefit will provide a prompt payment to an Eligible Offshore Employee for the amount he could expect to recover in a legal, equitable or admiralty proceeding, less an amount held in escrow which on the average might be required as expenses of recovery and administration of the program. Upon completion of the procedures established by the Trustees, an Eligible Offshore Employee shall not have any responsibility to return any payment made to him, except for fraud or willful misrepresentation.

Section 2. Application for Benefits

A. Application

Application for benefits shall be made on forms provided by the Plan Office.

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PART I – INSURANCE FOR FAILURE OF WAGE PAYMENTS PROGRAM

Section 2. Application for Benefits (Continued)

B. Proof

Proof of the amount due as compensation must be submitted before any payment will be made. Normally, a statement from the Master of the vessel or the company will be the best evidence, and failure of allotment payments must be established. The Plan Office will assist in trying to establish facts from the Employer.

C. Payment

After completion of proof and execution of other documents, the Plan will pay to the Eligible Offshore Employee 90% of the amount of compensation ascertained to be due him. Except when procured by fraud or misrepresentation, this payment is final and not subject to any claim by the Plan. The remaining 10% of the full amount will be held in escrow subject to accounting.

D. Other Documents

1. Prior to payment, the Eligible Offshore Employee shall execute an assignment, in a form acceptable to the Trustees, of all his rights with respect to the wage payments involved, including an assignment of his maritime lien, and authorize the Trustees to sue for same either in his name or their names.

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PART I – INSURANCE FOR FAILURE OF WAGE PAYMENTS PROGRAM

Section 2. Application for Benefits (Continued)

D. Other Documents (Continued)

2. The Eligible Offshore Employees shall also execute an authorization for the Plan to apply the 10% full payment, held in escrow as above provided, for legal and administrative expenses incurred by the Plan in connection with the administration of the Wage Insurance Program.

Section 3. Exclusions

An Eligible Offshore Employee shall not be considered eligible for benefits under this Part I if he continues to work for an Employer after he has been advised by the Plan through the Organization that such Employer is delinquent in its contributions to the Plan.

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PART J - COAST GUARD LEGAL AID PROGRAM

PART J - COAST GUARD LEGAL AID PROGRAM

Upon request, the Plan shall provide legal representation for Eligible Offshore Employees who are brought before the U. S. Coast Guard on charges, except where charges have been brought because the Eligible Offshore Employee has refused to take a drug test. Such legal representation shall be provided only by attorneys designated by the Plan.

An Eligible Offshore Employee shall not be entitled to further benefits under this Program after he has received representation on charges arising out of three separate occasions.

In the event of an adverse decision following a hearing, an application may be made to the Board of Trustees for further representation in connection with appealing such decision. The granting of such further representation shall be at the discretion of the Board, after consideration of all the facts, except that where the decision following the hearing is one of revocation, legal representation shall be provided for an appeal of such decision of the Commandant, except where the revocation decision is based upon a positive drug test result. In the event the Commandant reverses the order of revocation in such case involving a positive drug test result, reasonable legal fees of the Eligible Offshore Employee will be reimbursed in connection with the appeal. In all cases, in the event the Commandant affirms the order of revocation, the granting of further legal representation shall be at the discretion of the Board, after consideration of all the facts.

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PART K - LICENSE INSURANCE PROGRAM

Section 1. License Insurance Program

The License Insurance Program provides Offshore Employees and Pacific Maritime Region Employees who are members of the Organization with the option to purchase license insurance for protection against loss of wages in the event of the suspension or revocation of the Officer's license, property damage, loss of personal effects and legal representation.

Section 2. Application Procedure and Commencement of Coverage

To obtain coverage under this Program, a Licensed Officer must submit an application and the applicable premium to the M.M.& P. Health & Benefit Plan through an Office of the Organization.

Coverage will take effect on the first day of the month which immediately follows the Plan's receipt and acceptance of the Officer's application and premium payment.

Coverage shall be on an annual basis. Annual renewals and annual premiums shall be at the rates then in effect as determined by the Board of Review of the M.M.& P. License Insurance Program, which Board shall be designated by the Board of Trustees of the M.M.& P. Health & Benefit Plan.

An Officer shall apply for coverage in the highest rating in which it is expected that he will serve during the policy period. If an Officer obtains employment in a higher Officer capacity than the policy level chosen, coverage will be suspended and not in effect during the period of such employment.

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PART K - LICENSE INSURANCE PROGRAM

Section 3. Benefits

A. Representation

A covered Officer will receive representation from counsel selected by the Board of Review in connection with administrative charges brought by the U. S. Coast Guard seeking the suspension or revocation of the Officer's license. Foreign counsel will be provided if the covered incident occurs within the jurisdiction of a foreign country. Coverage for legal services rendered by foreign counsel is limited to an amount up to \$500. Providing counsel to prosecute an appeal from an adverse determination by an Administrative Law Judge is solely within the discretion of the Board of Review of the M.M.&P. License Insurance Program.

B. Loss of Wages

In the event of a license suspension or revocation, coverage shall be as follows:

1. Payment for loss of wages during the period of outright suspension, at the monthly amount for which the premium has been paid in accordance with the schedule set forth below, up to a maximum period of 12 months. In the event of revocation, payment shall be for 12 months.

No loss of wages or subsistence will be payable if the Officer is able to serve his period of suspension during a period covered by a paid vacation.

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Section 3. Benefits. (Continued)

B. Loss of Wages (Continued)

2. Subsistence at the rate of \$20 per day during the period of outright suspension up to a maximum period of 12 months except as provided in Sub-Section (1) above. In the event of revocation, payment shall be for 12 months.
3. The amount of wages for which insurance is provided and the annual premiums therefore are as follows:

<u>Grade</u>	<u>Amount Monthly Wages Insured</u>	<u>Annual Premium</u>	<u>Safe Mariner Premium</u>
Master or Chief Engineer	\$5,000	\$162.50	\$146.25
Chief Officer or 1 st Asst. Engineer	4,500	78.75	70.87
2 nd Officer or 2 nd Asst. Engineer	3,500	57.75	51.97
3 rd Officer or 3 rd Asst. Engineer	3,000	49.50	44.55

C. Safe Mariner Rate

An applicant shall be eligible for the "Safe Mariner" Rate (constituting a 10% reduction from the standard rate), if, during the five-year period preceding the effective date of coverage:

1. no administrative charges have been brought by the U.S. Coast Guard seeking the suspension or revocation of the applicant's license, and

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Section 3. **Benefits** (Continued)

C. **Safe Mariner Rate** (Continued)

2. the applicant, if a Licensed Officer, has successfully completed at the Maritime Institute of Technology and Graduate Studies, Linthicum Heights, Maryland one of the following courses: the Shiphandling Simulator Course, the ARPA Course, the Radar Observer Course or any other course authorized by the Trustees.

D. **Property Coverage**

A covered Officer shall also be entitled to receive compensation for loss of personal effects and instruments and equipment up to a maximum amount of \$2,000 subject to the following conditions and exclusions.

1. The property was located on board the vessel to which the covered Officer was officially assigned and the damage or loss resulted from an accidental stranding, sinking, fire or explosion, collision, oil spill or grounding of the vessel during the period of damage.
2. The covered Officer shall report promptly every loss or damage to property to the Plan Office. A sworn proof of loss must be submitted to the Plan Office within ninety (90) days from the date of the loss.
3. This coverage does not extend to loss or damage to the covered Officer's property:

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PART K - LICENSE INSURANCE PROGRAM

Section 3. Benefits (Continued)

D. Property Coverage (Continued)

3. (Continued)

- a. when such property is not located on board the vessel to which the covered Officer is officially assigned as member of the crew;
- b. resulting from theft or misplacement of such property;
- c. arising from war, invasion, hostilities, rebellion, terrorist activity, insurrection, confiscation by order of any government or public authority or risks or contraband or illegal transportation or trade.

Section 4. Restrictions

- A. Coverage under this Program is applicable only with respect to incidents arising while the Officer, who must be otherwise eligible to serve in Covered Employment, as defined in Article I, is employed aboard, in the case of Offshore Employees, oceangoing vessels of 1,000 gross tons or over or, in the case of Pacific Maritime Region Employees, ferries, tugs and barges.
- B. Persons serving in the capacity of Pilot are not eligible for this benefit. Additionally, coverage will not be applicable when the incident which gives rise to the license suspension or revocation proceedings occurred when the Officer charged or under investigation by the Coast Guard was performing pilotage duties in United States waters where Pilots are available but were not utilized by the vessel.

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BENEFIT PROVISIONS

PART K - LICENSE INSURANCE PROGRAM

Section 4. Restrictions (Continued)

- C. Coverage under this Part is limited to the type of administrative proceeding described above, and does not provide for legal assistance or expenses in connection with any firing, a fine or penalty or any civil suit seeking a recovery of monetary damages. Coverage under this Part does not provide for the payment of any fines, penalties, judgments, awards, settlements or any monetary losses other than the loss of wages or subsistence payments as a result of a suspension or revocation of a license or document or loss of property as described below.

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ARTICLE IV
BENEFIT PROVISIONS
PART L – SCHOLARSHIP PROGRAM

Section 1. Scholarships

The Scholarship Program provides six college scholarships each year for qualified children of Offshore Employees, deceased Offshore Employees or Pensioners as defined in Section 7 of Article I, except for Pensioners continuing their coverage hereunder by self-payment pursuant to Article III, Section 8, and who are receiving a Regular, Early Retirement, Disability or Reduced Pension from the M.M.& P. Pension Plan.

Each scholarship shall have a maximum value of \$2,500 per year. New scholarships awarded, effective with the 1997/1998 school year, shall have a maximum value of \$5,000 per year. The award shall be renewable each year to a maximum benefit of \$10,000 and for new scholarships granted, beginning with the 1997/1998 school year, \$20,000 or until the student receives a Bachelor's Degree (whichever is earlier), provided the student's parents remain Eligible Parents as defined in Section 3 of this Part L and the student is an Eligible Dependent and continues to maintain the standards required by his/her college and the Scholarship Committee.

Each scholarship winner and alternate shall be selected by an independent Scholarship Committee composed of outstanding educators from colleges and universities.

Section 2. Eligibility of Candidate

In order to be eligible to participate in the M.M.& P. Scholarship Program, the candidate must be, at the time of application:

- A. a high school senior, who expects to graduate in January or June of a current school year;

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ARTICLE IV

BENEFIT PROVISIONS

PART L – SCHOLARSHIP PROGRAM

Section 2. Eligibility of Candidate (Continued)

- B. the candidate must meet the definition of Dependent Child under Article I, Section 10 A. of these Rules and Regulations;
- C. a Dependent Child of an Offshore Employee or deceased Offshore Employee or a Pensioner, each of whom meets the requirements set forth in Section 3 of this Article IV.

Section 3. Eligible Parents

A. Offshore Employees

Children of Offshore Employees who have 400 days of Covered Employment in the three (3) year period preceding the date of application, and who meet the eligibility requirements of this Plan on date of application for the Scholarship Program, may apply. Date of application is the date it is received by the M.M.& P. Health & Benefit Plan. Unless deceased, or receiving a pension from the M.M.&P. Pension Plan, the Offshore Employee must also be eligible to Health benefits on September 1 of the academic year for which the scholarship is awarded.

B. Deceased Employee

A Deceased Employee shall be a former Offshore Employee who met the eligibility requirements of this Plan at the time of death and who had at least 400 days of Covered Employment within the thirty-six (36) consecutive calendar month period immediately preceding his date of death.

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PART L – SCHOLARSHIP PROGRAM

Section 3. Eligible Parents (Continued)

C. Pensioner

Children of Pensioners shall be considered candidates for this Program, provided the child was a Dependent of the Pensioner at the time the Offshore Employee became a Pensioner.

Section 4. Selection of Scholarship Winners

Each winner and alternate shall be selected by an independent Scholarship Committee composed of outstanding educators from colleges and universities. The candidate will be 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 in post-college life.

The decision of the Committee shall be final.

Section 5. Amount of Scholarship

Each scholarship shall be in the amount per year of up to \$2,500 provided, however, that new scholarships awarded effective with the 1997/1998 school year shall have a maximum value of \$5,000 per year, as is determined to be reasonably required to cover the usual expenses incurred during the regular academic year in the college attended such as tuition, room and board, matriculation fees, etc.

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BENEFIT PROVISIONS

PART L – SCHOLARSHIP PROGRAM

Section 5. Amount of Scholarship (Continued)

The award shall be renewable September 1 of each year until the earlier of completion of the four (4) year program or until the requirements for a Bachelor's Degree have been met, provided the student maintains the required scholastic standards in the judgment of college officials and the Scholarship Committee. and provided he/she continues to be an Eligible Dependent.

The student must be enrolled at an accredited college or university on a full-time basis.

Any unused portion of a recipient's annual Scholarship award shall be forfeited and returned to the Plan.

Section 6. Payment of Scholarships

Upon enrollment of a scholarship winner at an accredited college or university, the amount of the scholarship award will be deposited annually with the school at the beginning of the September school year, in the name of the student, and will be disbursed in his behalf to cover expenditures.

Section 7. Selection of Colleges

The recipient of a scholarship award must attend an accredited college or university granting a 4-year or equivalent degree, which does not permit discrimination based on sex, race, creed, color or national origin in its overall enrollment policy, enrollment for any part of its curriculum, or the use of any of its facilities.

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BENEFIT PROVISIONS

PART L – SCHOLARSHIP PROGRAM

Section 7. Selection of Colleges (Continued)

Application for a scholarship does not constitute application for admission to college. The winner of a scholarship must conduct his own negotiation with the college of his choice for admission to the school.

Transferring from an accredited college to another will be permitted only between academic years, and scholarship winners must obtain written approval from the Scholarship Committee.

Section 8. Obligations of Scholarship Winners

The scholarship winner must enter an accredited college or university not later than the Fall of the year in which his scholarship is awarded. Except for military service, illness or other exceptional and extenuating circumstances, he will be required to continue his courses without interruption.

The scholastic records of the recipient will be reviewed each year by the Scholarship Committee to determine that academic and personal standards are being maintained.

Each scholarship winner who maintains the required personal and scholastic standards is assured the opportunity to continue his or her studies under the Scholarship Program until the earlier of completion of the 4-year program or until the requirements for a Bachelor's Degree have been met, or until his status as an eligible Dependent under this Plan ceases.

The recipient of one of these scholarships may not accept another competitive scholarship award. (Purely honorary awards are excepted.) This does not include any grants or awards based entirely on financial need.

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Section 9. Military Service

If the studies of the scholarship winner are delayed or interrupted by involuntary military service, the scholarship will be held in abeyance during such military service. The scholarship recipient should apply for reinstatement of his scholarship within three months after discharge and enroll in college not later than the next succeeding year.

Section 10. Illness

An illness, accident or an exceptional and extenuating situation which delays the scholarship recipient from commencing or continuing his college studies will be regarded as an acceptable reason for holding the scholarship in abeyance for the recipient.

Scholarship winners who may be prevented from starting or continuing their college courses because of illness or accident should promptly advise the Scholarship Committee.

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ARTICLE IV

BENEFIT PROVISIONS

PART M - BENEFITS FOR PENSIONERS

PART M - BENEFITS FOR PENSIONERS

The following benefits shall be available to Pensioners:

Section 1. Benefits for Co-Pay Pensioners Under and Over Age 65

- A. Co-Pay Pensioners and their eligible Dependents shall be entitled to the following benefits, provided they meet the requirements hereinafter set forth:
 - 1. Comprehensive Major Medical Benefits
 - 2. Prescription Drug Benefits
 - 3. Comprehensive Annual Physical Examination
 - 4. Vision Care Benefits
- B. Co-pay Pensioners who have retired on a Regular, Reduced, Early Retirement or Disability Pension from the M.M.& P. Pension Plan, and their eligible Dependents, shall also be eligible for Dental, Hearing Aid and Scholarship Program benefits as provided for under these Regulations.

Section 2. Benefits for Continuation of Coverage Pensioners Under and Over Age 65

Pensioners and certain Surviving Spouses who are receiving benefits pursuant to the Continuation of Coverage provisions of the Plan shall be entitled to:

- 1. Comprehensive Major Medical Benefits
- 2. Prescription Drug Benefits
- 3. Comprehensive Annual Physical Examination
- 4. Hearing Aid Benefits

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ARTICLE IV
BENEFIT PROVISIONS
PART M - BENEFITS FOR PENSIONERS

Section 3. General Provisions

A. Earnings Limitations for Pensioners Under Age 65

The foregoing benefits shall not be available to:

1. the Pensioner or his Dependent(s) if the Pensioner receives "Earnings" above the "Under Age 65 or Social Security Earnings Limitation" for that year;
2. any Dependent who receives "Earnings" above the "Under Age 65 Social Security Earnings Limitation" for that year;
3. Notwithstanding anything herein to the contrary, effective January 1, 2002, Pensioners under age 65 who retired under the M.M.& P. Pension Plan with twenty (20) or more years of Pension Credit (or who retired under such other pension plan as provided in, and who meets the conditions of, Article III, Section 2.A.8 herein) and/or their Dependent(s) under the age of 65, will be permitted to receive "Earnings" of up to \$25,000 per year without losing their eligibility to health benefits under this Article IV, Part M. Notwithstanding anything herein to the contrary, effective January 1, 2003, Pensioners under age 65 who retired under the M.M.&P. Pension Plan with twenty (20) or more years of Pension Credit (or who retired under such other pension plan as provided in, and who meets the conditions of, Article III, Section 2.A.8 herein) and/or their Dependent(s) under the age of 65, will be permitted to receive "Earnings" of up to \$26,000 per year without losing their eligibility to health benefits under this Article IV, Part M.

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ARTICLE IV

BENEFIT PROVISIONS

PART M - BENEFITS FOR PENSIONERS

Section 3. General Provisions (Continued)

A. Earnings Limitations for Pensioners Under Age 65 (Continued)

3. (Continued)

For purposes of this Paragraph A, "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, benefits received under government social insurance plans, such as Social Security, or passive investment income, such as dividends, interest, capital gains, rents or royalties. Notwithstanding anything herein to the contrary, effective January 1, 2005, Pensioners under age 65 who retired under the M.M.&P. Pension Plan with twenty (20) or more years of Pension Credit (or who retired under such other pension plan as provided in, and who meets the conditions of, Article III, Section 2.A.8 herein) and/or their Dependent(s) under the age of 65, will be permitted to receive 'Earnings' of up to \$27,000 per year without losing their eligibility to health benefits under this Article IV, Part M.

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ARTICLE IV

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PART M - BENEFITS FOR PENSIONERS

Section 3. General Provisions (Continued)

A. Earnings Limitations for Pensioners Under Age 65 (Continued)

3. (Continued)

Notwithstanding anything herein to the contrary, effective June 1, 2005, the Earnings Limitations amount hereunder is and will be the same Earnings Limitations amount as provided in Section 3.19(j) of the M.M.&P. Pension Plan Second Restated Regulations and as may be increased therein from time to time hereinafter. Effective January 1, 2011, a Pensioner and his Dependent under the age of 65 shall report to the Plan Office at the beginning of the year or at the time they reasonably expect that they will exceed the Earnings Limitation for that year in which case they will not be eligible for benefits under the Plan for the remainder of that year. Furthermore, they will be presumed to exceed the Earnings Limitation for the following year unless they can demonstrate to the Plan Office otherwise. If such a Pensioner or his Dependent fails to report that they will exceed the Earnings Limitation in a year that they do, their coverage under the Plan will be rescinded retroactively to the date they knew or would have reasonably expected to know that they would exceed the Earnings Limitation for that year and, in accordance with Article II, Section 7 hereinabove, the Pensioner or his Dependent will be required to reimburse the Plan for any claims paid by the Plan Office for claims incurred by them for that period their coverage is rescinded.

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PART M - BENEFITS FOR PENSIONERS

Section 3. **General Provisions** (Continued)

A. **Earnings Limitations for Pensioners Under Age 65** (Continued)

3. (Continued)

Notwithstanding anything herein to the contrary, effective January 1, 2014, Pensioners under age 65 who retired under the M.M.&P. Pension Plan and/or M.M.&P. Adjustable Pension Plan with twenty (20) or more years of Pension Credit (or who retired under such other pension plan as provided in, and who meets the conditions of, Article III, Section 2.A.8 herein) and/or their Dependent(s) under the age of 65, 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 their eligibility to health benefits under this Article IV, Part M.

Notwithstanding anything herein to the contrary, effective June 1, 2018, Pensioners and/or their Dependents will be permitted to receive “Earnings” through employment for the Maritime Institute of Technology and Graduate Studies, employment for the Organization or Plan Office, or shoreside employment for a Contributing Employer without losing their eligibility to health benefits under this Article IV, Part M.

Notwithstanding anything herein to the contrary, effective January 1, 2020, Pensioners under age 65 who retired under the M.M.&P. Pension Plan and/or M.M.&P. Adjustable Pension Plan with twenty (20) or more years of

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PART M - BENEFITS FOR PENSIONERS

Section 3. **General Provisions** (Continued)

A. **Earnings Limitations for Pensioners Under Age 65** (Continued)

3. (Continued)

Pension Credit (or who retired under such other pension plan as provided in, and who meets the conditions of Article III, Section 2.A.8 herein) and/or their Dependent(s) under the age of 65, will be permitted to receive "Earnings" of up to \$41,000 per year, and an additional "Earnings" of \$1,000 per year effective each January 1 thereafter up to a maximum of \$45,000 per year, without losing their eligibility to health benefits under this Article IV, Part M.

4. In order for a Pensioner and his Dependent(s) to be entitled to reinstatement of eligibility for benefits hereunder after their compensation falls below the levels provided here in above, he must continue, without interruption, to comply with the Co-Pay requirements of Article III, Section 2(A) (5) or the Continuation of Coverage provisions of Article III, Section 7.

5. The Plan may request from Pensioners and/or their Dependent(s) such information that in its sole discretion it deems necessary to verify that they have not exceeded the Earnings Limitations hereunder. Such requested information may include a copy of the Pensioner's and/or Dependent's federal income tax returns. Effective January 1, 2005 if a Pensioner and/or his Dependent(s) fails or refuses to provide such requested information, the

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PART M - BENEFITS FOR PENSIONERS

Section 3. **General Provisions** (Continued)

A. **Earnings Limitations for Pensioners Under Age 65** (Continued)

5. (Continued)

Plan may suspend the payment of benefits for that Pensioner and/or his
Dependent(s) until such requested information is provided.

B. **Coordination of Benefits-Medicare Eligible Pensioners**

In the case of a Covered Individual or Dependent Spouse who qualifies for Medicare, reimbursement for benefits under this Plan will be coordinated with the benefits payable under Medicare in accordance with Article V, Coordination of Benefits.

C. **Exclusions**

Except as provided in Article III, Section 2.A.8 herein, the above provisions and the benefits to which a Pensioner and his Dependent(s) are eligible, if any, shall be based only on Pension Credits and employment for which contributions were made by a contributing Employer to the M.M.& P. Pension Plan. "Purchased" Pension Credits pursuant to Article IV-B of the M.M.&P. Pension Plan Restated Regulations shall not be credited for any purpose under this Plan.

Section 4. **Reimbursement of Medicare Part B Premiums to
Certain Co-Pay Pensioners Eligible for Medicare**

Effective January 1, 2001, certain eligible Pensioners, as described below, who are eligible to receive and have opted for Part B coverage under Medicare, and are currently eligible for coverage pursuant to Article III, Section 2(A), and are complying with the "Co-Pay" requirements

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BENEFIT PROVISIONS
PART M - BENEFITS FOR PENSIONERS

Section 4. Reimbursement of Medicare Part B Premiums to
Certain Co-Pay Pensioners Eligible for Medicare (Continued)

of Article III, Section 2(A)(5), shall receive reimbursement for Medicare Part B premiums. Such reimbursement shall be payable retroactively at the end of each calendar quarter. The amount of such reimbursement shall be equal to the monthly Medicare Part B premium in effect for that quarter multiplied by three (3), or, if less, the number of months for which the Pensioner was eligible to receive, and opted for, Part B Medicare benefits.

The Pensioners eligible to receive this benefit shall be limited to Co-Pay Pensioners who, as of the later of January 1, 2001 or their pension effective date, have a gross monthly pension amount of \$2,000 or less from the M.M.& P. Pension Plan, prior to the application of any actuarial adjustments for benefit options, and who are receiving a Regular or Disability Pension. Reimbursement is not being made under this Section 5 for any Dependents who may also be eligible for Medicare. Furthermore, this reimbursement benefit is subject to renewal and extension by the Trustees each year at the last Trustee meeting of the prior year.

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ARTICLE IV
BENEFIT PROVISIONS
PART N – FEDERAL DRUG TESTING PROGRAM

Offshore Employees shall be eligible to receive drug testing required by federal law, as implemented by regulations issued by the U.S. Coast Guard. The drug test will be administered by entities who are authorized to administer such tests by the relevant federal agencies and with whom the Plan has contracted. The costs for such tests shall be paid by the Plan exclusively from a separate account that shall be funded by the Employers with contributions in an amount to be determined by the Employers and the Organization sufficient to cover the direct costs of the tests plus reasonable expenses of administering the benefit.

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ARTICLE V

COORDINATION OF BENEFITS

Section 1. Description of Benefits

This Plan coordinates benefits with other Health Plans in cases where Covered Individuals are liable for Allowable Expense (as defined below). If a Covered Individual is not liable for an Allowable Expense, this Plan will not coordinate benefits. Coordination of Benefits shall apply to the following:

- A. The benefits as set forth in Article IV, Part A, B, C, F, G and H.
- B. All benefits for persons covered by or eligible for Medicare, furnished by or payable by any State, Federal or other political subdivision will be coordinated in accordance with the rules set forth in Section 4 of this Article.
- C. Medical benefits for Eligible Employees and Dependents if both Employee and spouse are eligible as a member under the Plan.

The above benefits under this Plan provided for all Covered Individuals will be coordinated, in accordance with the provisions set forth under this Article V, with the benefits provided under any other group-type coverage sponsored by employers, unions, associations, organizations or government, whether insured or service type, to provide a combination of payments up to, but not exceeding, one hundred percent (100%) of the Covered Individuals Allowable Expenses. However, in no event shall the amount payable by the Plan exceed the amount which would have been paid if there were no other health coverage involved.

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ARTICLE V
COORDINATION OF BENEFITS

Section 2. Definitions

A. Health Plan

The term Health Plan as used herein, shall mean any program of coverage providing benefits as set forth in Section 1, except the following:

1. Individual or family policies, or individual or family subscriber contracts.
2. Medical payment benefits customarily included in the traditional automobile contract.

If the other Health Plan providing benefits for a Covered Individual does not have a coordination of benefits or duplication of benefits provision, benefits payable for Allowable Expenses under the other Health Plan will be paid in full before any benefits are paid by this Plan. The term Health Plan shall be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract or arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits, and that portion which does not.

B. Allowable Expense

The term Allowable Expense as used herein shall mean any necessary "Allowable Charge" for medical care and services, as defined under Article I, Section 13, of these Rules & Regulations, at least a portion of which is covered under at least one of the Health Plans covering the person for whom claim is made.

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ARTICLE V
COORDINATION OF BENEFITS

Section 2. Definitions (Continued)

B. Allowable Expense (Continued)

When a Health Plan provides benefits in the form of service rather than cash payment, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

C. Preferred Provider Contract

Preferred Provider Contract means a contract under which a medical provider contracts with a Plan to provide services at the rates specified in the contract. It does not have to be an exclusive arrangement.

Section 3. Determination of Benefits

- A.** As to any claim of a Covered Individual, the benefits that would be payable under this Plan in the absence of this Coordination of Benefits provision for Allowable Expenses incurred with respect to such Covered Individual for such claim shall be reduced by the amount, if any, necessary so that the sum of such reduced benefits and all benefits payable for such Allowable Expenses under all other Health Plans, except as provided below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Health Plan shall be deemed to include the benefits that would have been payable had claim been duly made thereof.
- B.** If another Health Plan which contains a provision for coordination of benefits that would determine its benefits after the benefits of this Plan have been determined, and the rules set forth in paragraph C below would require this Plan to determine its

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ARTICLE V

COORDINATION OF BENEFITS

Section 3. Determination of Benefits (Continued)

B. (Continued)

benefits before such other Health Plan, then, the benefits of such other Health Plan will be ignored for the purposes of determining the benefits under this Plan.

C. For the purposes of paragraph B above, the rules for establishing the order of benefit determination are:

1. Eligible Employees, Pensioners and Spouses

The Health Plan covering the person as an employee pays benefits first, as a retiree or pensioner second, and as a dependent last.

2. Dependent Children of Eligible Employees and Pensioners

a. The Health Plan covering the parent whose birthday falls earlier in the calendar year pays first. The Health Plan covering the parent whose birthday falls later in the year pays second.

If both parents have the same date of birth, the Health Plan which has covered one of the parents longer will pay first, and the other parent's Health Plan pays second.

b. When the parents are separated or divorced and the parent with the greater custody of the child has not remarried, the benefits of a Health Plan which covers the child as a dependent of the parent with custody shall pay first and the benefits of the Health Plan which covers the child as a dependent of the parent without custody pays second.

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ARTICLE V

COORDINATION OF BENEFITS

Section 3. Determination of Benefits (Continued)

C. (Continued)

2. Dependent Children of Eligible Employees and Pensioners (Continued)

- c. Notwithstanding the above, should a Dependent Child be covered under this Plan as a dependent of an Eligible Employee or Pensioner, and also 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.

When the parents are divorced and the parent with the greater custody of the child has remarried, the benefits of a Health Plan which covers the child as a dependent of the parent with greater custody shall pay first, the benefits of a Health Plan which covers that child as a dependent of the step-parent shall pay second, and the benefits of a Health Plan which covers the child as a dependent of the step-parent will pay before the benefits of a Health Plan which covers that child as a dependent of the parent without or with lesser custody.

- d. Notwithstanding the foregoing, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a Health Plan which covers the child as a dependent of the parent with such financial responsibility shall pay first and the benefit of any

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COORDINATION OF BENEFITS

Section 3. Determination of Benefits (Continued)

C. (Continued)

2. Dependent Children of Eligible Employees and Pensioners
(Continued)

d. (Continued)

other Health Plan which covers the child as a Dependent Child shall
pay second.

D. When rules (1) and (2) of Subsection C above do not establish an order of benefit determination, the benefits of a Health Plan which has covered the claimant for the longer period of time shall pay first and the benefits of a Health Plan which has covered such person for the shorter period of time shall pay second.

E. The Health Plan which covers the claimant as an active employee shall be primary over the Health Plan which covers the claimant as a pensioner, or COBRA continuee.

Section 4. Medicare Eligible Covered Individuals

A. Medicare will be the primary and exclusive payor for those benefits which are not covered by the Plan, but are covered by Medicare.

B. This Plan will be primary and Medicare secondary for Eligible Employees and their Dependents. Effective for claims incurred on or after August 5, 1997, this Plan will be primary and Medicare secondary for the first thirty (30) months after entitlement to Medicare coverage for Eligible Employees and their Dependents who will become entitled to Medicare because of End Stage Renal Disease or who become

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Section 4. Medicare Eligible Covered Individuals (Continued)

B. (Continued)

entitled to Medicare because of End Stage Renal Disease less than thirty (30) months prior to claims incurred on or after August 5, 1997.

C. Medicare will be primary and this Plan secondary for Medicare eligible Pensioners and Pacific Maritime Region Retirees and their Medicare eligible Dependents.

D. In the case of a Covered Individual for whom Medicare is the primary payor, benefits under this Plan shall be provided in accordance with Section 1 of this Article V.

If a Covered Individual is eligible but failed to make necessary application for Medicare Part "B" Coverage, the amount Medicare would have paid, had proper application been made, will nevertheless be subtracted from Covered Expenses payable under this Plan.

If a Covered Individual who is eligible but failed to make necessary application for Medicare Part "B" Coverage incurs Covered Expenses that are subject to the No Surprises Act, such Covered Expenses will be payable in the same manner as a No Surprises Service and subject to applicable Cost Sharing.

Section 5. Coordination of Benefits under COBRA

In instances where COBRA Continuation Coverage has been extended pursuant to Article III, Section 10 (G)(2), benefits will be paid pursuant to the Coordination of Benefits provisions of this Article V.

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Section 6. Benefit Maximum

When the total amount of benefits otherwise payable under this Plan is reduced in accordance with this Article, each benefit that would be payable in the absence of this Article shall be reduced either proportionately or in another equitable manner as shall be determined by the Plan, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

Section 7. Duplicate Coverage Inquiries

For the purposes of determining the applicability of implementing the terms of this Article, or any provision of similar purpose of any other plan, the Health Plan may, without consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person which the Plan deems to be necessary for such purpose and in so acting the Plan shall be free from any liability/ that might arise in relation to such action. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this Article.

Section 8. Direct Payment to Other Carriers

Whenever payments which should have been made under this Plan in accordance with this provision have been made by any other Health Plans, the Plan shall have the right, exercisable alone and its sole discretion, to pay to any Health Plan making such other payments, any amounts the Plan shall determine to be warranted in order to satisfy the intent of this Article and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

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Section 9. Recovery of Overpayments

Whenever payments have been made by the Plan with respect to all Allowable Expenses in a total amount, at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right, exercisable alone and at its sole discretion, to recover such payments to the extent of such excess from among one or more of the following, as the Plan shall determine any persons to, or for, or with respect to, whom Plan payments were made; any insurance companies; or any other organization. The Plan shall also have the right, exercisable alone and its sole discretion, to take such actions as set forth in Article II, Section 7 hereinabove.

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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;

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- (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.

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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 Plan shall furthermore have a constructive trust, lien and/or equitable lien by agreement in favor of the Plan on any amount received by a Covered Individual or a representative of a Covered Individual (including an attorney) that is due to the Plan under this Article, and any such amount is deemed to be held in trust by a Covered Individual for the benefit of the Plan until paid to the Plan. A Covered Individual consents and agrees that a constructive trust, lien and/or equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by

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agreement, a Covered Individual agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Any refusal by a Covered Individual to allow the Plan a right to subrogation or to reimburse the Plan from any recovery he receives, no matter how characterized, up to the full amount paid by the Plan on a Covered Individual's behalf relating to the applicable injury or sickness, will be considered a breach of the agreement between the Plan and a Covered Individual that the Plan will provide the benefits available under the Plan. Further, by accepting benefits from the Plan, a Covered Individual affirmatively waives any defenses, he may have in any action by the Plan to recover amounts due under this Article or any other rules of the Plan, including but not limited to a statute of limitations defense or a preemption defense to the extent permissible under applicable law.

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.

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Section 1. Amendments

The Trustees shall have the right, in their discretion, to alter or terminate the amount or conditions hereof with regard to any benefit, and otherwise to amend any other provisions of these Rules and Regulations.

Section 2. Interpretation

The Trustees shall have the right, in their discretion, to interpret and construe the terms and provisions of the Rules and Regulations and any such interpretation or construction shall be final and binding upon all persons concerned.

Section 3. Notice of Denial

If a claim for any benefit hereunder is denied, in whole or in part, the Administrator shall promptly send, in writing, a notice to such claimant, setting forth the specific reasons for such denial.

Section 4. Appeals Procedure

A. Settlement of Disputes

No Covered Individual ("Claimant") shall have any right or claim to benefits under these Rules and Regulations or from the Plan, except as specified in these Rules and Regulations. Any dispute as to eligibility, type, amount, manner or duration of benefits under these Rules and Regulations or any amendment or modification thereof shall be resolved under and pursuant to these Rules and Regulations and such decision shall be final and binding on all parties. Claims for disability benefits are addressed in Section 4H herein and Sections 4C through 4G of this Article

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Section 4. Appeals Procedure (Continued)

A. Settlement of Disputes (Continued)

VII do not apply to the review of such claims, unless specifically referenced.

B. Claims and Incomplete Claims

No Plan benefits will be paid unless the Claimant (or his authorized representative) submits a written claim to the Administrator. The claim must include any evidence as the Administrator shall reasonably require to substantiate the nature, amount, and timeliness of any charges incurred for which benefits are claimed. In the event that any Pre-Service Claim does not include all of the necessary information, or otherwise fails to follow the Plan's procedures for filing claims as set out in Section 4 of this Article VII, the Administrator shall notify the Claimant or his authorized representative of the informational or procedural deficiency and how it may be cured within five (5) days (or within 24 hours, in the case of an Urgent Care Claim).

C. Notification of Decisions on Benefit Claims

- 1. Urgent Care Claims.** In the case of a claim for Urgent Care, the Administrator shall notify the Claimant of the Plan's benefit determination (regardless of whether the determination is adverse) as soon as possible, recognizing the medical exigencies particular to the Claimant's situation, but not later than seventy-two (72) hours after

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Section 4. Appeals Procedure (Continued)

C. Notification of Decisions on Benefit Claims (Continued)

1. Urgent Care Claims. (Continued)

receipt of the claim by the Plan. However, if the Claimant fails to provide information sufficient to determine whether, or to what extent, benefits are covered or payable under the Plan, the Administrator shall notify the Claimant as soon as possible, but not more than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be given a reasonable amount of time, taking into account the Claimant's circumstances, but not less than forty-eight (48) hours, to provide the necessary information. Notification of any adverse benefit determination must be made according to the requirements as to method and content set out in Section 4D of this Article VII.

The Administrator must notify the Claimant of the Plan's benefit determination as soon as possible, but in no event more than forty-eight (48) hours after the earlier of: (a) the Plan's receipt of the specified information; or (b) the end of the period afforded the Claimant to provide the specified additional information.

The Claimant may, at his option, extend the time periods specified above for action by the Plan on a claim for Urgent Care benefits.

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Section 4. Appeals Procedure (Continued)

C. Notification of Decisions on Benefit Claims (Continued)

2. **Pre-Service Claims.** In the case of a Pre-Service Claim, the Administrator shall notify the Claimant of the Plan's benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Administrator (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies the Claimant or his authorized representative before the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall describe the required information, and the Claimant or his duly authorized representative shall be given at least forty-five (45) days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination shall be made in accordance with Section 4D of this Article VII.

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Section 4. Appeals Procedure (Continued)

C. Notification of Decisions on Benefit Claims (Continued)

3. **Concurrent Care Claims.** Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that involves Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and the Administrator shall notify the Claimant or his authorized representative of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours before the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Section 4D of this Article VII.

4. **Post-Service Claims.** In the case of a Post-Service claim, the Administrator shall notify the Claimant or his authorized representative of the Plan's adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim, in accordance with Section 4D of this Article VII.

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Section 4. Appeals Procedure (Continued)

C. Notification of Decisions on Benefit Claims (Continued)

4. Post-Service Claims. (Continued)

This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such extension is necessary due to matters beyond the control of the Plan and notifies the Claimant or his authorized representative before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant or his authorized representative to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant or his authorized representative shall be given at least forty-five (45) days from receipt of the notice within which to provide the specified information. For purposes of the various time periods set out in this Section 4C of Article VII, the period of time within which a benefit determination must be made shall begin at the time a claim is filed in accordance with Section 4B of Article VII, above, regardless of whether all the information necessary to make a

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Section 4. Appeals Procedure (Continued)

C. Notification of Decisions on Benefit Claims (Continued)

4. Post-Service Claims, (Continued)

benefit determination is included with the filing. In the event that a period of time is extended as permitted by this Section 4C of Article VII due to the failure of a Claimant or his authorized representative to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant or his authorized representative until the date on which the Claimant or his duly authorized representative timely responds to the request for additional information.

Notwithstanding the foregoing, effective January 1, 2022, a Non-contracted Provider of No Surprises Services will receive an initial payment or notice of denial of payment for No Surprises Services claim within 30 calendar days of the Plan's receipt of the billed charges and all information necessary to adjudicate the claim.

D. Method and Contents of Denial Notices

Any notice of the denial of a claim for benefits shall be given to the Claimant or his authorized representative in a written form. Such notice shall include: (1) the specific reason or reasons for the adverse benefit

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Section 4. Appeals Procedure (Continued)

D. Method and Contents of Denial Notices (Continued)

determination; (2) reference to the specific section of the Rules and Regulations on which the determination is based; (3) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material is necessary; (4) a description of the review procedures set out in this Section 4 of Article VII and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review; (5) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; (6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, 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; and (7) in the case of an adverse benefit

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Section 4. Appeals Procedure (Continued)

D. Method and Contents of Denial Notices (Continued)

determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims.

E. Appealing an Adverse Benefit Determination

Within one hundred eighty (180) days after receipt by the Claimant of written notification of the denial (in whole or in part) of his claim, the Claimant or his duly authorized representative, upon written application to the Administrator, may request a review of such denial. Although the request for review shall be made to the Administrator, the denial shall be reviewed by a committee of reviewers that is independent of the Administrator, as specified below (the "Reviewers"). In the case of a claim involving Urgent Care, a Claimant may make a request for an expedited appeal of an adverse benefit determination to the Administrator orally and all necessary information concerning the Urgent Care claim, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available expeditious method.

The Reviewers' review shall not afford deference to the initial adverse benefit determination and the Reviewers shall not be a person or contain a person who made the adverse benefit determination that is the subject of

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Section 4. Appeals Procedure (Continued)

E. Appealing an Adverse Benefit Determination (Continued)

the appeal or be the subordinate of any individual who made the initial determination. The Reviewers will provide the Claimant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits and will provide a Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. The Reviewers' decision shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If an adverse benefit determination is appealed on the basis of medical judgment, the Reviewers shall consult with an independent health care professional who is qualified in the areas of dispute and who shall not have been involved in the initial claim denial. The Reviewers shall identify 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.

F. Decision on Appeal

The Reviewers shall make a prompt decision on the review of any claim denial. All appeals of adverse benefit determinations shall be decided, and notice of

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Section 4. Appeals Procedure (Continued)

F. Decision on Appeal (Continued)

the decision on appeal shall be given to the Claimant or his duly authorized representative, according to the following timetable:

1. **Urgent Care Claims.** An appeal of an adverse benefit determination involving Urgent Care by a Claimant or his authorized representative shall be decided and notice issued to the Claimant or his authorized representative as soon as possible, but in no event later than seventy-two (72) hours after the Administrator received the request for review on appeal.
2. **Pre-Service Claims.** An appeal of an adverse benefit determination of a Pre-Service Claim by a Claimant or his authorized representative shall be decided and notice issued to the Claimant or his authorized representative within a reasonable period, but not more than thirty (30) days, after the Administrator has received the request for the review on appeal.
3. **Post-Service Claims.** An appeal of an adverse benefit determination of a Post-Service Claim by a Claimant or his authorized representative shall be decided and notice issued to the Claimant or his authorized representative no later than the date of the meeting of the Reviewers that immediately follows the Administrator's

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Section 4. Appeals Procedure (Continued)

F. Decision on Appeal (Continued)

3. Post-Service Clams. (Continued)

receipt of a request for review, unless the request for review is filed within thirty (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 shall 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 shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Reviewers will notify the Claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

- 4. Concurrent Care Claims.** An appeal of an adverse benefit determination involving Concurrent Care by a Claimant or his authorized representative shall be decided and notice issued to the Claimant or his authorized representative as soon as possible, but

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Section 4. Appeals Procedure (Continued)

F. Decision on Appeal (Continued)

4. Concurrent Care Claims (Continued)

in no event later than seventy-two (72) hours after the Administrator has received the request for the review on appeal, if the Claim involves Urgent Care; thirty (30) days, in the case of a Pre-Service Claim; or the time period set forth in Section 4E3 of Article VII, above, in the case of a Post-Service Claim.

G. Contents of Notice of Decision on Appeal. The Reviewers shall provide the Claimant or his duly authorized representative with written notice of the Plan's benefit determination on review in accordance with the applicable time frames set out in Section 4F of Article VII, above. In the case of an adverse benefit determination, the notice shall set forth, in a manner calculated to be understood by the Claimant: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific section of the Rules and Regulations on which the benefit determination is based; (3) a statement that the Claimant is entitled to receive, without charge, reasonable access to any document: (a) the Reviewers relied on in making the determination, (b) submitted, considered or generated in the course of making the benefit determination, (c) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the

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Section 4. Appeals Procedure (Continued)

G. Contents of Notice of Decision on Appeal. (Continued)

denied treatment without regard to whether the statement was relied on;
(4) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical condition, or a statement that this will be provided without charge on request; (5) a statement describing any optional appeals procedures and the Claimant's right to receive information about the procedures, as well as the Claimant's right to bring a civil action under ERISA Section 502(a); and (6) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

H. Disability Claims. Notwithstanding the foregoing, if the claim is for a disability benefit, the Administrator will notify the Claimant within a reasonable period of time of its determination, not later than forty-five (45) days after receipt of the claim by the Administrator. If the Administrator decides that special circumstances require an extension of time for processing the disability benefit claim, the Administrator will

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Section 4. Appeals Procedure (Continued)

H. Disability Claims. (Continued)

provide the Claimant with written notice of the extension, before the end of the initial 45-day period, explaining the reason for the extension and the date the Administrator expects to make a decision. This extension will not exceed thirty (30) days, unless the Administrator determines that the decision cannot be made within the extension period. The Administrator may then begin a second 30-day extension, as long as the Administrator provides the Claimant with written notice, by the end of the first 30-day extension, of the reason(s) for the second extension and the date it expects to render a decision. Both notices for extension will include: (1) the standards on which entitlement to a disability benefit is based, (2) any unresolved issues that prevent a decision on the claim, and (3) the additional information needed to resolve the issues. The Claimant will have forty-five (45) days to provide any specific information needed by the Administrator. If the claim for a disability benefit is denied, the Administrator shall provide the Claimant with a notice as set forth in Section 4D of Article VII, but without regard to Subsection (7).

In the case of an appeal of a claim for a disability benefit, except as provided below with respect to applicable timeframes in which a decision must be made, the provisions of Section 4E of this Article VII shall apply. An appeal of an adverse benefit determination of a disability claim by a

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Section 4. Appeals Procedure (Continued)

H. Disability Claims. (Continued)

Claimant or his authorized representative shall be decided and notice issued to the Claimant or his authorized representative 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 thirty (30) days preceding the date of such meeting.

In such case, a benefit determination may be made not 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 shall 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 shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Reviewers will notify the Claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

If the claim for a disability benefit is denied, the Administrator shall provide the Claimant a notice as set forth in Section 4G of Article VII,

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Section 4. Appeals Procedure (Continued)

H. Disability Claims. (Continued)

except without regard to the timeframes mentioned in the first sentence thereof.

If a claim for disability benefit, including a claim related to a rescission of coverage, is filed on or after April 1, 2018, the Administrator shall provide the Claimant with a notice as set forth in Section 4.D of Article VII, but without regard to Subsection (7), and the following additional information:

(1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's claim, without regard to whether the advice was relied upon in making the benefit determination, and/or disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; (2) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Rules and Regulations relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Rules and Regulations

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Section 4. Appeals Procedure (Continued)

H. Disability Claims. (Continued)

do not exist; (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits (as described in Section 4.E of Article VII); and (4) a statement prominently displayed in any applicable non-English language, as defined in guidance published by the Secretary of Labor pursuant to 29 C.F.R. § 2560.503-1(o), clearly indicating how to access the language services provided by the Plan.

In the case of an appeal of a claim for a disability benefit, including a claim related to a rescission of coverage, filed on or after April 1, 2018, the provisions of Sections 4.E and 4.G of Article VII shall apply, except as provided above with respect to the applicable timeframes in which a decision must be made, and with the addition of the following requirements: (1) before the Plan can issue an Administrator will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Reviewers, Plan, or other person making the benefit determination (or at the direction of the Reviewers, Plan or such other person) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review

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Section 4. Appeals Procedure (Continued)

H. Disability Claims. (Continued)

is to be provided to give the Claimant or his duly authorized representative a reasonable opportunity to respond prior to that date; (2) before the Plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the Administrator will provide the Claimant, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is to be provided to give the Claimant or his duly authorized representative a reasonable opportunity to respond prior to that date; (3) any notification of benefit determination on appeal shall include the information described in Section 5 of Article VII, and shall include a statement indicating that the Claimant's right to bring a Section 502 claim is subject to the limitations period set forth in Section 5 of Article VII, including the calendar date on which the contractual limitations period expires for the claim.

- I.** Effective January 1, 2022, if a Claimant receives an adverse benefit determination that relates to a No Surprises Service, the Claimant may be entitled to appeal the decision to an external independent review organization ("IRO") within four months of the receipt of the adverse determination on appeal. External review is limited to claims involving

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Section 4. Appeals Procedure (Continued)

I. (Continued)

whether the Plan is complying with the surprise billing and cost sharing protections under the No Surprises Act. No other denials will be reviewed by an IRO unless otherwise required by law. Requests for external review must be filed with the Plan Office. All such external review requests shall, within five business days following the receipt of the external review request, receive a preliminary review to determine whether: the Claimant is or was covered under the Plan at the time the health care item or service was provided; the request for external review concerns payment for No Surprises Services; the Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeal process; and the Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Administrator will issue a written notification of its determination to the Claimant, including, if applicable, the reason for the request's ineligibility for external review or a description of any information or materials necessary to perfect the request for external review. If additional information or materials are necessary, the Claimant shall have

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Section 4. Appeals Procedure (Continued)

I. (Continued)

until the later of the four-month filing period or 48 hours following receipt of the written notification to provide the additional information or materials. Upon completion of a preliminary review that determines that the matter is eligible for external review under these procedures, the Administrator shall refer the matter to an IRO. The determination of the IRO shall be binding except to the extent that other remedies may be available under federal law. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination on appeal, the Plan shall immediately provide payment for the No Surprises Service claim.

Section 5. 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

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Section 5. Civil Actions (Continued)

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, an Eligible Employee, Pensioner, 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 an Eligible Employee, Pensioner, and his or her 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.

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ARTICLE VIII
RECIPROCAL BENEFITS BETWEEN THE M.M. & P.
HEALTH AND BENEFIT PLAN and THE ARA WELFARE PLAN

Section 1. Purpose

Reciprocal health and welfare benefits are to be provided for Plan Participants who, because of transfer of participation between the M.M.& P. Plan and another maritime multi-employer welfare plan with which the M.M.& P. Health and Benefit Plan has a reciprocity arrangement pursuant to an agreement between the Organization and the union whose members participate in such other maritime multi-employer welfare plan (individually and collectively referred to hereinafter as "Plan" or "Plans") may become ineligible for health and welfare benefits or qualify for a reduced benefit under either Plan.

Section 2. Signatory Funds

- A. Under this reciprocity agreement, the "Host Fund" shall transfer contributions to the "Primary Fund", subject to the conditions set forth in Section 4. The terms "Host Fund" and "Primary Fund" shall have the respective meanings set forth in Section "3".
- B. Each Plan will retain its own Plan Year.
- C. Eligibility for benefits under each respective Plan shall be determined on the basis of the rules and regulations of each Plan.

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Section 3. Definitions

- A. "Temporary Participant" means, with respect to each Plan, an employee who (i) was, or is, a Participant in a Plan maintained by a Fund, and either (ii) was a Participant in the Plan maintained by the other Fund prior to such participation in (i) above, or (iii) has requested, in the manner provided in subsection (D), that he be deemed a Participant in the Plan maintained by the other fund and is licensed for employment in the job classifications covered by the collective bargaining agreements pursuant to which the other fund was established and is maintained.
- B. "Host Plan" means, with respect to each Temporary Participant, the Plan maintained by a Fund to which employer contributions are required on account of a Participant's employment subsequent to his commencement of participation in the Primary Plan.
- C. "Primary Plan" means, which respect to each Temporary Participant, the Plan maintained by a Fund in which an employee participated prior to the first date on which he was employed under conditions requiring contributions to the Host Plan, or in which the employee has requested to be deemed a participant, pursuant to subsection (A) (iii).
- D. A request by an employee pursuant to subsection (A) (iii) shall be made in writing and filed with the Plan Administrator. Such request shall be filed prior to the date on which, in the absence of such request, the employee would become a participant in the Plan other than the Plan in which he wishes to be deemed a Participant.

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Section 4. Transfer of Contributions Attributable to Temporary Participant (Continued)

B. (Continued)

2. (Continued)

agreement, the agreement requiring the smallest employer contributions shall be the collective bargaining agreement of reference.

C. Amounts required to be transferred under the terms of this Section shall be transferred within 30 days after the receipt of the employer contributions attributable to the employment of a Temporary Participant.

D. In the event than an employer is delinquent in making contributions to the Host Plan, the Primary Plan shall suspend any credit to the Temporary Participants of such employer until such delinquencies are satisfied.

If it is necessary for a Host Plan to undertake collections procedures against a Temporary Participant's employer, the Host Plan shall deduct from the amount determined under subsection (B) of this section the amounts expended in collecting the delinquencies.

Section 5. Crediting of Employment of Temporary Participants

A. For each Temporary Participant, employment for which employer contributions to a Host Plan are made shall be treated for all purposes as if it were employment for which contributions are made to the Primary Plan.

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Section 5. Crediting of Employment of Temporary Participants (Continued)

- B. In the event contributions are transferred by the Host Plan to the Primary Plan pursuant to Section 4, the Host Plan shall not credit any service by such Temporary Participant for purposes of determining eligibility for or the amount of benefits under the Host Plan.
- C. This provision is not intended to alter or modify in any way the existing eligibility rules of the Primary Plan or the Host Plan.

Section 6. Arbitration

This provision shall apply for purposes of this Article, notwithstanding any provision in either Plan to the contrary. Any dispute, controversy or claim arising out of or relating to the application of this Reciprocal Agreement, or any portion thereof, shall be settled by arbitration before an arbitrator designated by the American Arbitration Association in accordance with its then prevailing rules. The award of the arbitrator shall be final, binding and conclusive upon the parties to the dispute and may be enforced in any federal court of competent jurisdiction.